2025
BENEFITS GUIDE

accupac

WELCOME TO **ACCUPAC'S ANNUAL OPEN ENROLLMENT!**

Here's where to find ...

Accupac is pleased to present your 2025 Open Enrollment information. During Open Enrollment, you must actively enroll in benefits, or you will not have benefits effective January 1, 2025. This Open Enrollment newsletter explains your benefit options available to you and what is changing for the new plan year. Our benefit plan year will be from January 1, 2025 through December 31, 2025.

Each year, Accupac takes a close look at our benefits package to ensure that we offer the best value and quality coverage for you and your family. For the year to come, please make sure to evaluate your needs, learn about your benefit options, and make smart decisions about your health and well-being. We will continue to offer a comprehensive selection of benefits that you and your family can use to protect your health, finances, and future.

For any questions regarding 2025 Open Enrollment, please reach out to Health Advocate at 866-799-2691.

A few notes about enrolling in benefits

The choices you make during enrollment will be in effect for the 12-month plan year from January 1, 2025 to December 31, 2025. However, you may make changes during the year if you experience a qualified life event. If you need to report a status change during the year, you will need to contact the Human Resources Department with the necessary changes within 31 days of the event.

Here are some examples of qualifying life events:

- Birth, legal adoption or placement for adoption.
- Marriage, divorce or legal separation.
- Dependent child reaches age 26.
- Spouse gains or loses employment or eligibility with their current employer.
- Death of your spouse or dependent child.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program.
- Change in residence that changes coverage eligibility.
- Court-ordered change.

Dependent Eligibility

You may enroll your eligible dependents when you enroll yourself. Dependents who are eligible for benefit coverage include:

- Your legally married spouse*
- Your dependent children

** See Spousal Exclusion at right*

Included in the definition of dependent child(ren) are:

- Your naturally born child(ren), legally adopted child(ren), step-child (ren), or court-ordered dependent child(ren) for whom you are the court-appointed legal guardian
- Your dependent child(ren) up to age 26 whether they are a fulltime student or not. Coverage ends at the end of the month following the date they turn 26.
- Your continuously disabled dependent child(ren) [if disabled prior to age 26] who are incapable of self-sustaining employment and dependent upon you for support, regardless of age

Spousal Exclusion

If your spouse is employed with another employer and is eligible for his/her employer's group medical, prescription, dental and vision coverage, your spouse is not eligible to enroll in Accupac's medical, prescription, and dental and vision plans. This exclusion applies regardless of whether the available coverage is contributory or non-contributory. If your spouse does not have coverage available through his/her employer or is unemployed, the spousal exclusion may be waived by submitting a Spousal Coverage Certification. If your spouse is employed with Accupac, employee and spouse can enroll in the same Accupac plan.

Dependents may now be covered under the dental plan until age 26.

HOW TO ENROLL

This year's Open Enrollment is an "active" enrollment. If you don't take action and you don't enroll in benefits, you will not have benefits effective January 1, 2025. Current elections will not rollover!

Enroll in your Benefits

For this year's Open Enrollment, employees will actively enroll online through Benetrac.

To access Benetrac, employees will log in to your PayChex FLEX accounts at www.paychexflex.com. Once you are logged in, you can access the "Benefits" tab which will direct you to Benetrac for enrollment. If you do not have a PayChex account, you will need to create one. Talk with your payroll administrator and request a copy of your Worker Profile, which is available from your record in the People List by clicking Get Profile. This gives you key information that's needed to sign up.

Once in Benetrac, you can manage and enroll in Accupac's 2025 benefits:

1. Click I AGREE when prompted.
2. Click PROCEED TO MY BENEFITS.
3. For each benefit listed by your employer, click MANAGE BENEFIT

To enroll in a benefit:

1. Select Add or View Plan/Options if you were not previously enrolled in the benefit, or select Change or View Plan/Options if you are currently enrolled.
2. You may be prompted to select dependents, answer pre-enrollment questions, or identify as a smoker or non-smoker.
3. Select a Plan(s).
4. Note: The employee cost displayed is based on the number of family members you selected in the previous step. If you want to compare costs, you can change the number of dependents on the plan by clicking GO BACK and unchecking the boxes next to the dependents' names.
5. The reason is automatically set to Open Enrollment.
6. Click I AGREE.

To terminate a benefit you are currently enrolled in:

1. Select Decline Benefit.
2. Select an option from the Reason drop-down menu.
3. The Event Date will automatically populate.
4. Click I AGREE.

To review and finalize your benefits elections after managing all of your available benefits:

1. Click REVIEW & FINALIZE.
2. Review the elections listed.
3. To change any of the benefits you selected, click RETURN TO MY BENEFITS.
4. Make any necessary changes and click REVIEW & FINALIZE again.
5. Review the elections listed.
6. Click AGREE TO ABOVE AND FINALIZE MY SELECTIONS.

Note: The system will automatically decline any benefits you did not actively enroll in if you are not currently enrolled in that benefit.

EMPLOYEE ADVOCACY THROUGH HEALTH ADVOCATE!

Navigate your Accupac Benefits with an Advocate by your side!

Navigating the healthcare system can be tough. And sometimes just finding the right answer takes more time than any of us have in our busy lives. Accupac's goal is to simplify your healthcare experience. That's why Accupac continues our offering through Health Advocate to provide custom employee support for enrolling in benefits and answering questions after open enrollment.

Health Advocate works with LanguageLine to support multiple languages. All you have to do is let the Advocate know what your preferred language is, and our Advocate will dial in the interpreter. The Advocate proceeds to speak to you, as the interpreter provides live translation.

During anytime time of the year, you and your family members can reach out to Health Advocate with questions like:

- Who can I call for help?
- What questions should I ask my doctor?
- Can you explain/fix my bill?
- Is this doctor in-network? How does his/her costs compare to other Doctors in my area?

For Open Enrollment, you can reach out to Health Advocate with questions like:

- Can you walk me through the various medical and prescription drug plan options?
- Based on my needs, which plan seems best suited for me and my family?
- How will the various deductibles, copays and coinsurance affect me?
- And more!

AETNA MEDICAL PLANS

Accupac is committed to helping you and your dependents maintain your health and wellness by providing you with access to the highest levels of care. We offer you a choice of three medical plan options for 2025:

- **AETNA HEALTH MAINTENANCE ORGANIZATION (HMO) SELECT PLAN**
  Under the Aetna HMO plan, or "Aetna Select" you must select a Primary Care Physician (PCP) to handle all of your care and you are required to obtain a referral to see a specialist. The PCP may be a family doctor, pediatrician, or general practitioner that will provide your care and will refer you to specialists or facilities for treatment when medically necessary. Your PCP will provide routine care for illness, injury, and preventive care such as periodic physical exams, eye exams, well-baby visits, and immunizations. You may change your PCP at any time by calling Aetna Member Services or by accessing Aetna Navigator online. To find a provider search under "Aetna Select."
- **AETNA CHOICE POINT-OF-SERVICE II (POS) PLAN**
  Aetna's Choice POS II Plan gives you the choice of selecting a primary care physician and the option to self-refer when you need specialty care. Each time you need care, you may see your PCP, who will provide basic, routine services and referrals for specialty care. Or you may seek care on your own, without the help of your PCP. Benefits are highest and your out-of- pocket cost lowest when care is provided or coordinated by an in-network provider. To find a provider search under: Aetna Choice POS II (Open Access).
- **AETNA HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**
  Aetna's HDHP Managed Choice Plan is designed to give you more control and responsibility over how you spend — or save your health care dollars. Once the deductible is met, the plan pays 100% for in-network services. Although the HDHP option has a higher deductible, your payroll deductions will be lower. Additionally, you are eligible for an HSA if you are enrolled in the HDHP. You may use the money in your HSA to pay all or a portion of your annual deductible, copayments, coinsurance, or other eligible out-of-pocket costs. Refer to page 6 for more information on how the HDHP and HSA work. To find a provider, search under: Aetna Choice POS II (Aetna Health Fund).

We will continue the health savings account (HSA) which can be paired with the HDHP to help you save on eligible health care expenses.

Aetna offers a large network of health care professionals that provide quality and cost-effective care. To find a participating network provider, visit DocFind online at www.aetna.com.

Accupac will give a $25 reward in 2025 for anyone and their dependents under the age of 18 that receives their Annual Physicals. In order to be eligible, you must be enrolled in Accupac's medical insurance plan.

Annual physicals are considered preventative and covered at 100% on ALL plans.

A few examples of preventative visits are: Annual Well Check with your PCP, Preventative Mammograms, Preventative Colonoscopies, OB-GYN Visit, etc.

Medical Plan Summaries

Side-by-side

	HDHP Managed Choice		HMO Select	Choice POS II	
	You Pay In-network	You Pay Out-of-network	You Pay In-network Only	You Pay In-network	You Pay Out-of-network
Annual Deductible					
Individual	$3,300	$5,000	$1,500	$1,000	$2,000
Family	$6,600	$10,000	$3,000	$2,000	$4,500
Referral Required?	No	No	Yes	No	N/A
Out-of-pocket maximum (includes deductible)					
Individual	$6,600	$10,000	$4,000	$6,600	$25,000
Family	$13,200	$20,000	$8,000	$13,200	$50,000
Selection of PCP Required?	No	N/A	Yes	No	N/A
Preventive care	$0	40% after ded	$0	$0	40% after ded
Office visit					
PCP Copay	30% after ded	40% after ded	$40 ded waived	$20 ded waived	40% after ded
Specialist Copay	30% after ded	40% after ded	$80 ded waived	$40 ded waived	40% after ded
Mental Health	30% after ded	40% after ded	$40 ded waived	$20 ded waived	40% after ded
Diagnostic Procedures					
X-Ray	30% after ded	40% after ded	30% after ded	30% after ded	40% after ded
Laboratory	30% after ded	40% after ded	0% after ded	0% after ded	40% after ded
Complex Imaging	30% after ded	40% after ded	30% after ded	30% after ded	40% after ded
Emergency room	30% after ded	30% after ded	$350 ded waived	$250 ded waived	$250 ded waived
Urgent care	30% after ded	50% after ded	$100 ded waived	$50 ded waived	40% after ded
Inpatient care	30% after ded	40% after ded	30% after ded	30% after ded	40% after ded
Outpatient care	30% after ded	40% after ded	30% after ded	30% after ded	40% after ded
Teladoc (General Medicine; Non-Specialist)	$56	N/A	$0 ded waived	$0 ded waived	N/A
Durable Medical Equipment	30% after ded	40% after ded	50% after ded	30% after ded	40% after ded
Vision Eyewear (once every 24 months)	Up to $100 allowance		Up to $100 allowance $50 eye exam	Up to $100 allowance	

Effective Jan. 1, 2025

Medical and prescription biweekly employee payroll contributions

	HDHP Managed Choice	HMO Select	Choice POS II
Employee	$61.96	$108.03	$131.00
Employee + spouse	$184.14	$273.43	$311.13
Employee + child(ren)	$148.02	$222.52	$260.41
Family	$248.95	$367.83	$425.59

Employees who use tobacco/nicotine contributions

	HDHP Managed Choice	HMO Select	Choice POS II
Employee	$96.58	$142.65	$165.62
Employee + spouse	$218.76	$308.05	$345.74
Employee + child(ren)	$182.63	$257.13	$295.02
Family	$283.56	$402.45	$460.21

TOBACCO CESSATION

Tobacco/Nicotine Surcharge

If you are a tobacco/nicotine user, a $75 monthly surcharge will be added to your medical /Rx contributions beginning January 1st, 2025, through December 31st, 2025. This surcharge can be removed by completing the Aetna "Say Goodbye to Tobacco" pathways. Not only will completing these pathways help you save on your biweekly medical/Rx contributions, but you will also begin your journey towards breaking your tobacco/nicotine habits.

To complete this program, visit Aetna.com and log in to your member portal. Within the member portal, select "Well Being Resources" and choose the "Say Goodbye to Tobacco" Pathway. Within the Pathway, there are 4 goal-oriented steps. **All 4 steps must be completed in their entirety before June 30th to have the surcharge removed.**

What Are the Goals of This Program? The tobacco cessation program focuses on avoiding triggers and learning how to replace the habit. The pathway includes various phases such as contemplation, ready to quit and quit. During the contemplation phase, Pathways provides members with educational support. Once members progress to the ready phase, Pathways will introduce new habits to help displace tobacco consumption.

How Long Will This Program Take to Complete? The duration of the tobacco cessation pathway varies depending on the goals set, which are dynamic based on the pathway type. However, the minimum duration is 6-weeks, but may be longer. Be sure to begin your journey well before June 30th!

DEADLINE TO COMPLETE: Employees have until **June 30th, 2025, to fully complete the Aetna "Say Goodbye to Tobacco" pathways.** If you complete the full program by June 30th, 2025, you will be reimbursed back to January 1st, 2025, the difference between tobacco/nicotine free contributions and tobacco/nicotine user contributions. Additionally, starting July 1st, 2025, your biweekly contributions will be changed to the non-tobacco/nicotine user contributions.

Go Generic! Keep You and Your Wallet Healthy

1. **What are generic drugs?**
   Generic drugs are prescription medications that have the same active ingredients, dosage amounts, strength, safety, and quality as brand-name prescription medications.
2. **Are generic drugs just as safe as brand-name drugs?**
   Yes. Laboratories that produce generic drugs must meet the same high FDA standards as the facilities of brand-name drugs, and all generic drugs are FDA-approved to be therapeutically equivalent to brand-name drugs.
3. **Why are generic drugs less expensive?**
   When a new medicine is invented, a patent is filed so that no other company may reproduce that drug. While the patent is current, companies can charge a much higher price for the drug because there is no competition. In addition, companies often spend large amounts of money for advertising and promotion, further increasing the cost of the brand name medication.

   When a medication's patent expires, other companies may produce this drug, creating generic medications. Due to increased competition, and because these other companies rarely spend money on advertising, the price of the generic drug is significantly lower.
4. **What is different about generic?**
   The appearance of brand-name drugs is protected by law, so generic drugs will have different shapes, flavors, and/or colors. However, since the active ingredients are the same, they will work the same way in your body as the brand-name drug.
5. **Does every brand-name drug have a generic drug equivalent?**
   No. Pharmaceutical companies have a patent on their brand name medications, so new drugs will not have a generic equivalent until the patent expires.
6. **What if my brand-name drug is not available in generic form?**
   Even if your brand name drug is not available in generic form, there may be a different generic drug that could work just as well. Ask your doctor if a therapeutic alternative might be right for you. A generic therapeutic alternative is the equivalent for a different brand-name drug and treats your condition using a different active ingredient. If your doctor agrees, you can feel confident about using the generic therapeutic alternative and feel good about saving money too!

CVS PRESCRIPTION DRUG COVERAGE

When you enroll in an Accupac medical plan, you automatically receive prescription drug coverage through the CVS Pharmacy. Your Prescription drug plan will be administered through CVS Employers Health effective January 1, 2025. There is a dedicated Customer Care team available 24 hours a day, seven days a week. They can be reached at 844.371.0844.

	HDHP Managed Choice		HMO Select	Choice POS II	
Retail (30-day Supply)	In-network	Out-of-network	In-network Only	In-network	Out-of-network
Tier 1 - Generics	$25 after ded	40% of submitted cost after the applicable preferred copay	$25 ded waived	$25 ded waived	50% of submitted cost after the applicable preferred copay
Tier 2 - Preferred	$50 after ded		$50 ded waived	$50 ded waived	
Tier 2 - non-preferred	$75 after ded		$75 ded waived	$75 ded waived	
Mail Order (90-day Supply)	In-network	Out-of-network	In-network Only	In-network	Out-of-network
Tier 1 - Generics	$50 after ded	N/A	$50 ded waived	$50 ded waived	N/A
Tier 2 - Preferred	$100 after ded		$100 ded waived	$100 ded waived	
Tier 2 - non-preferred	$150 after ded		$150 ded waived	$150 ded waived	

Save Money - Use Mail Order!

The prescription plan also includes the CVS Caremark Mail Service Pharmacy, which allows you to purchase a 90-day supply of medications you take on an ongoing basis (known as maintenance drugs). You don't have to worry about making a trip to the pharmacy every 30 days, and 90-day supplies typically cost less than three separate 30-day supplies.

To enroll, call Customer Care at 844-371-0844 or register at www.caremark.com/startnow and follow the guided steps to request a prescription.

Fill your prescriptions on time

CVS offers convenient options for filling your medication so you never run out. Choose the one that's right for you.

- Pick up your refills at any CVS Pharmacy®. With more than 9,900 locations, there's always one nearby
- Have refills delivered to your door. You'll pay just one copay* for a 90-day supply with no-cost shipping from CVS Caremark® Mail Service Pharmacy
- Let us manage your refills. Sign up for automatic refills at Caremark.com or in our mobile app

Caremark Cost Plus:

Aetna partners with GoodRx to provide members access to Caremark Cost Plus, which will help you save money on prescription drugs. Members should continue to use your ID card when picking up your prescriptions, and on the back end, best prices will now automatically be applied. This is now a seamless process to help you avoid spending time shopping around for the best price. Member's out-of-pocket expenses will automatically apply to your deductible and out-of-pocket threshold.

Specialty Medications: CVS Specialty provides specialized care and support along with your medication for complex conditions (such as rheumatoid arthritis, multiple sclerosis, HIV and cancer).

You are given a CVS Specialty CareTeam led by pharmacists and nurses to support you 365 days a year. They'll show you how to take your medication correctly, help you manage side effects and stay on track. Helpful resources are available at CVSspecialty.com/EducationCenter. A choice of pick up at **CVS Pharmacy® or home delivery at no extra cost.**

Specialty Drug Program - PrudentRx: PrudentRx is integrated into the POS and HMO prescription drug plans to help curb the increasing costs of specialty drugs. When utilizing this program, you will spend $0 out-of-pocket for any specialty medication on the specialty drug list if you participate in the program.

All eligible members' enrollment will begin automatically in the PrudentRx program, but members can choose to opt out of the program by calling **1-800-578-4403**. Some manufacturers require members to actively sign up to obtain the copay assistance that they provide for their medications. PrudentRx will contact members if they are required to enroll in the copay assistance for any medication that they take.

Save time, keep costs down and stay on top of your prescriptions. Do it all at Caremark.com and the CVS Caremark mobile app.

- Find a network pharmacy to keep medication costs as low as possible
- See if a medication is covered to get the most affordable option
- Compare drug costs to see where you can save
- Sign up to get email or text messages about your prescriptions and more
- Request refills and keep track of prescriptions for your family

HSA AND HIGH DEDUCTIBLE HEALTH PLAN
FREQUENTLY ASKED QUESTIONS

If you elect the HDHP, you will be provided with the opportunity to enroll in a health savings account that you can use in conjunction with the consumer-driven health plan. Below are frequently asked questions and answers surrounding the HDHP and HSA.

What is an HSA?

The HSA is a tax-favored account used in conjunction with an HSA-compatible health plan. The HSA allows you to contribute funds on a pre-tax or tax-deductible basis, which you may use to pay for eligible medical, dental and vision expenses. Eligible expenses are defined by the IRS Publication 502 on www.irs.gov. If you don't use all the money in your account, the balance rolls over to following years. Those dollars continue to earn interest — and continue to be available for medical expenses year after year.

Who is eligible to establish an HSA?

You are eligible to open an HSA provided you have met the following criteria:

- Must be enrolled in a HDHP and not also be covered by another health plan that is not a HDHP
- Not listed as a dependent on another person's tax return
- Not be enrolled in Medicare

How is an HSA-eligible HDHP plan different than a traditional health plan?

Health insurance premiums are lower than the cost of traditional health insurance. The average premium reduction is 20-30% as compared to traditional health insurance.

How can an HSA save me money?

The principal balance may be held in a guaranteed fixed interest rate investment option. Interest is tax-free and higher than in many other types of savings accounts. Distributions for qualified expenses are also tax-free.

Can I still go to my regular doctor?

Yes. With an HSA eligible HDHP, you are free to use any in-network doctor and hospital you choose. With an HSA eligible HDHP, you will still have an insurance ID card, and you will need to make sure that you present this card anytime you go to the doctor or pharmacy. This will ensure that you always get any network discounts available to you, and your medical provider will be able to file a claim with Aetna so any out-of-pocket amounts will be applied to your deductible.

How does it work?

Since an HSA is a tax advantaged account, you will need to be able to prove that money you spend from your HSA is for eligible medical expenses. Remember to save your receipts for all of your HSA expenses. You are not required to submit your receipts when you use your funds, but you will need them if you are ever audited by the IRS. You can use your HSA debit card to pay for expenses when you are billed, or you can pay out-of-pocket and reimburse yourself at a later date.

Will I have to pay whatever the doctor charges me and how will I be able to obtain a timely reimbursement?

In most cases, doctors are generally encouraged to wait for the insurance company to process your claim before they request payment from their patients. You should also wait for your insurance to process your claim before making any payment to the providers. Aetna negotiates a price with its network doctors which is usually much less than what the doctor typically charges, and that savings is passed on to you.

Does having an HSA affect my participation in a health care FSA?

If you are enrolling in the HDHP and currently have an FSA, you cannot contribute to an HSA at the same time. These are IRS rules and can be referenced at www.irs.gov.

How much can be in the HSA account?

For 2025, you can save up to the maximum contribution limit of $4,300 for an individual HSA health plan and $8,550 for a family HSA health plan each year.

If you are married and your spouse has a family HDHP, then both spouses are determined to have family coverage. This is true even if one spouse has a family plan and the other has a self-only plan. Each spouse may have an HSA, and together you may contribute up to the family limit. You may not each contribute up to the family limit.

If you are age 55 and older you may contribute an additional $1,000 to your HSA. This is a "catch up" contribution that may be made each year that you are eligible for a HDHP. You may no longer contribute once you enroll in Medicare.

Is the HSA account portable?

Yes. You keep your HSA even if you change jobs, change medical coverage, retire or make other life changes.

Who Administers the HSA?

Accupac partners with Inspira to manage your HSA. When you enroll in the HDHP, you will need to open an HSA through Inspira. You will receive an Inspira card in the mail which will help make it easy for you and your family members to pay for eligible expenses with the funds in your account.

There is a $4.20 Monthly Account Maintenance Fee associated with your Inspira HSA.

You can access your account online at inspirafinancial.com, where you can view educational materials, forms, frequently asked questions and eligible expense listings. You will need to register your first time logging in. Inspira customer service representatives are also available to help you with any questions. To speak with a representative, call the toll free number at 1-844-729-3539.

CVS MINUTE CLINIC

Sometimes things just happen. Your kid develops flu symptoms after your primary care office has closed for the day. You step on a tack over the weekend. We get it, things happen, and when they do, you want to be able to access care at a price you can afford. That's why we're offering a new perk to eligible Aetna members: access to all covered MinuteClinic services at no cost to you, or low cost to you, based on your plan design.

What is MinuteClinic?

- MinuteClinic is a walk-in clinic inside select CVS Pharmacy® and Target stores and is the largest provider of retail health care in the United States, making it easy to access care in your neighborhood.
- MinuteClinic offers a broad range of services to keep you and your family healthy. MinuteClinic health care providers treat and diagnose a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate.
- The MinuteClinic program is fully integrated into Aetna's web and mobile tools and its provider search functionality. Members can use the provider search to lookup nearby MinuteClinic locations and estimate the cost of services compared to other sites of care. When members perform a search based on specific conditions, MinuteClinic locations will be highlighted when appropriate.

How do I use MinuteClinic

It's as simple as going to your local physician and receiving care. Your covered family members can take advantage of this benefit, too. You can walk in or schedule appointments online beforehand. And for even more convenience, you can pick up your prescription on-site. MinuteClinic is open 7 days a week, including evenings and weekends.

For your best health, we encourage you to have a relationship with a primary care physician or other doctor. Tell them about your visit to MinuteClinic, or MinuteClinic can send a summary of your visit directly to them.

Note: Eligible Aetna members who enroll in qualified high-deductible health plans will receive lower-cost care for covered minor illness and injury services provided at MinuteClinic and can receive preventive services at no cost share. However, in order to receive no-cost care on all covered services, they will need to first meet their deductible. Once the deductible has been met, those members will be able to access covered MinuteClinic services at no cost share.

TELADOC

All Accupac Aetna members will automatically be enrolled in Teladoc. Teladoc gives you 24/7/365 access to a doctor through the convenience of phone or video consults. It's an affordable option for quality medical care.

Why Should I Use Teladoc

- Talk to a doctor anytime, anywhere you happen to be
- Receive quality care via phone or online video
- Prompt treatment - average call back in 16 minutes
- A network of doctors that can treat children of any age
- Secure, personal & portable electronic health record (EHR)
- No limit on consults

When Can I Use Teladoc?

- When you need care now
- If your doctor is unavailable
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Get the Care You Need

Teladoc doctors can treat many medical conditions, including

- Cold & flu symptoms
- Allergies
- Bronchitis
- Skin problems
- Respiratory infection
- Sinus problems
- And more!

Accupac Employee Testimonial:

"When I called Teladoc for the first time, I couldn't believe how easy it was. I was home sick with a toddler and going to the doctor's office wasn't ideal since it was flu season. I called, spoke to a doctor, and was diagnosed over the phone. The doctor then called me in a prescription. The process couldn't have been easier."

Cost Summary

	HDHP Managed Choice	HMO Select	Choice POS II
General Medicine (Non-Specialist)	Deductible Then 20%	No Charge	No Charge
Behavioral Health	Deductible Then 20%	$30 Copay	$20 Copay
Dermatology	Deductible Then 20%	$50 Copay	$40 Copay

You can see a Psychiatrist and Dermatologist through Teladoc!

Talk to a doctor anytime at no cost

- Teladoc.com/Aetna
- 1.855.Teladoc (835-2362)
- Facebook.com/Teladoc
- Teladoc.com/mobile

**$0 copay only applies to the HMO Select and Choice POS plans. if you are enrolled in the HDHP and have satisfied your deductible, please bring proof of your non-specialist general medicine Teladoc visit to HR and you will be reimbursed the amount of visit.*

WHERE DO I GO FOR CARE?

If you're faced with a sudden illness or injury, making an informed choice on where to see medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. If you suddenly fall ill or become injured, how can you determine which facility is most appropriate for your condition?

Doctor's Office

When you have any medical concerns, your primary doctor can oversee your care and provide routine services.

- Routine check-ups
- Immunizations
- Preventative services
- Manage your overall health

Teladoc

You have access to Teladoc from anywhere - home, work, or on the road - and let the doctor come to you! Teladoc doctors diagnose nonemergency medical problems, recommend treatment, and can even call in a prescription to your pharmacy of choice, when necessary.

- Respiratory infections
- Ear infections
- Urinary tract infections
- Allergies
- Colds and flu
- Sore throat

Urgent Care

Urgent care centers are not equipped to handle life-threatening injuries, illnesses or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.

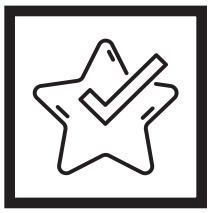
- Controlled bleeding or cuts that require stitches
- Diagnostic services (x-rays, lab tests)
- Ear infections
- High fever or the flu

Emergency Room

The emergency room (ER) is equipped to handle life-threatening injures and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to other patients.

- Compound fractures
- Deep knife or gunshot wounds
- Moderate to serious burns
- Poisoning or suspected poisoning
- Seizures or loss of consciousness
- Serious head, neck or back injuries

Choosing the appropriate place of care will not only ensure prompt and adequate medical attention, but will also help reduce any unnecessary expenses. Although urgent care centers are usually more cost-effective, they are not a substitute for emergency care.



AETNA HEALTH & WELLNESS

There are added-value benefits available through your medical plans that are designed to encourage healthy behaviors. Additionally, discounts are available on products and services to help improve your health and save you money. Visit www.aetna.com for access to the following programs:

Through Aetna's Health and Wellness Programs, you can receive discounts on:

- Gym memberships
- Home exercise products and equipment
- Eye care, eyewear, and accessories
- LASIK eye surgery
- Over-the-counter vitamins
- Massage therapy
- Chiropractic visits
- Acupuncture
- Dietetic counseling
- Hearing aids and exams
- Weight Management Programs
- Aetna Natural Products and Services℠
- Vitamins
- Water Piks

Programs to help manage your health

Acupuncture: This is a covered benefit under the Accupac medical plan.

Simple Steps: Includes programs for smoking cessation, stress management, dealing with depression, nutrition and diet information, as well as an on-line Health Risk Assessment.

Informed Health Line: — You have 24/7/365 access to the Aetna online medical database for health information and to speak with a registered nurse for questions on health issues.

The following programs add value to your plan and are yours at no additional cost just because you're an Aetna member:

- National Medical Excellence Program
- Fitness Program
- Vision Programs
- Alternative Health Care Programs
- Informed Health Line®

Get Active!℠: Features an online fitness and nutrition tracker, team-based challenges, social networking, emails, newsletters, activity tracking, full reporting capabilities, and the option to purchase a welcome kit that includes a pedometer.

Get Active! is a year-round program that offers inviting, seasonal challenges to keep people moving and motivated through the year. It starts with an eight-week team challenge and continues with other shorter challenges. All are supported by the program's social networking component, which drives engagement and helps create lasting behavior change.

Member Payment Estimator: Log on to Aetna Navigator to find out what a medical service will cost before you make the appointment. This tool will let you compare costs for up to three local providers or facilities at a time and provide you with a real-time cost estimate based on your plan.

Aetna Member Website: As an Aetna member, you have access to Aetna Member Website, your online resource for personalized benefits and health information. Aetna members can take full advantage of the interactive website to complete a variety of self-service transactions online. You can access the site 24 hours a day, 7 days a week—from wherever you have Internet access.

Aetna Member Website helps you make the most of your benefits plan. You can:

- Review who is covered on your plan
- Obtain instant eligibility information or a replacement member ID card
- Check the status of a medical or pharmacy claim
- Research the price of a drug and learn if there are less-costly alternatives
- Price a medical procedure
- Contact Aetna Member Services

SUPPLEMENTAL HEALTH BENEFITS

Aetna Critical Illness Insurance

Critical Illness Insurance provides a cash benefit when a covered person is diagnosed with a covered critical illness or event after coverage is in effect.

	Benefit
Employee	$10,000 or $20,000
Spouse	50% of employee face amount
Children	50% of employee face amount

Aetna Hospital Care Coverage

Hospital care coverage provides a benefit according to the schedule below when a covered person includes a hospital stay resulting from a covered injury or covered Illness.

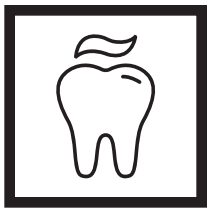
	Benefit
Admission	$1,000
Hospital Daily Stay	$100
ICU Daily Stay	$200
Substance Abuse Daily Stay	$100
Rehabilitation Unit Daily Stay	$50

Register on the My Aetna Supplemental app or on the member portal at Myaetnasupplemental.com to view plan documents, submit and track claims, and sign up for direct deposit.

Aetna Accidental Injury Insurance

Accidental Injury coverage provides a benefit according to the schedule below when a covered person suffers covered Injuries or undergoes a broad range of medical treatments or case resulting from a covered accident.

	Benefit
Initial & Emergency Care	
Ground Ambulance / Air Ambulance	$300 / $1,500
Emergency Room / Hospital	$150
Diagnostic Exam (x-ray or lab)	$50
Physician Office Visit	$150
Follow-up Care	
Emergency Room / Hospital	$50
Physician Office Visit	$50
Therapy services: Speech, occupational, physical therapy or cognitive rehabilitation	$25
Fractures and Dislocations	
Per Covered Surgically repaired fracture	Up to $8,250
Per Covered non-Surgically repaired fracture	Up to $4,125
Chip Fracture (percent of fracture benefit)	25%
Per Covered Surgically repaired Dislocation	Up to $6,000
Per Covered Non-Surgically repaired Dislocation	Up to $3,000
AD&D and Paralysis	
Accidental Dismemberment	Up to $10,000
Paralysis	Up to $10,000



DELTA DENTAL PLAN

Our dental plan is offered through Delta Dental and you have access to the Delta Dental PPO Program network of dentists.

Under Delta Dental's PPO plan, you have the option of going in or out of the Delta Dental network of providers. The network is extensive and the benefits are similar in- or out-of-network; however, your benefit level is higher if you use in-network providers.

In-network dentists are required to accept the Delta Dental negotiated fee as payment in full. If you decide to use a nonparticipating dentist, your out-of-pocket expenses may be more, since you will be required to pay for any difference between the dentist's usual fee and Delta's payment for the approved service. Preventive Care is covered at 100% in or out of the network (subject to plan limits).

To find a participating dentist, visit the Delta Dental website at deltadentalins.com. Then click "Find a Dentist" in the top right of the webpage.

Dental plan summary

Delta Dental	PPO (In-Network)	Premier (In-Network)	Non-Delta (Out-of-Network)
Feature/Service	Employee Cost Save		
Annual Deductible Individual Family	 $50 $150		
Annual Maximum per Person	$1,500		
Preventive and Diagnostic	0%	0%	0%
Basic Services	20%	20%	20%
Major Services	50%	50%	50%
Endodontic/Periodontal	20%	20%	20%
Orthodontia (Eligible dependent children up to age 19)	50%	50%	50%
Orthodontia Lifetime Maximum	$1,000		

*Subject to annual deductible

Delta Dental's PPO and Premier dental networks are both considered "in-network". If you visit a provider participating in the "PPO" network, you will experience greater savings due to deeper provider negotiations. If your provider is in the "Premier" network, you will receive the normal in-network discounts.

To know which tier your provider participates in, search your provider using Delta's "Find a Dentist" tool!

Dental biweekly employee payroll contributions

Delta Dental	
Single	$14.10
Employee + Spouse	$38.16
Employee + Child(ren)	$38.16
Family	$38.16

Accupac will give a $25 reward to any employee that receives their annual dental cleaning in 2025!

In order to be eligible, you must be enrolled in the Accupac dental insurance plan.

EYEMED VISION PLAN

EyeMeds's vision care benefits include coverage for eye exams, standard lenses and frames, contact lenses and discounts for laser surgery. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers who belong to the EyeMed network. When you use an out-of-network provider, you will have to pay more for vision services. Once enrolled, you will receive an ID card in the mail. ID cards can also be printed at www.eyemedvisioncare.com.

Eye exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious.

Vision plan summary

Eyemed Vision	Insight Network	
Feature/Service	In-network	Out-of-network
Exam	Once every plan year	
Frames	Once every other plan year	
Exam at PLUSProvider	$0 Copay	Up to $40
Exam	$10 Copay	Up to $40
Frames at PLUS Provider	$0 copay; 20% off balance over $170 allowance	Up to $84
Frames	$0 copay; 20% off balance over $120 allowance	Up to $84
Lenses	Once every plan year	
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Contact Lenses	Once every plan year	
Contacts	$0 copay; 15% off balance over $120 allowance	Up to $84

Vision biweekly employee payroll contributions

Eyemed Vision	
Single	$2.09
Employee + Spouse	$3.96
Employee + Child(ren)	$4.17
Family	$6.13

Save even more with PLUS Providers!

PLUS Providers are already in-network so the extra perks are built right into your vision benefits.

$50 Additional frame allowance from PLUS Providers. No promo codes, no coupons, no paperwork, no claims. The same vision care, plus a little more savings.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Inspira will continue to administer the Flexible Spending Account options for the 2025 plan year. You are able to enroll in the FSA even if you do not enroll in Accupac's Medical or Dental plans. Flexible Spending Accounts (FSAs) are an easy and convenient way to get more out of your paycheck. It allows you to set aside a predetermined amount of your pre-tax dollars to cover certain out-of-pocket expenses as they occur throughout the benefit plan year. Since an FSA is a tax advantaged account, you will need to be able to prove that money you spend from your FSA is for eligible medical expenses. Remember to save your receipts for all of your FSA expenses.

Health Care Flexible Spending Account

A Health Care FSA can reimburse you for eligible medical and dental expenses, up to the amount you contribute for the plan year. Your Health Care FSA lets you pay for qualified medical and dental care expenses not covered by your insurance plan with pre-tax dollars. The expenses must be primarily to alleviate a physical or mental defect or illness, and be adequately substantiated by a medical practitioner. For example, cash that you now spend on deductibles, copayments or other out-of-pocket medical expenses can instead be placed in the Health Care Spending Account, pre-taxed. The maximum amount you can contribute to the Health Care FSA is $3,300.*

*Subject to change per IRS guidelines

Dependent Care Flexible Spending Account

If you need child care for your dependents to allow you or your spouse to work or attend school full-time, you can open a dependent care FSA. This allows you to be reimbursed on a pretax basis for child care. You can contribute up to $5,000 ($2,500 if married and file individual tax return) for the Dependent Care FSA for children under age 13 and for disabled adults in your care.

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Remember: Use it or lose it

Use all your contributions each plan year because no funds can be carried over to the next year.

FSA STORE & MOBILE APP

The FSA Store is a great educational and retail site that stocks thousands of FSA eligible products. Each product is clearly marked on the site to eliminate confusion about which products require a prescription and which do not. You can shop for eligible items such as bandages, vitamins, and thousand of products in between. You can also search for an eligible provider to find eligible services from dermatologists to ophthalmologist near you.

You can visit FSA Store's Learning Center for answers to all of your FSA-related questions. The informative site is available to make sure you are aware of the many positive FSA benefits available to you.

The goal of Accupac is to help you make the most of your Flexible Spending Account, and with the many features of the FSA Store, we are confident that we can make this benefit simple and rewarding for you.

Visit the FSA Store at www.fsastore.com.

Inspira Mobile app

With our free Inspira Mobile app, you can easily access your account information in the palm of your hand. Simply "tap" to:

- Check your account balance and view account activity
- View your account alerts
- Access the Eligible Expense Scanner to verify if an item is an eligible health care expense
- Review a list of common eligible expense items
- Pay your providers directly from your account
- Take pictures of receipts and pay yourself back for eligible expenses
- Submit a claim

How to Substantiate a Claim:

Occasionally, Inspira will reach out to ask for information needed to approve your reimbursement. To be proactive, make sure that you obtain the below information every time you expect an Inspira reimbursement:

- Patient's Name
- Providers Name
- Specific Service Provided that day
- Date of Service
- Exact Cost of Service

These 5 items can be found on the Explanation of Benefits from the insurance provider, for prescription drug, an RX ledger can be obtained from the pharmacy, if needed.

Download now!

- You can download the app from your mobile device's app store.
- The app is supported by the following devices:
  - iOS version 10 or above on iPhone® 5S, iPad Air®, iPad Mini® 2 or newer models
  - Android version 4.4 (Kitkat) or above on phones or tablets
- There's no fee to download the app. Anyone with an Inspira account can use it for free.

ADDITIONAL ACCUPAC BENEFITS

During this annual enrollment period, you may also enroll in, or change your elections for the following Accupac benefits:

- Supplemental life insurance for you (Proof of Good Health may be required for any new amounts elected or waived when first eligible)
- Life insurance for your dependents (Proof of Good Health may be required for any new amounts elected or waived when first eligible)

The following benefits are provided to all Accupac employees as part of your total compensation/ benefits package. Your enrollment is not required for these benefits below:

- Basic Life/AD&D Insurance (Accupac-paid)
  - Accupac provides all employees with basic life coverage of 1x annual salary to a maximum benefit of $250k.
- Disability Insurance (Accupac-paid)
  - Accupac provides short term disability coverage to all employees at no additional cost to you.

What is "Proof of Good Health"?

If electing voluntary life insurance for yourself and/or your spouse, you may be required to submit evidence of insurability to Lincoln Financial Group before your election is approved. For 2025, Accupac is allowing employees who have not received a prior coverage denial through Lincoln the opportunity to enroll up to the Guarantee Issue amount without submitting evidence of insurability*. Please contact Health Advocate for more information.

*Approval and/or denial is determined by Lincoln Financial Group. Official plan documents govern full eligibility requirements.

RETIREMENT

Take advantage of the company match and vesting schedule!

Accupac will contribute 50% for each dollar you contribute, up to 8% of your eligible contribution. This means that if you contribute 8% or more, the Company will contribute 4% to your account. Each year on July 1st, employees participating in the Accupac retirement plan will have employee contributions automatically increased by 1% up to 8% maximum. If you do not want to participate, you must log into your personal fidelity account & opt out.

What does the company match mean for you?

Accupac contributes directly to your retirement savings account! Matching contributions can help your Plan account grow. You can take advantage of 100% of this "free" money by contributing 8% of your eligible compensation.

What does vesting mean?

The term vesting refers to the portion of your account balance that you are entitled to under the Plan's vesting schedule. You are always fully and immediately vested in any elective contributions you make to the Plan. You receive vesting credit for company contributions based on the number of years worked determined by your date of hire

What is the change to the vesting schedule?

Company matching contributions and earnings will be subject to the following vesting schedule:

Vesting Schedule

Years of Service	Vesting %
1	33
2	66
3	100

What do you need to do?

To find out your current contribution percentage, increase your contribution, or determine what an increase could mean to you, please contact Fidelity Investments.

- Visit www.netbenefits.com.
- Call the Fidelity Retirement Benefits Line at 800-294-4015, Monday through Friday from 8:30 a.m. to 8 p.m. Eastern time, to speak to a Fidelity representative.
- Contact our plan advisor, Nick Adornetto at 215-787-8974 or via email at nick@pillarbenefits.net (FYI, Nick can answer questions but is not able to make changes to your account over the phone).

PET DISCOUNT PLAN

You can enroll in pet insurance through Pet Benefit Solutions. Your pets are part of your family, and you'll do anything to keep them happy and healthy. But with the cost of pet care on the rise, it isn't always easy.

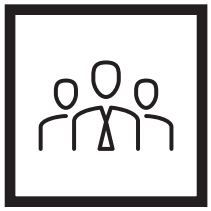
That's why we offer Total Pet Plan, which makes pet care more affordable. Enroll in Total Pet and get the same high-quality products and services your pets are used to, just at a lower price!

The plan includes:

- Discounts on products & Rx
- Discounts on veterinary care
- 24/7 Pet telehealth
- Lost pet recovery service

Make sure your vet partners with Pet Benefit Solutions to receive discounts. To find a participating vet, visit petbenefits.com or call (800)-891-2565.

To enroll, use Accupac's specific link: petbenefits.com/land/accupac.



WORK/LIFE EMPLOYEE ASSISTANCE PROGRAM (EAP)

Expert Help When You Need It Most!

Your Health Advocate services give you access to experts who can support you in handling a wide range of healthcare issues and help you work through personal, family or work issues. We'll get to the heart of your issue, no matter how complex. We'll help you:

- **Understand how your benefits work** and clarify copays and deductibles
- Get answers to your **insurance and claims questions** and resolve **billing issues**
- **Quickly connect** to all of your benefits
- Identify **emotion** and **mental health issues** and find **strategies to cope** with the help of an EAP Professional
- Access more **long-term help** from qualified professional, if needed
- Connect with specialists for help with **work/life balance, legal** and **financial issues**

Accupac, partnering with Health Advocate, is committed to providing affordable, accessible, and convenient behavioral health resources to all employees, spouses, dependents, parents and parents-in-law. Visit HealthAdvocate.com/members for compassionate support over the phone when you need it most, virtual counseling and face-to-face support sessions.

Emotional Support

Offers confidential counseling support from an EAP Professional to help you work through issues impacting your life and well-being.

Our Counselors can help address:

- Anger, grief, loss, anxiety
- Job stress, burnout, work conflict
- Martial relationships, family issues
- Addiction, eating disorders, mental illness

Work and Life Balance

Through EAP, you also have access to a team of Work/Life Specialists to help find resources to better balance work and life and feel more productive.

Our Work/Life Specialists can help with:

- Time management
- Locating childcare and eldercare resources and concerns
- Personal/family/elder law, identity theft
- Financial resources for debt management, budgeting, credit issues
- Plus, we can connect you to financial and legal consultants

Remember: Health Advocate is available year-round and during open enrollment. Employees are encouraged to contact Health Advocate will all benefits related questions.

During Open Enrollment, Health Advocate can walk you through your benefit options and provide expert advice on which plans might best be suited for your needs and the needs of you family!

How to Reach a Health Advocate Professional

Call 866-799-2691 or visit the website at HealthAdvocate.com for more information. Health Advocate can be accessed 24 hours, 7 days a week. Normal business hours are Monday – Friday between 8 a.m. and 9 p.m. EST. After hours and during weekends, on call staff are always available for assistance with issues that need to be addressed during non-business work hours.

CALM - ACCUPAC'S ADDITIONAL MENTAL HEALTH RESOURCE

Free Calm Subscription: The world's #1 app for sleep, meditation and relaxation. Millions of people are experiencing lower stress, less anxiety, improved focus and more restful sleep with Calm. Whether you have 30 seconds or 30 minutes, Calm content is made to suit your schedule and needs.

Follow the below instructions to redeem your Calm Premium subscription:

1. Download and open the Calm app
2. Create an account with a personal email address and go to **Profile > Settings > Link Organization Subscription**
3. Click on **Redeem via EMAIL**
4. Enter your credentials to activate your free subscription. If at any point you're asked to enter your organization name, please enter **ACCUPAC**

If you already have an existing Calm account, go to your Settings > Link Organization Subscription and follow steps 3 and 4.

Once you've signed up, you can add up to 5 dependents (age 16 years or older) via the "Manage Subscription" page inside your Calm account at www.calm.com. Need help? Reach out to the Calm Support Team with any questions.

CONTACTS

Medical
Aetna

Website: aetna.com
Customer service: 800.843.3661
or call the number on the back
of your card

Pharmacy
CVS

Website: caremark.com
Customer service: 844.371.0844

Dental
Delta

Website: deltadentalins.com
Customer service: 800-932-0783

Vision
EyeMed

Website: eyemed.com
Customer service: 866.939.3633

Health savings account (HSA)
Inspira

Website: Inspirafinancial.com
Customer service: 844.729.3539

Flexible spending account (FSA)
Inspira

Website: Inspirafinancial.com
Customer service: 844.729.3539
Fax: 888.238.3539

Life and AD&D Insurance
Lincoln Financial Group

Website: lincolnfinancial.com
Customer service: 800.423.2765

Disability
Lincoln Financial Group

Website: lincolnfinancial.com
Customer service: 800.423.2765

Employee Assistance Program
Health Advocate

Website: HealthAdvocate.com/Accupac
Customer service: 866.799.2691

Health Assistance
Health Advocate

Website: HealthAdvocate.com/Accupac
Customer service: 866.799.2691

Pet Insurance
Pet Benefit Solutions

Website: petbenefits.com
Email: info@petbenefits.com
Customer service: 888.913.7387

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

Accupac

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Accupac About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM Accupac ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Accupac and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Accupac has determined that the prescription drug coverage offered by the Accupac Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Accupac Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Accupac Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Accupac Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Accupac prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 2152567015. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Accupac changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	October 15, 2024
Name of Entity/Sender:	Kimberly Weirman
Contact—Position/Office:	Benefits Coordinator
Address:	1501 Industrial Blvd. Mainland, PA 19451
Phone Number:	2152567015

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

ACCUPAC
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

Accupac Employee Health Care Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Accupac is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.
5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected,

or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Kimberly Weirman
Benefits Coordinator
2152567015

Effective Date
The effective date of this notice is: October 15, 2024.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

ACCUPAC EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Kimberly Weirman
Benefits Coordinator
2152567015

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;

- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.
Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.
Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Kimberly Weirman
Benefits Coordinator
1501 Industrial Blvd.
Mainland, PA 19451
2152567015

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Accupac Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan issuer at .

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Accupac Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Accupac Employee Health Care Plan at:

Kimberly Weirman
Benefits Coordinator
2152567015

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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