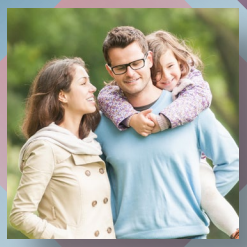
2025 OPEN ENROLLMENT BENEFITS FOR RETIREES



A MESSAGE FROM HUMAN RESOURCES

Infineum continuously seeks ways to provide colleagues with competitive and high quality health care options at a reasonable cost. As a self-funded medical plan sponsor, Infineum pays for actual medical costs rather than using an insured arrangement. This allows us to closely monitor and manage plan costs and design based on our own population's claims experience. In 2024, Infineum's medical claims cost experience has increased significantly. As a result, Infineum will adjust colleague contributions for each medical plan effective 1/1/2025 to account for actual claims experience.

Please continue to help us control Infineum healthcare costs by keeping up with preventive care services, choosing Aetna network providers, and by taking the following actions.

Please see Page 29 for the Summary Annual Report and Page 30 for the Creditable Coverage Notice.

STAY WELL

- Enjoy a healthy lifestyle
- Avoid processed foods and maintain a healthy weight
- Get regular exercise (30 minutes/day, 3-5 days/week)
- Avoid smoking
- Limit alcohol consumption

USE PREVENTIVE CARE

- Choose a primary care physician (PCP) and get annual, no-cost well-visits
- Follow-up with age-appropriate diagnostic tests and vaccinations, as recommended by your PCP
- Maintain regular communication with your physician

AVOID THE EMERGENCY ROOM

- Use CVS Minute Clinics or Urgent Care centers (walk-in medical clinics) for non-life-threatening emergencies. These offer faster care at low or no-cost for basic services
- Use your PCP for general examinations and well-visits
- Continued access to telemedicine visits in 2025, with the same cost sharing as in-person visits

NOTE: **You may be liable for charges from out-of-network providers (subject to deductible and co-insurance) related to an ER visit in a participating hospital, if the visit is not a true emergency.**

UNDERSTAND THE COSTS OF YOUR MEDICAL CARE

- Use Aetna network providers whenever possible
- Use the provider directory at **http://www.aetna.com/docfind/custom/mymeritain/**
- Look for Aetna providers who meet quality and cost-efficiency measures
- Pay attention to Explanations of Benefits (EOBs) and associated provider statements

WELCOME TO YOUR BENEFITS

Infineum offers a comprehensive, affordable benefits package to you and your family. Our benefits provide protection and support to help you achieve your health, financial, and wellness goals. This brochure outlines the benefits package and how you can take maximum advantage of all the benefits available. Please take the time to review your current coverage and to read the Open Enrollment materials. This will ensure that you can make an informed decision on the benefits and coverage levels that are best for you and your family. During our annual open enrollment period, retirees have the opportunity to enroll in, or make changes to their benefit plans.

TABLE OF CONTENTS

BENEFIT PLAN CHANGES FOR 2025 - RETIREES UNDER AGE 65

Medical Plans

- Based on actual claims cost experience.
  - Plan 1 contributions will increase by 8%
  - Plan 2 will be discontinued effective 1/1/2025

Dental Plan

- No changes to dental plan contributions for 2025.

Medicare Supplement Plan and Medicare Part D Plan

- No changes to Medicare Supplement Plan contributions for 2025.

ALLOWABLE CHANGES DURING OPEN ENROLLMENT

Change	Action Required
Enroll in Medical Plan (no previous coverage)	Benefits Change Form
Add eligible dependents to Medical Plan	Benefits Change Form
Drop eligible dependents from Medical Plan	Benefits Change Form
Drop Medical Coverage	Benefits Change Form
Enroll in Dental Plan (no previous coverage)	Benefits Change Form
Add eligible dependents to Dental Plan	Benefits Change Form
Drop eligible dependents from Dental Plan	Benefits Change Form
Drop Dental Coverage	Benefits Change Form

NOTE: All changes will take effect on January 1, 2025.

Complete and mail Benefits Change Form to:

Jamie Fasino, Infineum USA Inc. 1900 E. Linden Ave. Linden, NJ 07036 or, scan and email to **Jamie.Fasino@Infineum.com**

Forms must be received no later than November 30, 2024.

All retirees enrolled in Plan 2 during the 2024 plan year will automatically be enrolled in Plan 1 for the 2025 plan year. ***NO ACTION IS REQUIRED IF YOU WISH TO CONTINUE WITH YOUR CURRENT ENROLLMENT.***

MEDICARE SUPPLEMENT PLAN – REMINDER

The Infineum Medicare Supplement Plan is a medical plan for retirees, survivors and eligible family members who are eligible for Medicare. Currently, it is designed to work with Medicare in order to provide coverage similar to that provided to colleagues and retirees who are not yet eligible for Medicare.

You must meet several conditions to be eligible for the Infineum Medicare Supplement Plan. You must: 1) be eligible for Medicare, and you must have retired from Infineum with retiree status; or 2) be an eligible family member of an Infineum retiree or an eligible family member of a deceased Infineum colleague/retiree. **In either case, the Infineum Medical Plan must have covered you immediately prior to your Medicare Supplement Plan eligibility in order to qualify.**

If you have not been contacted by the Plan Administrator regarding sign-up for the Medicare Supplement Plan before your 65th birthday, contact Infineum Human Resources at **908.474.2273** to start the process. You will also be provided with a revised coupon booklet from Infineum's Retiree Billing Administrator that includes the cost for the Medicare Supplement Plan.

Important Information: If you are an Infineum Retiree, under age 65, and you receive disability benefits from Social Security for 24 months, you should automatically be enrolled in Medicare Part A and Part B effective on the 25th month of disability. While you are not required to enroll in Medicare Part B, your Infineum Medicare Supplement Plan will assume you are enrolled in Medicare Part B.

Things to Consider (when Medicare Disabled)…

1. Infineum, as well as your Medical Provider, will not be notified right away of your early Medicare Disability status. You MUST immediately notify Infineum Human Resources (**908.474.2273**) of your disability status to ensure that you are moved into the Infineum Medicare Supplement Plan on the date that coincides with your Medicare Part(s) A & B effective date.

2. If you decide to waive your Medicare Part B status upon disability, your Infineum Medicare Supplement Plan will still assume you are enrolled in Medicare Part B, and will process/pay claims as if Medicare is the "primary payer" and the Infineum Medicare Supplement Plan is the "secondary payer". Your out-of-pocket costs will increase if you make the decision to decline Medicare Part B.

MEDICAL PLAN COMPARISON CHART

MERITAIN HEALTH

Infineum offers employees medical plans through Meritain Health. This chart shows a summary of those benefits. You will have lower out-of-pocket costs if you use in-network providers. Additional benefit information can be found in your Summary of Benefits (SBC).

Plan Name	Plan 1	Medicare Supplement*
IN-NETWORK BENEFITS		
Deductible (Calendar year	$0	$0
Out-of-Pocket Maximum (Calendar year)	$5,000/$10,000	$2,000/$4,000
Coinsurance (Patient pays)	$0	$0
Physician Services **Primary Care Physician** (PCP) **Specialist** **Preventive Care**	$25 copay $40 copay Covered 100%	Deductible & Coinsurance
Routine Labs	Office: PCP $25, Specialist $40 Outpatient/Independent Facility: Covered 100%	Deductible & Coinsurance
Routine X-Rays	Office: PCP $25 or Specialist $40 Outpatient/Independent Facility: Covered 100%	Deductible & Coinsurance
Inpatient Hospital	Covered 100%	Deductible & Coinsurance
Outpatient Surgery	Covered 100%	Deductible & Coinsurance
Emergency Room	$100 copay, waived if admitted	Deductible & Coinsurance
Urgent Care	$25 copay	Deductible & Coinsurance
PRESCRIPTION BENEFITS		
Retail (31 day supply) Generic/Preferred Brand/ Non-Preferred Brand/Specialty	$15/$40/$60	Refer to page 15 for co-payments
Mail Order (90 day supply) Generic/Preferred Brand/ Non-Preferred Brand/Specialty	$20/$60/$100/$100	Refer to page 15 for co-payments
OUT-OF-NETWORK BENEFITS		
Deductible (Calendar/Plan year)	$1,000/$2,000	N/A
Out-of-Pocket Maximum (Calendar/Plan year)	$5,000/$10,000	N/A
Coinsurance (Patient pays)	40%	N/A

*No network applies to the Medicare Supplement Plan.

DOC FINDER

Find Care® Online Directory

Aetna Choice® Point of Service (POS) II

It's easy to find doctors and hospitals in your network

When you and your family need care, you can look for doctors and hospitals in the Aetna Choice POS II network. It's easy when you use the Find Care online directory from Aetna®. *With up-to-date listings, you can search for providers by name, specialty, gender, hospital affiliations and more.

Find Aetna providers online in just a few quick steps

You can use the directory anywhere you have internet access. Just:

1. Visit **https://www.aetna.com/dsepublic/#/mymeritain**.
2. Key in the ZIP code, city, county or state of the desired geographical area in the *Enter location here* field. Click *Search*.
3. Key in *Aetna Choice POS II (Open Access)* under *Select a Plan*. **Or** you can select *Aetna Choice POS II (Open Access)* from the list of plans. Click *Continue.*
4. There are two options available to search for providers. The guided flow search uses some of our most commonly searched terms and easily organizes them for our users to find. To use the guided search flow, choose and click on one of the categories under *Find what you need by category*. **Or see step five.**
5. Use the search box, which includes type-ahead suggestions and will present provider, facility, specialty and condition search options based on what is entered. These suggested options will present an exact match or relevant providers. *What do you want to search for near* (will display your chosen location).
6. Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.
7. Narrow your search results by using the *Filter & Sort* option. Choices include *Gender, Languages, Hospital Affiliations, Office Detail, Individual Practice Association Affiliations, Group Affiliations* and *Provider Type*.

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DOC FINDER

Why choose a primary care physician (PCP)?

Meritain Health® does not require you to choose a PCP, but we encourage you to choose one. Your PCP knows your health care needs, so they can help manage your health and coordinate your care. To find and choose a PCP, use the *Find Care* tool on your member website.

Find providers by phone

Need a provider when you're not near a computer? No problem. Simply call the Aetna Provider Line at **1.800.343.3140** from 8:00 AM–9:00 PM ET, Monday through Friday.

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates.

Providers are independent contractors and are not agents of Aetna or Meritain Health. Provider participation may change without notice. Neither Aetna nor Meritain Health provides care or guarantees access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

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ACCESS MENTAL WELL-BEING SERVICES FROM ANYWHERE

Access Mental Well-being Services from Anywhere

With telehealth and virtual mental well-being programs, you can easily get help you need from providers who are part of your network. So, whatever you're facing, you'll have support, including counseling, medication or help with mental health concerns. Plus, you can see providers when and where it's convenient for you.

However, depending on your plan coverage, some services may not be covered. You'll want to confirm telehealth eligibility by checking your member website for plan details or calling the number on your ID card, prior to receiving services. Below is a list of providers you can access for a variety of concerns or conditions.

Depression, anxiety or mental well-being concerns

Ages	Provider	Contact	Availability
0 up to age 18	Brightline	**https://www.hellobrightline.com/meritain**	Nationwide
5 and up	Telemynd	**1.866.991.2103** or **https://Telemynd.com/meritain**	Nationwide
13 and up	Talkspace	**https://www.talkspace.com/Meritain**	Nationwide
18 and up	Meru Health	**https://www.meruhealth.com/sign-up/meritain/**	Nationwide
18 and up	Brightside Health	**www.brightside.com/meritainhealth/**	Nationwide
18 and up	AbleTo	**1.844.330.3648** or **https://member.ableto.com/meritain/**	Nationwide

Eating disorders

Ages	Provider	Contact	Availability
4 to 26	Equip Health	**1.855.387.4378** or **https://equip.health**	Nationwide

Telehealth (telemedicine) or virtual services: connects you and your provider via a secure televideo platform for counseling, support, education and medication management from the location of your choice.

Availability: specific availability by state is subject to change without notice.

To learn more about your benefits or if you have any questions, simply call the number on the back of your medical ID card.

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EXCLUSIVE EMPLOYEE DISCOUNTS

Exclusive Employee Discounts

Your nationwide deals await

LifeMart® Employee Discount Program

Browse big savings on major brands for all your health and wellness needs. LifeMart is your employer's way of saying thanks for your hard work—and helping you keep more of your paycheck.

Access LifeMart anywhere, anytime, on any device. It's the fast and easy way to:

- Save money on all your health and wellness needs—from gyms, to diet plans, groceries and everything in between.
- Access offers personal wellness products and services—LifeMart also offers deals on everyday needs such as travel, tickets, car rentals, electronics and more.
- Get deals for the family—such as pet products, child care discounts, products for aging loved ones and more!
- Save time with instant, one-stop shopping—with no need to run out to the store or search the web.
- Discovering exclusive new deals on the brands you love—offers are updated regularly.

Getting Started with LifeMart

Accessing LifeMart is easy. Just complete the online registration by filling out your first name, last name, email address and a password. Once you're registered, you will be able to view and access discounts. Members also have the option to opt-in or out of of email notifications.

There are a few different ways to access LifeMart

1. Through your Meritain Health® member website. Click the *LifeMart* link under *Tools and Resources*, or click the *LifeMart* tile at the bottom of your homepage. From here, you'll be able to search for discounts directly within your member website.
2. Scan the QR below to be taken directly to LifeMart and start searching for discounts!
3. With the LifeMart mobile app you can access LifeMart discounts anywhere, anytime. Simply download the app and you can browse major savings on the go. It's available for download in the Google Play Store™ and iTunes Store®. **Please note:** you'll need to register online to access the LifeMart mobile app.

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EXCLUSIVE EMPLOYEE DISCOUNTS

Need Help?

You can reach out to the LifeMart help desk via email for assistance. Just click on the *Need Help* link in LifeMart! The Need Help feature also has commonly asked questions and answers to assist you. You can also use the direct customer support email **helpdesk@lifecare.com**.

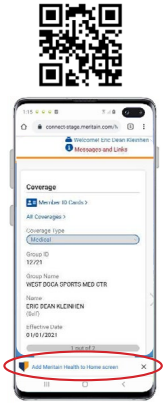
HOW TO ACCESS YOUR MOBILE APP – ANDROID

How to Access Your Mobile App

Android™ Phones

1

Once you log in to your member website through **www.meritain.com**, or **by scanning the QR code**, you'll be prompted with the pop-up message *Add Meritain Health® to Home Screen* at the bottom of the page. Click this message.



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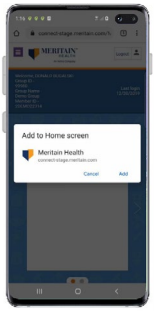
Then, click *Add* to add the app to your home screen.



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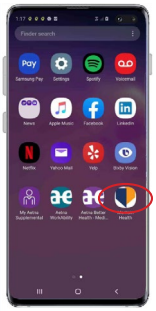
You should see the Meritain Health logo on your phone's home screen.



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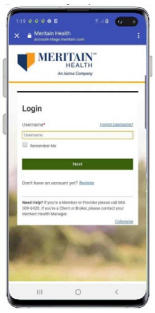
Now, simply launch the app from your home screen and log in.



What you'll need to submit a claim

- Patient's information
- Provider's information including name, address where services were provided and Tax Identification Number (TIN)
- Detailed invoice including procedure (CPT) code or description of services and diagnosis code

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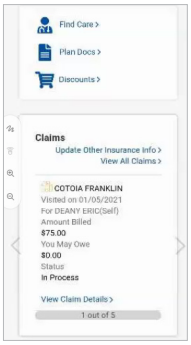
HOW TO ACCESS YOUR MOBILE APP — ANDROID

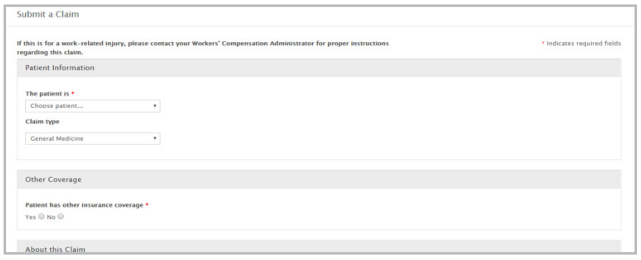
How to submit a claim online

1. After logging in to your Meritain Health account via the app, click on *Submit a Claim* at the top of the page.

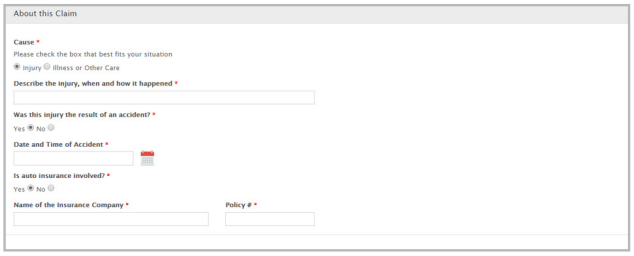
   Claims can be submitted for any covered member.



2. Select *General Medicine* under the *Claim Type* drop-down. Select *Illness, or Other Care* or *Injury*, depending on your claim. You will be guided to answer additional questions in order to complete the claim.

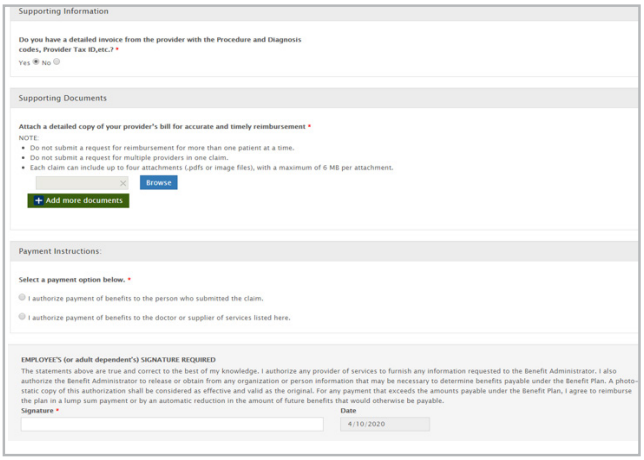


3. Next, you'll be asked to enter information about your provider.
   - If you click *Yes* for a detailed invoice, there will be no additional questions and you'll be instruced to add the required documents. You can take a picture of your documentation and attach it.
   - If you click *No* for a detailed invoice, you'll then be guided through additional required questions, starting with hospitalization.
   - You can then electronically sign and submit the claim.



4. If there is no detailed invoice from the provider, you must complete the *Additional Information Page* to submit the claim.
   - Additional information includes diagnosis code, procedure code, service date, place of service and charges.

5. Lastly, you'll specify who will receive payment—you or the provider. If you select the provider, you'll need to provide the name and Tax Identification Number (TIN) of the provider to receive payment.
   - If selecting *Pay To Member*, proof of payment will need to be submitted as part of your documentation.



Questions?

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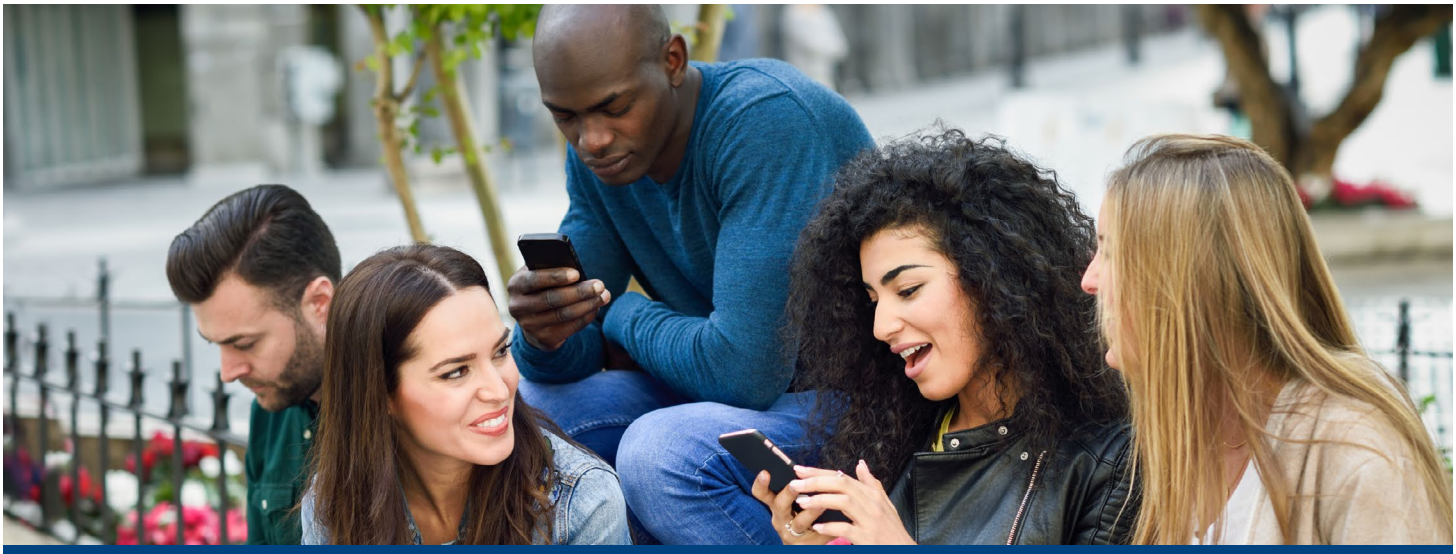
HOW TO ACCESS YOUR MOBILE APP — IPHONE

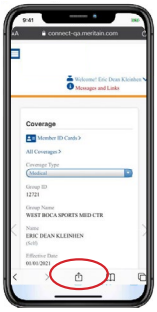


How to Access Your Mobile App

iPhone®

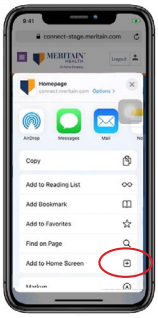
1

Once you log in to your member website through **www.meritain.com**, or **by scanning the QR code**, click the icon at the bottom of the page shown here.



2

Then, scroll through the menu options and select *Add to Home Screen*.

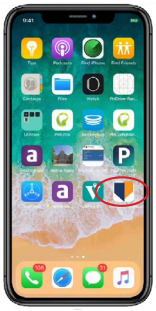


3

Click *Add* in the upper right-hand corner.

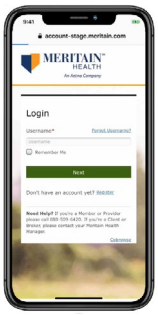
4

Your Meritain Health® app logo will then be installed and added to your home screen.



5

Now, you're all set to log in through the mobile app!



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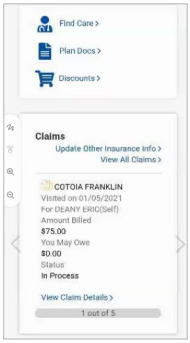
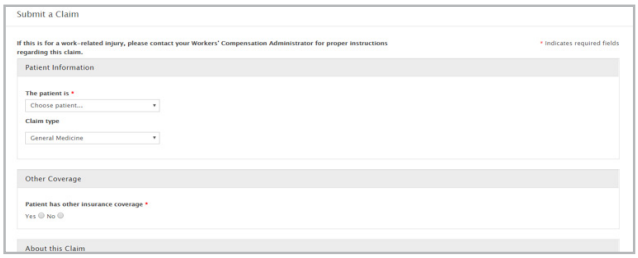


2. Select *General Medicine* under the *Claim Type* drop-down. Select *Illness, or Other Care* or *Injury*, depending on your claim. You will be guided to answer additional questions in order to complete the claim.



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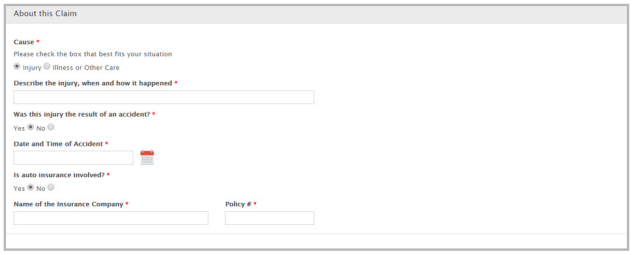

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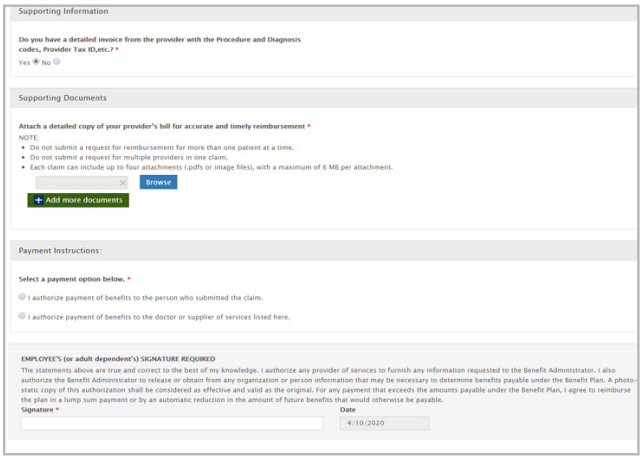

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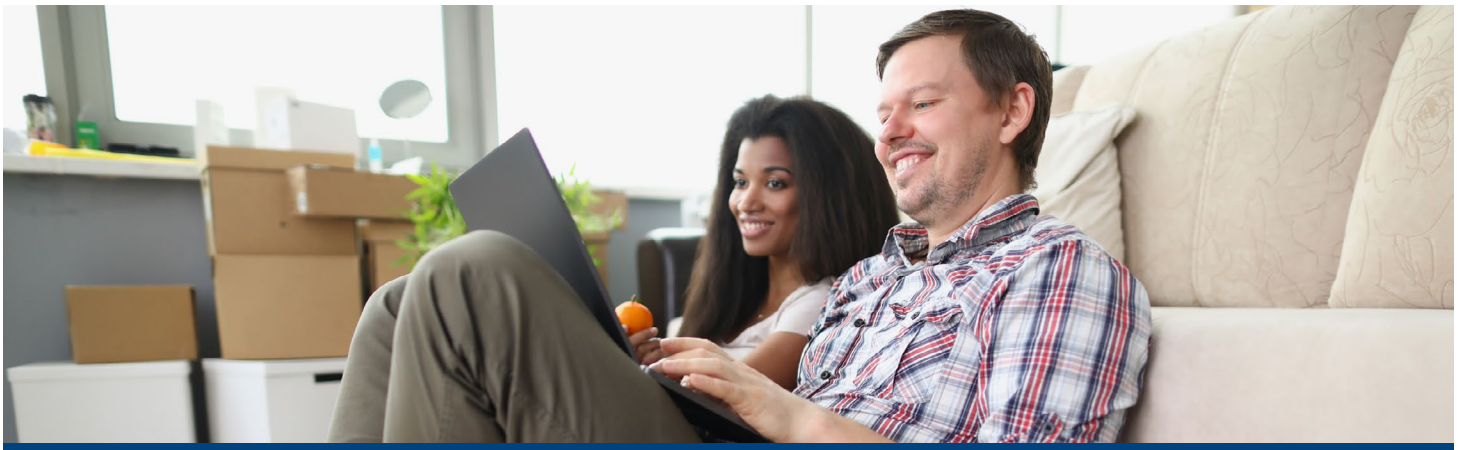
ACCESSING OTHER INSURANCE COVERAGE (OIC) ONLINE



Accessing Other Insurance Coverage (OIC) Online

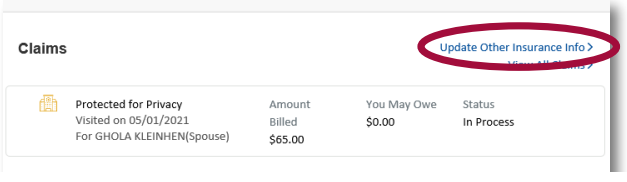
Your health care benefits plan includes a provision called Coordination of Benefits (COB). This means if one person is covered by two benefit plans, both plans share responsibility for covering that person's health care expenses. This helps prevent duplicate payments and helps hold down health care costs.

Examples of other coverage include: Medicare (due to age or disability), group coverage through a family member's employer, association coverage through a group you or a family member belongs to, student health coverage, or coverage mandated by a divorce decree.

Meritain Health® may sometimes ask you to update this information so we can keep our records current.

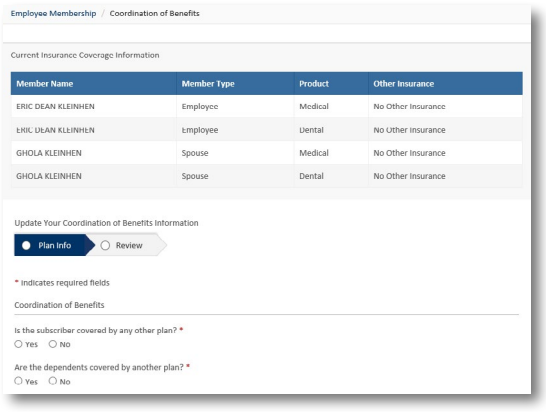
Meritain Health REQUIRES THAT YOU UPDATE THIS INFORMATION ANNUALLY IN JANUARY in order for claims to be processed accurately and without delay.

1 Select *Update Other Insurance Info*, located on the main homepage under the *Claims* section.



2 You'll be asked if you or any dependents have other coverage, other Medicare coverage and/or other Medicaid coverage. Simply answer *Yes* or *No* to report if you or anyone in your family has other health coverage.

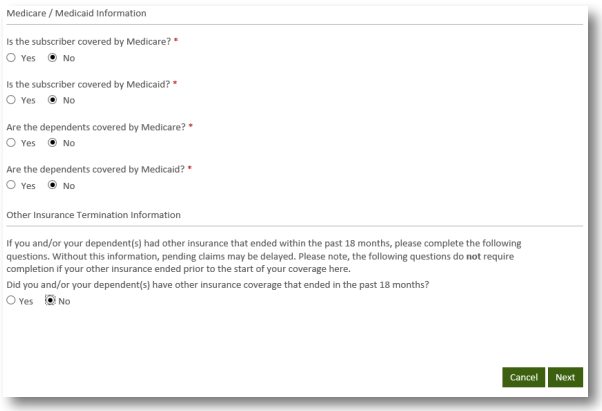
3 If you answer *Yes*, you'll be asked for information about the other coverage like start date, carrier name, policy holder name, date of birth, etc. Just fill out the forms that open when you select



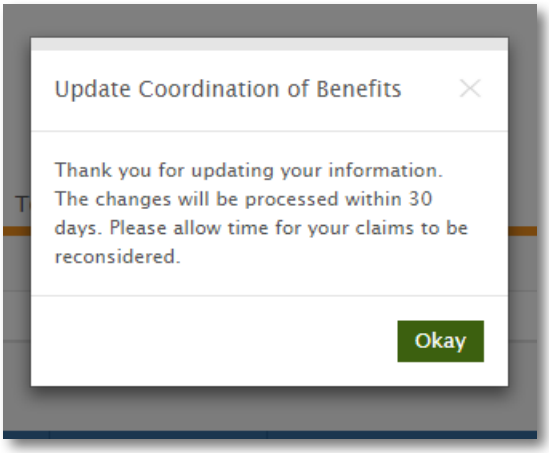
Meritain Health®
an aetna company

ACCESSING OTHER INSURANCE COVERAGE (OIC) ONLINE

4 After you complete the form, click *Next* to see a summary of the information.



5 If you agree with the summary, click *Submit* in the bottom right corner. If you need to make changes, click *Edit* at the top of the summary.



If you have any questions, you can call Customer Service at the number on the back of your ID card for assistance.

Please note: failure to update your COB will result in claims denial.

Other COB options are available

- You can *email* your COB form to:
  Forms.Direct@meritain.com
- Or you can mail it to:
  Meritain Health
  Eligibility Department
  P.O. Box 853921
  Richardson, TX 75085-3921
- Or fax to **716.541.6672**
  You should keep a copy of the fax confirmation record if you plan to call to confirm receipt.

WHAT IS HINGE HEALTH?

Meritain Health an aetna company

Hinge Health

What is Hinge Health?

How does the program work?
Hinge Health provides personalized care plans to help people accomplish their health goals related to musculoskeletal **(back, muscle, and joint)** health.

How does Hinge Health help?
They assess your condition and match you to a care team to help personalize your treatment to you.

Who is in my care team?
Depending on your treatment plan, your care team could include a physical therapist and a health coach. You will keep the same care team throughout your experience.

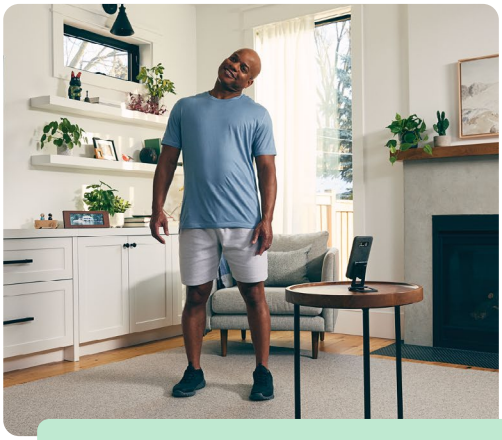
What could be included in my treatment plan?

1. **Access to the Hinge Health app** with guided exercise therapy
2. **Virtual visits** with members of your care team
3. **Kit with a tablet and tools** to assist in guiding exercise therapy

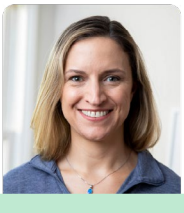
How much does the program cost?
It's free for eligible participants. This includes access to your care team, the Hinge Health app, and any materials that we send to assist in your care.

Who is eligible?
Participants must be 18+ and enrolled in a Meritain Health® medical plan.

How do I apply?
Take a short online questionnaire following the link below, telling us about your pain. No referral or diagnosis needed from a doctor.



Exercise therapy made easy
Follow along in the app for simple, 10-minute exercise therapy sessions.



Treatment from your care team
Get help overcoming pain, recovering from an injury, preparing for surgery, and more!

Scan the QR code to learn more or apply at
hinge.health/meritainhealth
or call (855) 902-2777

READY, SET, ENROLL!

Meritain Health
an aetna company

Hinge Health

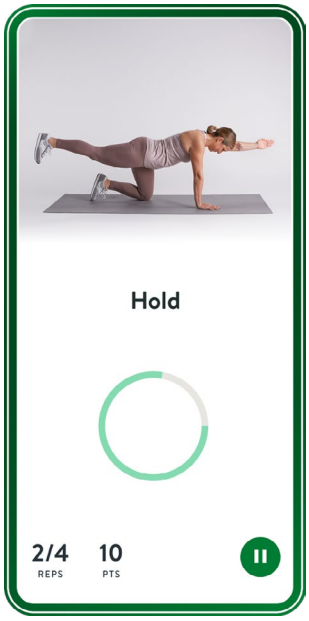
Ready, set, enroll!

Open enrollment around the bend.

Join Hinge Health for exercise therapy without leaving home. No copays. No office visits. Reduce your back and joint pain in just 15 minutes a day. Best of all, there's no cost to you — your Hinge Health benefit is 100% covered by Meritain Health.

Join Hinge Health to:

- Overcome pain or limited movement
- Recover from a recent or past injury
- Keep your joints healthy and pain free



Scan the QR code to learn more
hinge.health/resources
Questions? Call (855) 902-2777

Eligibility: Participants must be 18+ and enrolled in a Meritain Health® medical plan.

PRESCRIPTION BENEFITS

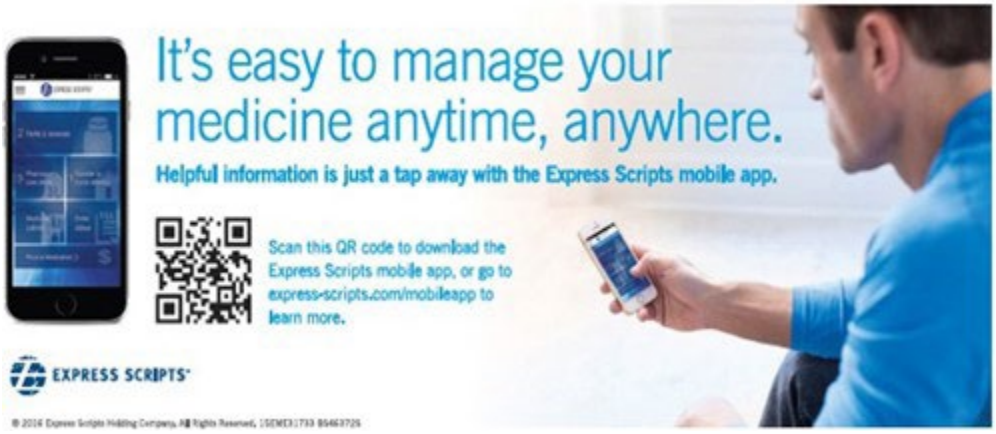
EXPRESS SCRIPTS

The plan provides coverage for generic drugs, brand name drugs on a formulary, and brand name drugs not listed on the formulary. Please be sure to provide your Express Scripts Pharmacy ID card to your pharmacy when filling prescriptions.

If you are taking any maintenance medications, it's beneficial to fill a 90 day prescription through the Mail Order service with Express Scripts. You will save money! Refer to the table on this page for details.

To get setup with Mail Order, you may call the Express Scripts customer service number listed on the back of your ID card. You will need to mail your completed Mail Order form in with your prescription and applicable payment. Within a couple of weeks, you will be setup in the system and then able to later request refills either online or over the phone.

Plan Name	Rx Copays
Retail (30 day supply) Generic / Preferred Brand / Non-Preferred Brand / Specialty	Preferred $20 / $50 / $70 / $70 Standard $25 / $55 / $75 / $75
Retail (31-60 day supply) Generic / Preferred Brand / Non-Preferred Brand / Specialty	Preferred $40 / $100 / $140 / $140 Standard $45 / $105 / $145 / $145
Retail (60-90 day supply) Generic / Preferred Brand / Non-Preferred Brand / Specialty	Preferred $60 / $150 / $210 / $210 Standard $65 / $155 / $215 / $215
Mail Order (90 day supply) Generic / Preferred Brand / Non-Preferred Brand / Specialty	$20 / $60 / $100 / $100



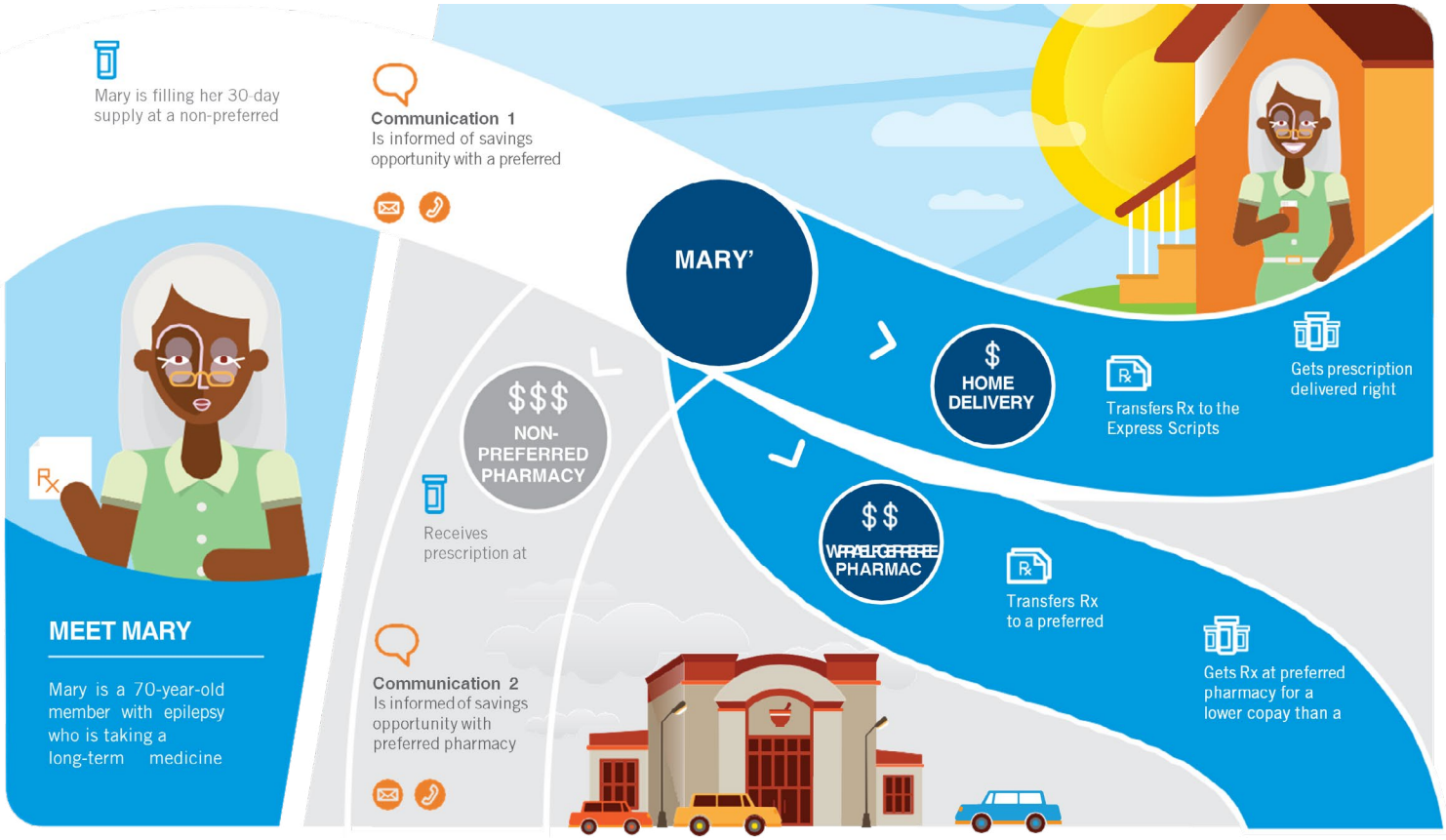
Express Scripts mobile app:

- Refill prescriptions
- See order status and claims
- Find and compare prices
- Access your ID card

MPVN CHAIN PHARMACIES

MEDICARE PREFERRED VALUE NETWORK

Comprehensive preferred provider network of 27k+ pharmacies. *Retail pharmacy participation is contracted and may be subject to change)*



- Offers convenience with choice of a preferred or non-preferred pharmacy, or home delivery from the Express Scripts Pharmacy℠
- Members are prompted to choose a preferred pharmacy or home delivery to increase savings

DENTAL PLAN

AETNA

Dental coverage is key to your overall health. Infineum offers you and your family a Dental plan through Aetna. This Dental plan offers coverage for the following expenses:

Network name: Dental PPO/PDN with PPO II and Extend		
Plan Features	**In-Network***	**Out-of-Network**
Deductible (Calendar/Plan year) Waived on Preventive Services	$25/$75	$25/$75
Benefit Maximum (Calendar/Plan year)	$1,250[1]	$1,250[1]
Preventive Services Routine exams and cleanings, fluoride treatments, sealants, and X-rays	100%	100%
Basic Services Simple fillings and extractions, root canals, oral surgery, and gum disease treatment	80%	80%
Major Restorative Services Crowns and dentures	50%	50%
Orthodontia Services	50% $1,000 maximum	50% $1,000 maximum

* You will pay less for services when you use in-network providers. The plan's level of reimbursement is lower for services provided by out-of- network providers. For more information about the network go to **aetna.com**.

[1] Benefit Maximum increases to $1,500 with at least one dental visit each year.

Aetna Dental® plans

You don't need a dental ID card to get dental care

We want to make doing business with us easier than ever.

How will my dentist know I'm an Aetna Dental member? When you visit your dentist, simply tell the office your name, date of birth or member ID number.

But what if I want a card?

Easy — use our mobile app or go online. Log in to your secure member website at **aetna.com.**

You can print out an ID card for you and your dependents by selecting "ID Card" and then selecting "View ID Card."

If your electronic ID card says **"No Election" or "Invalid Choice,"** then your plan requires you to choose a primary care dentist (PCD) who is in our network. Until you choose one, your benefits and claims may be affected.*

Here's what else you can do online:

- Find or select a dentist
- View claims and claim address
- Manage your health care spending

aetna®

Aetna Dental® plans

Log in to your secure member website at **aetna.com** to explore the resources available to you. Call **1-877-238-6200** if you have any questions — 24 hours a day, 365 days a year.

*California/Arizona DMO® plan participants: If you have not selected a PCD, one may have been selected for you. View your electronic ID card to determine if one was selected on your behalf.

aetna®

Aetna Mobile — find what you need, wherever, whenever

To learn how to download the free Aetna Mobile app to access your ID card or dental benefits information when you're on the go, visit us at **aetna.com/mobile**.

Aetna Dental® PPO plan

Choosing your dental plan

See if your dentist is in the network
You may want to see if your dentist is in our network. Go to **Aetna.com** to use our provider search tool.

Check your costs
Dental plans are all different. So you won't see cost information here. Instead, check your benefits summary to find your share of the costs.

This may include your:

Deductible — the dollar amount some plans require you to pay for services before coverage starts.

Coinsurance — the percentage of dental care expenses you pay after your deductible. Your dental plan pays the rest. For example, you pay 20%, and your plan pays 80%.

Your dental plan may have yearly and lifetime limits on coverage. There also may be age and frequency limits on some services.

FSA
HSA

If you have a health savings account (HSA) or a flexible spending account (FSA), you can use those funds to help with costs.

Sign up today! You can visit any licensed dentist — in or out of network.

Your options	Pick your dentist	How it works
In network No paperwork Lower costs	Visit a dentist in the Aetna Dental PPO* network.	• Network dentists offer special rates for covered services. So your share of the cost is usually lower. • Network dentists file claims for you.
Out of network Choices	Visit any licensed dentist outside the network.	• You may pay more when you get care from dentists who aren't in the network.** • You may have to file your own claims.

*In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN).

**Out-of-network benefits are paid based on recognized charge levels, as determined by Aetna and specified in your plan documents.

Dental PPO insurance plans are underwritten and/or administered by Aetna Life Insurance Company (Aetna).

Manage your benefits, connect to care, handle claims — from anywhere

The Aetna Health℠ app and your Aetna® member website are personalized, seamless and easy to use. Once you're a member, here's how you can connect:

Go to Aetna.com

Go to **Aetna.com** to create an account and log in to your member website.

Get the Aetna Health app

Get the Aetna Health app by texting "GETAPP" to **90156** for a link to download the app and create an account. Message and data rates may apply.*

VISION BENEFITS

A Look at Your VSP Vision Coverage

With VSP and INFINEUM USA INC. 30072285, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.
vsp PREMIER PROGRAM
Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

Shop online and connect your benefits.
eyeconic a vsp vision company
Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.
You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!
Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

vsp vision care

More Ways to Save

Extra
$20
to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to
40%
Savings on lens enhancements‡

Create an account today.
Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

INFINEUM USA INC. 30072285 and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
01/01/2025

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$15	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$30**	
FRAME+	• $140 featured frame brands allowance • $120 frame allowance • 20% savings on the amount over your allowance • $65 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

COLLEAGUE ASSISTANCE

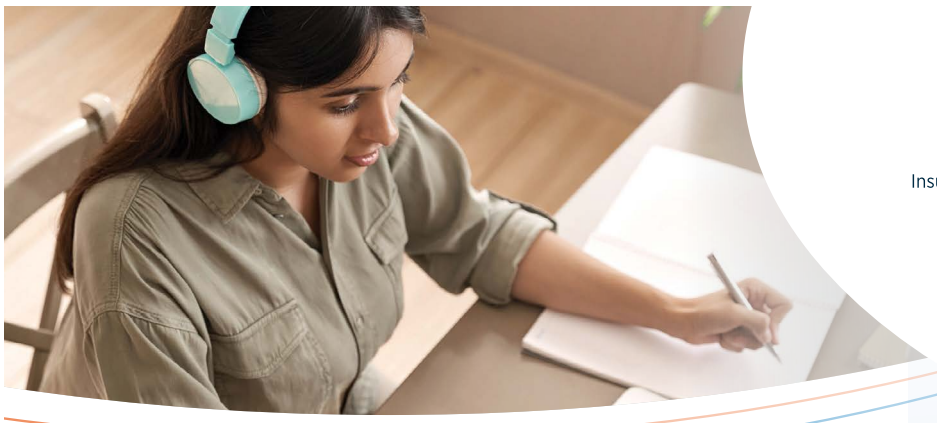
Infineum USA - Colleague Assistance Program

Call CAP at **800.554.6931** or visit us on the web at **www.myCigna.com**
Employer ID: infineum

Cigna

Face-to-face assistance			
Service level	• 24/7 telephonic access	• Network health care professional referrals	
Participant services	• Telephonic consultation • Crisis intervention services • Community resources	• Healthy Rewards® discount program • Online assessment tools • Online article library	• Online access and referrals • Up to 8 sessions per issue, per member, per year
Organizational services	• Account management • Unlimited management consultation and referral	• Online management reporting	• 10 service hours annually per 1,000 employees for orientations, seminars or training, onsite crisis intervention
Full-service work/life support			
Telephone, click-to-chat, web mail	• **Child care** – Child care centers, family child care homes, in-home care, babysitting agencies and options, nanny agencies and options, au pair agencies and options • **Senior care** – Home health agencies, nursing homes, assisted living facilities, continuing care retirement communities, social and recreational programs • **Prenatal care** – Birthing methods, nutrition, exercise, diet and child care pre-planning • **Adoption** – State adoption specialist, adoption support groups, private adoption, national adoption organizations	• **Parenting** – Child development, sibling rivalry, separation anxiety, sleep and bedtime routines, toilet training • **Summer care** – Residential camps, day camps, traditional camp programs, specialized camp programs • **Special needs** – Common childhood illnesses, children with multiple disabilities, developmental delays • **Pet care** – Veterinarians, insurance, pet sitting resources, obedience training, pet stores, pet supply catalogs • **Education** – Kindergarten programs, public schools	• **Legal** – 30-minute free consultation, 25% discount on usual fees, referrals to local providers • **Identity theft** – 60-minute free consultation with a fraud resolution specialist • **Financial services** – 30-minute free phone consultation with a qualified specialist on issues such as tax preparation, debt counseling and planning for retirement. 25% off tax preparation.
Online resources and tools	• **Parenting** – Adoption, child care, developmental stages, kid's well-being, education • **Aging** – Adults with disabilities, aging well, planning for the future, U.S. systems for the elderly, housing options, home care, health, caregivers, grief and loss • **Balancing** – Personal growth, communication, families, relationship, grief and loss, mental health, addiction and recovery	• **Thriving** – Health tools, live healthy, healthy eating, medical care, infant and toddler health, child health, adolescent health, women's health, men's health, senior health, health challenges • **Working** – Accomplished employee, effective manager, career development, training and development, workplace productivity, workplace diversity, workplace safety • **Living** – Consumer tips, home improvement, home buying or selling, moving, financial, legal, legal ready docs, errands online, safety, pets, travel and leisure time, fraud and theft	• **Educational materials** • **Personal assessments** • **Interactive tools** • **Self-search resource locators** • **Email for consultant-assisted search** • **Live messaging for consultant-assisted search** • **Web seminars**
Referrals and fulfillment	• Up to three qualified referrals where available; if additional needed, participant calls back	• Turnaround Time: 12 business hours; emergency is six business hours	• Online and print fulfillment materials

BENEFIT ADVOCATE CENTER



Gallagher

Insurance | Risk Management | Consulting

Ask Your Advocate Team

Put our team to work to maximize your healthcare benefits.

Gallagher is ready to help you get the most from your benefit program by providing support from an advocate at no cost to you. Get assistance with:

1. **Explanation of benefits**
   Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
2. **Prescription challenges**
   Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization for a medication?
3. **Benefits questions**
   Are you unsure if the insurance company will pay for a certain procedure?
4. **Claim issues**
   Did you receive a bill from a doctor but don't know why?
5. **Difficult situations**
   Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

Connect with Us

Infineum USA Inc.
Advocate Center

833.525.7102
bac.infineum@ajg.com

Hours of operation

Monday – Friday

8 a.m. – 6 p.m.

ajg.com **The Gallagher Way.** Since 1927.

CONTACTS

Contact Information			
Plan	**Carrier**	**Phone Number**	**Email/Website**
All Benefits	Gallagher Benefit Services	1.833.525.7102	bac.infineum@ajg.com
Medical	Meritain Health	1.800.925.2272	www.meritain.com
Prescription	Express Scripts	1.866.544.2891	www.express-scripts.com
Dental	Aetna	1.877.238.6200	www.aetna.com
Vision	VSP	1.800.877.7195	www.vsp.com
Colleague Assistance Plan	Cigna	1.800.554.6931	www.mycigna.com

MONTHLY PLAN RATES

Monthly Plan Rates	Single		Individual + Adult		Individual + Child(ren)		Family	
	Colleague	**Infineum**	**Colleague**	**Infineum**	**Colleague**	**Infineum**	**Colleague**	**Infineum**
Plan 1* Meritain/Aetna	$243	$971	$462	$1,858	$414	$1,660	$618	$2,471
Medicare Supplement Meritain	$173	$296	$346	$587	NA	NA	NA	NA
Dental Plan PPO/PDN with PPO II	$26	$26	$47	$39	$47	$39	$75	$57

EXTENDED COVERAGE OF DEPENDENTS

UP TO AGE 26

You may recall that the Patient Protection and Affordable Care Act (PPACA), commonly referred to as “health care reform,” was signed into law by President Obama on March 23, 2010. One of the provisions of this law required health care plans to extend dependent care coverage to eligible individuals through age 26, beginning no later than March 23, 2011. As a result of this legislation, dependent children who are under age 26, unless other coverage is available through his/her employer or spouse, may remain on the Infineum Medical Plan. Beginning in 2014, children up to age 26 can stay on their parent’s employer plan even if they have another offer of coverage through an employer. Eligibility for this coverage does not depend on full time student status, marital status, financial dependency or residence in the parental home. New Jersey colleagues should note that, because the Infineum Medical Plan is self-funded, it is not subject to the expanded coverage provisions of the recently enacted N.J. Dependent Under 31 Law (DU31).

WOMEN'S PREVENTIVE CARE

WITH NO COST SHARING

On August 1, 2011, the Department of Health and Human Services (HHS) released an amendment to the Interim Final Regulations for preventive care under the Patient Protection and Affordable Care Act (PPACA). The amendment applies to non-grandfathered individual insurance policies as well as non-grandfathered insured and self-insured group health plans.

The amendment provides additional guidelines for women's preventive services. Health plans will need to cover women's preventive services, including birth control, without copayments or deductibles. The guidelines reflect the recommendations made in July 2011 by the independent Institute of Medicine.

For plan years beginning on or after August 1, 2012, non-grandfathered plans will be required to cover the following additional preventive care services for women with no cost sharing:

Plans may impose cost sharing on brand name preventive drugs if a generic version is available and is just as effective and safe for the patient to use. Cost sharing would not be permitted on the generic drug.

For more detail on the amendment and the additional preventive care services for women, visit:
www.hrsa.gov/womensguidelines/ or
http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html

For more information on the existing PPACA preventive care guidelines, visit:
http://www.healthcare.gov/center/regulations/prevention/taskforce.html

Services include:

- Annual well-woman visits
- Screening for gestational diabetes
- HPV DNA testing for women 30 years and older
- Sexually-transmitted infection counseling
- HIV screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies, and counseling

SUMMARY ANNUAL REPORT

FOR INFINEUM HEALTH & WELFARE BENEFIT PLAN

This is a summary of the annual report of the Infineum Health & Welfare Benefit Plan, EIN 74-2890923, Plan No. 501, for period January 1, 2023 through December 31, 2023. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Information Regarding Your Medical and Dental Plans*

All participant contributions and employer contributions are used to pay benefit claims and administrative expenses. For the period January 1, 2023 through December 31, 2023 this included employer contributions of $13,643,461 for medical and $460,103 for dental. For this same period, participants contributed $3,481,344 for medical and $508,330 for dental.

Insurance Information

The plan has contracts with United of Omaha Life Insurance Company, ACE American Insurance Company, and Connecticut General Life Insurance Company to pay Life Insurance, Long-term Disability, Accidental Death & Dismemberment, and Employee Assistance Plan claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2023 were $947,637.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write Infineum USA Inc., 1900 East Linden Avenue, Linden, NJ 07036, **800.441.1074**.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan at Infineum USA Inc., 1900 East Linden Avenue, Linden, NJ 07036 and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

* Information provided in this paragraph is not required to be reported to the Department of Labor. It is provided for your information only.

LEGAL NOTICES

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Infineum Medical Plan (**IMP** which includes HDHP or Plan1) and your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan or not. If you are considering joining, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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. Infineum USA Inc. has determined that the prescription drug coverage offered by its IMP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in Medicare prescription drug coverage.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan while still retaining your IMP coverage, your current IMP coverage will not be affected. Prescription drug coverage plan provisions/options under the Infineum plans are described in detail in the respective Summary Plan Descriptions available via the USA Colleague Handbook page on the Infinet or on the US Alumni Portal at **www.Infineum.com/AlumniPortalUS**. Medicare eligible participants can keep Infineum's coverage, if otherwise eligible; if they elect part D, the Infineum plan will coordinate with Part D coverage.

Your current IMP coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits.

Your IMSP coverage includes a Medicare Part D Plan. If you cancel or drop your IMSP coverage, be aware that you will not be able to re-enroll in the IMSP at any later time even for coverage for health expenses other than prescription drugs. You should compare your current coverage provided under the IMSP, including which drugs are covered, with the coverage and cost of plans offering Medicare prescription drug coverage in your area before you make the decision to drop your IMSP coverage. If you enroll in another Medicare Part D Plan, your IMSP coverage will be terminated (both medical and prescription drug coverage). **If you cancel or drop your IMP coverage, without immediately enrolling in both the IMSP and Medicare, then you will not be eligible to enroll in the IMSP at a later date.**

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Infineum USA Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information.

NOTE: You'll get this notice annually, as a new hire and if this coverage through Infineum USA Inc. changes. You also may request a copy of this notice at any time.

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, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Infineum USA Inc. – Human Resources Dept.
Contact:	Benefits Advisor, LBTC 1033
Address:	1900 E. Linden Avenue, Linden, NJ 07036
Phone Number:	908.474.2273

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

1 Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.

2 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by **HealthCare.gov** and either submit a new application or update an existing application on **HealthCare.gov** between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit **HealthCare.gov** or call the Marketplace Call Center at **800.318.2596**. TTY users can call **855.889.4325**.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency.
Visit **https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/** for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your HR Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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 **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 **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
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com/ HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid. georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ | 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/ iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/ hipp 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/ benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/ applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ 800.657.3672
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
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 and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 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
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

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.

Your Rights and Protections Against Surprise Medical Bills

This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- **Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- **Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of- network providers can’t balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

For New Jersey residents: On June 1, 2018, New Jersey Governor Phil Murphy signed the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the NJ Surprise Bill Act) into law. This legislation, in part, prohibits the practice of balance billing patients and increases transparency in medical billing. The purpose of the law is to protect patients from unexpected or “sur- prise” medical bills that sometimes arise when a patient unknowingly receives treatment from an out-of-network provider and is then billed for the difference between the provider’s billed charges and reimbursement received from payors for services performed in emergency room/urgent and/or inadvertent care settings. Generally, the NJ Surprise Bill Act applies to fully insured plans, the State Health Benefit plans, and self-funded plans that have opted into being governed by the NJ Surprise Bill Act. Beginning January 1, 2022, the new Federal No Surprises Act will govern self-funded surprise bill claims that have not opted into NJ law and those fully insured claims for services not covered by the NJ Surprise Bill Act, such as post-stabilization care.

When balance billing isn’t allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out- of-pocket limit.

If you believe you’ve been wrongly billed, you may contact Meritain Health Customer Service at **800.925.2272** or Infineum Human Resources at **908.474.2273**.

Visit **https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/surprise-billing-requirements-final-rules-fact-sheet.pdf** for more information about your rights under federal law.

Visit **https://www.nj.gov/dobi/division_consumers/insurance/outofnetwork.html** for more information about your rights under New Jersey state laws.

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This benefits guide prepared by

Gallagher

Insurance | Risk Management | Consulting