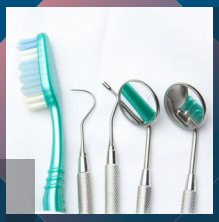
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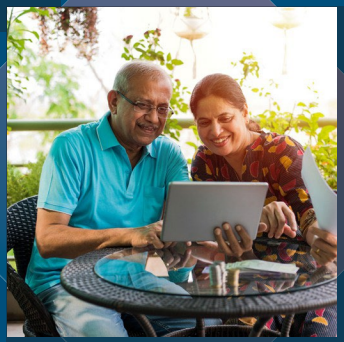
2027 OPEN ENROLLMENT BENEFITS FOR RETIREES













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.

IF YOU ARE NOT MAKING ANY CHANGES TO BENEFIT PLAN COVERAGE, NO ACTION IS REQUIRED.

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 30 for the Summary Annual Report and Page 31 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 2027, 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.

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BENEFIT PLAN CHANGES FOR 2027 - RETIREES UNDER AGE 65

Medical Plans

- GLP-1 medications prescribed for weight loss will no longer be covered. Coverage will continue for Type 2 Diabetes Mellitus (T2D).
- The fertility benefit lifetime maximum will increase to $10,000.
- Due to extremely high-cost claim experience associated with out-of-network providers, the following Plan 1 design changes will be implemented:
  - Out-of-Network deductible increases to **$3,000/$6,000** (Individual/Family).
  - Out-of-Network out-of-pocket maximum increases to **$10,000/$20,000** (Individual/Family).
  - Emergency Room copay increases to **$200**.
- Plan 1 contributions will remain unchanged.

Dental Plan

- The orthodontic lifetime maximum will increase to **$1,500**.
- Dental contributions will remain unchanged.

Medicare Supplement Plan and Medicare Part D Plan

- No changes to Medicare Supplement Plan contributions.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

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, 2027.

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 between November 1 and November 30, 2026.

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	$200 copay, waived if admitted	Deductible & Coinsurance
Urgent Care	$25 copay	Deductible & Coinsurance
PRESCRIPTION BENEFITS		
Retail (30 day supply) Generic/Preferred Brand/ Non-Preferred Brand	$15/$40/$60	Refer to page 20 for co-payments
Mail Order (90 day supply) Generic/Preferred Brand/ Non-Preferred Brand	$20/$60/$100	Refer to page 20 for co-payments
OUT-OF-NETWORK BENEFITS		
Deductible (Calendar/Plan year)	$3,000/$6,000	N/A
Out-of-Pocket Maximum (Calendar/Plan year)	$10,000/$20,000	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 the 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.brightline.com	NY, NJ, CT, MA, WA
5 and up	Alma Health	https://helloalma.com/meritain	Nationwide
5 and up	Rula	https://www.rula.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
13 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	CVS® MinuteClinic®	1.855.417.2486 or https://CVS.com/mentalhealth	CVS® MinuteClinic® in select markets

Serious mental health conditions

Ages	Provider	Contact	Availability
11 to 34	Charlie Health	1.866.491.5196 or https://CharlieHealth.com/	AK, AZ, CA, CO, DE, FL, GA, ID, IL, IN, IA, MD, MI, MO, MT, ND, NE, NM, NV, NH, NJ, NY, NC, OH, OR, PA, SC, TN, TX, UT, WA, WI, WY

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Eating disorders

Ages	Provider	Contact	Availability
All ages	Equip Health	**1.855.387.4378** or **https://equip.health/get-treatment**	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.



This flyer is for information and is not meant as medical advice. Health benefits plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change.

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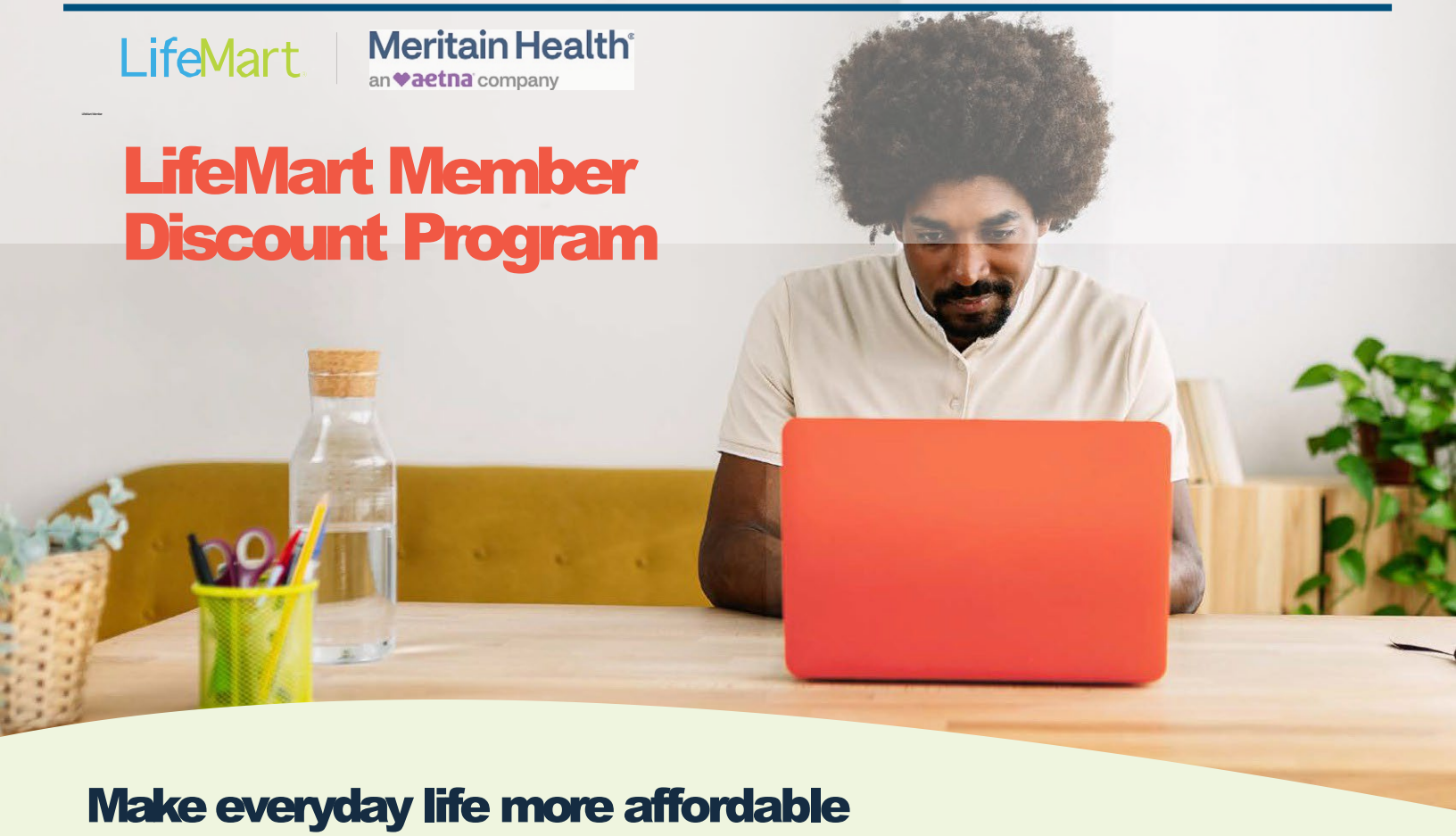
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LifeMart Member Discount Program



Make everyday life more affordable

LifeMart offers exclusive savings on major purchases and everyday essentials from brands you know and love, all in one convenient location. With discounts on travel, entertainment, child & senior care, wellness, home & auto, and so much more - LifeMart is the way to save.

Saving with LifeMart is easy:

- Search for discounts by category
- Select an offer to review the details
- Simply follow the redemption instructions to access discounts

Plus, you can access LifeMart discounts anywhere, anytime, with the LifeMart mobile app*. Simply download the app and you can browse major savings on the go. Available for download in the Google Play Store and iTunes Store.

**Pre-registration is required.*

Enroll or login to
START SAVING



Receiving Services Outside the U.S.

What if I need emergency care outside of the U.S.?

Your plan covers emergency room care outside of the country at the in-network level. If you have an urgent medical situation requiring emergency care while you're traveling, you'll have to pay out-of-pocket at the time of the service to be reimbursed later. Be sure to get a receipt in English for services rendered, including:

- Diagnosis. • Procedure. • Amount paid.

Then, simply file a manual claim with Meritain Health® for reimbursement. Keep in mind, expenses for health care services or supplies outside the U.S. sought for the express purpose of receiving medical treatment are not considered eligible.

Submitting a claim is easy

1. Just visit **www.meritain.com** to download and print a claim form.
2. Then, you'll need to complete the form, which should only take a couple of minutes. Be sure to fill out the entire form or it'll be sent back to you, and the processing of your claim will be delayed.
3. Attach the original invoice you received from your provider. The invoice should include:
   - The patient's name.
   - The date of service.
   - The name, address and telephone number of the provider.
   - A description of the services provided.
   - The amount paid.
4. Mail the completed form and original invoice to the address on the back of your member ID card.

Where's my check?

Allow time for your claim to be processed and your reimbursement check to be mailed to you. In the meantime, you can check your claim status online at **www.meritain.com**.

Additional questions?

Just call Meritain Health Customer Service at the number located on your ID card.

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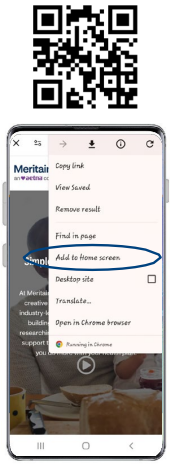


How to Access Your Mobile App

Android™ Phones

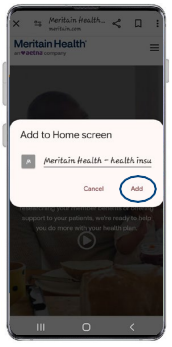
1

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.



2

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



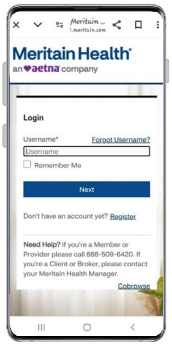
3

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



4

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



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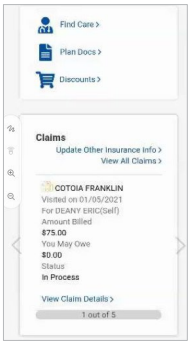
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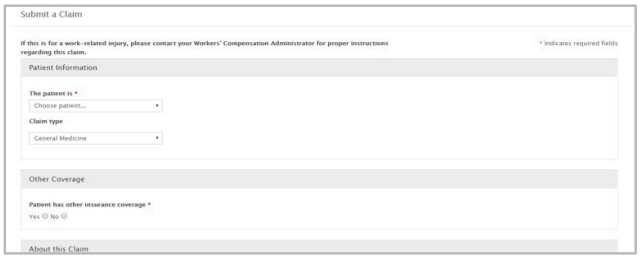
How to submit a claim online

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

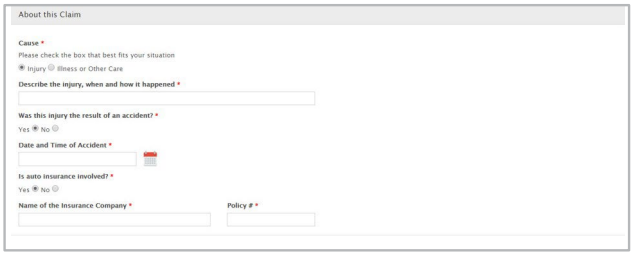
   Claims can be submitted for any covered member.



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.

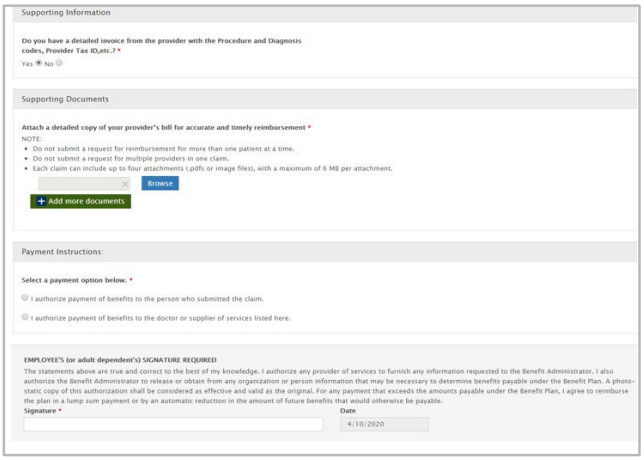


3. Next, you'll be asked to enter information about your provider.
   - If you click *Yes* for a detailed invoice, there will be no additional questions and you'll be instructed to add the required documents. You can take a picture of your documentation and attach it.
   - If you click *No* for a detailed 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 A*dditional 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?

Just give us a call at the number on the back of your ID card.

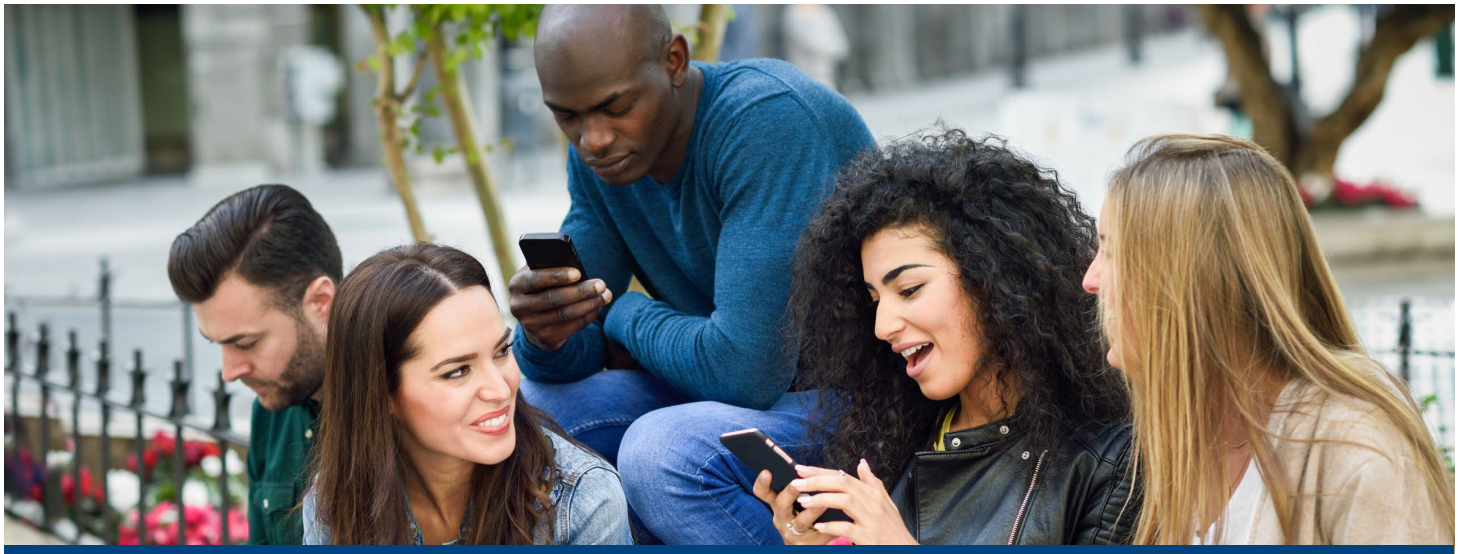
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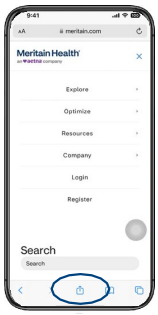


How to Access Your Mobile App

iPhone®

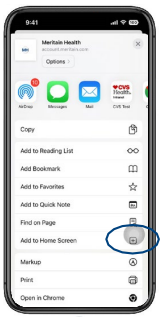
1

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.



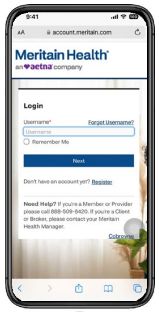
4

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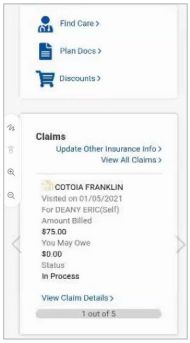
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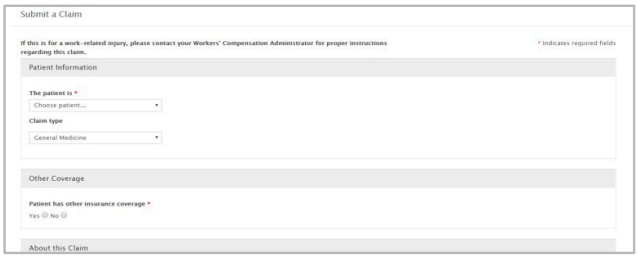
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1. After logging in to your Meritain Health account via the app, click on *Submit a Claim* at the top of the page.

   Claims can be submitted for any covered member.

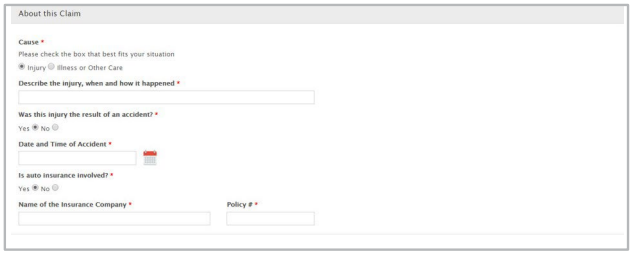


2. Select *General Medicine* under the *Claim Type* drop-down. Select *Illness, or Other Care* or *Injury*, depending on your claim. You will be guided to answer additional questions in order to complete the claim.

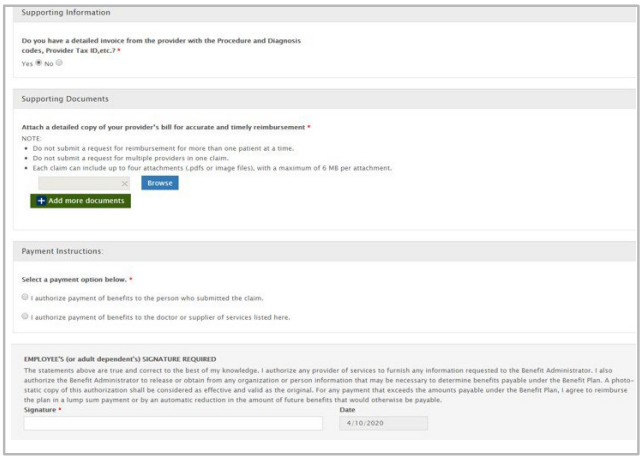


3. Next, you'll be asked to enter information about your provider.

   - If you click *Yes* for a detailed invoice, there will be no additional questions and you'll be instructed 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 A*dditional 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?

Just give us a call at the number on the back of your ID card.

Simple. Transparent. Versatile.
At Meritain Health®, we're creating unrivaled connections.

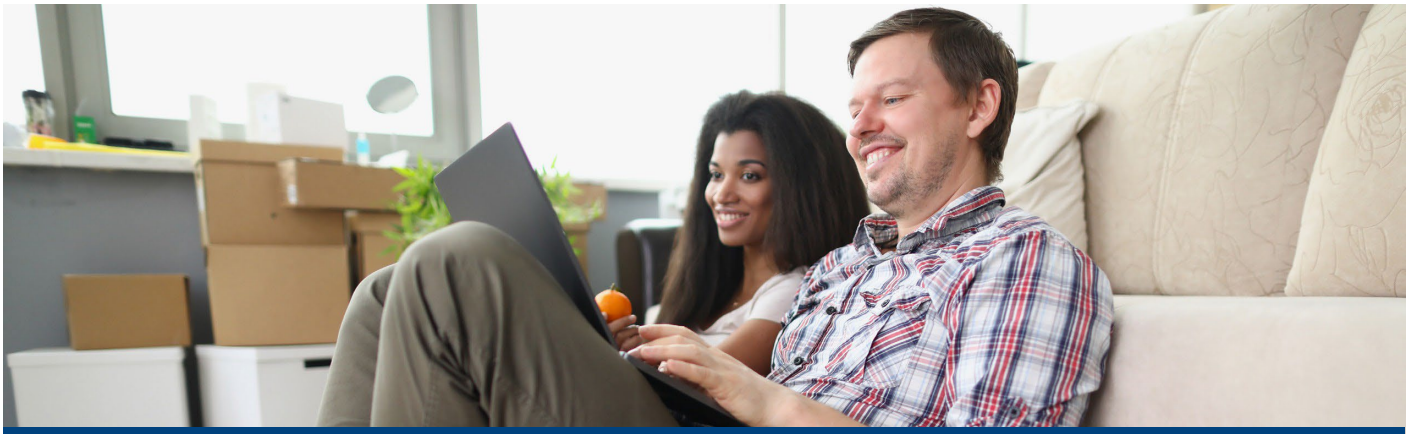
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ACCESSING OTHER INSURANCE COVERAGE (OIC) ONLINE

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



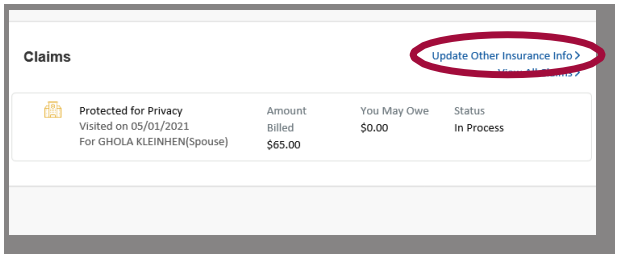
Accessing Other Insurance Coverage (OIC) Online

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.

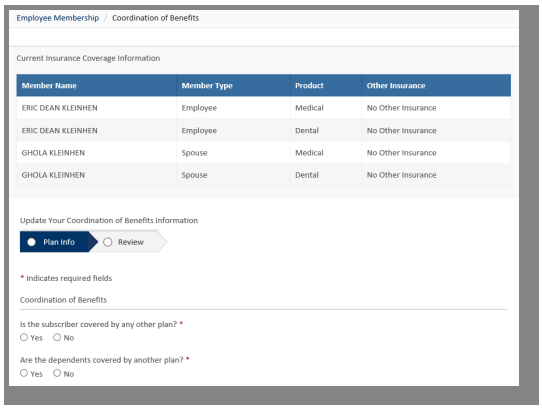
Meritain Health® may sometimes ask you to update this information so we can keep our records current.

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.

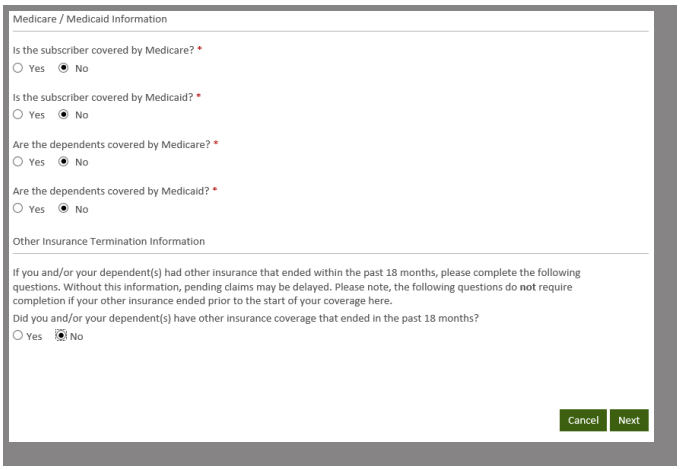
3 If you answer *Yes*, you'll be asked for information about the other coverage like start date, carrier name, policy holder name, date of birth, etc. Just fill out the forms that open when you select *Yes*.



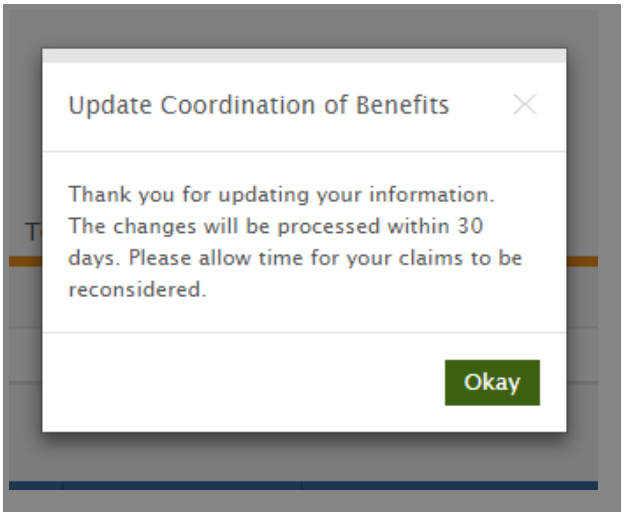
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ACCESSING OTHER INSURANCE COVERAGE (OIC) ONLINE

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.

Simple. Transparent. Versatile.
At Meritain Health®, we're creating unrivaled connections.

Follow us: @meritainhealth | Meritain Health

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WHAT IS HINGE HEALTH?

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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?

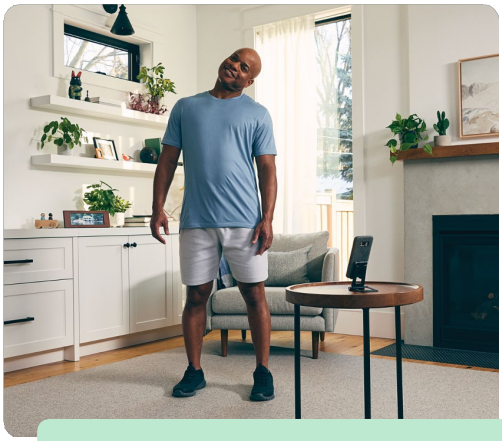
It's free for eligible participants. This includes access to your care team, the Hinge Health app, and any materials that we send to assist in your care.

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.





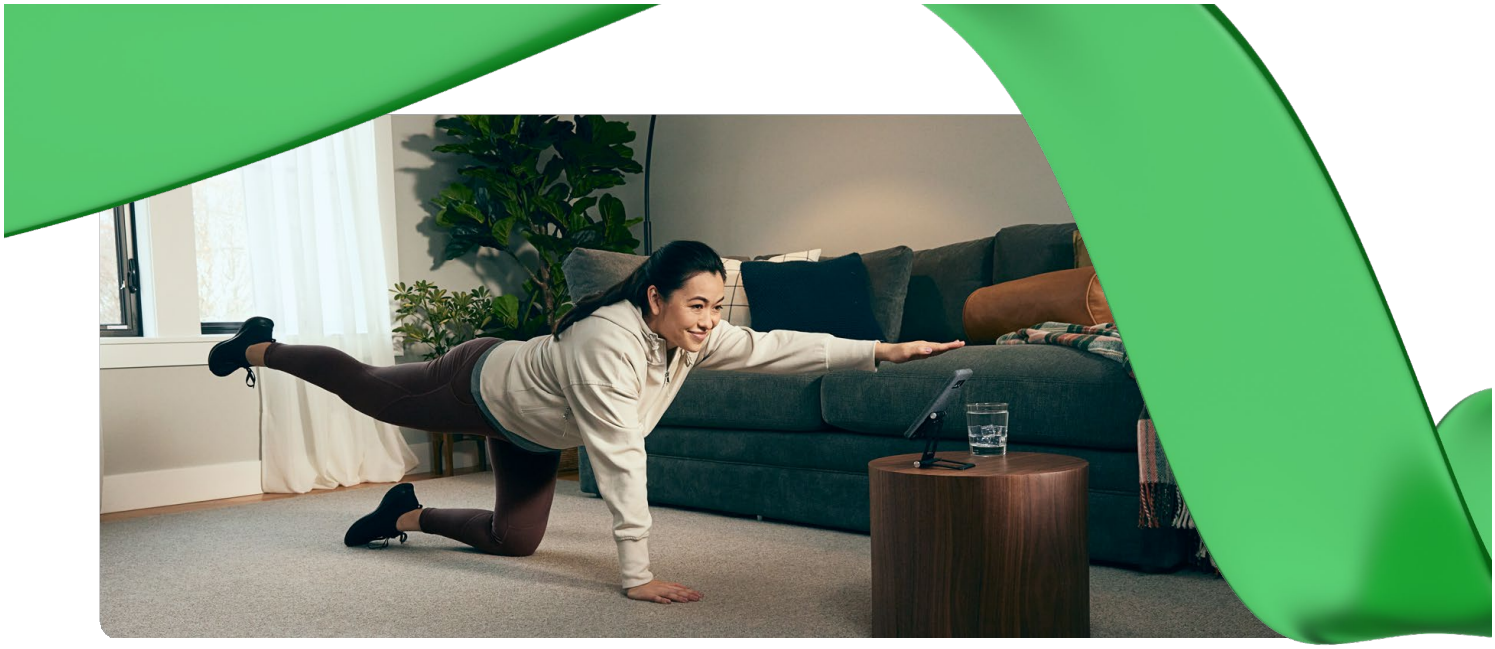


Treatment from your care team

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!



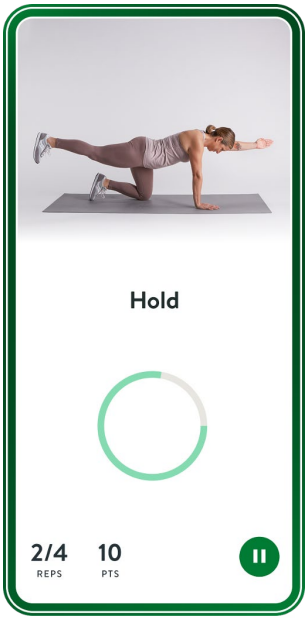
Meritain Health
an aetna company

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 set up 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 set up in the system and then able to later request refills either online or over the phone.

For Retirees under Age 65 on Plan 1

Plan Name	Rx Copays
Retail (30 day supply) Generic / Preferred Brand / Non-Preferred Brand	$15 / $40 / $60
Retail (31-60 day supply) Generic / Preferred Brand / Non-Preferred Brand	$30 / $80 / $120
Retail (61-90 day supply) Generic / Preferred Brand / Non-Preferred Brand	$45 / $120 / $180
Mail Order (90 day supply) Generic / Preferred Brand / Non-Preferred Brand	$20 / $60 / $100

For Retirees age 65+ on Medicare Supplement/Medicare Part D Plan

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 (61-90 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



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% $1,500 lifetime maximum	50% $1,500 lifetime 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.



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.

vsp vision care

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.

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: **1.800.877.7195** 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:
01/01/2027

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

Employee Assistance & Work/Life Support Program

24/7

Support for your mind and body.

EAP National Wellness Seminars: Take part in bi-monthly seminars year-round on topics that apply to real-life concerns. Join live or on demand from a computer, smartphone or tablet at: **Cigna.com/EAPWebCasts**.

Behavioral Awareness Series: We offer free behavioral health awareness seminars on autism, eating disorders, substance use and children's behavioral health issues. For more information, visit: **Cigna.com/individuals-families/health-wellness**.

Suicide Awareness and Prevention: Find crisis resources and information at **Cigna.com/SuicidePrevention**.

Call anytime for questions or support.

1.877.622.4327
myCigna.com
Employer ID: Infineum
(for initial registration)
TTY/TDD users call 711

Employee Assistance & Work/Life Support Program

24/7

Employee assistance program (EAP) services are in addition to, not instead of, your health plan benefits. These services are separate from your health plan benefits and do not provide reimbursement for financial losses. Program availability may vary by plan type and location, and are not available where prohibited by law. Some work/life services offered under the Employee Assistance Program may be provided by a Cigna Healthcare-contracted third-party vendor.

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For the employees of Infineum USA and their household members.



Real support for real life

Get to know the Employee Assistance & Work/Life Support Program

937484 b 12/24 SR#

Here to help. And support. And problem-solve.

With our Employee Assistance & Work/Life Support Program, you can get support for everyday issues and life challenges. The Employee Assistance & Work/Life Support Program is here to connect you with real people who can help you find real solutions to life's challenges.

These services are all confidential and available at no additional cost to you and anyone living in your household.

To access mindfulness exercises and discover stress management techniques, explore our Managing Stress Toolkit at **Cigna.com/ManagingStress**.



Emotional Health

Get 1-8 sessions per issue per year with a dedicated, licensed counselor at no cost to you.

Start by calling or using live chat to get a referral. Face to face or virtual sessions available for topics such as:

- Relationships and parenting
- Behavioral health and substance use
- Stress management

Home Life Referrals

Referrals for community resources/services

- **Adoption:** Learn more about your options and the agencies that can help.
- **Child care:** We'll help you find a place, program or person that's right for your family.
- **Education guidance:** We'll help you make the best decisions for your family for college searches and more.
- **Convenience services:** Shorten your to-do list with referrals for home maintenance, relocation, dining and more.
- **Senior care:** Learn about solutions related to caring for an aging loved one.
- **Pet care:** From veterinarians to dog walkers, we'll help you ensure your pets are well taken care of.
- **Prenatal care:** Find guidance through every pregnancy stage.

Financial and Legal Assistance

- **Legal consulting:** Get a free 30-minute consultation with a network attorney and 25% off select fees.†
- **Financial services referral:** Free 30-minute financial consultations by phone per topic and 25% off tax preparation.†
- **Identity theft:** Get a free 60-minute expert consultation by phone for prevention or if you are victimized.

†Customers are required to pay the entire discounted charge for any discounted legal and/or financial services. Legal consultations related to employment matters are excluded. Additional restrictions may apply.

Employee Assistance & Work/Life Support Program

24/7

Connect anytime

Call **1.877.622.4327**.
TTY/TDD users call 711.

Connect through
myCigna.com

Employer ID: Infineum
(for initial registration)

cigna healthcare

Connect anytime

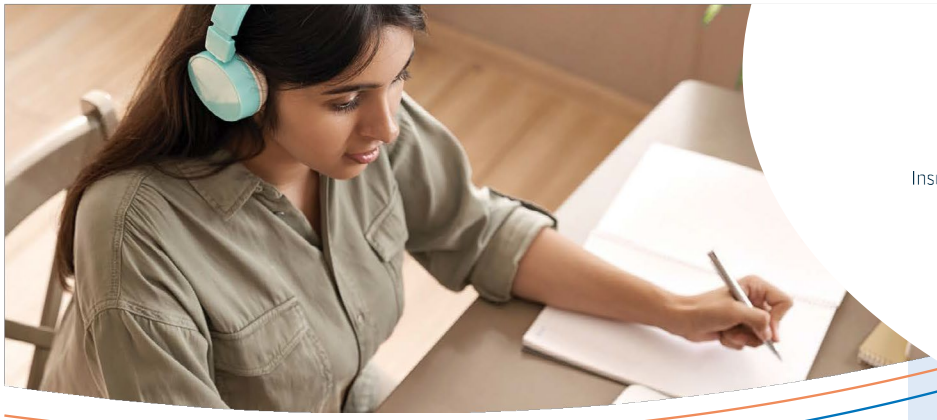
Call **1.877.622.4327**.
TTY/TDD users call 711.

Connect through
myCigna.com

Employer ID: Infineum
(for initial registration)

cigna healthcare

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

1.833.525.7102
bac.infineum@ajg.com

Hours of operation

Monday – Friday
8 a.m. – 6 p.m.

ajg.com The Gallagher Way. Since 1927.

Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc. is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Neither Arthur J. Gallagher & Co., nor its affiliates provide accounting, legal or tax advice.
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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	1.877.622.4327	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	N/A	N/A	N/A	N/A
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 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/

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, 2025 through December 31, 2025. 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, 2025 through December 31, 2025 this included employer contributions of $12,515,756 for medical and $543,213 for dental. For this same period, participants contributed $3,852,357 for medical and $507,318 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, 2025 were $1,085,026.

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

Important Notice from Infineum USA Inc.

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 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.**

If you are an active employee, and become eligible for Medicare, you remain eligible to participate in the IMP whether you enroll in Medicare or not. While you are working as an active employee, the IMP remains primary for you and most of your eligible family members. There is no expectation that you enroll in Medicare Parts A and B until after you are no longer an active employee.

If you are a retiree or survivor, and become Medicare eligible, you are no longer eligible for the IMP coverage and are expected to enroll in Medicare Parts A and B and move to the Infineum Medicare Supplement Plan (IMSP) as soon as you are eligible, even if you do not enroll in Medicare. Note that Medicare eligibility may be acquired on the basis of age, or because of disability status under Social Security.

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 15th to December 7th.

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 you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date:	**October 1, 2026**
Name of Entity/Sender:	**Infineum USA Inc. – Human Resources Dept.**
Contact—Position/Office:	**Benefits Advisor, LBTC 1033**
Office 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 Employment-Based 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.

[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.

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.

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 1-800-318-2596. TTY users can call 1-855-889-4325.

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 **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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/ | Phone: 1-855-692-5447

ALASKA – Medicaid

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

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

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+)

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

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

ILLINOIS - Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid application website: https://abe.illinois.gov
HIPP Hotline Number: 217-524-8268
HIPP Email: hfs.boc.hipp@illinois.gov

INDIANA – Medicaid

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)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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

LOUISIANA – Medicaid

Louisiana Medicaid Website:
https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
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
Medicaid Website:
https://www.nj.gov/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)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
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
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
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
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
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
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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, 2026, 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.

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 “surprise” 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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