

EMPLOYEE BENEFITS

Curtis Lumber

2026 Benefit Enrollment Guide



**MARSHALL
+STERLING**

Secure your Success



885 Route 67
Ballston Spa, NY 12020
518-490-1388

Dear Employee:

Welcome to our January 1, 2026 – December 31, 2026 Benefits Open Enrollment. Our goal is to provide you and your family with cost-efficient and comprehensive benefits. These programs are reviewed annually to ensure they are in line with the current trends and remain in compliance with government regulations such as the Health Care Reform legislation. Please read this Benefits Guide to gather important details about your benefits and learn about your contributions as an aid to making your final decisions.

The definition of “full-time” for healthcare benefit eligibility purposes is working on average 30 or more hours per week. Curtis Lumber will track your hours and notify you if you are eligible for benefits. More information on eligibility to participate in our healthcare plan can be found in the plan documents, which can be obtained by contacting our Human Resources department.

Open Enrollment

Open Enrollment is the window of opportunity to make changes to your benefit elections or enroll if you previously waived coverage. It is the time of year to make sure that you have enrolled in the health benefits that meet your healthcare needs and fit into your overall financial plan. Ask yourself:

- Does your current coverage meet your family's needs?
- Did you get married, divorced, have a child or another qualifying status change since you last looked at your benefits?
- Were you covered under a spouse and now would like to be covered primarily by your employer?
- Verify that your enrolled dependents meet the definition of an eligible dependent. Medical coverage is provided for dependent children up to their 26th birthday under Health Care Reform. Other benefit plans are subject to plan age limits.

The Summary of Benefits and Coverage (SBC) for our medical plans, along with the Glossary of Health Coverage and Medical Terms, are also available. Upon request a paper copy will be provided at no charge.

Under the Affordable Care Act, you are required to maintain healthcare coverage for yourself and your dependent children.

Changing Your Benefits After Open Enrollment

After open enrollment you may change your benefits only if you have met a qualified status change, such as loss of other medical coverage, the birth of a child, divorce or a child reaching the coverage maximum age limit.

Please do not hesitate to contact Human Resources with any questions or concerns regarding your benefits.

Sincerely,

Lisa Yorks

Benefits & Leave Manager

Eligibility & Enrollments

Eligibility

Employees who regularly work 30 hours a week are eligible to participate in the Curtis Lumber Company's Benefits Program. If you enroll in coverage, you may also enroll your "eligible dependents" into the following plans: medical, dental, vision and supplemental life insurance.

Additionally, Variable Part Time employee's who meet the full-time definition defined by the Affordable Care Act (ACA), are eligible to participate in the medical plan(s). If eligible, you may also enroll your "eligible dependents" into a medical plan.

Your "eligible dependents" include:

Eligible Dependents:

- Same or opposite sex spouse
- Unmarried/married dependent children (not their spouse or dependents) to their 26th birthday
- Unmarried/married dependent children (not their spouse or dependents) of any age who are physically or mentally disabled
- **Unmarried dependent children to their 26th birthday for life insurance**

Termination of Benefits Coverage

Your benefits coverage ends as follows:

Medical, dental, vision, Health Savings Account, Supplementary Benefits terminate on the day of termination.

Basic Life, AD&D, Disability, Supplemental Life Insurance and Supplemental AD&D will terminate on the date of termination (this also includes any other company-paid or sponsored benefit not listed).

Medicare Eligible

If you are actively working and you or your spouse is eligible for Medicare benefits, please see the outline below:

Medicare Eligibility Reason	Primary Payor	Secondary Payor
Over 65 years of age	Anthem	Medicare
Due to disability	Anthem	Medicare

New Hires

New hires and newly eligible employees may enroll in the Health and Welfare plans when they first join Curtis Lumber Company. New hires must elect benefits within 31 days of their date of hire; otherwise, they will have to wait until the next Open Enrollment period to elect benefits.

The following provides an overview of benefit election requirements and effective dates.

Benefit	Action Required	Benefit Effective Date
Medical, Prescription, Dental, Vision, HSA, Vol Life, Supplementary Benefits	Associate must actively elect these benefits	Associates are eligible 30 days from date of hire
Basic Life, Accidental Death and Dismemberment	Associate does not elect these benefits	Associates are eligible 30 days from date of hire
Short Term Disability and Long Term Disability	Associate must actively elect these benefits to select the Pre or Post tax	Associates are eligible 30 days from date of hire

Medical



The EPO (Exclusive Provider Organization) medical plans, through the Anthem network, delivers in-network only benefits. Members must seek care from participating providers, except in the case of a life- or limb-threatening emergency. If care is received from a non-participating provider, the claim will not be paid. **It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.**

Plan Features	Hybrid EPO Copay Plan	Anthem \$20/\$50 Copay Plan – No Longer Available, Only Grandfathered Members
	In-Network	In-Network
Deductible / Maximum Period	Calendar Year (1/1-12/31)	Calendar Year (1/1-12/31)
Plan Year Deductibles (Indiv / Family)	\$750/\$1,500	\$0 / \$0
Deductible Type	Embedded	N/A
Plan Year Out-of-Pocket Max (Indiv / Family)	\$6,600 / \$13,200	\$6,600 / \$13,200
Out-of-Pocket Type	Embedded	Embedded
Medicare Part D Coverage	Creditable	Creditable
Referral Needed	No	No
Network	PPO/EPO	PPO/EPO
Preventive Care	Covered in Full	Covered in Full
Primary Care Visit	\$20 Copay after deductible	\$20 Copay
Telemedicine Visit	\$20 Copay after deductible	\$20 Copay
Specialist Visit	\$50 Copay after deductible	\$50 Copay
Diagnostic Lab	Covered in Full after deductible	\$20 Copay
X-Rays	Covered in Full after deductible	\$20 Copay
Complex Images	Covered in Full after deductible	\$20 Copay
Prenatal Office Visit	\$20 copay for initial visit, then no charge after the deductible	Covered in Full
Delivery (Maternity)	\$20 copay for initial visit, then no charge after the deductible	\$750 Copay
Inpatient Services (Maternity)	\$350 Copay after deductible	\$500 Copay
Hospital Outpatient Services	\$250 Copay after deductible	\$525 Copay
Hospital Inpatient Services	\$350 Copay after deductible	\$750 Copay
Mental Health Outpatient Services	Covered in Full after deductible	Covered in Full
Emergency Room	\$150 copay after deductible	\$375 copay
Land/Air Ambulance	Covered in Full after deductible	Covered in Full
Urgent Care	\$35 Copay after deductible	\$75 Copay
Retail Pharmacy / RX (30 Day Supply)	\$10 / \$60 / \$75/ \$100/ \$125 copay after deductible	\$10 / \$60 / \$75/ \$100/ \$125 copay after deductible
Mail Order Pharmacy / RX (90 Day Supply)	\$20/ \$120/ \$150/ \$200/ \$250 copay after deductible	\$20/ \$120/ \$150/ \$200 / \$250 copay after deductible

* Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member.
 * Embedded Deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits.
 * Inpatient admissions, outpatient surgery, x-rays, high level imaging, mental health and substance abuse require preauthorization. Please refer to your Certificate of Coverage for detailed information.

The EPO (Exclusive Provider Organization) medical plans, through the Anthem network, delivers in-network only benefits. Members must seek care from participating providers, except in the case of a life- or limb-threatening emergency. If care is received from a non-participating provider, the claim will not be paid. **It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.**

Plan Features	Anthem HDEPO (HSA Qualified)
	In-Network
Deductible / Maximum Period	Calendar Year (1/1-12/31)
Plan Year Deductibles (Indiv / Family)	\$2,000 / \$4,000
Deductible Type	Aggregate
Plan Year Out-of-Pocket Max (Indiv / Family)	\$6,600 / \$13,200
Out-of-Pocket Type	Embedded
Medicare Part D Coverage	Creditable
Referral Needed	No
Network	PPO/EPO
Preventive Care	Covered in Full
HSA Funding	See HSA page
Primary Care Visit	\$10 Copay after deductible
Telemedicine Visit	Covered in Full
Specialist Visit	\$40 Copay after deductible
Diagnostic Lab	No Charge
X-Rays	No Charge
Complex Images	No Charge
Prenatal Office Visit	Covered in Full after deductible
Delivery (Maternity)	Covered in Full after deductible
Inpatient Services (Maternity)	\$250/admission
Hospital Outpatient Services	\$150 Copay after deductible
Hospital Inpatient Services	\$250 Copay after deductible
Mental Health Outpatient Services	No Charge
Emergency Room	\$150/Visit
Land/Air Ambulance	No Charge
Urgent Care	\$35 Copay after deductible
Retail Pharmacy / RX (30 Day Supply)	\$10/ \$60/ \$75/ \$100/ \$125 copay after deductible
Mail Order Pharmacy / RX (90 Day Supply)	\$20/ \$120/ \$150/ \$200/ \$250 copay after deductible

* Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member.
 * Embedded Deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits.
 * Inpatient admissions, outpatient surgery, x-rays, high level imaging, mental health and substance abuse require preauthorization. Please refer to your Certificate of Coverage for detailed information.

Prescription Drug Coverage



Prescription Drug Coverage

Our medical plans include prescription drug coverage from **CVS Caremark**, managed by **Meritain Health**.

This includes generic, preferred brand name, non-preferred brand name, and specialty drugs.

Manage your Prescriptions online at www.caremark.com. Find network pharmacies, check drug costs, refill prescriptions, and set up **Mail Order for eligible maintenance medications**.

Certain specialty medications may be filled through the **CVS Caremark Specialty Pharmacy**. Visit: <http://CVSspecialty.com/go> to get started.



Pillar RX is a copay assistance program that helps reduce costs for certain high-cost medications you may be taking to manage your health.

Copay assistance is offered by certain drug manufacturers to assist in paying most or all of the copay applied to certain high cost medications.

Pillar RX provides personal hands on support so you will receive the maximum assistance available. You will be contacted by Pillar RX if you are prescribed a drug that falls within the program.



CanarX is an International Prescription Service Provider (IPSP) based in Canada that aims to provide access to affordable maintenance medications. They work with government-licensed pharmacies in

Canada, the UK, and Australia to supply brand-name medications with copays as low as \$0. This service is voluntary and works in conjunction with AngioDynamics benefits.

Learn more at <https://www.canarx.com>

Curtis Lumber Company 2026 Health Savings Account

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is used in conjunction with an HSA-qualified health plan like the Anthem Hybrid HDEPO offered by Curtis Lumber Company. This unique account allows you to save for medical, dental and/or vision expenses tax-free, or to save for those funds for use in the future.

HSAs offer a **triple tax advantage**. They allow you to:

- Save money – tax-free!
- Accumulate interest and earnings – tax-free!
- Spend on qualified healthcare expenses – tax-free!

You own the money in your HSA! The account is yours, just like a checking or savings account. Any money left over at the end of the year is yours to keep and rolls forward to be used in the future. You keep the account even if you change medical plans, employers, stop working or retire.

Contributing to your HSA

There are certain criteria you must meet to be eligible to contribute to an HSA:

- You must be enrolled in an HSA-qualified medical plan like the Anthem Hybrid HDEPO offered by Curtis Lumber Company, and you cannot be covered by any other medical plan that is not HSA-qualified.
- You cannot be covered under Medicare; TRICARE or receiving VA benefits.
- You cannot be eligible to be claimed as a dependent on another individual's tax return.
- You must be 18 years or older.
- You must be a U.S. resident.

You can put money (or “make contributions”) into your HSA, a few ways:

- **Pre-tax payroll contributions.** You can elect to have an amount regularly deducted from your paycheck.
- **Post-tax contributions.** You can initiate an online transfer, which moves money directly into your HSA from your personal savings or checking account.
- **Transfers from an existing IRA.** You can irrevocably elect to make a once-in-a-lifetime, tax-free, direct trustee-to-trustee transfer of a “qualified HSA funding distribution” from your IRA (traditional or ROTH) into your HSA.

Is Curtis Lumber Company contributing to your HSA?

Yes, participants enrolled in the employer-sponsored **Anthem Hybrid HDEPO** health plan will receive an employer contribution of **\$1,000.00 (Individual coverage)** or **\$2,000(2-Person/Family coverage)** around **1/5/26**.

Then an additional **\$46.45 (Individual)** or **\$90.91 (2-Person/Family)** on the **1st of each month (2/1/26 – 12/31/26)**. **Midyear enrollees will receive the monthly contributions**. Your employer’s contributions are added to your contributions and will count toward the annual limits set by the IRS.

The IRS limits the total amount that can be contributed to an HSA each year, based on your age and coverage level:

	2025		2026	
	Single	Family	Single	Family
Contribution Limit	\$4,300	\$8,550	\$4,400	\$8,750
“Catch-Up Contributions” for age 55+	\$1,000			

“Catch-Up contributions” provide an opportunity for those age 55+ to put an additional \$1,000 into an HSA. If you have high-deductible health plan (HDHP) coverage for the full year, you can make the full 55+ contribution regardless of when your 55th birthday falls during the year. If you did not have HDHP coverage for the full year, you must pro-rate your contribution for the number of full months you were “eligible”, i.e., had HDHP coverage. However, if you are covered on December 1st, you are treated as if you had HDHP coverage for the entire year and can make the full contribution amount. You may also contribute an additional \$1,000 if your spouse is over age 55, but the contributions go into a separate HSA under his or her name and social security number with a separate debit card per IRS guidelines.

Do you already have an HSA? Roll your old plan into your new HSA to keep everything organized in one place. Any money you roll from one HSA to another doesn’t count towards the annual contribution limits. Combining your accounts could save you money since there are no fees to use your new account! Just download the HSA Transfer Form from your WEX Health Portal and send it to your current custodian to get the process started!

How your account works

There are two parts to your HSA account: a **Cash Account** and an **Investment Account**. Initially, your money will be held in an interest-bearing cash account that is FDIC insured. Once your balance has reached \$1,000 (or another limit you specify), you can choose to use the Investment Account feature to invest the funds in the many mutual funds offered. Any interest or earnings on the account will be added to your account balance and continue to grow tax-free. You control all the investment decisions made for your account.

You can view and manage your account balances easily on your portal or through the mobile app.

WEX Health Online Portal

You’ll be given access to a secure, easy-to-use WEX Health online portal where you can:

- track your account balance,
- store receipts and documents
- view your investment accounts, and
- request distributions to pay yourself back for out-of-pocket expenses.

You can access the **WEX Health portal** at <https://msflex.lh1ondemand.com/>

Using your HSA

You can use your money (or “make distributions”) to pay for qualified expenses two main ways:

By making purchases using your Flex Debit Card Your Flex Debit Card is the easiest way to access the money in your HSA. The card links to the available funds in your HSA. When you use the card, payments are automatically withdrawn from your account. It’s that easy!

By requesting reimbursement for payments you’ve made You can also pay for expenses out-of-pocket and be reimbursed for the expense after the fact by requesting a distribution from your HSA.



If you receive a bill in the mail, you can still pay with your Flex Debit Card by inputting the debit card information in the credit card payment section or you can pay with your own money and be reimbursed for the expense from your account at a later date by requesting a distribution from your HSA.

Keep in mind, you can only use your Flex Debit Card if you have enough money in the account to cover the payment amount. If you do not have enough funds in your HSA to cover an eligible expense, there are a few options. As long as the account was open when the expense was incurred, you could:

- Pay for the expense out of pocket and then reimburse yourself from your HSA when your account balance has grown
- Pay for the expense out of your pocket and then change your elected HSA contribution amount to increase your balance faster. When you have enough money in your account you can submit for reimbursement of the expense.
- Make an additional contribution to the account online via WEX Health - or by completing an HSA Contribution Form and submitting it, along with a check, to MSEB.

What are “eligible expenses”?

Your HSA can be used tax-free to pay for IRS-qualified expenses for **yourself, your spouse or a tax dependent**. Some examples of these expenses are:

- | | | | |
|---------------------|------------------|--------------------|------------------|
| ▪ Copays | ▪ Teeth cleaning | ▪ Contact lenses | ▪ Physical exams |
| ▪ Flu shots | ▪ Office visits | ▪ Physical therapy | ▪ Chiropractor |
| ▪ Hospital services | ▪ Surgery | ▪ Co-insurance | ▪ Lab fees |

You can also use your HSA to buy over-the-counter medications and medical supplies tax-free!

It is important to note that using your HSA for non-qualified expenses could result in taxes and penalties. For a complete explanation of qualified expenses, visit the IRS website (www.irs.gov) and review Publication 502.

Although you do not need to substantiate your expenses or send in your receipts, you should keep record of your expenses for up to 7 years in case you are ever audited.

HSA FAQ's

Is an HSA the same as an FSA?

No! Although HSAs (Health Savings Accounts) and FSAs (Flexible Spending Accounts) both use pretax dollars to pay for eligible medical expenses, but there are important differences.

- Any HSA money you don't use in one calendar year carries over to the next, while there are limits to the amount of FSA money you can carry with you into a new year.
- You can only use the HSA funds after they have been deposited into your account, while elected FSA funds are available for use *prior* to contributions being made.
- HSA funds can be used to pay for healthcare costs in retirement, including some medical care premiums. *See the HSA Guide for more information.*

What happens if I leave my current employer?

Your HSA is **portable**, which means it is yours to keep should you change employment. You may choose to roll the funds over to another HSA if offered through your new employer, or you can leave them with Marshall+Sterling Employee Benefits for a cost of \$30 annually.

What happens when I die?

You will assign a beneficiary to your HSA who becomes the account owner if you die. Your HSA can transfer to your spouse tax free upon your death. If you name a non-spouse beneficiary, such as your estate or other entity, the value of the HSA is taxable to them upon your death.

Can I be enrolled in Medicare and have an HSA?

You are not eligible to *contribute* to a health savings account if you are enrolled in Medicare health insurance or are age 65 and collecting, or beginning to collect, Social Security benefits (which automatically triggers your enrollment in Medicare Part A). However, if you have an HSA balance from your previous coverage, you can continue to use those funds to pay for qualified expenses tax-free.

My spouse has a Medical FSA or Health Reimbursement Arrangement (HRA) through his/her employer. Can I still have an HSA?

If your spouse participates in a Health FSA or HRA and those benefits cover your healthcare expenses, then you are not eligible to contribute to an HSA. However, if your spouse has a "limited-purpose" FSA or HRA that covers vision and dental care expenses only then you may participate in an HSA. You can still enroll in your employer's HSA-qualified health plan, but you cannot open or contribute to an HSA.

What are "eligible expenses"?

Find more information about HSAs, as well as tools, calculators, and other resources on the **WEX Health portal** (<https://msflex.LH1ondemand.com>).

HSA Eligible Health Care Expenses

Please note that Marshall+Sterling does not intend this list to be comprehensive tax advice. For more detailed information, please consult IRS Publication 502 or see your tax advisor.

HSA Eligible Health Care Expenses

- Acne medications and treatments
- Acupuncture
- Alcoholism treatment
- Allergy and sinus, cold, flu and cough remedies (antihistamines, decongestants, cough syrups, cough drops, nasal sprays, medicated rubs, etc.)
- Allergy shots and testing
- Ambulance (ground or air)
- Antacids and acid controllers (tablets, liquids, capsules)
- Antibiotic and antiseptic sprays, creams and ointments
- Anti-itch and insect bite remedies
- Antifungals
- Antidiarrheals
- Anti-gas and stomach remedies
- Artificial limbs
- Baby care (diaper rash ointments, etc.)
- Blind services and equipment
- Braces and supports
- Breast pumps for nursing mothers
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Contact lens solution
- Contraceptives (condoms, gels, foams, suppositories, etc.)
- Crutches, wheelchairs, walkers
- Deaf services -- hearing aid/batteries, hearing aid animal & care, lip reading expenses, modified telephone, etc.
- Dental care (non-cosmetic)
- Dentures
- Diabetic testing supplies/equipment
- Diagnostic tests & products
- Digestive aids
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription Eye examinations and eyeglasses)
- Durable medical equipment (power chairs, walkers, wheelchairs, CPAP equipment and supplies, etc.)
- Eye drops, ear drops, nasal sprays
- Eczema and psoriasis remedies
- First aid kits
- Hemorrhoidal preparations
- Home diagnostic (pregnancy tests, thermometers, blood pressure monitors)
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Laxatives
- Medicated band aids and dressings
- Menstrual products
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices
- Motion sickness remedies
- Nicotine medications (smoking cessation aids)
- Non-medicated band aids, rolled bandages and dressings
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations and surgeries (legal & non-cosmetic)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Over the counter medications
- Oxygen/oxygen equipment
- Pain relievers (aspirin, ibuprofen, acetaminophen, naproxen, etc.)
- Physical exams (except for employment-related physicals)
- Physical therapy
- Psychiatric care,
- PPE (masks, hand sanitizer, and sanitizing wipes)
- Radial keratotomy
- Reading glasses
- Sleep aids and sedatives
- Smoking cessation
- Surgery (non-cosmetic)
- Telephone for the hearing impaired
- Transportation (essentially and primarily for medical care; limits apply)
- Vaccinations
- Wart removal remedies, corn patches
- X-rays

HSA Eligible Health Care Expenses - *Medical Necessity or Prescription Required*

Copy of prescription as well as detailed receipt required for reimbursement:

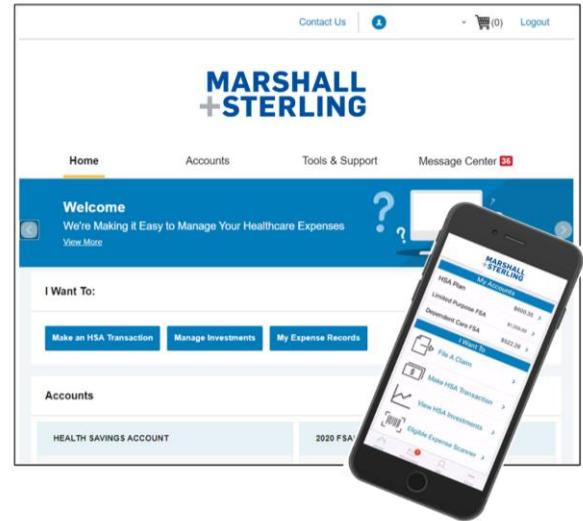
- Antiparasitic
- Birthing Classes
- Car Modifications
- Hydrogen peroxide
- Massage Therapy
- Psychologists, psychotherapists
- Schools and education (special and residential)
- Sexual dysfunction treatment
- Therapy treatments
- Vitamins and Nutritional supplements
- Weight loss programs

Your WEX Health Portal and Mobile App

Marshall+Sterling, in partnership with WEX Health, provides you an online system and mobile app that gives you access to your account information along with any other plans you're enrolled in through Marshall+Sterling. This is convenient, easy-to-access, customized and secure. Plus, it's available to you 24/7!

With this access you can:

- Check your up-to-the-minute account balances
- Store receipts and documents
- View your investment accounts
- Request distributions to pay yourself back for out-of-pocket expenses
- Sign up for or update your direct deposit information
- And much more!



The portal also has links to calculators, tools and other resources to help you plan and make sure you have all the information you need.

Once you are enrolled, your online account will be set-up by Marshall+Sterling's Flex team (this can take up to a week after the start of the Plan Year).

Your login credentials will be supplied to you. To login, go to <https://msflex.lh1ondemand.com>.

Make sure you download the Mobile App!

Go to the app store on your smartphone or tablet and search for **MSEB Flex**. Use the same username and password you use to login online. Upon your initial login, you will create a 4-digit code that you will use to get into the app each time you log in.

With the mobile app you can get on-the-go access to much of the same functionality built into your online portal. The app also has useful tools like a built-in eligibility expense scanner and the option to take and upload photos of your receipts for electronic recordkeeping.

Your Flex Debit Card



Your Flex Debit Card provides easy access to all accounts you are enrolled in through Marshall+Sterling. If you have an HSA, FSA, LPFSA, DCAP, Transit Plan or HRA, you will access all funds using the same Flex Debit Card. This card is equipped with "Smartcard" technology and draws from the appropriate account based on each expense.

Your card arrives already activated. You can continue to use your card until its marked expiration date. Marshall+Sterling Employee Benefits will automatically replace your card with a new one when it expires. Your card is equipped with mobile payment functionality- you can add it to your mobile wallet to pay for eligible expenses right from your smartphone at participating retailers. You can also replace your card or order extra cards on your Wex Health Portal.

Rx Discount Programs

Purchases through a discount program will not apply toward your annual deductible or the annual out-of-pocket max.

BLINK·HEALTH

www.blinkhealth.com

Same Medication, Same Pharmacy, Lower Price

No matter if you are insured, uninsured or something in between, we offer some of the lowest prices on over 15,000 medications. Simply pay online before you pick up at your pharmacy to save up to 95%. No membership fees. Fully refundable.

- **Search for Your Prescription**

Find savings of up to 95% on over 15,000 medications

- **Pay For It Online or Through The App**

You'll get a Blink Card – that's your proof of purchase. You can print it out. We'll also text it to you.

- **Pick Up At Your Pharmacy**

When your pharmacist asks for payment, show them your Blink Card. You'll pay nothing at the pharmacy.

GoodRx

www.goodrx.com

Stop Paying Too Much For Your Prescriptions!

Every GoodRx collects millions of prices and discounts from pharmacies, drug manufacturers and other sources.

Here's how you can use it to save:

- **Use GoodRx's Drug Price Search to Compare Prices**

See which pharmacy near you offers the best price. We don't sell the Medications, we tell you where you can get the best deal on them.

- **GoodRx Will Show You Prices, Coupons, Discounts & Savings Tips**

Get your prescriptions cheaper with deals at pharmacies near you.

- **Download GoodRx's iPhone or Android App**

Get drug prices and coupons on the go.

- **Receive A Discount Savings Card**

Keep your GoodRx card in your wallet for easy access when you need it.



The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use SydneySM Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health. Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICESM Managed Care, Inc. (RIT), Healthy AllianceSM Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem Healthchoice Assurance, Inc., and Anthem Healthchoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the tradename of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCSSWD), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association, Anthem is a registered trademark of Anthem Insurance Companies, Inc.

116947MUMENARS VP00 BY Rev. 12/22

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar anthem.com/es.



Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.



Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/register to access most of the same features from your computer.

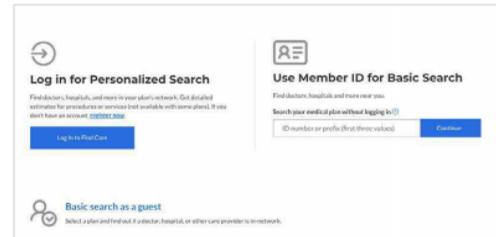
Use the Find Care tool at [anthem.com](https://www.anthem.com) to find an Anthem provider

Anthem's Find Care tool was created to make it easy to find the care you need. Use this quick step-by-step guide to help you find care.

Step 1

Go to [anthem.com/find-care](https://www.anthem.com/find-care).

- For guests — Choose **Basic search as a guest**.
- For members — You can either select **Log in for Personalized Search** on the left or you can search without logging in by selecting **Use Member ID for Basic Search** on the right.



Step 2

Scroll down and complete the following fields:

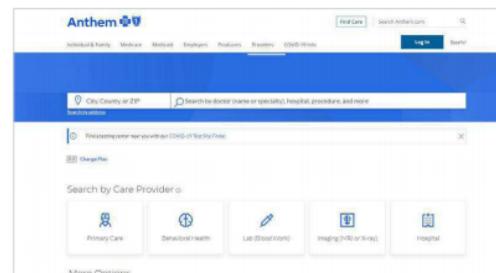
- Select the type of plan or network — Use the drop-down menu to choose **Medical Plan or Network**
- Select the state — Use the drop-down menu to choose **New York**
- Select how you get health insurance — Use the drop-down menu to choose **Medical Networks**
- Select a plan or network — Use the drop-down menu to choose **Blue Access (Employer Sponsored)**
- Select the **Continue** button.



Step 3

Enter the city, county, or ZIP code on the top left. You now have two options to narrow your search:

- **Option 1** — Enter a care provider or hospital by name or specialty in the search box. The results will appear below the *search box*, where you can select the name for more details about the care provider or hospital.
- **Option 2** — **Search by Care Provider**. Select the icon of the type of care provider you're looking for. The results will appear on a new screen, and you can select the care provider or hospital name for additional details.



Step 4

View your search results:

- Choose the printer icon to print the results of your search, or select the email icon to email the search results.
- Select a care provider name to see more details.
- Choose **Back to Find Care** on the upper left or **Back** button at the bottom of the screen to return to your results.



We are here to help

If you have questions, please call Member Services using the phone number listed on the back of your health plan ID card.





Choose doctors in your plan's network to save on costs



Choosing a doctor you trust is important, and choosing one in your plan's network can keep your costs down.

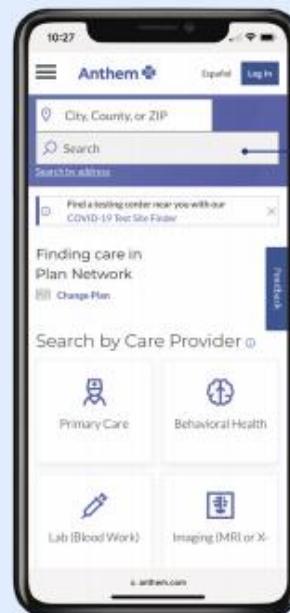
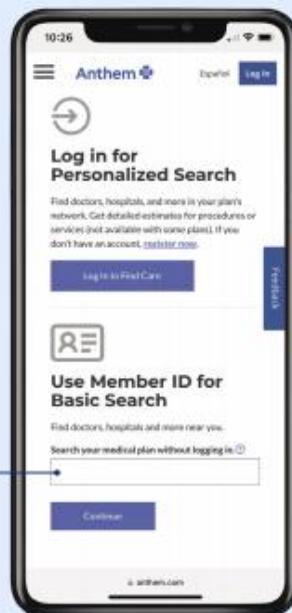
Using the **Find Care** tool on the **SydneySM Health** app and on anthembluecross.com can help you do both.

Find Care brings together details about doctors, hospitals, and pharmacies in your plan's network. You can search by name, specialty, or procedure. You can also compare costs, choose English or Spanish, and see office hours.* To make sure your care provider is in your plan's network, view the doctor or facility profile.

How it works

1 Go to anthembluecross.com/find-care.

2 For Group name enter Prefix under *Search your medical plan without logging in* and select **Continue**.



3 On the next screen, you can search for the care you need.

Download the Sydney Health app

Scan the QR code with your phone's camera and start your search today!



*Details and restrictions may vary by insurance plan and provider. Some providers may require you to log in to the app. Sydney Health is available through the Sydney Health app. For more information, please contact your plan administrator. © 2024 Anthem Blue Cross and Life Insurance Company of America. All rights reserved. Anthem Blue Cross and Life Insurance Company of America is a registered trademark of Anthem Blue Cross and Life Insurance Company of America. All other trademarks are the property of their respective owners.



Receive virtual care and support 24/7 with our Sydney Health app

Now you can connect more easily to the care you need through our SydneySM Health app. Have a video visit with a doctor on your mobile device or computer with a camera, 24/7.

Visit with a doctor for common health concerns

Doctors are available anytime, with no appointments or long wait times. They can help you with these types of conditions:

- COVID-19
- Flu
- Cold and fever
- Minor rashes
- Sore throat
- Headaches

During your video visit, the doctor will assess your condition, provide a treatment plan, and send prescriptions to the pharmacy of your choice, if needed.



What people say about virtual care visits²

89%

said the doctor they saw was professional and helpful

92%

thought the doctor understood their concerns

92%

were able to book a virtual visit sooner than an in-person visit

How to download our Sydney Health app:



Scan the QR code with your phone's camera or visit the App Store[®] or Google Play[™].

100520191144161101 6/6 06/21



Here's how to access the program through virtual care:

Download our no-cost **Sydney Health** app.

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for our app and **anthebluecross.com**.
3. Select **Care** and then select **Virtual Care**.

Visit **anthebluecross.com**.

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for **anthebluecross.com** and our **Sydney Health** app.
3. From the **Care** tab, select **Virtual Care** in the drop down menu. Then, click **Video Visit**



¹ For your privacy, defined by physical address

² Based on Sydney app, for more details, contact your doctor.

³ In order to use the app, you must be a member of the plan and have a valid email address. For more information, please contact your doctor or call 1-800-444-4444. If you are not a member of the plan, please contact your doctor or call 1-800-444-4444. You may be able to use the app if you are a member of the plan and have a valid email address.

⁴ The app is available for download on the App Store and Google Play. For more information, please visit www.sydneyhealth.com.

Sydney Health is offered through the company's Health Plan. For more information, please visit www.anthebluecross.com or call 1-800-444-4444. For more information, please visit www.anthebluecross.com or call 1-800-444-4444.

© 2024 Anthe Blue Cross of Michigan. All rights reserved. Anthe Blue Cross of Michigan is a registered service mark of Anthe Blue Cross of Michigan. Anthe Blue Cross of Michigan is a registered service mark of Anthe Blue Cross of Michigan. Anthe Blue Cross of Michigan is a registered service mark of Anthe Blue Cross of Michigan. Anthe Blue Cross of Michigan is a registered service mark of Anthe Blue Cross of Michigan.



Having a primary care doctor makes a difference

Stay healthy and help lower your healthcare costs over time with a PCP

The right doctor can have a positive impact on your health and well-being. Choosing one in your plan can save you money as well. The following information can help you find a doctor who is a good fit for you and your family.

Why you should have a primary care doctor

A primary care provider (PCP) serves as your main doctor and is your first stop when you need care.

When you see the same doctor over time, they can:

<p>See the full picture of your health</p>	<p>Save you time and money</p>	<p>Coordinate your care or treatments</p>	<p>Help you avoid costly ER visits</p>	<p>Assist you after hours</p>
				
<p>They know your health history and can connect the dots quickly if you have a health issue.</p>	<p>A PCP helps you stay healthy with preventive care and can help manage chronic conditions and medications.</p>	<p>They help ensure tests aren't needlessly repeated, your medicines work well together, and your other doctors agree on your health needs.</p>	<p>Call your PCP first when you have an illness, minor injury, or flare-up of a chronic condition. They can advise you where to go for care.</p>	<p>Many PCPs now have evening and weekend hours. Some may also offer telehealth virtual visits.</p>

The main types of primary care doctors include:

- **Family practitioners and general practice doctors** treat people of all ages. This type of doctor might be a good choice if you want to keep your family's care "under one roof."
- **Internal medicine doctors**, also called internists, treat adults and may have special knowledge about certain health problems. If you have a long-term health condition, an internist who specializes in your issue may be a good fit.
- **Pediatricians** specialize in caring for children, from birth to early adulthood.



What to consider when choosing your doctor

Every doctor is different. Take time to find a doctor who makes you feel comfortable, listens to your needs, and explains things clearly. It's also important to find out if the doctor:

- Is part of your health plan's network. You'll pay less out of pocket for your visits, preventive care screenings, vaccines, and annual physicals. If your doctor is not in your plan's network, you may not be covered at all.
- Has the training and background to treat your health problems.
- Has an office in a convenient location, close to your home or work.
- Holds office hours that work with your schedule.
- Offers telehealth options, such as text, email, phone, or video visits.

You can visit different doctors in your plan's network to find the one who is right for you. If you're not happy with your first choice, it's okay. You may be able to change your primary care doctor depending on your plan.



Three ways to find a doctor in your plan:

1. Download the Sydney HealthSM mobile app, log in, and select **Find Care**.
2. Call Member Services at the number on your ID card.
3. Scan the QR Code below or log in at **anthebluecross.com** and choose **Find Care**.



Use your phone's camera to scan this QR code.



Your plan covers telehealth visits

Virtual care, also known as telehealth, is a simpler way to talk to a doctor and can be a good option for some urgent issues. Ask your doctor if they offer telehealth visits. You can also access telehealth 24/7 through the Sydney HealthSM mobile app.

If you believe you are having a life-threatening emergency or your health is in serious jeopardy, call 911 immediately.

Sources

WebMD website: <http://www.webmd.com> (accessed July 2, 2017).
Centers for Disease Control and Prevention website: <http://www.cdc.gov/family/doctor/> (accessed July 2, 2017).

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another health care provider in your plan's network. If you receive care from a doctor or health care provider in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carston Digital Platforms, a separate company of Verity mobile application services on behalf of your health plan.

Anthem BlueCross is the trade name of Anthem HealthChoice, Inc. and Anthem HealthChoice Assurance, Inc. Anthem BlueCross + Care is the trade name of Anthem + Care, independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Dental



The Guardian DentalGuard plan allows you the freedom to see the dentist of your choice. You can utilize a large network of participating dentists who accept the Guardian DentalGuard Usual Customary or Reasonable (UCR) as payment in full after deductible and coinsurance. Dentists who participate in the Guardian DentalGuard network accept Guardian as payment in full after deductible and coinsurance. Non-Guardian dentists may not accept either MAC as payment in full and may balance bill without limit.

Plan Features	Guardian Dental Guard Base Plan	
	In-Network	Out-of-Network
Deductible / Maximum Accumulation Period	Plan Year(1/1-12/31)	
Dependent Age Limit	Up to Age 26	
Network	Dental Guard Preferred PPO	
Reimbursement Level	95 th Percentile UCR	
Waiting Period (for late entrants)	None	
Plan Deductible (Individual / Family)	\$50 / \$50	
Deductible Waived For	Preventive Care	
Preventive Care (Cleanings, Oral Exams, etc.)	90% Covered	80% Covered
Basic Procedures (Extractions, fillings, etc.)	90% Covered	80% Covered
Major Procedures (Crowns, dentures, etc.)	50% Covered	40% Covered
Child Orthodontia (up to age 19)	Not Covered	
Plan Year Maximum Benefit	\$1,500	
Orthodontia Lifetime	N/A	

- If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between what the provider charges and the Plan pays.
- Certain procedures may require a pre-treatment review.
- Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan.

Dental



The Guardian DentalGuard plan allows you the freedom to see the dentist of your choice. You can utilize a large network of participating dentists who accept the Guardian DentalGuard Usual Customary or Reasonable (UCR) as payment in full after deductible and coinsurance. Dentists who participate in the Guardian DentalGuard network accept Guardian as payment in full after deductible and coinsurance. Non-Guardian dentists may not accept either MAC as payment in full and may balance bill without limit.

Plan Features	Guardian Buy Up Plan	
	In-Network	Out-of-Network
Deductible / Maximum Accumulation Period	Plan Year (1/1-12/31)	
Dependent Age Limit	Up to Age 26	
Network	Dental Guard Preferred PPO	
Reimbursement Level	95 th Percentile UCR	
Waiting Period (for late entrants)	None	
Plan Deductible (Individual / Family)	\$50 / \$50	
Deductible Waived For	Preventive Care	
Preventive Care (Cleanings, Oral Exams, etc.)	90% Covered	80% Covered
Basic Procedures (Extractions, fillings, etc.)	90% Covered	80% Covered
Major Procedures (Crowns, dentures, etc.)	50% Covered	40% Covered
Child Orthodontia (up to age 19)	50% Covered	50% Covered
Plan Year Maximum Benefit	\$2,000	
Orthodontia Lifetime	\$2,000	

- If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between what the provider charges and the Plan pays.
- Certain procedures may require a pre-treatment review.
- Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan.

The Guardian Life Insurance Company of America vision plan allows you the freedom of seeing the provider of your choice. If you choose an in-network provider, you will have lower out-of-pocket expenses. After you have exhausted your funded benefit, you are also eligible to access significant discounts on materials through participating network providers.

Plan Features	Guardian Full Feature – Designer Davis Vision	
	In-Network	Non-Network Reimbursement
General Plan Information		
Dependent Age Limit	Up to Age 26	
Network	Davis Vision	N/A
Frequency of Service		
Exam	Once a year	
Frames	Once every other year	
Lenses /Contact Lenses	Once a year	
Vision Exam		
Eye Exam	\$20 copay	Amount over: \$50
Frames		
	\$135.00, 20% discount on amount over \$135.00	Amount over: \$48
Basic Lenses		
Single Vision	\$20 copay	\$48 copay
Lined Bifocal		\$67 copay
Lined Trifocal		\$86 copay
Lenticular		\$126 copay
Contact Lenses (in lieu of frames & lenses)		
Conventional	\$135.00, 15% discount on amount over \$135.00	Amount over: \$105
Planned Replacement / Disposable		
Medically Necessary	Covered in full	Amount over: \$210
Evaluation and fitting	Not Covered	Not Covered
Other Discounts		
Cosmetic Extras	Avg. 30% off retail price	No discounts
Laser Correction Surgery	20-35% off national average price thru Davis Laser vision network	No discounts

• Frequency based on last date of service.
 • The "frame allowance" or discounts associated with this vision plan may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail or independent provider locations. Members may submit an out-of-network claim for reimbursement on such frames up to the schedule amount indicated in the member's benefit summary/certificate of coverage.

The Guardian Life Insurance Company of America vision plan allows you the freedom of seeing the provider of your choice. If you choose an in-network provider, you will have lower out-of-pocket expenses. After you have exhausted your funded benefit, you are also eligible to access significant discounts on materials through participating network providers.

Plan Features	Guardian VSP Full Feature	
	In-Network	Non-Network Reimbursement
General Plan Information		
Dependent Age Limit	Up to Age 26	
Network	VSP	N/A
Frequency of Service		
Exam	Once a year	
Frames	Once every other year	
Lenses /Contact Lenses	Once a year	
Vision Exam		
Eye Exam	\$20 copay	Amount over: \$50
Frames		
	\$130.00, 20% discount on amount over \$130.00	Amount over: \$48
Basic Lenses		
Single Vision	N/A	\$48 copay
Lined Bifocal		\$67 copay
Lined Trifocal		\$86 copay
Lenticular		\$126 copay
Contact Lenses (in lieu of frames & lenses)		
Elective Lenses	Amount over: \$130	Amount over: \$120
Medically Necessary	Covered in Full	Amount over: \$210
Evaluation and fitting	15% off professional fee	No discounts
Other Discounts		
Cosmetic Extras	Average of 30% Discount	No discounts
Laser Correction Surgery – Usual Charge	Average of 15% Discount	No discounts
Laser Correction Surgery – Promotional Price	Average of 5% Discount	No discounts

• Frequency based on last date of service.
 • The "frame allowance" or discounts associated with this vision plan may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail or independent provider locations. Members may submit an out-of-network claim for reimbursement on such frames up to the schedule amount indicated in the member's benefit summary/certificate of coverage.



The road to well-being starts with a smile

Guardian’s dental app helps make it easy to understand and use your dental benefits

Taking the best possible care of your teeth can do so much more than brighten your smile. Good oral health is an essential part of your overall well-being,¹ and can impact how well you and your family members feel, think, and perform at work and beyond. That’s why we’re committed to helping make it easier for you to understand your dental benefits and quickly access the care you need.

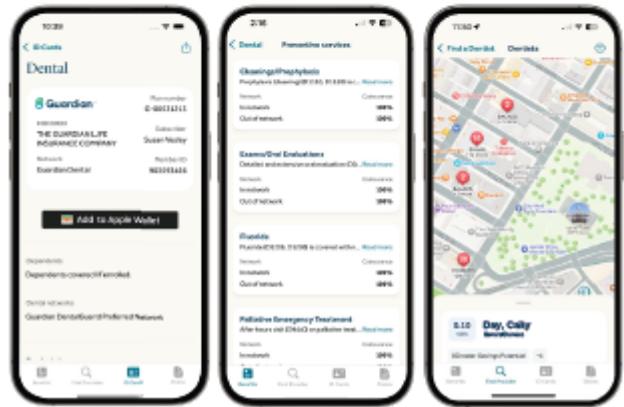
Convenient access to your dental benefits through the Guardian mobile app

In addition to downloading your digital ID card, you can use the app to:

- Stay on top of how much your plan has covered, including quick visibility to maximums and deductibles
- Find an in-network dentist near you
- Save your preferred in-network dentist to easily go back to later
- Track what claims have been paid and see what’s still pending
- And more!

On top of helping you save on dental care, your dental benefits open the door to help diagnose and prevent potentially serious health conditions sooner. Our dental app can help you stay on top of it all, with the information you need right in your pocket.

Take a sneak peek at the app



Download the Guardian dental app for a simpler benefits experience.



The Guardian Life Insurance Company of America
guardianlife.com

New York, NY
7216645.1 (10/26)

1 ["Oral health: A window to your overall health,"](#) Mayo Clinic, Oct. 28, 2021

Guardian® is a registered trademark of The Guardian Life Insurance Company of America, New York, NY. Copyright© 2024 The Guardian Life Insurance Company of America. All rights reserved. All scenarios and names mentioned herein are purely fictional and have been created solely for educational purposes. Guardian will never ask you to provide sensitive personal information, including SSN/DOB, nor login via QR codes.

Basic Life / AD&D



General Plan Information	
Eligibility	All Full-Time Employees
Employee Contribution	None – 100% Employer Paid
Term Life	
Benefit	\$25,000
Maximum Benefit	\$25,000
Accelerated Death Benefit	Available
Accidental Death & Dismemberment (AD&D)	
Benefit	\$25,000
Seatbelt And Airbag Benefit	If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by \$10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional \$5,000.00, for a total increase of \$15,000.00. However, in no event will the total increase exceed 10% of your optional group term life insurance benefit
Additional Features	
Conversion	Yes
Age Reduction Schedule	
At Age 65	35%
At Age 70	50%
At Retirement	Coverage terminates

- Guarantee Issue on voluntary life & AD&D amounts apply if you elect coverage within 30 days of your initial eligibility date. After 30 days of initial eligibility, you must provide Evidence of Insurability. Evidence of Insurability will be required for any future benefit increases.
- All unmarried dependent children in family unit are covered to from 14 days to age 26.
- Eligible children under 14 days of age receive a \$1,000 benefit

Voluntary Term Life



Benefit	Employee	Spouse	Dep Child(ren)
General Plan Information			
Eligibility	All Full-Time Employees		
Voluntary Term Life			
Benefit Increment	\$10,000	\$5,000	\$1,000
Maximum Benefit	\$500,000	\$100,000	\$10,000
Newly Eligible Guarantee Issue	Ages 15-64 \$150,000 Ages 65-69 \$10,000 Ages 70 and up, evidence of insurability is required for all amounts.	Spouse's Age 15-64 \$10,000 Spouse's Age 65 and up \$5,00	There is no guaranteed issue.
Additional Features			
Accelerated Death Benefit	If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by \$10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional \$5,000.00, for a total increase of \$15,000.00. However, in no event will the total increase exceed 10% of your optional group term life insurance benefit		
Seatbelt * Airbag Benefit	If a dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, we will increase the benefit amount by \$5,000.00. And if a dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase the benefit amount by an additional \$2,500.00, for a total increase of \$7,500.00. However, in no event will the total increase exceed 10% of the dependent's optional group term life insurance benefit.		
Waiver of Premium	Not Offered		
Evidence of Insurability (EOI)	Outside of initial enrollment & above GI Amounts		
Conversion	Offered		
Portability	Not Offered		
Age Reduction Schedule			
At Age 65	35%	35%	N/A
At Age 70	50%	Coverage terminates	

- Guarantee Issue on voluntary life & AD&D amounts apply if you elect coverage within 30 days of your initial eligibility date. After 30 days of initial eligibility, you must provide Evidence of Insurability. Evidence of Insurability will be required for any future benefit increases.
- All unmarried dependent children in family unit are covered to from 14 days to age 26.
- Eligible children under 14 days of age receive a \$1,000 benefit

Voluntary Short-Term Disability

General Plan Information	
Eligibility	All Full-Time Employees
Short-Term Disability	
Weekly benefit	60% of pre-tax weekly earnings
Maximum Benefit	\$1,154
Guaranteed Issue	There is no guaranteed issue. All amounts are approved.
Evidence of Insurability (EOI)	Yes, if not a new hire
Waiting Periods	Accident & Illness: 15 days
Maximum Payment Period	13 weeks

Group Long-Term Disability

General Plan Information	
Eligibility	All Full-Time Employees
Employee Contribution	None – 100% Employer Paid
Long-Term Disability	
Monthly Benefit	60% of pre-tax monthly earnings
Maximum Benefit	\$5,000
Waiting Periods	Accident & Illness: 15 days
Maximum Payment Period	Social Security Normal Retirement

Voluntary Benefits



The following supplemental benefit programs are available for you to choose from. These plans provide cash to help offset any unexpected medical expenses you or your family may experience, as the result of an accident, serious illness, or hospitalization. The money is paid directly to you and can be used to cover your health plan deductible and copays. This is another way to provide yourself financial protection for those unforeseen medical events, along with some peace-of-mind.

These supplemental plans can be used in conjunction with any medical plan. Individual and family coverage are available for each of the plans offered and can all be chosen independent of each other.

Accident

This plan offered through **Guardian** pays money directly to you for care of injuries that happen on or off the job, 24/7. Personal accident care pays for hospitalization, emergency care, ambulatory care, follow up visits and many other benefits.

Critical Illness

This plan provides cash benefits if you or a covered family member is diagnosed with a Heart Attack, Stroke, Cancer, End Stage Renal (Kidney) Failure, Major Organ Failure or Coronary Artery Disease. There is a \$50 wellness benefit for certain tests or procedures. You must be enrolled in a medical plan to enroll in this coverage.

Hospital Indemnity

Hospitalization can happen to anyone. And while medical insurance may cover those expenses, other costs can add up like extra childcare, transportation, help around the house, even pet care. There may also be deductibles and co-pays. That's where hospital indemnity coverage can help.



ID Watchdog

Protect your identity with ID Watchdog; they are everywhere you cannot be monitoring your credit and helping you better protect your identity. Sign up for their advanced identity monitoring services and protect yourself and your family. Check out IDwatchdog.com for details.



No one is immune to identity theft.

Better Protect What Matters Most.

Identity theft can affect anyone — from infants to seniors. Each generation has habits that savvy criminals know how to exploit — resulting in over \$47 billion lost in the US to identity fraud in 2024.¹ Take action with award-winning ID Watchdog® identity theft protection.

Greater Peace of Mind

With ID Watchdog® as an employee benefit, you have a more convenient and affordable way to help better protect and monitor your identity. You'll be alerted to potentially suspicious activity and enjoy greater peace of mind knowing you don't have to face identity theft alone.



ID Watchdog® was awarded the **2024 Best in Class Identity Protection Service Provider**

Why Choose ID Watchdog?

Financial & Identity Fraud Protection

Put your trust into an award-winning identity theft protection service, recognized by Javelin Strategy & Research as a "Best in Class" leader for three consecutive cycles — we've built a reputation on excellence for our capabilities in detection, monitoring, alerting, and prevention.

Personal Cyber Security

We want to empower you to navigate the digital world more safely. Our solution includes robust digital privacy and device security tools you can implement on your devices — helping to reduce the likelihood of cyber attacks, phishing, or other AI-powered scams.

Extensive Family Protection

We offer more features to help protect minors than any other provider. Our family plan helps you better protect your loved ones with personalized accounts for adult family members, family alert sharing, and exclusive features for children.²

Resolution & Insurance

We've made protecting you and your family from financial losses even easier — offering a financial safety net that makes sense for a broad array of situations to extend peace of mind. Even more, our team of resolution specialists are here to walk you through it, step by step.

Our US-based, customer care team is **here for you 24/7/365 at 866.513.1518.**

¹ 2025 Identity Fraud Study: Breaking Barriers to Innovation, Javelin Strategy & Research.

² Refer to your employer or ID Watchdog for family plan eligibility.

ID Watchdog® Platinum

Powerful features for end-to-end support

Financial Protection

- Credit Report Lock¹
- Blocked Inquiry Alerts
- 3 Bureau PreCheck²
 - Encourages potential lenders to verify your identity before extending credit.
- Subprime Loan Block³ 
 - Within the monitored lending network
- Credit Reports & VantageScore® Credit Scores | 1 Bureau Daily & 3 Bureau Annually
- Credit Score Tracker
- Credit Report Monitoring | 3 Bureau⁴
- Telecom & Utility Alerts
- High Risk Transaction Monitoring⁵ 
- Financial Accounts Monitoring
- Subprime Loan Monitoring⁶ 

Identity Fraud

- Dark Web Monitoring⁷ 
- AI Powered Phishing & Malware Alerts
- Social Accounts Monitoring 
- Public Records Monitoring 
- USPS® Change of Address Monitoring 
- Registered Sex Offender Reporting 
- National Provider ID Alerts

Personal Cyber Safety

- Digital Privacy Scans & Removal⁸

Family Protection

- Family Alert Sharing
- Child Credit Lock 
- Child Credit Monitoring 

Reimbursement & Support

- Personalized Identity Restoration,  including Pre Existing Conditions
- Online Resolution Tracker
- Up to \$5M Identity Theft Insurance⁹ 
 - Stolen Funds Reimbursement \$1M | Checking & Savings Accounts \$1M | 401k/HSA/529 Accounts
 - Home Title Fraud
 - Cyber Extortion
 - Professional Identity Fraud
 - Deceased Family Member Fraud
 - Senior Family Coverage
 - Up to \$500 Stolen Cash Replacement
- Cyber Crime Coverage¹⁰  **NEW** Up to \$5k
 - Online Fraud & Scams
 - Cyber Extortion Response
 - Cyberbullying Expenses
- Lost Wallet Vault & Assistance
- Deceased Family Member Fraud Remediation (Family Plan only)
- Credit Freeze Assistance
- Data Breach Notifications
- Solicitation Reduction
- 24/7/365 Customer Care Center
- Online Chat **NEW**

 Helps better protect children

NEW = Targeted to be available by Oct 2025*

1 Bureau = Equifax® | 3 Bureau = Equifax®, Experian®, TransUnion®



A child's identity can provide a blank slate for fraudsters



Help better protect your children from identity theft with features marked with this icon.

Special Employee Pricing Per Month

Employee	\$10.90
Employee + Family	\$18.90

Take a step to help better protect your identity.

Enroll in this valuable benefit today.

What You Need to Know

The credit scores provided are based on the VantageScore® 3.0 model. For three-bureau VantageScore® credit scores, data from Equifax®, Experian®, and TransUnion® are used respectively. Any one-bureau VantageScore® uses Equifax® data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.

(1) Locking your Equifax® credit report will prevent access to it by certain third parties. Locking your Equifax® credit report will not prevent access to your credit report at any other credit reporting agency. Entities that may still have access to your Equifax® credit report include: companies like ID Watchdog®, which provide you with access to your credit report or credit score, or monitor your credit report as part of a subscription or similar service; companies that provide you with a copy of your credit report or credit score, upon your request; federal, state, and local government agencies and courts in certain circumstances; companies using the information in connection with the underwriting of insurance, or for employment, tenant or background screening purposes; companies that have a current account or relationship with you, and collection agencies acting on behalf of those whom you owe; companies that authenticate a consumer's identity for purposes other than granting credit, or for investigating or preventing actual or potential fraud; and companies that wish to make pre-approved offers of credit or insurance to you. To opt out of pre-approved offers, visit www.optoutprescreen.com. (2) The 3-Bureau PreCheck feature is made available to consumers by Equifax® Information Services LLC and fulfilled on its behalf by Identity Rehab Corporation. (3) The monitored network does not cover all businesses or transactions. (4) Monitoring from TransUnion® and Experian® will take several days to begin. (5) There is no guarantee that ID Watchdog® is able to locate and scan a deep and dark websites where consumers' personal information is at risk of being traded. (6) There is no guarantee that we can detect or remove consumer personal information from all people search sites. (7) The Identity Theft Insurance is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Review the Summary of Benefits (www.idwatchdog.com/terms/insurance). (8) Available to all customers residing in the United States, including U.S. territories and the District of Columbia, with the exception of residents of New York. ID Watchdog® is not a licensed insurance producer. Benefits under the Master Policy are covered by HSB Specialty Insurance Company. Review the Summary of Benefits for further details and explanation. (www.idwatchdog.com/terms/cybercrimecoverage) *May be subject to delay or change.

Copyright © 2025 Equifax Inc., Atlanta, Georgia. All rights reserved. Equifax and ID Watchdog are registered trademarks of Equifax Inc. Other product and company names are property of their respective owners. 25_EWS_MKT_1628357517

EQUIFAX®



Easy access to your account



Curtis Lumber Co., Inc. Employee Savings & Profit Sharing Plan

Taking control of your retirement journey should be simple. That's why your Transamerica account is built for easy access on any device.



Set up your online account at
transamerica.com/portal

Getting started

- Click **Create an account** in the top-right corner
- You'll then be prompted to enter your full name, date of birth, Social Security number, and contact information
- Next, create a unique username and password and set up your security questions
- If you already have an online account, click **Log In** up in the top-right corner

Completing your profile

- If you're a first-time user, log in and click **VIEW DETAILS** next to your account. You can then set your contribution rate, create an investment strategy, and review and confirm your contact information.
- If you're already enrolled, review your contact email and phone number by clicking your initials in the top-right corner and selecting personal information. Consider adding your phone number and alternate email address and selecting text messages for important retirement plan reminders.

Once you're In

From the top navigation, scroll over the tabs – **My Plan, Investments, Contributions, Loans & Withdrawals, Documents & Forms, and Resources** – and select an option from the drop-down lists.

Here, you can take control of your retirement and plan for your financial future.

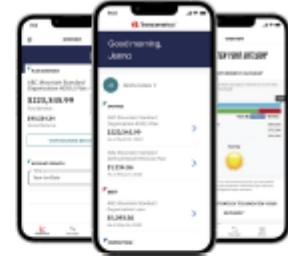
- Check account balance
- Use our *OnTrack*[®] tool to help create and easily modify your retirement income strategy
- Transfer between funds
- Review investment performance
- Manage contributions and fund allocations
- Name or change a beneficiary
- Review options for prior employer retirement plan accounts



Transamerica Retirement App

With the Transamerica Retirement App, preparing for the future has never been easier.

- Enroll in your plan
- Check your balance
- Adjust your contribution rate
- Manage your investments
- Add or update your beneficiaries
- Sign up for security alerts
- Review and update *Your Retirement Outlook*[®] personalized Income analysis
- Enable facial recognition for enhanced security



Set up Voice Pass: 800-755-5801

Transamerica Voice Pass, our voice-recognition system, can provide security and convenience without having to remember a password when you call our Customer Care team. Voice Pass will identify you based on a stored voiceprint as unique as your fingerprint. Once set up, all you'll need to do when you call is repeat the phrase, "At Transamerica, my voice is my password" to access your account.

Step 1: Call **800-755-5801**.

Step 2: Let us know who you are. If you're calling from the phone number we have on file, we'll identify you that way. If you're calling from a different phone number, enter or say your Social Security number.

Step 3: If it's your first time calling, follow the prompts to set up Voice Pass. If you've called before, we'll ask you to verify your identity with your voice.

Access your account to get started



Visit: transamerica.com/portal

IMPORTANT: The projections or other information generated by the engine, which produces *Your Retirement Outlook*[®], regarding the likelihood of various investment outcomes are hypothetical in nature, do not reflect actual investment results, and are not guarantees of future results. Results derived from the tool may vary with each use and over time. Please visit your plan website for more information regarding the criteria and methodology used, the engine's limitations and key assumptions, and other important information.

Securities offered by Transamerica Investors Securities, LLC (TIS), member FINRA, 440 Mamaroneck Avenue, Harrison, NY 10528. All Transamerica companies identified are affiliated but are not affiliated with your employer.

Resources

Before Enrolling, be sure to:

- **Consider your options.** Make sure you get the coverage that best suits your needs. Discuss with your spouse, partner or other family members to consider all sources of benefits coverage.
- Our insurance carriers offer a number of tools and resources available through their web sites that can help support your decision-making process. You can reach the carriers at:

Keep this guide handy - refer to the information in this guide to help you make wise benefit choices.

Anthem Medical

www.anthem.com

(844) 857-4415

Marshall+Sterling Employee
Benefits - FLEX

flex@marshallsterling.com

(518) 373-0069, opt. 4

Guardian

www.guardianlife.com

(888) 482-7342

VSP Vision

www.vsp.com

(800) 877-7195

Davis Vision

www.davisvision.com

(800) 999-5431

ID Watchdog

www.idwatchdog.com

(866) 513-1518

Marshall + Sterling – Michelle Conway

mconway@marshallsterling.com

Curtis Lumber - Lisa Yorks

lisa.yorks@curtislumber.com



Contact our Team: (866) 573-4768



New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

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 meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.96% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

An employer-sponsored 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% of such costs.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Lisa Yorks
Curtis Lumber Company
885 Route 67
Ballston Spa, NY 12020
518-490-1388
lisa.yorks@curtislumber.com

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.

¹ An employer-sponsored 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% of such costs.

General Group Health Plan Notices

Patient Protection Disclosure Notice

If your health plan generally allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

The Women’s Health and Cancer Rights Act of 1998

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis and complications resulting from a mastectomy, including lymph edema? Contact your employer for more information.

The Women’s Health and Cancer Rights Act (WHCRA), signed into law on October 21, 1998, contains protections for patients who select breast reconstruction in connection with a mastectomy. Plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy.

Women’s Health and Cancer Rights Act (WHCRA):

- Applies to group health plans for plan years starting on or after October 21, 1998.
- Applies to group health plans, health insurance companies or HMOs, if the plan or coverage provides medical and surgical benefits with respect to mastectomy.
- Requires coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient.

Under WHCRA, mastectomy benefits must include coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and treatment of physical complications of the mastectomy, including lymph edema;

Under WHCRA mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage. Therefore, the following **in-network** copays, deductibles and coinsurance apply:

Benefit	Hybrid EPO Copay Plan	Anthem \$20/\$50 Copay Plan	Anthem HDEPO (HSA Qualified)
Deductible	\$750 / \$1,500	\$0 / \$0	\$2,000 / \$4,000
PCP Office Visit	\$20 Copay after deductible	\$20 Copay	\$10 Copay after deductible
Specialist Office Visit	\$50 Copay after deductible	\$50 Copay	\$40 Copay after deductible
Inpatient Hospital Admission	\$350 Copay after deductible	\$750 Copay	\$250 Copay after deductible
Emergency Room	\$150 copay after deductible	\$375 copay	\$35 copay after deductible

The law also contains prohibitions against:

- Plans and issuers denying patients eligibility or continued eligibility to enroll or renew coverage under the plans to avoid the requirements of WHCRA.
- Plans and issuers providing incentives to, or penalizing, physicians to induce them to provide care in a manner inconsistent with the WHCRA.

If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependent(s), including your spouse, because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within "30 days" after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

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

A special enrollment opportunity may be available in the future if you or your dependent(s) lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependent(s) experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependent(s) become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependent(s) will have sixty (60) days to request special enrollment in the group health plan coverage. An individual must request this special enrollment within sixty (60) days of the loss of coverage described at bullet one, and within sixty (60) days of when eligibility is determined as described at bullet two.

To request special enrollment or obtain more information, contact your HR representative.

Lisa Yorks

Curtis Lumber Company
885 Route 67
Ballston Spa, NY 12020
518-490-1388

Lisa.yorks@curtislumber.com

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 includes states where employees currently reside which offer a premium assistance program as of July 31, 2023. Contact your State for more information on eligibility.

If you reside in a different state, please contact HR for more information on whether or not a premium assistance program is available there, as well as State contact information if applicable.

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

To see if any other states offer a premium assistance program, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor
Employee Benefits Security Administration**
www.dol.gov/agencies/ebsa
 1-866-44-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

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. 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.

A plan's prescription drug coverage is considered creditable coverage if the amount the plan expects to pay on average for prescription drugs for individuals covered by the plan is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average.

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. Your Employer has determined that the prescription drug coverage they offer 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 join a Medicare drug plan.

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 your employer 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 Marshall+Sterling at (866) 573-4768.

MARSHALL +STERLING

*Contact our team for all
your insurance needs!*

www.marshallsterling.com

- Employee Benefits
- Personal Home, Renter's & Auto
- Disability Insurance
- Long-Term Care
- Business Insurance
- Life Insurance
- Wealth Management