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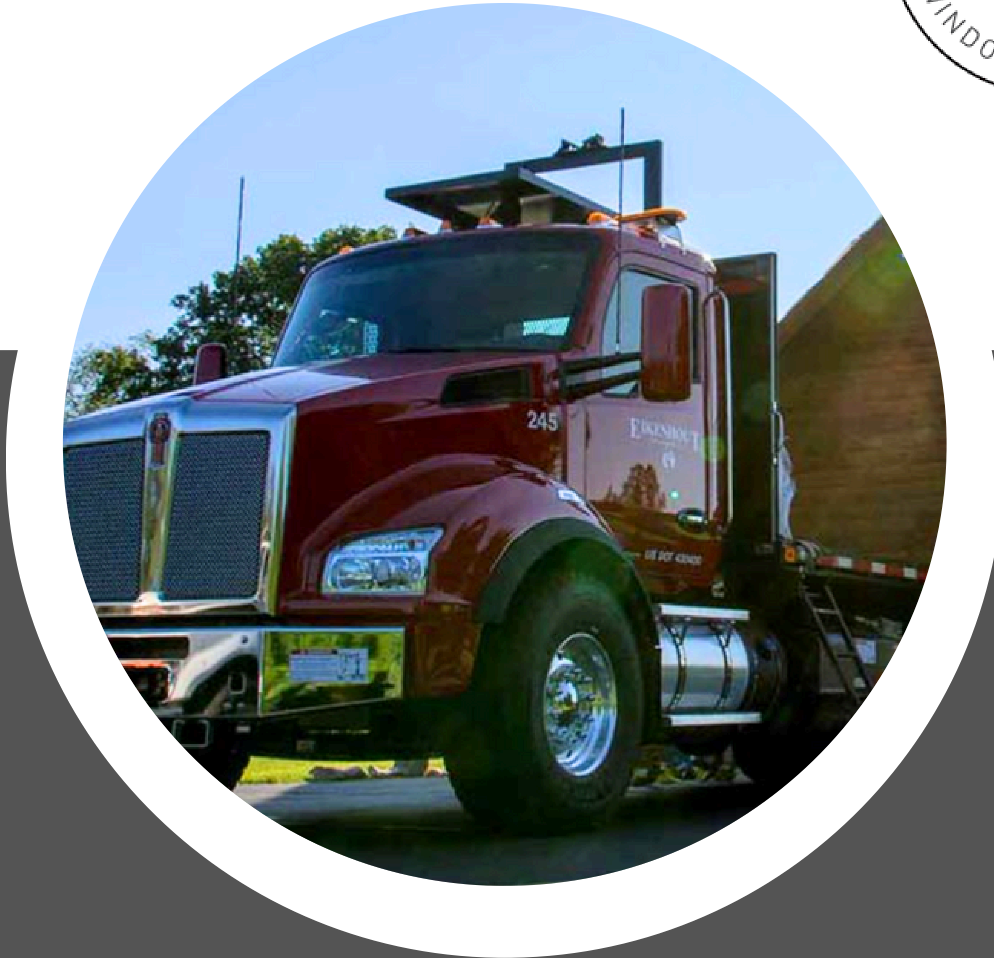


# EMPLOYEE
## Benefits Guide

PREPARED BY

VanWyk
RISK SOLUTIONS

# EMPLOYEE BENEFITS GUIDE

At Eikenhout, we value each employee. Our commitment to our employees is to provide an enriching environment where employees are engaged and are proud to be part of the team. This guide explains the great employee benefits offered at Eikenhout. Please carefully review this guide and the accompanying plan documents to make educated decisions on your elections, since they will remain for the upcoming year unless you experience a qualifying event.

## New Employees

This is your chance to elect benefits by enrolling yourself and your eligible dependents. If you decline benefits during the initial enrollment period, you will not be able to make a change until next year's open enrollment period – unless you experience a life event, such as but not limited to; a birth, adoption, marriage, or divorce.

## Benefit Highlights

- Health Insurance
- **Health Savings Account (HSA) - NEW**
- Dental Insurance
- Vision Insurance
- Flexible Spending Account
- Basic Life/AD&D
- Short-Term Disability
- Long-Term Disability
- Supplemental Life/AD&D
- Medicare Support
- **Pet Insurance - NEW**

## Section 125 Plan

Your benefits are offered through a Section 125 premium conversion plan meaning your premiums are paid through pre-tax payroll deductions, which reduces your tax liability.

## Contacts

| COVERAGE | CARRIER | Policy # | PHONE # | WEBSITE |
|---|---|---|---|---|
| **Health** | Blue Care Network | 166131 | 800.662.6667 | www.mibcn.com |
| **HSA** | Health Equity | NA | 877-284-9840 | www.healthequity.com |
| **Dental / Vision** | Guardian | 57682 | 888.482.7342 | www.guardiananytime.com |
| **Life / AD&D** | Guardian | 57682 | 888.482.7342 | www.guardiananytime.com |
| **Disability** | Guardian | 57682 | 888.482.7342 | www.guardiananytime.com |
| **FSA** | iSolved | 201343 | 866-370-3040 | www.isolvedbenefitservices.com |
| **Pet Insurance** | Pet Benefit Solutions | NA | 888-913-7387 | www.petbenefits.com |

## Van Wyk Risk Solutions Team

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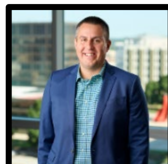

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*The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.*

# ELIGIBILITY & ENROLLMENT

## Employee Eligibility

Full-time employees working 30 or more hours/week.

As a new employee, you are eligible for health insurance on your date of hire, while all other elected benefits are effective on the first of the month following 90 days of employment. You must complete the enrollment process during onboarding.

## Spouse Eligibility

The employee's legally married spouse is eligible as a dependent.

## Child(ren) Eligibility

The employee's children are eligible until the end of the year in which they attain age 26 for medical, dental and vision coverage. Eligible dependent children include natural children, legally adopted children from the date the employee assumes legal responsibility; foster children that live with the employee, and for whom the employee is the primary source of financial support; children for whom the employee assumes legal guardianship, and stepchildren.

Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.

Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 can be dependents. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is required along with notification of a change in marital or tax exemption status which eliminates their eligibility.

## How to Enroll

Log in to [www.employeenavigator.com](http://www.employeenavigator.com) and complete the enrollment process. If you have questions, contact Human Resources.

## When to Enroll

Annual Open Enrollment: Nov. 11 – Dec. 2.
New Hires: Elections or waivers must be completed within 30 days of your date of hire.

## How to Make Changes

Unless you experience a qualifying life event, you cannot make changes until the next open enrollment period. Qualifying life events include things like:

- Marriage, divorce, legal separation, or death of a spouse
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan.

An election change must be made within 30 days of most qualifying events, though you may have up to 60 days for a change in Medicare or Medicaid eligibility status.

# WEEKLY PAYROLL DEDUCTIONS (52-pay)

Eikenhout pays 80% of the employee-only medical premium and 75% for dependents.  You are responsible for the remaining portion, which will be paid through pre-tax payroll deductions. If your spouse is eligible for health insurance through their employer, you must pay a $100 per month surcharge to enroll them in the Eikenhout group plan (in addition to the deductions noted below).

| **Health Coverage - HRA** | **Monthly Premium (100%)** | **Annual Premium (100%)** | **Employee Cost/Pay Non-Tobacco** | **Employee Cost/Pay Tobacco User** |
|---|---|---|---|---|
| Employee Only | 493.28 | 5,919 | 22.77 | 32.77 |
| Employee + Spouse | 1,213.20 | 14,558 | 64.30 | 74.30 |
| Employee + Child(ren) | 986.55 | 11,839 | 51.22 | 61.22 |
| Employee & Family | 1,394.51 | 16,734 | 74.76 | 84.76 |

| **Health Coverage - HSA** | **Monthly Premium (100%)** | **Annual Premium (100%)** | **Employee Cost/Pay Non-Tobacco** | **Employee Cost/Pay Tobacco User** |
|---|---|---|---|---|
| Employee Only | 445.43 | 5,345 | 20.56 | 30.56 |
| Employee + Spouse | 1,113.58 | 13,363 | 59.11 | 69.11 |
| Employee + Child(ren) | 890.86 | 10,690 | 46.26 | 56.26 |
| Employee & Family | 1,291.75 | 15,501 | 69.38 | 79.38 |

Employees must provide an updated tobacco and working spouse affidavit annually during open enrollment to qualify for the non-tobacco rates and avoid the $100 spousal surcharge.

| **Dental Coverage** | **Monthly Premium (100%)** | **Annual Premium (100%)** | **Employee Cost Per/Pay** |
|---|---|---|---|
| Employee Only | 29.17 | 350 | 1.35 |
| Employee + Spouse | 55.02 | 660 | 2.54 |
| Employee + Child(ren) | 69.35 | 832 | 3.20 |
| Employee & Family | 110.29 | 1,323 | 5.09 |

| **Vision Coverage** | **Monthly Premium (100%)** | **Annual Premium (100%)** | **Employee Cost Per/Pay** |
|---|---|---|---|
| Employee Only | 6.93 | 83 | 1.60 |
| Employee + Spouse | 13.17 | 158 | 3.04 |
| Employee + Child(ren) | 13.56 | 163 | 3.13 |
| Employee & Family | 19.33 | 232 | 4.46 |

# HEALTH INSURANCE

## Blue Care Network

Eikenhout offers eligible employees affordable, qualified medical coverage. The plans use the BCN HMO network so all care must be received in-network, except for emergencies. For additional plan details, please reference your summary of benefits & coverage document or inquire with HR.

| Medical Highlights | HMO $4,000 - HRA<br>In-Network Only | HMO $2,000 – HSA (NEW)<br>In-Network Only |
|---|---|---|
| | Annual Deductible | |
| Individual | $4,000 | $2,000 |
| Family | $8,000 | $4,000* |
| | Annual Out-of-Pocket Maximum | |
| Individual | $8,150 | $4,000 |
| Family | $16,300 | $8,000* |
| | Covered Services | |
| Preventive Care** | No Charge | No Charge |
| PCP / Specialist Office Visits | $20 / $40 copay | Deductible then 20% |
| Urgent Care / Emergency Room | $50 copay / $250 copay + Ded. & Coinsurance | Deductible then 20% |
| Inpatient Facility Fee | Deductible then 20% | Deductible then 20% |
| Diagnostic Imaging | Deductible then 20% / $150 copay for High-Tech Imaging | Deductible then 20% |
| | Prescription Drugs | |
| Value Generic / Generic | $6 / $40 copay | Deductible then $10 / $30 |
| Formulary Brand | $60 copay | Deductible then $60 |
| Non-Preferred Brand | $80 copay | Deductible then $80 |
| Specialty Drugs | 20% up to $200 / $300 max | Deductible then 20% |

***Mail-order prescription drugs are covered at 3x the retail copay less $10 for a 90-day supply***

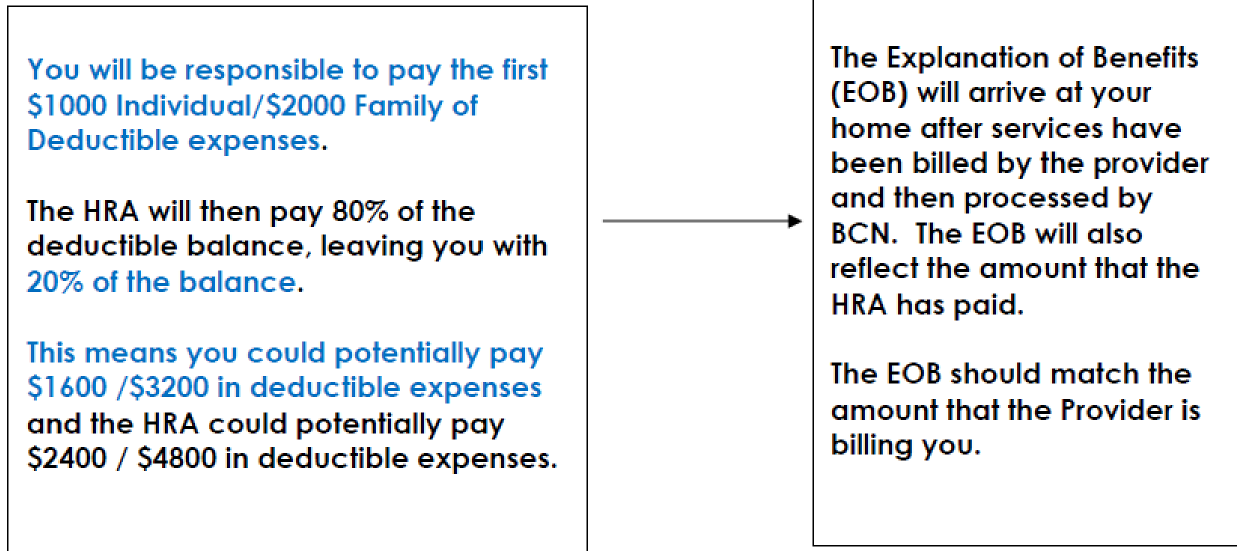
*An aggregate family deductible and out-of-pocket maximum means those enrolled with dependent(s) must satisfy the collective family deductible or out-of-pocket maximum.

**Preventive care visits are covered at 100%, however, diagnostic tests that are not deemed preventive will be subject to the deductible and coinsurance.

BCN requires the selection of a Primary Care Physician (PCP) for everyone enrolled on your contract. You can locate BCN HMO participating providers by using the “Find a Doctor” tool located at www.bcbsm.com.

## Blue Care Network

Eikenhout implemented a high-deductible health plan to reduce premiums. To limit the impact this has on our valued employees, we continue to fund the majority of the deductible for you and your family. Details regarding how the HRA funding works are noted below.




You can access your account at www.mibcn.com where you can view your claims, benefits, and other information. You must first register or log onto your Member Account to view personal information.

# HEALTH SAVINGS ACCOUNTS (NEW)

## Health Equity

### What is a Health Savings Account (HSA)?

A Health Savings Account, commonly known as an “HSA,” is a personal account you can open, add money to, and use for eligible healthcare expenses if you choose the HMO HSA $2,000 plan.

### Managing your HSA

Once you are covered by the HMO HSA $2,000 plan, an HSA account will be opened through Health Equity. You will have a single sign-on through your Blue Cross member portal, under the My Coverage / Spending Accounts tab. **Eikenhout will provide matching contributions of up to $50 per month for employee-only coverage or $100 per month when enrolling with dependents for a maximum of $600 or $1,200 per year. For balances exceeding $2,000, you may set up an investment account for long-term growth. opportunities.**

### Adding money

The government sets the annual dollar maximum that can be contributed to an HSA. Coverage of two or more people is considered family coverage. People who are age 55 or older can make additional catch-up contributions. You may contribute via pre-tax payroll deductions, or through the member portal using tax-deductible funds from another account.

| HSA Maximum Contribution Limits Combined (ER and EE) | |
|---|---|
| Employee Only | $4,300 |
| Employee + Dependent(s) | $8,550 |
| Age 55+ Catch-Up | $1,000 |

### Using HSA money

You decide when to spend money from your HSA. If you pay out of pocket for an eligible medical, dental, or vision expense, you can use your HSA debit card, use another method of payment and submit a claim to reimburse yourself, or choose to not reimburse yourself and let the money in your HSA grow in your investment account.

If you use your HSA money for expenses that are not eligible, you will pay a 20% penalty plus income tax on the amount. Once you turn age 65, you may use your HSA money for any expense, medical or not, but you will pay income taxes on ineligible, non-medical expenses. To view the full list of eligible expenses, visit www.irs.gov/publications and refer to Publication 969.

### Eligible expenses

Your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. Eligible expenses include deductibles, copays, and coinsurance as well as many over-the-counter pain relievers, cold and flu products, allergy products, heartburn medication, and menstrual products, among others.

| PORTABILITY | FLEXIBILITY | TAX SAVINGS | PREMIUM SAVINGS |
|---|---|---|---|
| • You own 100% of the deposited funds, meaning if you change employers or retire, you do not lose the money in the accounts regardless of who contributed the money. | • You can choose whether to spend the money on current medical expenses or you can save your money for future use since all money rolls over.<br>• Investment options are available for balances >$2,000. | • Contributions can be tax-free (pre-tax through payroll deductions) or post-tax and then tax-deductible.<br>• Earnings are tax-free.<br>• Funds withdrawn for eligible medical expenses are tax-free. | • By choosing the HSA-qualified plan, your payroll contribution is lower than the other traditional copay plan. |

## Guardian

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings, and x-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body – including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

For a complete list of your in-network and out-of-network benefits, please refer to your Dental Insurance Summary Plan Description, provided by Human Resources.

| **Dental Highlights** | **In-Network** | **Out-of-Network** |
|---|---|---|
| Annual Deductible | $25 per Individual / $75 per Family Max | |
| Benefit Maximum<br>Calendar Year | $1,000 per member | |
| Preventive Care<br>Oral exams, cleanings, fluoride, sealants, space maintainers, oral cancer screenings, x-rays | 100% Covered, No deductible | |
| Basic Services<br>Fillings, extractions, periodontics, endodontics, prosthodontic maintenance | 75% Covered, after deductible | |
| Major Services<br>Crowns, inlays, onlays, dentures, bridges, gen. anesthesia, etc. | 50% Covered, after deductible | |
| Orthodontia<br>(Children only to 19) | 50% Covered, No deductible | |
| Orthodontia<br>Lifetime Benefit Maximum | $1,000 | |

Guardian's out-of-network reimbursement level is very high and if you have a dentist that you trust - it may not make sense to change, unless you require significant dental work and would benefit from the typical 20-30% discount that an in-network dentist offers. A $250/$350 annual rollover benefit is available if you receive dental care that totals less than $500 per calendar year. This will increase your annual dental max.

Visit www.guardiananytime.com to search for in-network dentists – Select "Find a Dentist" and then search the PPO: DentalGuard Preferred network.

# VISION INSURANCE

Guardian

## Guardian / VSP

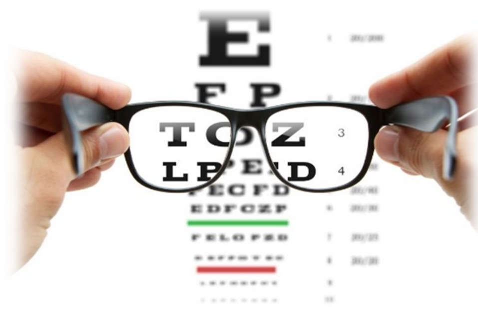
Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do all these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. Eikenhout’s vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams, and other procedures and provides specified dollar amounts for the purchase of eyeglasses or contact lenses.

For a complete list of your in-network and out-of-network benefits, please refer to your Vision Insurance Summary Plan Description, provided by Human Resources.

| **Vision Highlights** | **In-Network** | **Out-of-Network** |
|---|---|---|
| Exam<br>Once every calendar year | $10 Copay | $50 max allowance |
| Materials<br>Once every calendar year | $10 Copay | N/A |
| Lenses<br>Once every calendar year | $10 Copay | Single Vision: $48 max<br>Bifocal: Up to $67 max<br>Trifocal: Up to $86 max<br>Lenticular: Up to $126 max |
| Elective Contact Lenses*<br>Once every calendar year | $130 Allowance (copay waived) | $120 allowance (copay waived) |
| Medically Necessary Contact Lenses<br>Once every calendar year | Covered 100% | Up to $210 |
| Frames<br>Once every calendar year | $130 max plus 20% off balance | $48 max allowance |

*Contact lenses are covered in place of the spectacle lens and frame benefit each calendar year.

Visit www.guardiananytime.com to search for in-network vision providers – Select “Find a Vision Provider” and then “VSP” to search for in-network providers.



# FLEXIBLE SPENDING (FSA)

isolved Benefit Services

## iSolved Benefit Services

Healthcare related expenses can become overwhelming, especially when you're not prepared for them. Planning ahead by putting money in a healthcare flexible spending account (FSA) will help protect you and your family from unexpected qualified medical, dental, or vision expenses that you may incur throughout the year. In addition, you will reduce your tax liability since any money that you set aside in your FSA is non-taxable and immediately available for your use. The amount you contribute is not subject to either Federal Income Tax or Social Security Tax (FICA).

Eikenhout partners with iSolved Benefit Services for FSA administration. The company will allow employees to contribute up to $3,300 toward their healthcare FSA and up to $5,000 for their dependent care FSA.

FSA Carryover is limited to $660 for the 2025 plan year. Any leftover balance exceeding $660 will be forfeited at the end of the year so you must budget wisely. There are now many resources like www.amazon.com/fsa-store and www.fsastore.com where you can spend your surplus FSA dollars before expiration.

For additional information on either the Health FSA or Dependent Care FSA offered through iSolved, please see the additional resources in Employee Navigator or go to www.isolvedbenefitservices.com and login to your account.

You will not be automatically enrolled in the FSA for the upcoming plan year. You must select an amount in Employee Navigator during open enrollment if you wish to participate.

**Note: Employees may not elect both the BCN $2,000 HSA plan with HSA and the Flexible Spending Account. Instead of contributing toward your Healthcare Flexible Spending Account, you can make HSA contributions that will not expire and may be used for the same type of expenses.**

# INCOME PROTECTION BENEFITS

Guardian

Eikenhout strongly believes that our employees and their families deserve the sense of security that financial protection offers. The following benefits are being provided to ensure you are prepared for an unexpected event like an accident, illness, or premature death.

# BASIC LIFE / AD&D INSURANCE

## Guardian

Life insurance can help provide for your loved ones if something were to happen to you. Eikenhout provides full-time employees with 1x your annual salary up to $50,000 maximum in group life and accidental death and dismemberment (AD&D) insurance, payable to your named beneficiary(ies). In addition, the company provides your spouse with a $10,000 and children with a $1,000 life insurance policy.

Eikenhout pays for the full cost of this benefit – meaning this benefit is provided at **No Cost** to you. You are responsible for updating your beneficiary information, as needed.

# SHORT-TERM DISABILITY

## Guardian

Short-Term Disability Insurance replaces part of your lost income when you become unable to work due to a covered injury or illness. Eikenhout automatically enrolls employees in this benefit, at your expense, to ensure your income is protected for the 90 days leading up to when long-term disability benefits are paid. STD pays a benefit equal to 60% of your pre-disability earnings, up to $1,500 per week, and benefits begin on the 1st day after an accident or the 8th day of an illness. If you wish to waive this coverage, you must complete an affidavit and return it to HR before the close of open enrollment or your initial eligibility period.

# LONG-TERM DISABILITY

## Guardian

Long-Term Disability Insurance provides benefits that replace part of your lost income when you become unable to work due to a covered injury or illness that lasts longer than 3 months. Eikenhout provides full-time employees long-term disability insurance to replace 60% of their pre-disability earnings, up to a $6,000 monthly benefit, after satisfying a 90-day elimination period (amount of time disabled before benefits are payable). This is a company-paid benefit provided at **No Cost** to you. Beginning in 2025, Eikenhout provides a salary gross-up in the amount of your annual long-term disability premium (taxed weekly) to ensure any future long-term disability benefits are non-taxable to you.

# SUPPLEMENTAL LIFE / AD&D INSURANCE

## Guardian

While Eikenhout provides basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child or your home mortgage)? Depending on your needs, you may want to consider buying supplemental coverage.

The company provides benefit-eligible employees the opportunity to purchase Voluntary Life/AD&D Insurance coverage. Employees may also choose to purchase Life/AD&D Insurance for their spouse and dependent child(ren). The premium for this additional coverage is 100% paid for by you and is offered at negotiated group rates through the company. These rates may be challenging to obtain on your own.

**NEW HIRE NOTICE – If you are a new hire, this is your chance to receive Guarantee Issue coverage for yourself and your dependents. If you do not take advantage of this benefit now but then wish to enroll later, you will be subject to evidence of insurability (answer medical questions).**

| **VOLUNTARY SUPPLEMENTAL LIFE/AD&D COVERAGE HIGHLIGHTS** | |
|---|---|
| **Term Life and AD&D Coverage Amounts**<br>**Capped at 5x salary** | **Employee:** $500,000 max (in $10,000 increments)<br>**Spouse:** $100,000 max (in $5,000 increments) up to 100% of employee benefit<br>**Child(ren):** $10,000 max (in $1,000 increments) 14 days – 26 years |
| **Guarantee Issue Amount** | **Employee:** $150,000 / **Spouse:** $25,000<br>**If you enroll when first offered, you receive up to the listed amount without having to answer medical questions. Capped at 5x salary.* |
| **Reduction Schedule** | 50% at age 75 |
| **Additional Features** | Employees pay 100% of the cost. Login to the Navigator to view your age-based rates and to complete evidence of insurability, if needed. |

# MEDICARE

## Van Wyk Risk Solutions

If you or someone in your family is 65, or turning 65 in the coming year, then Van Wyk can help. Choosing your healthcare plan is extremely important. So, we have taken steps to ensure you receive the best guidance possible to understand your Medicare options.

To do this, we have partnered with Van Wyk Risk Solutions to provide free Medicare education programs and enrollment services to Eikenhout employees. Representing the most respected regional and national Medicare health insurance plans, Van Wyk provides free one-on-one, unbiased advice, practical decision support, and detailed coverage options based on the specific needs of eligible beneficiaries. This service is free to all Eikenhout employees and their spouses, parents, and loved ones who are eligible for Medicare.

| **MEDICARE<br>COVERAGE HIGHLIGHTS** |
|---|
| Assess your health needs to find a plan right for you |
| Provide Medicare coverage options from national healthcare carriers |
| Make recommendations and plan your Medicare transition timeline |
| Guide you step-by-step through the enrollment process |

You can easily schedule free one-on-one Medicare consultations to learn if Medicare is right for you.

You can email derekt@vanwykcorp.com or call him directly at (616)726.7183.

# PET INSURANCE (NEW)

## Pet Benefit Solutions

**Total Pet Plan** provides everything pets need for one low price! The pet care bundle includes everyday savings on veterinary care and pet products and access to other pet care services and discounts.

## Plan Details

Discounts on products and Rx:

Shop online for members-only pricing (up to 40% off) on everything dogs and cats need, including:

- Rx and non-Rx food; Flea & tick preventatives; Heartworm preventatives; Prescription medications; Treats; Toys; and more
- Free shipping or Caremark pharmacy pick-up

Discounts on veterinary care:

Instant 25% savings on in-house medical services at network vets for any type of pet, including:

- Exam fees; Vaccinations; In-house bloodwork; X-rays; Surgery; Dental cleanings; and more

24/7 pet telehealth:

Unlimited chat support from a live US-based veterinarian, even when a vet office is closed

Lost pet recovery service:

Durable pet ID tag with a cloud-based pet profile - available for any pet with a collar

Additional discounts at pet retailers and service providers:

Our PBS perks program provides exclusive pet discounts only available to our members

## Coverage Details

- Absolutely no exclusions for pre-existing health conditions or age
- No deductibles, waiting periods, or claims forms
- Covers all types of pets, from cats and dogs to exotics
- No annual or lifetime maximums

## Enrollment Details

Elections are made in Employee Navigator and paid via Post-Tax Payroll Deductions

| One Pet | Family Plan (2+ Pets) |
|---|---|
| $11.75 / month or $2.71 per pay period (52-pay) | $18.50 / month or $4.27 per pay period (52-pay) |

# PET INSURANCE

pbs

## Pet Benefit Solutions

**Wishbone** offers two reimbursement plans for cats and dogs: Accident & Illness and Wellness Care. Members visit any licensed veterinarian in the US and log in to their member portal for streamlined claims submissions. The accident and illness plan covers 80% of eligible expenses up to $10,000 per year, after a $250 deductible.

## Plan Details

| **ACCIDENT & ILLNESS COVERAGE**<br>**For the unexpected** | **WELLNESS PLAN**<br>**For regular routine visits** |
|---|---|
| • Pre-existing conditions are excluded from coverage<br>• Coverage begins after waiting periods have been met. Accident: 1 day; Illnesses: 14 days; Orthopedic conditions: 180 days<br>• Includes 24/7 pet telehealth<br>• Additional 10% reimbursed when member is enrolled in Total Pet Plan and uses a network veterinarian | • Two tiers available: up to $575 reimbursed<br>• Pets with pre-existing conditions are eligible<br>• Begins the day after the plan start date<br>• Does not require an accident and illness policy to enroll |

## Coverage Details

| **ACCIDENT & ILLNESS COVERAGE**<br>**For the unexpected** | **WELLNESS PLAN**<br>**For regular routine visits** |
|---|---|
| • Reimbursement on exam fees, diagnostics, & treatment due to eligible accidents and illnesses, including:<br>  ◦ Prescription medications; Surgery; Emergency visits & hospitalizations; X-rays; Physical therapy; Skin, ear, and eye infections; Allergies, and more<br>• Exclusions may apply. View a sample policy for full details: wishboneinsurance.com/policy | • Reimbursement on eligible veterinary care related to wellness visits, including:<br>  ◦ Exam fees; Vaccinations; Routine bloodwork; Fecal test; Urinalysis; Preventatives; Dental cleaning<br>• View a sample policy for full details: wishboneinsurance.com/wellness |

## Enrollment Details

You Enroll through a custom Eikenhout landing page and pay directly via Credit Card.

| **ACCIDENT & ILLNESS – Samples Rates** | | **WELLNESS PLAN** | |
|---|---|---|---|
| 1-Year-Old Mixed Breed Dog | $23.29/month | Essential ($300 annual benefits) | $14/month |
| 3-Year-Old Jack Russel Terrier Dog | $27.76/month | Premium ($575 annual benefits) | $25/month |
| 5-Year-Old Domestic Shorthair Cat | $24.78/month | | |

# BENEFIT TERMS & ACRONYMS

The world of health insurance has many terms that can benefit from clarification. Understanding your costs and benefits and estimating the price of a visit to the doctor becomes much easier once you can make sense of the terminology.

## Definitions

**Annual limit –** Cap on the benefits your insurance company will pay in a given year while you are enrolled in a health insurance plan.

**Claim –** A bill for medical services rendered.

**Cost-sharing –** Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, co-insurance, and co-payments.

**Co-insurance –** Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
*Example: John's second surgery occurs in the same plan year as his first surgery and costs a total of $3,200. Because he has only paid $800 toward his $1,000 annual deductible, John will be responsible for the first $200 of the second surgery. After that, he has met his deductible and his carrier will cover 80 percent of the remaining cost, for a total of $2,400. John will still be responsible for 20 percent, or $600, of the remaining cost. The total John must pay for his second surgery is $800.*

**Co-payment (copay)** – A fixed amount you pay for a covered health care service, usually when you receive the service.

**Deductible –** The amount you owe for health care services each year before the insurance company begins to pay.
*Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and must have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.*

**Dependent Coverage** – Coverage extended to the spouse and children of the primary insured member. Age restrictions on coverage may apply.

**Explanation of Benefits (EOB)** – A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed, and the total amount of patient responsibility for the claim.

**Group Health Plan** – A health insurance plan that provides benefits for employees of a business.

**In-network Provider** – A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.

**Inpatient Care** – Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.

**Insurer (carrier)** – The insurance company providing coverage.

**Insured** – The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder, and you will be the insured.

# BENEFIT TERMS & ACRONYMS

## Definitions

**Open Enrollment Period** – Time period during which eligible persons may opt to sign up for coverage under a group health plan.

**Out-of-network Provider** – A provider who is not contracted with your health insurance company.

**Out-of-pocket Maximum (OOPM)** – The maximum amount you should have to pay for your health care for one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered healthcare services or items for the rest of the year.

**Outpatient Care** – Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.

**Policyholder** – The individual or entity that has entered into a contractual relationship with the insurance carrier.

**Premium** – Amount of money charged by an insurance company for coverage.

**Preventive Care** – Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.

**Provider** – A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.

**Qualifying Life Event –** A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.

**Qualified Medical Expense** – Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

**Summary of Benefits and Coverage (SBC)** – An easy-to- read outline that lets you compare costs and coverage between health plans.

## Acronyms

**ACA** – Affordable Care Act

**CDHC –** Consumer driven, or consumer directed health care

**CDHP** - Consumer driven health plan

**CHIP** – The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.

**CPT Code** – Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.

**FPL –** Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.

# BENEFIT TERMS & ACRONYMS

## Acronyms

**FSA** – Flexible spending account. An employer-sponsored savings account for health care expenses.

**HDHP** – High deductible health plan

**HMO –** Health maintenance organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You may only receive care within the network to receive benefits.

**HRA –** Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.

**HSA** – Health savings account. A tax-advantaged savings account that accompanies qualified HDHPs.

**OAP –** Open Access Plus. A type of health plan that allows care to be received in and out of network without requiring a primary care physician to direct care.

**OOP** – Out-of-pocket limit. The maximum amount you must pay for covered services in a plan year.

**PreEx –** Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.

**QHP –** Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

# 2025 Benefits
# Legal Notices

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 addresses how an employer can enforce eligibility and enrollment for health care benefits and ensures that protected health information which identifies you is kept private. You have a right to inspect copy-protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you get access to the information, contact Human Resources.

The HIPAA Privacy Rule was effective beginning April 14, 2003. The Privacy Rule is intended to safeguard protected health information (PHI). The provisions of the Privacy Rule have a significant impact on those who deal with health information and on all citizens with regard to their personal PHI. Our health insurance broker and all our contracted plans adhere to the HIPAA Privacy Rule.

**Medicaid and the Children's Health Insurance Program (CHIP)**

If you're eligible for health coverage from Eikenhout, Inc. but can't afford the premiums, some states have premium-assistance programs that can help pay for coverage with funds from their Medicaid or CHIP programs. If you or your dependents are already enrolled in Medicaid or CHIP, 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, once it is determined that you or your dependents are eligible for premium assistance under either of these programs, the employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, and not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

**Women's Health and Cancer Rights Act Enrollment Notice**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses.
3. Treatment of physical complications of the mastectomy, including lymphedema.

**Newborns' and Mothers' Health Protection Act Disclosure**

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).

*2025 Benefits*

# Legal Notices

**Patient Protection Notice**

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your 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.

**HIPAA Special Enrollment Notice**

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

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

**HIPAA Privacy Notice**

Please contact HR if you have any questions or need assistance obtaining a privacy notice.

**Notice Extension of Dependent Coverage to Age 26 And Enrollment Opportunity**

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in medical, dental, and vision programs. For more information contact your plan administrator.

**Notice Lifetime Limit No Longer Applies and Enrollment Opportunity**

The lifetime limit on the dollar value of benefits under Blue Care Network medical program does not apply. Enrollment opportunities for individuals who previously lost coverage due to a lifetime limit are available. For more information contact your plan administrator.

*2025 Benefits*

# Legal Notices

**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)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | FLORIDA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Website: http://flmedicaidtplrecovery.com/hipp/<br>Phone: 1-877-357-3268 |
| **ALASKA – Medicaid** | **GEORGIA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: myakhipp.com<br>Medicaid Eligibility:<br>http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: http://dch.georgia.gov/medicaid<br>- Click on Health Insurance Premium Payment (HIPP)<br>Phone: 404-656-4507 |
| **ARKANSAS – Medicaid** | **INDIANA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com<br>Phone 1-800-403-0864 |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **IOWA – Medicaid** |
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus<br>CHP+ Customer Service: 1-800-359-1991/<br>State Relay 711 | Website: http://dhs.iowa.gov/hawk-i<br>Phone: 1-800-257-8563 |

| KANSAS – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Website: http://www.kdheks.gov/hcf/<br>Phone: 1-785-296-3512 | Website: https://www.dhhs.nh.gov/ombp/nhhpp/<br>Phone: 603-271-5218<br>Hotline: NH Medicaid Service Center at 1-888-901-4999 |
| **KENTUCKY – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: https://chfs.ky.gov<br>Phone: 1-800-635-2570 | Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br><br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **LOUISIANA – Medicaid** | **NEW YORK – Medicaid** |
| Website:<br>http://dhh.louisiana.gov/index.cfm/subhome/1/n/331<br>Phone: 1-888-695-2447 | Website:<br>https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MAINE – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Website: https://dma.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NORTH DAKOTA – Medicaid** |
| Website:<br>http://www.mass.gov/eohhs/gov/departments/masshealth/<br>Phone: 1-800-862-4840 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **MINNESOTA – Medicaid** | **OKLAHOMA – Medicaid and CHIP** |
| Website:<br>https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |
| **MISSOURI – Medicaid** | **OREGON – Medicaid** |
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br><br>Phone: 573-751-2005 | Website:<br>http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 |
| **MONTANA – Medicaid** | **PENNSYLVANIA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br><br>Phone: 1-800-694-3084 | Website:<br>http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm<br><br>Phone: 1-800-692-7462 |
| **NEBRASKA – Medicaid** | **RHODE ISLAND – Medicaid** |
| Website: http://www.ACCESSNebraska.ne.gov<br>Phone: (855) 632-7633<br>Lincoln: (402) 473-7000<br>Omaha: (402) 595-1178 | Website: http://www.eohhs.ri.gov/<br>Phone: 855-697-4347 |
| **NEVADA – Medicaid** | **SOUTH CAROLINA – Medicaid** |
| Medicaid Website: https://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 |

# Legal Notices

| SOUTH DAKOTA – Medicaid | WASHINGTON – Medicaid |
|---|---|
| Phone: 1-888-828-0059<br>Website: http://dss.sd.gov | Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program<br><br>Phone: 1-800-562-3022 ext. 15473 |
| **TEXAS – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website: http://mywvhipp.com/<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **UTAH – Medicaid and CHIP** | **WISCONSIN – Medicaid and CHIP** |
| Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 | Website:<br>https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf<br><br>Phone: 1-800-362-3002 |
| **VERMONT– Medicaid** | **WYOMING – Medicaid** |
| Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 | Website: https://wyequalitycare.acs-inc.com/<br>Phone: 307-777-7531 |
| **VIRGINIA – Medicaid and CHIP** | |
| Medicaid Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>CHIP Phone: 1-855-242-8282 | |

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
**www.dol.gov/agencies/ebsa**
**www.cms.hhs.gov**
1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20230 or email dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2023)

*2025 Benefits*

# Legal Notices

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

The right to COBRA continuation coverage was created by federal law, so that you and your covered dependents may continue your employer-sponsored benefits coverage at full cost (plus an administrative fee). After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost as a result of a qualifying event. If you're an employee, you'll become a qualified beneficiary if you lose your coverage for either of these reasons:

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

If you're the spouse/dependent of an Eikenhout, Inc. employee, you'll become a qualified beneficiary if you lose your coverage under the Plan for any of these reasons:

- Your spouse/parent dies
- Your spouse's/parent's hours of employment are reduced
- Your spouse's/parent's employment ends for reasons other than his or her gross misconduct
- Your spouse/parent is retired and becomes entitled to Medicare benefits
- You are divorced or legally separated from your spouse
- Child is no longer eligible for coverage under the Plan as a dependent child

# *2025 Benefits*
# Legal Notices

**Important Notice from Eikenhout, Inc. About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Blue Care Network 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Eikenhout, Inc. has determined that the prescription drug coverage offered by Blue Care Network 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 Can You Join a Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Eikenhout, Inc. coverage will not be affected. Medicare-eligible individuals can keep this coverage if they elect Part D and this plan will coordinate with Part D coverage. *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Eikenhout, Inc. coverage, be aware that you and your dependents will not be able to get this coverage back until open enrollment.

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Blue Care Network changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage…**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

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

Contact Position/Office: Human Resources at Eikenhout, Inc.
Address: 308 Wealthy St. SW Grand Rapids, MI 49503
Phone Number: (616) 459-4523

# 2025 Benefits

# Legal Notices

## New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 10-31-2023)

## PART A: General Information

When key parts of the healthcare 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 help you find health insurance that meets your needs and fits your budget. The Marketplace offers " one– stop shopping" to find and compare private health insurance options. 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 2013 for coverage starting as early as January 1, 2014, in your area.

### 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 9.12% 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.

### How Can I Get More Information?

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

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.