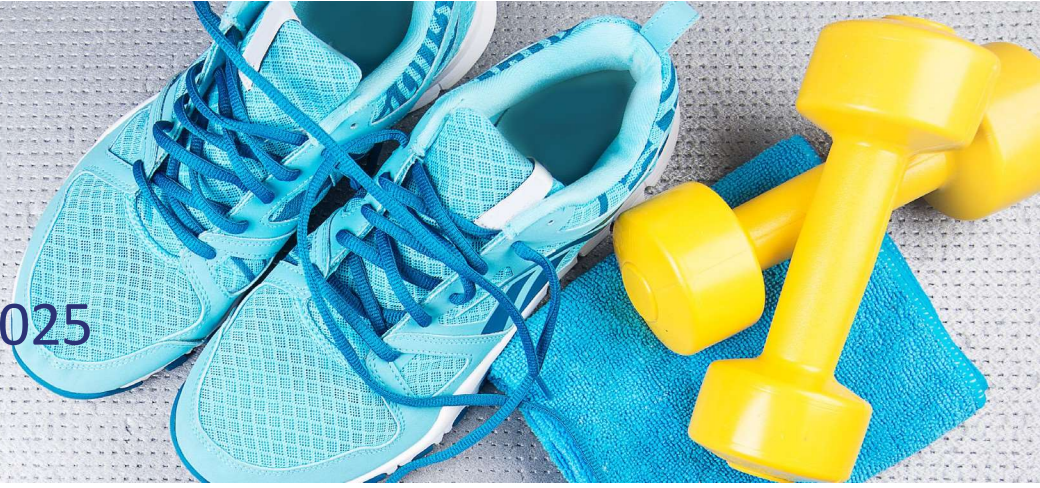
Healthtrax
FIT FAMILIES FOR LIFE



Open Enrollment 2025

June 6 through June 13

Dear Healthtrax Employees,

Open Enrollment for Health, Dental, Vision and your Voluntary Benefits begins on June 6th. This is your opportunity to review and make changes to your benefit choices.

After the Open Enrollment deadline of Friday, June 13th, your pre-tax election may not be changed during the plan year unless you experience a qualified lifestyle status event, including (but not limited to):

- Marriage
- Divorce / Legal separation
- Birth, death, adoption of a dependent
- Death of your spouse or a dependent
- Change in the eligibility status of a dependent
- Termination or commencement of your spouse's employment
- Change in benefit eligibility due to you or your spouse moving from part-time to full-time employment (or vice versa)
- You and your spouse taking an unpaid leave of absence
- You or your dependent(s) become eligible or lose eligibility under a CHIP plan

If you do experience a qualified lifestyle status event, you must provide the appropriate paperwork within 30 days of the event.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 16-17 for more details.

Remember... The Open Enrollment deadline is Friday, June 13, 2025!

Open Enrollment

This year all carriers will remain in force:

- Aetna for Medical and Prescription Drugs
- Diversified Administrators for Dental and Weekly Disability Income
- VSP for Vision
- Reliance Standard for Life, Voluntary Life and Long-Term Disability
- Transamerica for Group Accident, Critical Illness, and Universal Life coverages

On the BenAware enrollment landing page, your enrollment kit includes information you will want to read before you make decisions impacting your coverage for 2025-2026. Please share this material with other family members as appropriate.

NOTE: It is mandatory that you go through the enrollment process, even if you do not want to enroll in any of the insurance coverages. You must either enroll in coverage or waive coverage through the electronic enrollment process. If you still have questions after reviewing the information provided, please don't hesitate to use the following link to schedule an appointment with a BenAware advisor. The link is: **https://healthtraxinternational.fullslate.com/.**

Note… Benefit changes made during the Open Enrollment period will be effective July 1, 2025 – June 30, 2026.

Open Enrollment Instructions

- Log onto **http://healthtrax.benaware.com/**
- Use your social security number (SSN) to sign on
- Password = last 4 digits of your SSN and last two digits of your year of birth (example: born 1972 and last four SSN 1234 = "123472").
- Benefit Election Section – Indicate the level of coverage desired for each benefit or waive coverage if you do not wish to enroll.
- If electing coverage for dependents or designating a beneficiary, please complete the dependent / beneficiary section.
- Electronically sign your enrollment form by using your password.
- If you need further assistance, please log onto **https://healthtraxinternational.fullslate.com/** and make an appointment to speak with a benefit advisor.

Medical Insurance

Aetna

Below is a brief summary of the medical plans offered. For more complete details, please review the Aetna Plan Designs and Benefit Summaries in the "forms" library on the benefits site. Both PPO Plans will include Health Savings Account contributions for those eligible. With the exception of coverage for certain preventative medical services, the deductible must be met before any medical service or prescription is covered under both plans offered.

Plan Design	HSA 3750	HSA 3300
In-Network Benefits		
Deductible Type	Embedded	Embedded
Plan Year (PY) Deductible	$3,750 Individual / $7,500 Family	$3,300 Individual / $6,600 Family
Out-of-Pocket Maximum Type	Embedded	Embedded
PY Out-of-Pocket Maximum	$7,050 Individual / $14,100 Family	$6,000 Individual / $12,000 Family
Coinsurance (after deductible)	20%	10%
Preventive Care	Covered 100%	Covered 100%
Medical Services	20% after deductible	10% after deductible
Prescription Drugs	Subject to medical deductible See page 5 for details	Subject to medical deductible See page 5 for details
Out-of-Network Benefits		
PY Deductible	$6,000 Individual / $12,000 Family	$8,000 Individual / $16,000 Family
PY Out-of-Pocket Maximum	$12,000 Individual / $24,000 Family	$16,000 Individual / $32,000 Family
Coinsurance (after deductible)	50%	50%

Notes:

'*All services that are not preventive are subject to the deductible, including prescription drugs.

*Embedded = no individual within a family will pay more than the individual deductible / out-of-pocket amount.

Aetna Identification Card

You can easily view, print, and order a hard copy of your new Aetna ID card on Aetna Navigator. Here's how:

- Login to Aetna Navigator at www.aetna.com using your secure username and password
- On the left side under the "I want to" section with blue tabs, select "Get an ID Card"
- Select the member and card type and click "View Card"
- Click "View/Print ID Card" or "Order a Replacement Card"

If you have any dependents on your plan, you may be asked to validate that your dependent does not have other coverage following the first claim that is filed for your dependent annually.

Prescription Plan

The High Deductible Plans provide prescription benefits as noted below after meeting the deductible whether you choose the Fit or Active Plan option.

	Generic	Preferred Brand-Name on Control Drug List	Non-Preferred on Control Drug List
Retail Network Pharmacy (Up to 31-day supply)	$5.00 after deductible	$30.00 after deductible	$60.00 after deductible
Mail Service Network Pharmacy (Up to 90-day supply)	$10.00 after deductible	$60.00 after deductible	$120.00 after deductible

Forget your deductible on certain Preventative Prescriptions and just pay your copay!

For a list of medications which your deducible would be waived, please see the Preventive Drug List on BenAware's enrollment site or visit **www.aetna.com** and choose Drug look up – 2025 – Advance Control Plans – Aetna – 2025 – Other Plan Information – Preventive Drug List is available 24 hours a day, seven days a week through Aetna Navigator.

Specialty Drug Tiers

	Preferred Specialty on Control Drug List	Non-Preferred Specialty on Control Drug List
HSA 3750	$150 per Rx per fill after deductible	$300 per Rx per fill after deductible
HSA 3300	20% per Rx to maximum $150 per fill after deductible	50% per Rx to maximum $200 per fill after deductible

Please refer to your benefit plan and/or aetna.com for more on prescription benefits.

Medical Plan Payroll Deductions

Employee Contributions

Note: HSA Account funding shown for all plans is based on enrollment effective 7/1/2025. Actual funding will be determined based on quarter in which newly eligible employee enrolls.

Aetna PPO Plan – HSA $3,300 / $6,600 HSA Biweekly Deductions

		Annual HSA Account Contribution by Healthtrax		
Employee Medical Premium Contribution		**Electing HSA Plan**	**Over 5 Years of Employment**	**Maximum Healthtrax HSA Funding**
Employee Only	$155.00	$125	$125	$250
Employee + Spouse	$285.00	$250	$125	$375
Employee + Child(ren)	$225.00	$250	$125	$375
Family	$325.00	$250	$125	$375

Aetna PPO Plan – HSA $3,300 / $6,600 HSA Weekly Deductions (RI Employees)

		Annual HSA Account Contribution by Healthtrax		
Employee Medical Premium Contribution		**Electing HSA Plan**	**Over 5 Years of Employment**	**Maximum Healthtrax HSA Funding**
Employee Only	$77.50	$125	$125	$250
Employee + Spouse	$142.50	$250	$125	$375
Employee + Child(ren)	$112.50	$250	$125	$375
Family	$162.50	$250	$125	$375

Aetna PPO Plan - HSA $3,750 / $6,400 HSA Biweekly Deductions

		Annual HSA Account Contribution by Healthtrax		
Employee Medical Premium Contribution		**Electing HSA Plan**	**Over 5 Years of Employment**	**Maximum Healthtrax HSA Funding**
Employee Only	$115.00	$125	$125	$250
Employee + Spouse	$235.00	$250	$125	$375
Employee + Child(ren)	$175.00	$250	$125	$375
Family	$275.00	$250	$125	$375

Aetna PPO Plan - HSA $3,750 / $6,400 HSA Weekly Deductions (RI Employees)

		Annual HSA Account Contribution by Healthtrax		
Employee Medical Premium Contribution		**Electing HSA Plan**	**Over 5 Years of Employment**	**Maximum Healthtrax HSA Funding**
Employee Only	$57.50	$125	$125	$250
Employee + Spouse	$117.50	$250	$125	$375
Employee + Child(ren)	$87.50	$250	$125	$375
Family	$137.50	$250	$125	$375

The deductible must be met before most medical service or prescriptions are covered under the medical plans.

Health Savings Account

HSA Bank

Both Aetna Medical plans will be considered Qualified High Deductible Plans enabling eligible employees to open a Health Savings Account (HSA) with HSA Bank. Employees will be automatically enrolled as part of the open enrollment process, please be aware of any communication you receive from HSA Bank in order to ensure the timely opening of your HSA. Funds in your HSA cannot be used to reimburse medical expenses incurred prior to your opening of the account so it is important to open your HSA timely in order to be able to use funds for expenses incurred on or after your effective date.

As a newly enrolled employee, you will be eligible for prorated HSA contributions depending on the quarter in which you initially enroll in the medical plan. In subsequent years, should you remain eligible and continually enrolled, your HSA contributions will match those which are offered during open enrollment.

To be eligible for opening and contributing to an HSA, you must:

- Be enrolled in a qualified high-deductible health plan (HDHP)
- Not be claimed as another person's tax dependent
- Not be enrolled in any other non HDHP health plan, including Medicare, Tricare, or VA Benefits
- If you are collecting social security, you are likely enrolled in Medicare. If you are unsure, contact the Centers for Medicare Services at: **1.800.MEDICARE** or access **www.medicare.gov** and then check "your enrollment tool"
- Not be enrolled in a general purpose flexible spending account (FSA), but a limited purpose FSA may be available to you.

You can use your HSA to maximize tax savings and help pay for qualified medical costs during the plan year.

The Internal Revenue Service decides how much you can contribute to an HSA each year. For 2025, the limits are $4,300 for individuals and $8,550 for family coverage. The limits are indexed for inflation and adjusted each year. Individuals age 55+ may contribute an additional $1,000 annually.

Any amount contributed by Healthtrax on your behalf reduces the overall total of your own funds that you can deposit into the account. As the HSA is a bank account, unspent money in your HSA can be rolled over each year.

If you have concern about your eligibility for opening an HSA, please consult a tax professional.

Dental Insurance

Diversified Administration Corporation

Please see below for highlights of our dental plan.

Benefits	Coverage
Type A Services (Preventive Care)	Covered at 100% (no deductible)
Type B Services (Basic Care)	Covered at 80% (after deductible)
Type C Services (Major Care)	Covered at 50% (after deductible)
Calendar Year Deductible	$100 per Individual
Annual Maximum	$1,000 per person

Regardless of your medical plan selection, you must elect dental insurance separately. You also have the option to elect Dental only coverage (without medical coverage). The dental premium contributions are listed below:

Payroll Deductions	Bi-Weekly	Weekly (RI Employees)
Employee Only	$12.00	$6.00
Employee + Spouse	$24.00	$12.00
Employee + Child(ren)	$22.00	$11.00
Family	$30.00	$15.00

Weekly Disability Income

Diversified Administration Corporation

Eligibility for Weekly Disability Income coverage begins the first day of the month following one year of employment. For certified disabilities, benefit coverage begins on the First Day for an Accident, or on the Eighth Day for Sickness. The Benefit Period may continue up to a maximum of Thirteen (13) Weeks. The Benefit Amount equates to 60% of basic weekly earnings to a maximum of $600.00 per week. Healthtrax pays the entire premium costs of the Weekly Disability Income benefits.

Detailed information and pricing is included in the enrollment slides for these benefits.

Long Term Disability Insurance

Reliance Standard

Disability income protection insurance provides a benefit for "long term" disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period (90 consecutive days of total disability) and continue while you are disabled up to the maximum benefit duration.

To be eligible for this coverage, you must be an Active, Full-time employee with at least one year of service, working 30 or more hours per week, except any person working on a temporary or seasonal basis.

The monthly benefit is an amount equal to 60% of covered earnings, up to a maximum benefit of $6,000 per month.

Life and Accidental Death & Dismemberment (AD&D) Insurance

Reliance Standard

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by HealthTrax. The company provides basic life insurance in the amount of $20,000 for all full-time employees at no cost to you.

If you are over age 65, the amount of your benefit will be reduced to 65% of the original amount you would otherwise be eligible for; there is a further reduction to 40% of the original amount once you reach age 70 and to 20% once you reach age 75 and are still working full-time and eligible for benefits.

AD&D Insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. HealthTrax provides AD&D coverage of $20,000 at no cost to you.

Voluntary Term Life Insurance

Reliance Standard

During this enrollment period, you may purchase additional life insurance for you and your family with Reliance Standard, subject to evidence of insurability, outside of the initial open enrollment period. You may purchase up to $100,000 of coverage. Please Note: Family coverage is available with the purchase of employee coverage. Coverage may be subject to evidence of insurability requirements.

Voluntary Accidental Death & Dismemberment coverage is also available for you and/or your family at an additional cost.

Voluntary Universal Life

Transamerica

Unlike the term life offered through Reliance, Universal Life accumulates Cash Value. You will be able to maintain the plan, as long as you are alive with continued premium payments, it will not terminate when you reach a limiting age. Coverage may be available to you on a Guaranteed Issue basis, meaning there are no health questions to answer if this is your initial eligibility period. All other employees wishing to elect may be subject to Evidence of Insurability requirements. If you elect for yourself, you are also eligible to purchase coverage for your legal spouse and/or dependent children. Medical questions may apply for you, your spouse or children depending on the level of coverage you elect. For detailed information, please see the Universal Life Section on the BenAware enrollment system.

Voluntary Accident and Critical Illness Insurance

Transamerica

Accident Insurance pays a benefit directly to you to help with copays, deductibles and out of pocket expenses due to on or off the job accidental injuries. There are no medical questions required to enroll and coverage costs less than $4.00 per week for individuals. Family coverage is available as well. Accident insurance will pay a $50 physician outpatient treatment benefit in addition to your medical coverage. Critical Illness Insurance provides protection in the event of catastrophic illnesses such as cancer, heart attack, stroke and more. Benefits are paid directly to you in addition to your medical coverage. The Critical Illness policy also provides a $100 wellness screening benefit for each insured once per calendar year. Family coverage is available as well.

Vision Insurance

VSP

Refer to the VSP flyer for a plan summary.

Payroll Deductions	Bi-Weekly	Weekly (RI Employees)
Employee Only	$4.65	$2.33
Employee + Spouse	$7.44	$3.72
Employee + Child(ren)	$7.59	$3.80
Family	$12.24	$6.12

Contact Information

Benefit	Carrier	Phone	Web/Email
Medical and Prescription Drug	Aetna	888.982.3862	www.aetna.com
Dental and Weekly Disability Income	Diversified Administrators	888.322.2524	www.dgb-online.com
Long Term Disability and Voluntary Life	Reliance Standard	800.351.7500, #6	www.reliancestandard.com Customer Care Self Service: Enter last name, DOB, and claim number or last 4 SSN
Group Accident, Critical Illness, and Universal Life	Transamerica	888.763.7474	www.tebcs.com
Vision	VSP	800.877.7195	www.vsp.com
BenAware (Enrollment Support)	BenAware	866.591.7328	http://healthtrax.benaware.com/

Contact HR with any questions concerning your benefits.

Miscellaneous Items

- In order to maintain your insurance benefits, you must maintain an average 60 hours bi-weekly. Every employee is responsible for monitoring their hours. Status will be changed to part-time (ineligible for benefits) if an employee does not work 60 hours biweekly.
- You do not have to be enrolled in medical insurance to elect dental, vision coverage, voluntary life, accident or critical illness insurance.
- Summary Plan Descriptions are available through the Human Resources Department.

Glossary of Health Coverage and Medical Terms

This glossary has many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Bold blue text indicates a term defined in this Glossary.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal A: Request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Copayment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you get in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-Network Coinsurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-Network Copayment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Coinsurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Copayment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Summary of Benefit and Coverage: The Summary of Benefit and Coverage (SBC) will be provided by the insurance company. The SBC will detail what the insurance plan covers and what it costs. If you require more detail about your coverage and costs, you can obtain the complete terms in the plan document.

Legal Disclaimers

HIPAA Special Enrollment Rights

Healthtrax International, Inc. Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Healthtrax International, Inc.'s Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) - If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program - If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption - 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program - If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Vinnie Cardaropoli – CFO at **860.652.7066** or vrcardaropoli@healthtrax.net.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Legal Disclaimers

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women'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:

- 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: HSA 3300 (Individual: 20% coinsurance and $3,300 deductible; Family: 20% coinsurance and $6,600 deductible)

Plan 2: HSA 3750 (Individual: 20% coinsurance and $3,750 deductible; Family: 20% coinsurance and $6,400 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 860.652.7066 or vrcardaropoli@healthtrax.net.

Newborn's and Mothers' Health Protection Act Notice

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicare Part D Notice:

Important Notice from Healthtrax International, 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 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. 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. **Your employer has determined that the prescription drug coverage offered by the insurance company 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 employer coverage will not be affected. You can keep your current coverage and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current employer coverage, be aware that you and your dependents will be able to get this coverage back at the next 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 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 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 your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**July 01, 2025**
Name of Entity/Sender:	**Healthtrax International, Inc.**
Contact—Position/Office:	**Vinnie Cardaropoli – CFO**
Office Address:	**622 Hebron Ave, Suite 200**
	Glastonbury, Connecticut 06033
	United States
Phone Number:	**860.652.7066**

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice, along with proof of the qualifying event to: Vinnie Cardaropoli, CFO, vrcardaropoli@healthtrax.net.

How is COBRA continuation coverage provided?

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

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Proof of disability and notice should be provided within 60 days to Vinnie Cardaropoli, CFO, vrcardaropoli@healthtrax.net.

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Keep your Plan informed of address changes

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

Plan contact information

Healthtrax International, Inc.
Vinnie Cardaropoli – CFO
622 Hebron Ave, Suite 200
Glastonbury, Connecticut 06033
United States
860.652.7066

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) includes two disclosure provisions for group health plans.

1. The criteria for medical necessity determinations with respect to mental health or substance use disorder benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request.
2. The reason for any claim denial must be made available, upon request, to the participant or beneficiary. The regulations clarify that, in order for plans subject to ERISA to satisfy this requirement, disclosures must comply with the ERISA claims and appeals procedure regulations. This means that such disclosures must be provided automatically and free of charge.

The regulations clarify that this disclosure must be made in a form and manner consistent with the rules for group health plans in the ERISA claims procedure regulations. For non-ERISA plans, compliance with the ERISA regulations will satisfy these requirements.

Break Time for Nursing Mothers Under FLSA

This notice provides general information on the break time requirement for nursing mothers in the Patient Protection and Affordable Care Act ("PPACA"), which took effect when the PPACA was signed into law on March 23, 2010 (P.L. 111-148). This law amended Section 7 of the Fair Labor Standards Act (FLSA).

General Requirements

Employers are required to provide "reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk."

Employers are also required to provide "a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk."

The FLSA requirement of break time for nursing mothers to express breast milk does not preempt State laws that provide greater protections to employees (for example, providing compensated break time, providing break time for exempt employees, or providing break time beyond 1 year after the child's birth).

Time and Location of Breaks

Employers are required to provide a reasonable amount of break time to express milk as frequently as needed by the nursing mother. The frequency of breaks needed to express milk as well as the duration of each break will likely vary.

A bathroom, even if private, is not a permissible location under the Act. The location provided must be functional as a space for expressing breast milk. If the space is not dedicated to the nursing mother's use, it must be available when needed in order to meet the statutory requirement. A space temporarily created or converted into a space for expressing milk or made available when needed by the nursing mother is sufficient provided that the space is shielded from view, and free from any intrusion from coworkers and the public.

Coverage and Compensation

Only employees who are not exempt from the FLSA's overtime pay requirements are entitled to breaks to express milk. While employers are not required under the FLSA to provide breaks to nursing mothers who are exempt from the overtime pay requirements of Section 7, they may be obligated to provide such breaks under State laws.

Employers with fewer than 50 employees are not subject to the FLSA break time requirement if compliance with the provision would impose an undue hardship. Whether compliance would be an undue hardship is determined by looking at the difficulty or expense of compliance for a specific employer in comparison to the size, financial resources, nature, and structure of the employer's business.

All employees who work for the covered employer, regardless of work site, are counted when determining whether this exemption may apply.

Employers are not required under the FLSA to compensate nursing mothers for breaks taken for the purpose of expressing milk. However, where employers already provide compensated breaks, an employee who uses that break time to express milk must be compensated in the same way other employees are compensated for break time. In addition, the FLSA's general requirement that the employee must be completely relieved from duty or else the time must be compensated as work time applies.

Where to Obtain Additional Information

For additional information, visit our Wage and Hour Division Website: **http://www.wagehour.dol.gov** and/or call our toll-free information helpline, available from 8 a.m. to 5 p.m. in your time zone, **866.4USWAGE (866.487.9243)**.

HIPAA Notice Of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Healthtrax International, Inc. is committed to the privacy of your health information. The administrators of the Healthtrax International, Inc. Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Vinnie Cardaropoli – CFO at 860.652.7066 or vrcardaropoli@healthtrax.net.

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

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

[1] [2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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.

Your Rights Under USERRA: The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service;

Then an employer may not deny you:

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., preexisting condition exclusions) except for service-connected illnesses or injuries.

Enforcement

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **866.4.USA.DOL** or visit its website at **http://www.dol.gov/vets**.

An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

In addition, an employer may not retaliate against anyone assisting the enforcement of USERRA rights, including testifying or making statement in connection with a proceeding under USERRA, even if that person has no service connection. **800.336.4590**

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

PPACA Annual Disclosure Notice for Participants

Employer Name: Healthtrax International, Inc.

Insurance Company: Aetna

Status: Non-grandfathered plan / Self-funded

Effective Date: July 1, 2025

Patient Protection Disclosure

The Healthtrax International, Inc. Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Aetna at 888.982.3862 or www.aetna.com.

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

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Aetna at 888.982.3862 or www.aetna.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 of states is current as of March 17, 2025. Contact your state for more information on eligibility.

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/ programs/third-party-liability/childrens-health-insurance- program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/ dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/ hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/ HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

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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.

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

Notes

This Enrollment Guide serves as a summary of various plans included in the Healthtrax Benefits Program, effective July 1, 2025. Complete details of the plans are included in the official plan documents and contracts. If there is a difference between this Enrollment Guide and the legal documents or contracts, then the documents or contracts will govern in every instance. In addition, Healthtrax International, Inc. reserves the right to change or terminate the Healthtrax Benefits Program, individual plans or any provisions of any plan, at any time.

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

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting