Orsini

2025-26

Employee Benefits Guide

Provided to you by:

HAUSER

Welcome

We would like to welcome you to the 2025-26 annual benefits summary package for ***Orsini***. This packet contains summaries of the benefits offered to you by ***Orsini***. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This benefits guide provides an overview of benefit plans, including eligibility, election periods and costs. In addition, the guide offers descriptions and explanations of each coverage plan option. We urge you to carefully consider all aspects of these programs, including their premiums, accessibility to health care services, flexibility, and restrictions.

Info on the Go!

Scan with your Smartphone to access your 2025-26 Benefits Guide and enrollment materials online ANYTIME.

Table of Contents

Benefit	Enrollment Optional or Automatic	Coverage
Medical	**Optional** You and *Orsini* share the cost	*Orsini* will offer three plans through Blue Cross Blue Shield of IL; a Preferred Provider Organization Plan (PPO), a Health Maintenance Organization Plan (HMO), and a High-Deductible Health Plan (HDHP) with a Health Savings Account (HSA).
Health Savings Account (HSA)	**Optional** *You and Orsini* contribute	If you elect to participate in the $3,500 HDHP medical plan, you can contribute pre-tax dollars to use for eligible heath care expenses. *Orsini* will also contribute money to your HSA. You will receive a debit card from HealthEquity to access the funds in your HSA.
Dental	**Optional** You and *Orsini* share the cost	*Orsini* offers comprehensive dental coverage through *Delta Dental of IL*.
Vision	**Optional** You pay the cost	*Orsini* offers a vision plan through *Delta Vision*.
Basic Life and AD&D	**Automatic** *Orsini* pays the cost	*Orsini* pays for Basic Life and AD&D in the amount of $50,000.
Voluntary Life	**Optional** You pay the cost	You may elect life insurance in $10,000 increments in the amount of 5x your earnings to maximum of $500,000. You can also purchase life insurance for your spouse and child(ren).
Voluntary Short-Term Disability (STD)	**Optional** You pay the cost	You may elect short-term disability coverage. This benefit provides you with 60% of your annual base salary to a weekly maximum of $1,200.
Voluntary Long-Term Disability (LTD)	**Optional** You pay the cost	You may elect long-term disability. This benefit provides you with income protection, after 180 days of a covered disability in the amount of 60% of annual base salary to a monthly maximum of $5,000.
Voluntary Accident	**Optional** You pay the cost	You may elect Accident coverage that provides you with a lump sum cash payment to help cover expenses such as emergency room visits.
Voluntary Critical Illness	**Optional** You pay the cost	You may elect Critical Illness coverage that provides you with a lump sum cash payment should you experience a serious illness.
Employee Assistance Program (EAP)	**Automatic** *Orsini* pays the cost	*Orsini* provides you and your household members with access to free, confidential support to help with personal or professional problems.

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Enrolling and Eligibility

Who is Eligible?

If you are a full-time employee, you are eligible to enroll in benefits described in this guide. You are eligible for benefits on the **first of the month following your date of hire.**

You may enroll your eligible dependents in the same plans you choose for yourself, including medical, dental, vision and voluntary life insurance coverage. Eligible dependents may include the following:

- ✓ Your legal spouse
- ✓ Your Domestic Partner (same sex)
- ✓ Your children up to age 26
- ✓ Your unmarried dependent children over age 26 who are incapable of self-care because of a disability and who rely on you for support

When you enroll dependents, please submit copies of the following (if applicable):

- ✓ Marriage Certificate, an Affidavit of Domestic Partnership or Common Law Marriage
- ✓ Birth Certificate(s)
- ✓ Adoption Papers or papers to show legal adoption proceedings have started

If you do not provide this documentation within 31 days of hire, your dependents will not be enrolled in benefits.

Enrolling for Coverage

Your enrollment period is a valuable time to review your benefits and choose the best options for you and your family. Review the 2025-26 Employee Benefits Guide to understand the coverage available and changes to the ***Orsini*** Benefit Program. **You can enroll in coverage within 31 days of your hire date or during the annual open enrollment period.**

Newly hired full-time employees enrolling for the first time will make their benefit elections via (*ADP*), our online enrollment tool. You can make your benefit elections during the enrollment window, and coverage begins on the first of the month following your date of hire.

Please visit Sign In | WFNPortal to access your account profile. Your personal benefit elections will be housed in *ADP.*

Everyone can access their benefit information via the *ADP* Portal to enroll and/or amend their benefits.

Eligibility and Enrolling

Active Enrollment

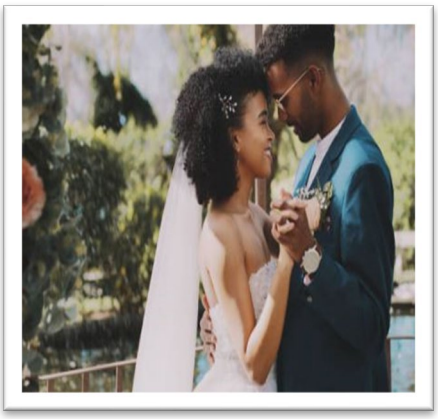
ACTION REQUIRED: EVERYONE must access *ADP* to enroll or waive benefits.

If you do not access *ADP* to make your benefit elections during open enrollment, you will NOT be enrolled, and your benefits coverage will end August 31, 2025. Current elections will NOT remain in force for 2025-26 if you do nothing. If you have questions, please contact Human Resources.

Changing Your Coverage During the Year

Whether you are a newly hired employee or a current employee enrolling during the annual open enrollment, the elections you make at this time will remain in effect until ***Orsini's*** next open enrollment period, unless you have a qualifying life event (as defined by the IRS) that allows a mid-year plan change.

These changes include (but are not limited to):



- ✓ Birth or adoption of a baby or child
- ✓ Loss of other healthcare coverage
- ✓ Eligibility for new healthcare coverage
- ✓ Marriage
- ✓ Divorce
- ✓ Change in child's dependent status

If you experience a qualifying life event, or if you have questions, please contact Human Resources (HR). You have 30 days after a qualifying event to notify HR and request a change to your benefit elections.

Note: The benefit changes you make must be consistent with the life event.

When Dependent Children Age Out
Dependent children can remain on the medical, dental and/or vision coverage(s) until the end of the month in which they turn 26, at which time their coverage will be cancelled. Coverage under Voluntary Life and AD&D ends on their 26th birthday.

Medical & Prescription Drug Benefits

Plan Year - September 1st through August 31st

BlueCross BlueShield of Illinois

Orsini offers a comprehensive benefits program to help you and your family protect your health and financial security. Your benefits are a valuable part of your compensation; we encourage you to learn how the plans work so you can get the most from them. These plans encourage you to seek care from In-Network providers on the PPO and HDHP plans, which provide a higher level of benefit. You may choose to use Out-Of-Network providers, but if you do, your benefits will be reduced, and your out-of-pocket expense will increase. The HMO plan does require you to select a primary care provider and obtain a referral in order to see a specialist.

The following chart provides a summary of the key features of the **Medical** benefit options. Complete benefit summaries are available on the *ADP Portal.*

	$3,500 HDHP	**$2,000 PPO**	**$0 HMO**
Network	**Broad PPO**	**Broad PPO**	**Blue Advantage HMO**
PCP Required?	**No**		**Yes**
Referrals Required for Specialist?			
Services	**In-Network**	**In-Network**	**In-Network ONLY**
Deductible	*Embedded	*Embedded	N/A
- Individual	$3,500	$2,000	$0
- Family	$7,000	$4,000	$0
Coinsurance	20%	20%	0%
Max. Out-of-Pocket (Includes deductible, coinsurance & copays) - Individual - Family	 $7,000 $14,000	 $5,000 $10,000	 $1,500 $3,000
Physician Office Visit (Primary/Specialist)	20% After Deductible	$20/$40 Copay	$20/$40 Copay
Preventative Care (Adult/Well-Child)	Covered at 100%		
Emergency Room	20% After Deductible	$150 Copay	$150 Copay
Urgent Care	20% After Deductible	20% After Deductible	$0 Copay
Inpatient Service	20% After Deductible	20% After Deductible	$100 Copay (per day 1st 5 days)
Outpatient Diagnostic X-Ray / Laboratory / Complex Imaging	20% After Deductible	20% After Deductible	$0 Copay
Outpatient Services	20% After Deductible	20% After Deductible	$0 Copay
Prescription Drugs - Retail *(30-day supply)*	After deductible: Preferred: 10%/10%/20%/30%/40% Non-Preferred: 20%/20%/30%/40%/50%	$10/$40/$60/$60	Expense Limit: $1,000 individual. $3,000 family $10/$40/$60/20%
- Mail Order *(90-day supply)*	After deductible: Preferred: 10%/10%/20%/30% Non-Preferred: 20%/20%/30%/40%	$20/$80/$120/Not Available	$20/$80/$120/20%

***Embedded** deductible and out-of-pocket (OOP), means that a "per member" deductible and OOP are embedded within the "per family" thresholds. Each covered family member is subject only to their "per member" deductible or OOP, and the family's exposure as a whole is limited by the family deductible and OOP limits.*

Medical & Prescription Drug Benefits

BlueCross BlueShield of Illinois

Medical Key Reminders

- ✓ To limit your Out-of-Pocket expenses, please seek services from a *BCBS of IL* provider. To find a provider, visit https://www.bcbsil.com/find-care/find-a-doctor-or-hospital.
- ✓ If services are provided by a non-*BCBS of IL* provider, the member is responsible for any amounts exceeding the "allowable charges," in which case balance billing could occur.
- ✓ Dependent Child Age Limits: Covered to age 26.

Choose Generics - The member pays the applicable copay (if applicable) only if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between. Be sure to discuss this with your physician when he or she writes your prescription.

Prescription Drug Coverage

We know prescription drug coverage is important to you and your family, so when you elect medical coverage, you are automatically covered under the prescription drug plan. You may fill your prescriptions at participating retail pharmacies. Under the prescription drug coverage, the mail order option allows you to buy qualified prescriptions in larger 90-day quantities for a slightly higher copay amount as a 31-day supply at the retail pharmacy. Mail order saves you time on trips to the pharmacy because prescriptions are delivered right to your door.

There are several categories of drugs under the plans. The differences between these categories are described below:

Drug Tier	Includes	Helpful Tips
Tier 1	**$ Lower cost** Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pockets costs.
Tier 2 and 3	**$$ Mid-range cost** Medications that provide good overall value. A mix of brand name and generic drugs.	Use Tier 2 or Tier 3 drugs, instead of Tier 4, to help reduce your out-of-pocket costs.
Tier 4	**$$$ Highest cost** Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics.	Many Tier 4 drugs have lower-cost options in Tiers 1, 2 or 3. Ask your doctor if they could work for you.

Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on https://account.bcbsil.com/ or by calling *BCBS of IL*. **The prescription drug formulary name is Performance.**

Helpful Terms

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible to pay the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Out-of-Pocket Maximum – The most you would pay out-of- pocket for covered services in a year. Once you reach your out- of-pocket maximum, the plan covers 100% of eligible expenses.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Where To Seek Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

Primary Care Center

When would I use this?

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?

- ✓ Routine checkups
- ✓ Immunizations
- ✓ Preventive Services
- ✓ Manage your general health

What are the costs and time considerations?

- ✓ Often requires a copay and/or coinsurance.
- ✓ Normally requires an appointment.
- ✓ Usually little wait time with scheduled appointment.

Telehealth

When would I use this?

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of issues can they treat? *

- ✓ Cold & flu symptoms
- ✓ Urinary tract infection
- ✓ Allergies
- ✓ Bronchitis
- ✓ Sinus problems

What are the costs and time considerations?

- ✓ Often requires a copay and/or coinsurance.
- ✓ Access to care is usually immediate.
- ✓ Certain states may not allow for prescriptions through telemedicine or virtual visits.

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word emergency appears in the company name.

Urgent Care Center

When would I use this?

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for **non**-life-threatening injuries or illnesses.

What type of care would they provide? *

- ✓ Strains, sprains
- ✓ Minor broken bones
- ✓ Minor infections
- ✓ Minor burns
- ✓ X-Rays

What are the costs and time considerations? **

- ✓ Often requires a copay and/or coinsurance that is generally higher than an office visit.
- ✓ Walk-in patients welcome but waiting periods may be longer as patients with more urgent needs will be treated first.

Emergency Room

When would I use this?

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of issues can they treat? *

- ✓ Heavy bleeding
- ✓ Chest pain
- ✓ Major burns
- ✓ Spinal injuries
- ✓ Severe head injury
- ✓ Broken bones

What are the costs and time considerations? **

- ✓ Often requires a much higher copay and/or coinsurance.
- ✓ Open 24/7 but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

**This is sample of services and may not be all-inclusive.*

***Cost and time information represent average only and are not tied to a specific condition or treatment.*

Health Savings Account (HSA)

Plan Year - September 1st through August 31st

Orsini will offer an HSA to those who enroll in the $3,500 HDHP Medical Plan. The HSA provides you with the ability to save and use pre-tax dollars to pay for eligible medical expenses (i.e., deductible). You can save approximately 25 percent of each dollar spent on medical expenses when you participate.

Contributions to your HSA are withdrawn from your paycheck on a pre-tax basis. This means you don't pay federal income taxes, Social Security taxes, or local income taxes on the portion of your paycheck you contribute to the HSA. **See HSA State Taxation information below.*

What are the benefits of an HSA?

- ✓ Funds Rollover – No "use it or lose it" provision.
- ✓ Earns Interest – Monies accrue tax-free interest.
- ✓ Portable – Yours to keep. If you leave your employers, your HSA funds go with you.

In addition to the company contribution, you may elect to make a personal contribution, which is 100% tax deductible from your gross income. The "combined" contributions made into your HSA account cannot exceed the following IRS limits set for calendar year 2025:

- $4,300 single
- $8,550 family (any level of coverage including one or more dependents)
- If you are 55 or over, you can add an additional contribution of $1,000

The ***Orsini*** **Annual** Employ*er* HSA Contributions are as follows:

Employee Only	**$500**
Employee + Spouse	**$500**
Employee + Child(ren)	**$500**
Family	**$500**

Orsini partners with HealthEquity to provide HSA services. You will be able to manage your account online, submit eligible claims, review your account balance, review your claim history, and more.

You can use your HSA to pay for a wide range of IRS-qualified medical expenses for yourself, your spouse, or tax dependents. An IRS-qualified medical expense is defined as an expense that pays for healthcare services, equipment, or medications. To view the list of eligible expenses, please visit: HSA Eligible Expenses.

**HSA State Taxation: There are currently three states that, unlike the federal government, subject your HSA contributions (associate and employer) to state income taxes. The three states are New Jersey, California, and Alabama. Similarly, these three states also subject earnings (interest and capital gains) on your HSA to state taxation. There are currently two other states, New Hampshire, and Tennessee, that subject earnings on the account (but not the contributions) to state taxes. Tax laws are subject to change. Please contact your state tax authority or consult with a tax advisor to confirm the details for your state.*

Dental Benefits

Plan Year - September 1st through August 31st

Dental coverage is important to your overall health and wellness. You can enroll in dental benefits through *Delta Dental* for yourself and your family. The dental plan features a network of dentists and specialists who have agreed to provide services at a discounted price.

If you choose to go to a dentist out of the network, you may be balanced billed for any charges over what is considered "the maximum allowable charge" (MAC). For an out-of-network provider, MAC means the dental plan will only pay up to the set in-network rate for a covered service even if the provider charges more. The member is responsible for paying the difference between the provider's fee and the MAC amount. In order to get the most from your benefits we encourage you to see an in-network dentist.

Please note, ID Cards are not required for you to receive services. Providers can confirm coverage with your Social Security Number.

The following chart shows the features of the **Dental** benefit option. A complete benefit summary is available on our *ADP* Portal.

	Delta Dental HMO **Network: Dental Care**		**Delta Dental PPO** **Network: Delta Dental PPO**	
Services	**In-Network Only**		**In-Network**	**Out of Network**
Deductible	None		$50 Single $150 Family	$50 Single $150 Family
Preventive Services *(Exams, Cleanings, X-Rays, Sealants, Fluoride)*	$0		100% Covered	100% Covered
Basic Services	Office Visit: Fillings: Perio-Surgery: Scaling & Root Planning: Simple Extractions: Surgical Extractions:	$0 $0-$65 $45-$165 $0-$45 $0-$118 $65-$145	10% after Deductible	20% after Deductible
Major Services	Root Canal: Single Crown:	$97-$465 $135-$297	40% after Deductible	50% after Deductible
Orthodontia	Up to $2,125 to age 19 Up to $2,625 age 20+		50%, up to $1,500 Lifetime max per child *(up to age 19)*	
Annual Maximum	Unlimited		$2,000	
Reimbursement	N/A		Maximum Allowable Charge*	

***** With a maximum allowable charge reimbursement plan, benefits for a given dental procedure are calculated according to the maximum allowable charge for a particular area.

Voluntary Vision Benefits

Plan Year - September 1st through August 31st

Your vision health is an important part of complete wellness. *Delta Vision* is pleased to present your vision benefits which are designed to give you and your covered family members care, value, and service to help maintain good vision and overall health.

Please note, ID Cards will not be issued. Cards are not required for you to receive services. At the point of service, simply provide your name, SSN and DOB to your care provider. Any dependents on your plan can also use your SSN to get care. You can download a virtual card by visiting eyemedvisioncare.com/member.

In order to limit your Out-of-Pocket expenses, seek services from a Delta Vision in-network provider.

***Network Name**: Insight*

The following chart shows the features of the **Vision** benefit option. A complete benefit summary is available on our *ADP Portal.*

Services	*In-Network Member Cost	Out-of-Network Reimbursement
Annual Comprehensive Eye Exam *(Every 12 months)*	$10 copay	Up to $35
Standard Frame *(Every 12 months)*	$150 allowance Additional 20% off balance over allowance	Up to $75
Standard Plastic Lenses *(Every 12 months in lieu of contact lenses)*		
Single Vision	$25 copay	Up to $25
Bifocal	$25 copay	Up to $40
Trifocal	$25 copay	Up to $55
Contact Lenses *(Every 12 months in lieu of frames and lenses)*		
Conventional	$150 allowance Additional 15% off balance over allowance	Up to $120
Disposable	$150 allowance	Up to $120

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Cost of Coverage *(per 26 pay periods)*

Orsini pays a portion of your health care premiums; however, we do require employees to contribute toward their health care costs as well. Employees pay a dollar amount based on the level of coverage they select. The following Employee Payroll Deductions will be effective for this plan year and will be reflected on your first paycheck after your effective date.

MEDICAL Plan Payroll Deductions (Per 26 Pay Periods)

	Employee	Employee + Spouse	Employee + Child(ren)	Family
$3,500 HDHP	$54.16	$162.76	$132.07	$275.67
$2,000 PPO	$174.31	$449.17	$420.85	$787.72
$0 HMO	$135.94	$354.99	$336.31	$629.74

DENTAL Plan Payroll Deductions (Per 26 Pay Periods)

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Delta Dental PPO	$13.84	$29.92	$28.47	$56.58
Delta Dental HMO	$2.00	$5.00	$7.00	$12.00

VISION Plan Payroll Deductions (Per 26 Pay Periods)

Employee	Employee + Spouse	Employee + Child(ren)	Family
$2.91	$5.67	$6.35	$9.17

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

Plan Year - September 1st through August 31st

Group Life and AD&D

Coverage is available through *Principal*. Life and AD&D insurance is an important benefit as it provides your beneficiaries financial protection in the event of a tragic loss.

Orsini provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance and **pays for 100% of the coverage.**

The amount provided by ***Orsini*** is **$50,000**

Age Reduction: If you are age 65 or older, the amount of your Group Life Insurance will reduce to the following percentage of its original value:

Age of Employee	Reduction
65 but less than 70	**35%**
70 or older	**50%**
Terminate upon retirement	

Please make sure to add your beneficiary(ies) information upon enrollment.

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Voluntary Life Insurance

Plan Year - September 1st through August 31st

Voluntary Life

If you need additional Life insurance to meet your financial needs, you can purchase **Voluntary Life** insurance through after-tax payroll deductions for yourself, your spouse, and your child(ren). Life insurance is about more than paying for memorial services, it is about making sure your family can maintain its standard of living if something happens to you. The amount of coverage your family needs depends on your personal situation (other income, monthly expenses, short and long-term debt such as credit card or mortgage expenses, etc.).

By purchasing voluntary life insurance, you also get additional benefits including grief counseling, and planning services, will preparation, and estate services. Should you leave the company, you can elect to continue this coverage directly with *Principal*. Benefit reductions begin at age 70.

Employee Benefit Amount: Life	✓ Increments of $10,000 to a maximum of lesser of five (5) times salary or $500,000. ✓ New Entrants: Guarantee Issue (GI) Amount $150,000 (under age 70)
Spouse Benefit Amount: Life	✓ Increments of $5,000 to a maximum of $100,000. Not to exceed 100% of the employee election. ✓ New Entrants: GI Amount $30,000 (under age 70)
Child(ren) Benefit Amount: Life	✓ $5,000 or $10,000 ✓ New Entrants: GI Amount $10,000

Amounts over the GI are subject to Evidence of Insurability (EOI).

Evidence of Insurability (EOI) Rules

- ✓ **New entrant:** If you elect coverage when you are initially eligible, EOI is required only for any amount over $150,000.
- ✓ **New entrant:** If you elect coverage for your spouse or domestic partner when you are initially eligible, EOI is required only for any amount over $30,000.
- ✓ Employees who previously declined coverage during their initial enrollment (as new entrant) can elect coverage for themselves and their spouse but must complete the required EOI form.
- ✓ Coverage for your dependent child(ren) ends on his or her 26th birthday.
- ✓ Annual Enrollment: Employees who previously elected coverage for themselves can increase their coverage by two $10,000 increments without providing EOI. If you wish to increase your coverage by greater than $20,000, you must complete the required EOI form.
- ✓ Annual Enrollment: Employees who previously elected coverage for their spouse can increase spousal coverage by two $5,000 increments without providing EOI. If you wish to increase spousal coverage by greater than $10,000, you must complete the required EOI form.

Evidence of Insurability (EOI): is required if you did not apply for coverage when you were initially eligible (as a new entrant) or if you are requesting an amount of coverage that exceeds the maximum guaranteed issue amount in your plan. You will have 31 days to provide a complete EOI. Once your EOI is reviewed by Principal, they will notify you in writing, approving, or denying your request for coverage. **If you do not complete EOI within 31 days or are denied the increase by the carrier, coverage will revert back to your original election(s).**

Voluntary Disability Income Benefits

Plan Year - September 1st through August 31st

If you become disabled and cannot work, no benefit becomes more important to your financial security than Disability Income protection. Disability coverage provides income protection in the event that you experience a non-occupational injury or illness that prevents you from working. You have the option to purchase Short-Term Disability (STD) and Long-Term Disability (LTD) insurance, via payroll deduction. These coverages are offered by *Principal.*

Short-Term Disability Insurance (STD)

Elimination Period	0 days accident / 7 days illness
Income Replacement	60% of your pre-disability earning
Maximum Benefit	$1,200 weekly
Maximum Benefit Period	26 weeks

If an eligible employee is disabled/injured more than 1 consecutive calendar days or sick for more than 7 consecutive calendar days on an approved leave of absence per company policy, they must first use PTO. Once that is exhausted an application can be made for short-term disability benefit, which will pay 60% of your weekly pay up to a maximum benefit of $1,200 per week, for a maximum of 26 weeks.

You pay 100% of this coverage.

Long Term Disability Insurance (LTD)

If an employee is disabled for more than three consecutive months, application can be made for long-term disability benefits, which will pay 60% of your salary for up to Social Security Normal Retirement Age (SSNRA). **You pay 100% of this coverage.**

Elimination Period	180 days
Income Replacement	60% of your pre-disability earning
Maximum Benefit	$5,000 Monthly
Maximum Benefit Period	Social Security Normal Retirement Age (SSNRA)

Helpful Terms

Elimination Period – It is the period of time you have to wait before benefits begin, starting the day you become ill or injured.

Maximum Monthly Benefit – This is the highest dollar amount a disabled employee can receive on a monthly basis under the LTD plan.

Pre-Disability Earnings – The amount of a policyholder's wages or salary in effect on the day before the disability began.

Maximum Benefit Period – This is a maximum length of time during which benefits will be paid.

A complete benefits summary and the cost related to this benefit are available on our *ADP* Portal.

Voluntary Benefits

Orsini offers a suite of voluntary benefits for you and your family. These voluntary benefits are offered by Principal.

Voluntary Accident

Accidents can happen when you least expect them. While you cannot always prevent them, you can get help to make your recovery less expensive and stressful by purchasing accident insurance.

You have the option of purchasing an accident plan that offers **24-hour on & off the job coverage**.

A complete benefit summary and cost is available on *ADP*.

Accident Insurance	MONTHLY cost to you
Employee	$9.03
Employee & Spouse	$13.32
Employee & Child(ren)	$15.91
Employee & Spouse/Child(ren)	$24.02

Voluntary Critical Illness

If you're diagnosed with a serious illness, one of the last things you want to worry about is your finances. A critical illness policy can provide you with a lump-sum cash benefit upon diagnosis of a critical illness. The benefit can be used to pay out-of-pocket expenses or to supplement your daily cost of living.

A Critical Illness insurance policy helps provide protection from a variety of covered conditions, so you can focus on getting well.

- ✓ Pays a benefit to you if you are diagnosed with a major illness such as Cancer, Heart Attack, or Stroke
- ✓ There is no benefit waiting period
- ✓ You can choose the benefit amount that is right for you
  - Increments of $5,000
  - To a maximum of $100,000
  - Guaranteed Issue is $30,000

Added Value Programs

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) provides a network of experienced professionals who can offer counseling for you and your dependents facing difficult legal, emotional, or financial issues. Counselors and qualified professionals are available 24 hours a day, 365 days a year, and all calls are completely confidential – nothing is reported back to your employer. Services include online resources, 3 in-person counseling sessions, and unlimited telephonic counseling. The EAP is available to all employees.

Topics Include:

- ✓ Family
- ✓ Parenting
- ✓ Addictions
- ✓ Emotional
- ✓ Legal
- ✓ Financial
- ✓ Relationships
- ✓ Stress

For more support or information please visit www.member.magellanhealthcare.com (**program name:** Principal Core) or talk with a specialist at 1-800-450-1327.

Travel Assistance

Those enrolled in Life and AD&D insurance, Principal offers you travel assistance through *AXA Assistance USA*. The AXA Assistance USA program can bring help, comfort, and reassurance if you face a medical emergency while traveling 100 or more miles from home. Whether you are traveling for business or leisure, you and your loved ones can receive support 24 hours a day, 7 days a week.

- Emergency travel arrangements
- Lost or stolen travel documents
- Language translation services
- Return of traveling companion
- Emergency pet boarding and/or return
- ID recovery assistance
- Vehicle return
- Destination information

For a complete list of *AXA Assistance USA* services go to www.principal.com/travelassistance or call 1-888-647-2611 for more information.

Added Value Programs

Will Preparation and Estate Guidance

No matter how well you plan your life, you can be sure unforeseen challenges will arise. If you are enrolled in Life and AD&D insurance, you have access through Principal to help manage these challenges. The program provides access to a wide array of services to help you and your loved ones through life's difficulties.

Services include:

Online Will Preparation – Having a will is important because it allows you to designate who will receive your property and assets when you die. Without one, your state determines how your estate is distributed.

Living Will – You have access to create a living will which lets your family and health care providers you're your wishes for medical treatment if you're no longer able to make them yourself.

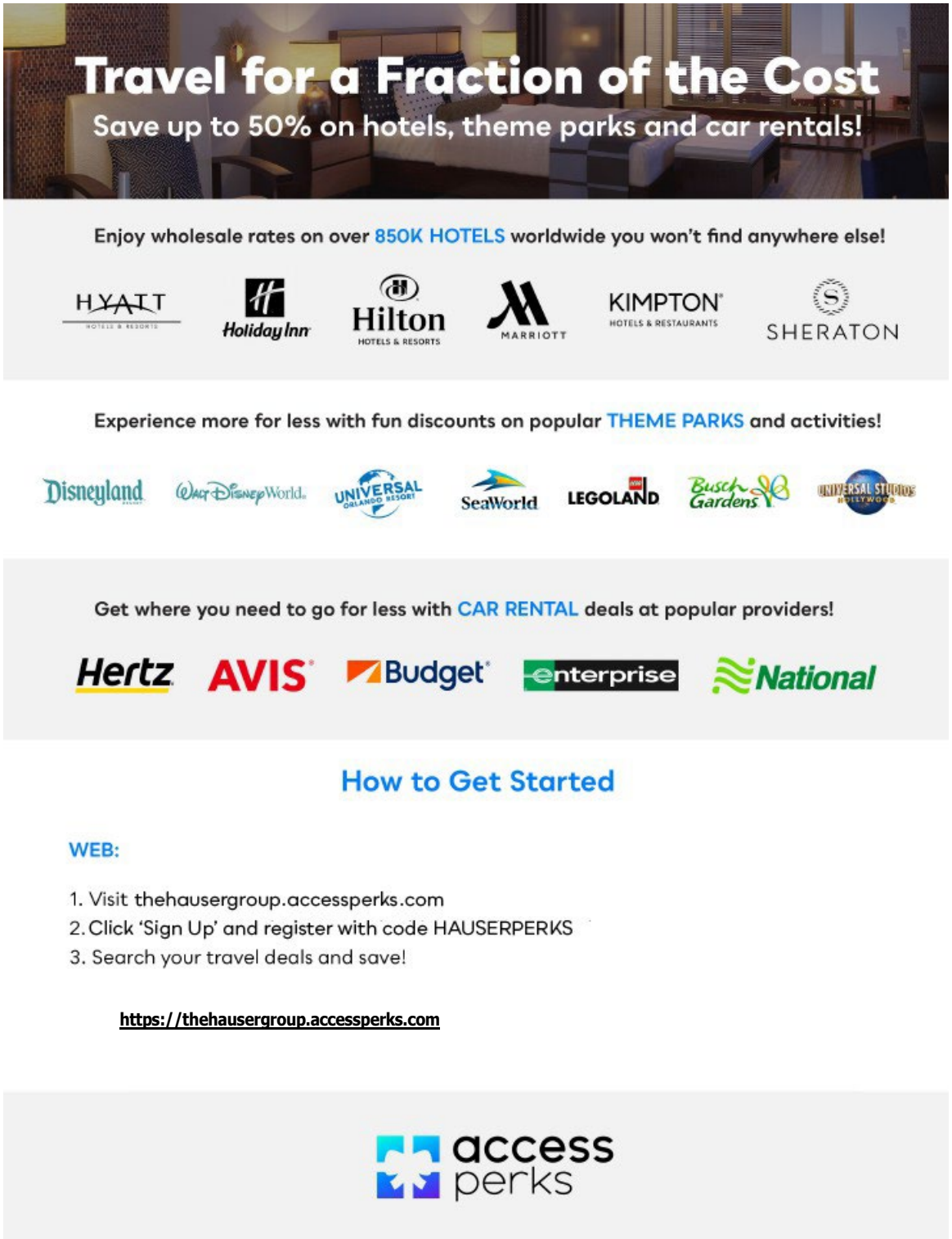
Guidance Resources – You have access to guidebooks and articles on a wide range of topics — including legal, financial, family, and career. It is a way to stay "in the know" on important matters that impact both your personal and professional life.

Identity Theft Resources – Identity theft is widespread, and everyone is vulnerable. You have access to an identity theft victim action kit to help speed your recovery if you experience identity theft.

Authorization for a Minor's Medical Treatment – Allows you to grant consent for medical personnel to treat your child(ren) if you're away and can't be reached.

It is easy to access services, just call **1-800-546-3718** or visit www.ARAGWills.com/Principal all first-time users will need to register by completing the required fields. Your group policy number is 1193668.

Added Value Programs



Contacts

Your Carriers

Contact Name	Contact Information
Medical **Blue Cross Blue Shield of IL (BSBCIL)**	Phone: **1 (800) 538-8833** Website: www.bcbsil.com
Health Savings Account (HSA) **HealthEquity**	Phone: **1 (866) 346-5800** Website: www.healthequity.com
Dental **Delta Dental**	PPO Phone: **1 (800) 323-1743** DHMO Phone: **1 (800) 942-3772** Website: www.deltadentalil.com
Vision **Delta Vision**	Phone: **1 (866) 723-0513** Website: www.deltadentalil.com/deltavision
Life and AD&D and Disability **Principal**	Phone: **1 (800) 986-3343** Website: www.principal.com
Accident and Critical Illness **Principal**	Phone: **1 (800) 986-3343** Website: www.principal.com
Employee Assistance Program (EAP) **Principal**	Phone: **1 (800) 450-1327** Website: www.member.magellanhealthcare.com **program name:** Principal Core
Added Value Programs **Principal**	**Travel Assistance:** Phone: **1 (888) 647-2611** Website: www.principal.com/travelassistance.com **Wills and Legal center:** Phone: **1 (800) 546-3718** Website: www.aragwills.com/principal

Your Human Resources Team

Contact Name	Title	Phone	Email
Clara Coca	Human Resources Director	(773) 425-2347	ccoca@orsinihc.com
Tetyana Prannychuk	Human Resources Manager	(708) 548-0200	tprannychuk@orsinihc.com
Sabrina Gates	Human Resources Generalist	(708) 941-8412	sgates@orsinihc.com

Your Hauser Team

Contact Name	Contact Information	Description
Julie Price, **Client Executive**	Phone: (513) 410-2797 Email: jprice@thehausergroup.com	Julie is responsible for benefit plan presentations to members and assisting in developing Wellness initiatives. Also, a day-to-day point contact for plan questions, eligibility, and assistance in resolving an escalated claim.
Dineka Johnson, **Senior Consultant**	Phone: (513) 885-0917 Email: djohnson@thehausergroup.com	Dineka ensures that your health plan runs smoothly and efficiently. He will oversee any question or issue that you wish to elevate to a management level.

Important Notices

Notice of Patient Protections & Prior Authorization Procedures

Your **Blue Cross Blue Shield IL (BCBS)** plan allows you to visit any doctor or hospital you choose. However, Prior Authorization is required for certain services. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, certain Specialty Drugs, and Durable Medical Equipment costing $500 or more. Contact **Blue Cross Blue Shield IL (BCBS)** Customer Service using the number on the back of your medical ID card or online at **www.bcbsil.com** to find out which services require Prior Authorization. You can also call the customer service department to find out if your admission or other service has received Prior Authorization. For more information, please refer to your Evidence of Coverage document located online at **www.bcbsil.com.**

Women's Health and Cancer Rights Act of 1998

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including Lymphedemas, in a manner determined in consultation with the attending physician and the patient.

The coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. For more information, please refer to your Evidence of Coverage document located online at **www.bcbsil.com.**

Newborns and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice of Special Enrollment Rights

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 31 days after you 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 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

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 Medicaid 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/flmedicaidtplrecovery.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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Notice of Privacy Practices

Blue Cross Blue Shield IL (BCBS) is required to maintain the privacy of all medical information as required by applicable laws and regulations; provide a notice of privacy practices to all Members; inform Members of the Plan's legal obligations; and advise Members of additional rights concerning their medical information. For more information, please refer to your Evidence of Coverage document located online at **www.bcbsil.com.**

All Members will be notified of any changes by receiving a new notice of the Plan's privacy practices. You may request a copy of this notice of privacy practices at any time by contacting **Blue Cross Blue Shield IL (BCBS).**

Uniformed Services Employment and Reemployment Rights Act of 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave.

Important Notice from Orsini About Your Prescription Drug Coverage and Medicare for plans:

- **$3,500 HDHP**
- **$2,000 PPO**
- **$0 HMO**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] 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. *Orsini* has determined that the prescription drug coverage offered by the $3,500 HDHP, $2,000 PPO and $0 HMO 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 ***Orsini*** coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). *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 ***Orsini*** coverage, be aware that you and your dependents will not be able to get this coverage back until the next annual open enrollment period or a mid-year qualifying event.

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 ***Orsini*** 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 ***Orsini*** 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:	09/01/2025
Name of Entity/Sender:	Orsini
Contact-Position/Office:	Human Resources
Address:	1111 Nicholas Blvd, Elk Grove, IL 60007
Phone Number:	847-734-7373

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB No. 1210-0149 (expires 12-31-2026)

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% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [1][2]

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

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

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

Where 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 **HUMAN RESOURCES DEPARTMENT**.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Orsini Pharmaceutical Services, LLC	32-0108171
5. Employer address	6. Employer phone number
1111 Nicholas Blvd	(847) 734-7373

7. City	8. State	9. ZIP code
Elk Grove Village	IL	60007

10. Who can we contact about employee health coverage at this job?	
Clara Coca	
11. Phone number (if different from above)	12. Email address
	ccoca@orsinihc.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

[X] All employees. Eligible employees are:

Full-time Employees working 30+ hours per week

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[X] We do offer coverage. Eligible dependents are:

1. Legal Spouses
2. Domestic Partners (same sex)
3. Dependents up to age 26

[ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here is the employer information you will enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)

☐ 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____(mm/dd/yyyy) (Continue)

for employers but will help ensure employees understand their coverage choices.

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan?$ 117.35
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
B Employer won't offer health coverage
Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $ _____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of1986)

ADDRESS: 1111 Nicholas Blvd.
Elk Grove Village, IL 60007
PHONE: (847) 734-7373

Orsini

The information in this Enrollment Guide is presented for illustrative purposes and the text contained herein was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.