

Employee Benefits Guide

Plan Year: 2026-2027



Welcome

We would like to welcome you to the 2026-27 annual benefits summary package for **Orsini**. This packet contains an overview 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 2026-27 Benefits Website and enrollment materials online ANYTIME!

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Benefit	Enrollment Optional or Automatic	Coverage
Medical & Pharmacy	Optional You and Orsini share the cost	Orsini will offer three plans through Cigna; 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 health 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 pay the cost	Orsini offers comprehensive dental coverage through <i>Sun Life</i> . You can choose between a PPO plan or DHMO plan.
Vision	Optional You pay the cost	Orsini offers a vision plan through <i>EyeMed</i> .
Basic Life and AD&D	Automatic Orsini pays the cost	Orsini pays for Basic Life and AD&D in the amount of \$50,000 through <i>Lincoln</i> .
Voluntary Life and AD&D	Optional You pay the cost	You may elect life insurance in \$10,000 increments to a 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 choose 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 coverage. 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.

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):

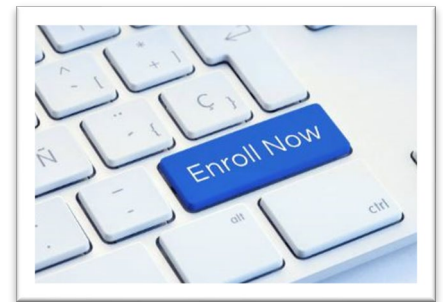
- ✓ Marriage Certificate, an Affidavit of Domestic Partnership or Common Law Marriage
- ✓ Birth Certificate(s)
- ✓ Adoption Papers or papers to show legal adoption proceedings have started

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 2026-27 Employee Benefits Guide or visit the Benefits Website (www.orsinibenefits.com) 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

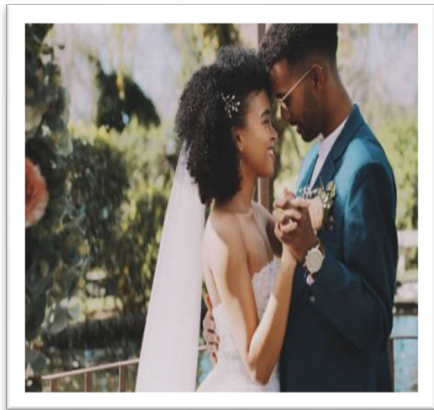
Active Enrollment

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, 2026**. Current elections will **NOT** remain in force for 2026-27 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.



Medical & Prescription Drug Benefits

Plan Year – September 1st through August 31st



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	Open Access Plus (OAP)	Open Access Plus (OAP)	Cigna One Health
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	10%	10%	0%
Max. Out-of-Pocket (Includes deductible, coinsurance & copays)			
- Individual	\$7,000	\$5,000	\$1,500
- Family	\$14,000	\$10,000	\$3,000
Physician Office Visit (Primary/Specialist)	10% After Deductible	\$20/\$40 Copay	\$20/\$40 Copay
Preventative Care (Adult/Well-Child)	Covered at 100%		
Emergency Room	10% After Deductible	\$150 Copay	\$150 Copay
Urgent Care	10% After Deductible	10% After Deductible	\$0 Copay
Inpatient Service	10% After Deductible	10% After Deductible	\$100 Copay (per day 1 st 5 days)
Outpatient Diagnostic X-Ray / Laboratory / Complex Imaging	10% After Deductible	10% After Deductible	\$0 Copay
Outpatient Services	10% After Deductible	10% After Deductible	\$0 Copay
Prescription Drugs			
- Retail (30-day supply)	After deductible: 10%/20%/30%/40%	\$10/\$40/\$60/\$60	\$10/\$40/\$60
- Mail Order (90-day supply)	After deductible: 10%/20%/30%/Not Available	\$20/\$80/\$120/Not Available	\$20/\$80/\$120
Prescriptions Expense Limit	N/A	\$2,000 individual \$4,000 family (Integrated with deductible and Max. out-of-pocket)	\$1,000 individual \$3,000 family (Separate from Max. out-of-pocket)

**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



Medical Key Reminders

- ✓ To limit your Out-of-Pocket expenses, please seek services from a Cigna provider. To find a provider, visit: [Cigna Health Care Provider Directory](#) .
- ✓ If services are provided by a non-Cigna 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.

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.

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.

Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on [myCigna - Get Access to Your Personal Health Information](#) or by calling Cigna. The prescription drug formulary name is **Value**. The Pharmacy Drug List can be found here: [Drug List](#)

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
- ✓ Preventive Services
- ✓ Immunizations
- ✓ 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
- ✓ Allergies
- ✓ Bronchitis
- ✓ Urinary tract infection
- ✓ 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 burns
- ✓ Minor broken bones
- ✓ X-Rays
- ✓ Minor infections

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 (e.g., deductible).

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 employer, 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 2026:



The **Orsini Annual** Employer HSA Contributions are as follows:

- \$4,400 single
- \$8,750 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

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:** For federal tax purposes, HSA contributions, earnings, and qualified distributions receive favorable tax treatment. However, California and New Jersey currently do not conform to the federal tax treatment of HSAs. In these states, HSA contributions (both employee and employer) are generally subject to state income tax, and HSA earnings (such as interest, dividends, and capital gains) may also be taxable. State tax laws are subject to change. Please consult your state tax authority or a qualified tax advisor regarding your specific situation.*

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 *Sun Life* 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 see an out-of-network dentist, you may be balance-billed if the dentist's charges exceed the plan's reimbursement amount. Out-of-network covered services are reimbursed based on the **90th percentile of usual, customary, and reasonable (UCR)** charges in your geographic area. If your dentist charges more than this amount, you are responsible for paying the difference. To maximize your dental benefits and minimize your out-of-pocket costs, we encourage you to visit 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.

	HMO Network: Heritage Series	PPO Network: Sun Life Dental	
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)	\$0	100% Covered	90% Covered
Basic Services (Fillings, extractions, periodontal maintenance)	Office Visit: \$10 Fillings: \$20-\$110 Perio-Surgery \$200-\$350 Scaling & Root Planning \$39-\$65 Simple Extractions: \$20-\$65 Surgical Extractions: \$20-\$65	20% after Deductible	30% after Deductible
Major Services (Implants, crowns, dentures)	Root Canal: \$100-\$465 Single Crown: \$365-\$305	50% after Deductible	50% after Deductible
Orthodontia	None	50%, up to \$1,500 Lifetime max per child (up to age 26)	
Annual Maximum	Unlimited	\$2,000	
Reimbursement	N/A	 90 th Percentile	

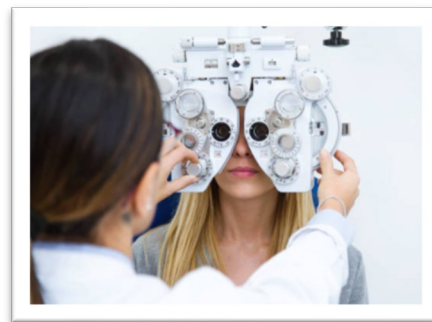
Voluntary Vision Benefits

Plan Year – September 1st through August 31st



Your vision health is an important part of complete wellness. EyeMed 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 www.eyemed.com.



In order to limit your Out-of-Pocket expenses, seek services from an Eye Med 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 \$40
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 \$30
Bifocal	\$25 copay	Up to \$50
Trifocal	\$25 copay	Up to \$70
Contact Lenses (Every 12 months in lieu of frames and lenses)		
Conventional	\$150 allowance Additional 15% off balance over allowance	Up to \$75
Disposable	\$150 allowance	Up to \$75

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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)

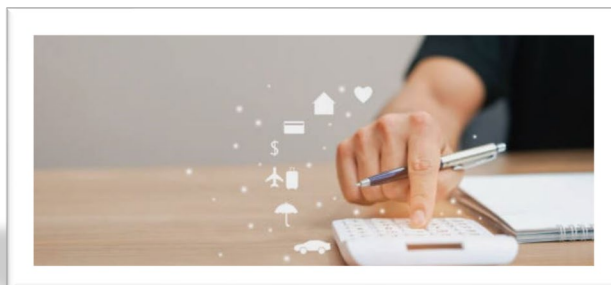
	Employee	Employee + Spouse	Employee + Child(ren)	Family
\$3,500 HDHP	\$24.16	\$162.76	\$102.06	\$275.67
\$2,000 PPO	\$144.31	\$435.32	\$390.85	\$773.88
\$0 HMO	\$135.94	\$354.99	\$336.31	\$629.74

DENTAL Plan Payroll Deductions (Per 26 Pay Periods)

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Sun Life Dental PPO	\$17.58	\$35.16	\$33.84	\$60.23
Sun Life Dental HMO	\$5.38	\$9.11	\$12.62	\$14.90

VISION Plan Payroll Deductions (Per 26 Pay Periods)

Employee	Employee + Spouse	Employee + Child(ren)	Family
\$2.81	\$5.47	\$6.12	\$8.84



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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 *Lincoln*. 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* to all Management employees is \$100,000 and to all other employees 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	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 and Accidental Death & Dismemberment



Plan Year – September 1st through August 31st

Voluntary Life and AD&D

If you need additional Life insurance to meet your financial needs, you can purchase **Voluntary Life and AD&D** 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.).



Should you leave the company, you can elect to continue this coverage directly with *Lincoln*. Benefit reductions begin at age 70.

Employee Benefit Amount: Life & AD&D	✓ Increments of \$10,000 to a maximum of \$500,000. ✓ New Entrants: Guarantee Issue (GI) Amount \$300,000
Spouse Benefit Amount: Life & AD&D	✓ Increments of \$5,000 to a maximum of \$100,000. Not to exceed 100% of the employee election. ✓ New Entrants: GI Amount \$100,000
Child(ren) Benefit Amount: Life & AD&D	✓ \$10,000 ✓ New Entrants: GI Amount \$10,000

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

Evidence of Insurability (EOI) Rules

- ✓ **TRUE OPEN ENROLLMENT for 9/1/2026:** If you are not currently enrolled or you are enrolled for less than the guarantee issue amounts, you can elect coverage up to the guarantee issue amounts without completing EOI.
- ✓ **New entrant:** If you elect coverage when you are initially eligible, EOI is required only for any amount over \$300,000.
- ✓ Coverage for your dependent child(ren) ends on his or her 26th birthday.

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 *Lincoln*.

Short-Term Disability Insurance (STD)

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.**

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

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 *Lincoln*.

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
 - Option of \$10,000 or \$20,000
 - Guaranteed Issue is \$20,000



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, 5 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 [GuidanceResources Online®](#) (new users select register and use web id: LFGSupport) or talk with a specialist at 1-888-628-4824.

Travel Assistance

Those enrolled in Life and AD&D insurance, Lincoln offers you travel assistance through *TravelConnect*. The TravelConnect 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
- Return of traveling companion
- ID recovery assistance
- Vehicle return
- Destination information



For a complete list of *TravelConnect* services go to [My On Call Portal](#) and enter Group ID: LFGTravel123 or call 1-866-525-1955 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. You have access through Lincoln 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:

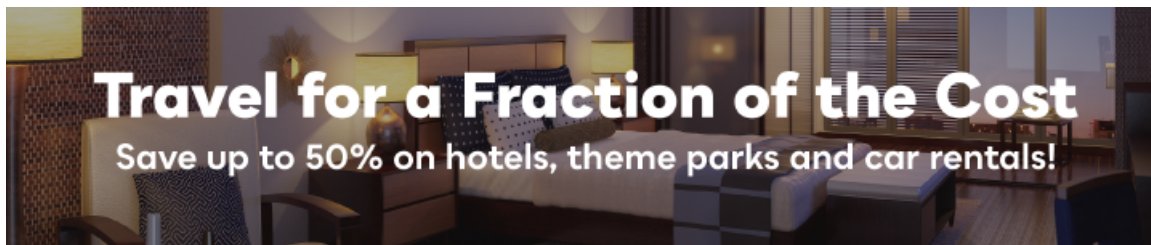
Online Will Preparation – Having a will is important because it allows you to designate who will receive your property and assets when you die. Without one, your state determines how your estate is distributed.

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.

For more support or information please visit [GuidanceResources Online®](#) (new users select register and use web id: LFGSupport) or talk with a specialist at 1-888-628-4824



Added Value Programs



Enjoy wholesale rates on over **850K HOTELS** worldwide you won't find anywhere else!



Experience more for less with fun discounts on popular **THEME PARKS** and activities!



Get where you need to go for less with **CAR RENTAL** deals at popular providers!



How to Get Started

WEB:

1. Visit thehausergroup.accessperks.com
2. Click 'Sign Up' and register with code HAUSERPERKS
3. Search your travel deals and save!

<https://thehausergroup.accessperks.com>



Contacts

Your Carriers

Contact Name	Contact Information
Medical & Pharmacy Cigna	Phone: 1 (800) 997-1654 Website: www.cigna.com
Health Savings Account (HSA) HealthEquity	Phone: 1 (866) 346-5800 Website: www.healthequity.com
Dental Sun Life	Phone: 1 (800) 786-5433 Website: www.sunlife.com
Vision EyeMed	Phone: 1 (866) 723-0513 Website: www.eyemed.com
Life/AD&D and Disability Lincoln	Phone: 1 (800) 423-2765 Website: www.lincolnfinancial.com
Accident and Critical Illness Lincoln	Phone: 1 (800) 423-2765 Website: www.lincolnfinancial.com
Employee Assistance Program (EAP) Lincoln	Phone: 1 (888) 628-4824 Website: GuidanceResources Online® WebID: LFGSupport
Added Value Programs Lincoln	Travel Assistance: Phone: 1 (866) 525-1955 Website: My On Call Portal Will Prep: Phone: 1 (888) 628-4824 Website: GuidanceResources Online® WebID: LFGSupport

Your Human Resources Team

Contact Name	Title	Phone	Email
Meredith Pond	Director, People Operations	(773) 425-2347	hr@orsinihc.com
Haley Baron	HR Administrator	(224) 623-1495	

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 **Cigna** plans allow 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 **Cigna** Customer Service using the number on the back of your medical ID card or online at www.cigna.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.cigna.com.

Women's Health and Cancer Rights Act of 1998

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 this plan. Therefore, the following deductibles and coinsurance apply:

- **Open Access Plus HDHP \$3,500 Deductible**
- **Open Access Plus PPO \$2,000 Deductible**
- **HMO Cigna One Health**

If you would like more information on WHCRA benefits, call your plan administrator **1-800-583-8833**.

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 January 31, 2026. 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.flmedicaidtprecovery.com/flmedicaidtprecovery.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	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	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: HHSHIPPPProgram@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 January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Orsini Pharmaceutical Services' *Group Health Plan* (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- a. Your past, present, or future physical or mental health or condition;
- b. The provision of health care to you; or
- c. The past, present, or future payment for the provision of health care to you.

I. Contact Information

If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact Human Resources Department at 508-283-5350.

II. Effective Date

This Notice is effective March 9, 2026.

III. Our Responsibilities

We are required by law to:

- a. maintain the privacy of your PHI;
- b. provide you with certain rights with respect to your PHI;
- c. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
- d. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

I. How We May Use and Disclose Your PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient.

For Treatment. When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Substance Use Disorder (SUD) Treatment Information. Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

As Required by Law. We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose PHI to certain employees of the Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

I. Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your PHI for public health activities. These activities generally include the following:

- a. to prevent or control disease, injury, or disability;
- b. to report births and deaths;
- c. to report child abuse or neglect;
- d. to report reactions to medications or problems with products;
- e. to notify people of recalls of products they may be using;
- f. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- g. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your PHI if asked to do so by a law-enforcement official.

- a. in response to a court order, subpoena, warrant, summons, or similar process;
- b. to identify or locate a suspect, fugitive, material witness, or missing person;
- c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- d. about a death that we believe may be the result of criminal conduct; and
- e. about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your PHI to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your PHI to researchers when:

- a. The individual identifiers have been removed; or
- b. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

IV. Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

Government Audits. We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

V. Other Disclosures

Personal Representatives. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- a. You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or
- b. Treating such person as your personal representative could endanger you; and
- c. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

VI. Your Rights

You have the following rights with respect to your PHI:

Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if

the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your PHI, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a. is not part of the medical information kept by or for the Plan;
- b. was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- c. is not part of the information that you would be permitted to inspect and copy; or
- d. is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

IX. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

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 Pharmaceutical Services About Your Prescription Drug Coverage and Medicare for plans:

- **Open Access Plus HDHP \$3,500 Deductible**
- **Open Access Plus PPO \$2,000 Deductible**
- **HMO Cigna One Health**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage **Orsini Pharmaceutical Services** 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 Pharmaceutical Services** has determined that the prescription drug coverage offered by the **Cigna Plans** are, 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.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under your **Cigna Plans** are creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 **Cigna Plan** coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Whetstone Distribution coverage, be aware that you and your dependents will not be able to get this coverage back until next Annual Open Enrollment or a mid- year qualifying event.

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:	09/01/2026
Name of Entity/Sender:	Orsini Pharmaceutical Services
Office Contact/Position:	Meredith Pond/Director, People Operations
Phone:	(800) 410-8575
Address:	1111 Nicholas Blvd, Elk Grove, IL 60007



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.

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.

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

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.

married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **YOUR 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](https://www.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 Orsini Pharmaceutical Services, LLC		4. Employer Identification Number (EIN) 32-0108171	
5. Employer address 1111 Nicholas Blvd.		6. Employer phone number (800) 410-8575	
7. City Elk Grove	8. State IL	9. ZIP code 60007	
10. Who can we contact about employee health coverage at this job? Meredith Pond			
11. Phone number (if different from above)		12. Email address mpond@orsinihc.com	

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

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

☒ All employees. Eligible employees are:
Full-time Employees working 30+ hours per week

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

1. Legal Spouses/Domestic Partners
2. Dependents up to age 26
3. Dependents over age 26 with disabilities

☐ We do not offer coverage.

☒ 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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 for employers but will help ensure employees understand their coverage choices.

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)

☐ No (STOP and return this form to employee)

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** (don't 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 didn't receive any other discounts based on wellness programs.

- a. How much would the employee have to pay in premiums for this plan? \$52.35
- 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 If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

- ☐ 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

ⁱAn 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 of 1986)