2025 BENEFIT GUIDE

CORE

Note: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 21 for more information.

WELCOME TO YOUR BENEFITS!

Channel Partners Solutions believes that personal well-being and self-care, along with work and life enrichment, are aspects of individual and organizational growth. We offer a supportive environment that provides our employees with encouragement, opportunity, and rewards for healthy lifestyles and career dedication.

That's why at Channel Partners Solutions we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work life balance.

HERE'S WHERE TO FIND...

STAYING HEALTHY

- Medical through Cigna
- Dental through Cigna
- Vision through Cigna

WORK/LIFE BALANCE

- Employee Assistance Program (EAP) through Lincoln Financial

FEELING SECURE

- Basic Life and Accidental Death & Dismemberment (AD&D) through Lincoln Financial
- Supplemental Life and Accidental Death & Dismemberment (AD&D) through Lincoln Financial
- Short-Term and Long-Term Disability through Lincoln Financial
- Supplemental Medical Benefits Through Lincoln Financial
- Flexible Spending Accounts (FSA) through WEX Benefits
- Health Savings Account (HSA) through WEX Benefits
- 401(k) through Lincoln Financial

WHO IS ELIGIBLE?

MEDICAL

All full-time employees working a minimum of 30 hours per week will be eligible the first of the month following 30 days of continuous employment.

Effective January 1, 2019, legislation eliminated the penalties associate with the Affordable Care Act's individual shared responsibility provision (also known as the individual mandate), effectively eliminating the federal requirement that individuals maintain qualifying health coverage.

However, please note that the following states have enacted state-based individual mandates:

- California (effective January 1, 2020)
- District of Columbia
- Massachusetts
- New Jersey
- Rhode Island (effective January 1, 2020)
- Vermont (effective January 1, 2020)

Residents failing to enroll in Minimum Essential Coverage in these states may be subject to a tax penalty. Please consult with your tax advisor for further details.

You may also elect coverage for your dependents including:

Your legal spouse.
Domestic partners.

Your children from birth to age 26, married or unmarried.

WHEN CAN I ENROLL?

As a benefits-eligible employee, you have the opportunity to enroll in or make changes to your benefit plans during our benefits enrollment period. Open Enrollment is November 25 to December 9, 2024 with your benefit choices being effective January 1, 2025. Our benefits plan year is January 1, 2025 to December 31, 2025.

If you're enrolling as a new employee, you become eligible for benefits 1st of the month following 30 days of employment and you must enroll within 30 days upon hire to have coverage for the rest of the plan year. You may also need to enroll for the next plan year's benefits during the enrollment period.

DID YOU KNOW?

Florida residents, from 26-years-old until age 30, provided the child is unmarried and does not have a dependent of their own, and is not covered under a plan of their own (proof of age and dependency are required), are eligible.

NOTE: Dependent verification will be required. Please upload your marriage certificate or child's birth certificate, if applicable, into ADP.

HOW TO ENROLL?

Carefully review the plan information in this benefit guide and all other plan materials included in your enrollment packet. The insurance carriers' websites also provide important information and tools that can help you make enrollment decisions. Consider the needs of any dependents you may have. If you are married, review any coverage currently offered through your spouse's employer to avoid costly duplicate coverage.

Channel Partners Solutions may require proof of your spouse/domestic partner and dependents eligibility. Please upload your marriage certificate, notarized affidavit of domestic partner union, or child's birth certificate to the ADP portal. If you have any questions regarding this process contact your HR Team.

WHAT'S NEXT?

Once you have reviewed all the options available to you, be sure to visit the ADP benefits portal.

If you decline to participate in any of the group benefits programs, you will need to wait until the next Open Enrollment period, unless you experience a qualifying life event which includes, but are not limited to:

- Marriage, divorce, annulment, legal separation.
- Birth or adoption of an eligible child.
- Death of a spouse or other dependent.
- A spouse's employment begins or ends.
- You or your spouse experience a change in work hours that affects benefit eligibility.
- A dependent's eligibility status changes due to age, student status, marital status or employment.
- Eligibility for Medicaid or CHIP (60-day special enrollment).
- Loss of Medicaid or CHIP (60-day special enrollment).

NOTE: All changes due to a qualifying life event must be made within 30 days of the family status change. Please contact Human Resources with any questions.

DID YOU KNOW?

You may not cancel your benefit elections unless you have a qualifying life event.

⚠ IMPORTANT!

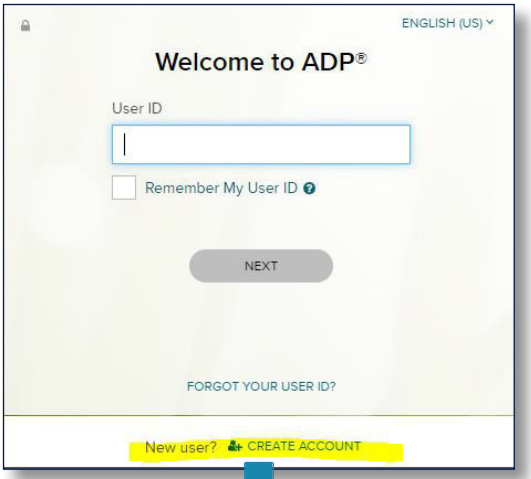
If you miss four FULL continuous pay periods, your policy will be canceled and you will be offered COBRA.

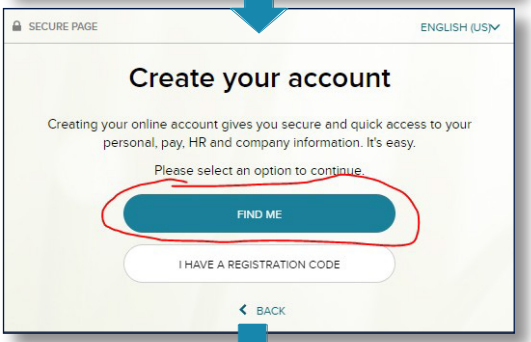
HOW TO REGISTER WITH ADP

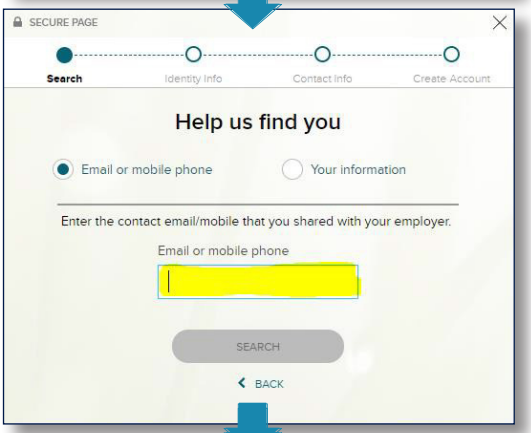
To enroll in benefits you must register with ADP. If you are already registered with ADP, please log into the website below to enroll in benefits.

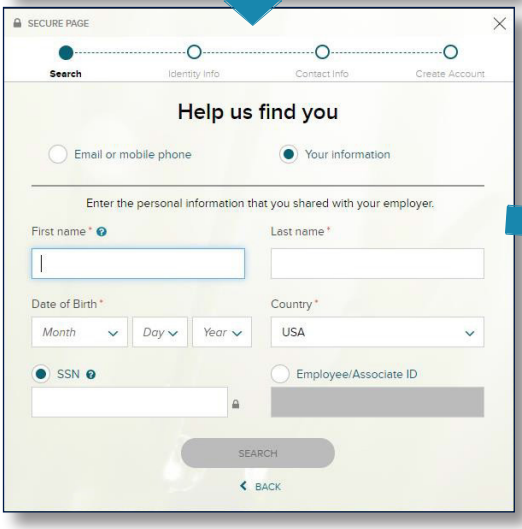
- **Step 1:** Please go to **https://workforcenow.adp.com**, click the link to *"Create Account"*;
- **Step 2:** Select *"Find Me"*;
- **Step 3:** Enter an **email address or mobile phone number** that you shared with the company;
- **Step 4:** Once email or phone number is confirmed, employee will be prompted to enter **identification details**;
- **Step 5:** Employee will be issued **a verification code issued to email or mobile**, all codes are unique (below code is just an example) and you will enter code when prompted;
- **Step 6:** Once verification code has been entered you will be prompted to enter your **primary contact information**. This would be an email or phone number used to receive notifications from ADP;
- **Step 7:** The final step to create your account is to make your own user ID and password.

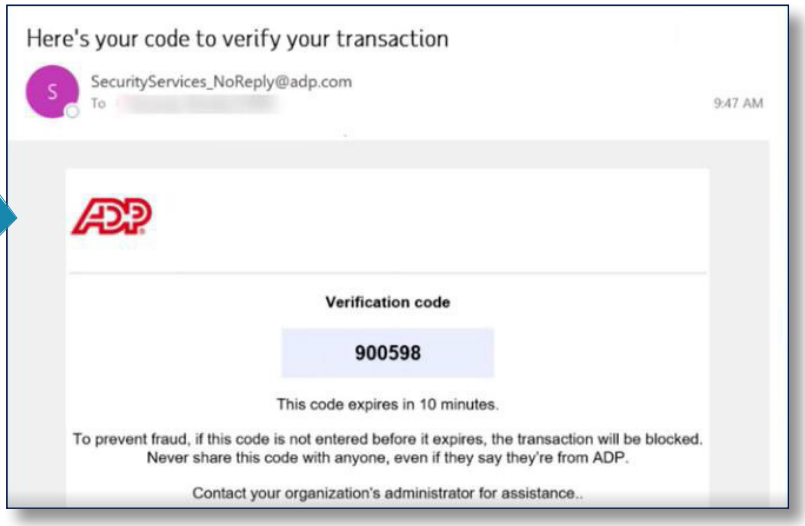
You will not need to log into ADP to complete your benefit enrollment. Please go to **https://workforcenow.adp.com** and log in as a user.





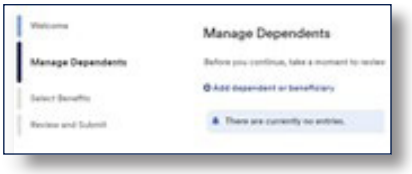






HOW TO ENROLL IN BENEFITS THROUGH ADP

Employees who qualify for ACA coverage through Cigna or Hawaii residents only.



1. **Log into ADP; Go to https://workforcenow.adp.com**
2. **Launch the Benefit Enrollment Wizard**

   Go to *"Myself">"Benefits">"Enrollments"*. On the "*Open Enrollment*" tile click "*Start Enrollment*". This will launch the Benefits Enrollment Wizard. Please review the information on the "*Welcome*" page and select "*Next*".

3. **Manage Dependents and Beneficiaries**

   Under "*Manage Dependents*" – review your dependents and beneficiaries. Any previous dependents or beneficiaries will display for your review. If correct, click "*Next*".

   - To make edits, click the 3-dots next to the person's name.
   - To add a new dependent and beneficiary – select add "*Dependent or Beneficiaries*" and follow the steps. Once done – select "*Next*".

IMPORTANT!

Any new dependents or changes to existing dependents will route to HR for approval. Please wait for approval before continuing with your enrollment. HR will approve within 1 business day.

4. **Enroll in Benefits**
   - Begin by selecting the plans under *"Eligible Plans"*.
     - Under *"Eligible Plans"* are what benefit plans you are eligible for.
   - Click "*View All Plans*" next to each plan name to see the eligible benefits.
   - Under *"Covered Individuals"* select who would be covered in this plan.
     - This would be your dependents.
     - Some plans will not have this option.
   - Click on "*Select Plan*" for the plan you want to enroll in if multiple plans are listed.
   - Select "*Confirm Details*".
   - Elect "*Confirm*" to finalize enrolling the plan. If you do not hit "*Confirm*" twice you will not be enrolled.
5. **Cycle through Step 4 for all Benefit Options**

   Continue to the next eligible benefit in the menu under "*Eligible Plans*". Cycle through steps for ALL benefit options listed.

IMPORTANT!

After enrolling in a new plan or making any changes, you must select "Confirm Details" and "Confirm" to enroll in the plan. If you exit a screen without completing Step 4 , your selections or changes will not be saved.

6. **Continue to Summary and Submit Enrollment**

   Once you cycle through all eligible benefits using the enrollment wizard, select "*Next*". Review the summary page listing your benefit selections. If everything is correct, select "*Submit Enrollment*". Then choose *"Yes"* to submit enrollment. You will receive a confirmation email.

IMPORTANT!

If you fail to click "Submit Enrollment" and then select "Yes", your enrollments will NOT be routed for processing!

DON'T FORGET

Enrollment for 2025 is mandatory. If no action is taken, your benefits will end on 12/31/2024.

MEDICAL BENEFIT CHOICES

HOW TO CHOOSE THE RIGHT HEALTH PLAN

We understand your medical insurance coverage is extremely important to you. We offer different medical plan options in an effort to provide effective medical coverage for you and your family members. Take time to consider the level of coverage you need, and the premium cost you can afford before deciding which medical plan is the best choice for you and your family members. Channel Partners Solutions offers qualifying and affordable coverage to all full-time eligible employees. By electing one of these options, you are fulfilling your requirement to meet the individual federal mandate. Should you choose to explore coverage options from the Public Exchange, www.healthcare.gov, you will not qualify for a subsidy.

NOTE FOR MASSACHUSETTS'S EMPLOYEES: The Cigna medical Low-Deductible Plan is not ACA compliant which makes it not a creditable coverage by the state of Massachusetts.

OPTIONS	MEETS YOUR INDIVIDUAL COVERAGE MANDATE	PROVIDES MINIMUM AND AFFORDABLE COVERAGE UNDER ACA
Option 1 – OAP 750	√	√
Option 2 – OAP 2500	√	√
Option 3 – HDHP 1750	√	√
Option 4 – HDHP 4000	√	√

To help you decide which plan is best for you and your family, the chart below provides an overview of each of the plan options.

PLAN NAME	SUMMARY
OAP 750	This plan offers comprehensive coverage with a lower deductible and out-of-pocket maximums. It has a deductible that applies to some services and copays that apply to others. Your costs for covered services are capped at $3,500 per person or a maximum of $7,000 for a family, as long as you remain in-network.
OAP 2500	This plan offers comprehensive coverage at a higher contribution cost than the High-Deductible Plans. Your costs for covered services are capped at $5,000 per person or $10,000 for family, as long as you remain in-network.
HDHP 1750	This plan offers comprehensive coverage with the lower contribution cost. You are responsible to pay negotiated rates for all services until you reach the deductible. Costs are capped at $6,000 individual or $12,000 family. This plan allows you to contribute to a Health Savings Account.
HDHP 4000	This plan offers comprehensive coverage at the lowest contribution cost. You are responsible to pay negotiated rates for all services until you reach the deductible. Costs are capped at $6,750 individual or $13,500 family. This plan allows you to contribute to a Health Savings Account.
All Plans	Cover preventive services with no deductible or coinsurance, provided you receive these services from a provider within your plan's network. All plans have limits or exclusions. You will need to pay for any limits or exclusions on your benefits. These limits may include a number of refills for certain drugs, a number of visits to certain specialists, and a number of days covered for certain benefits. In addition, you should carefully review all exclusions noted. Please refer to the Summary Plan Description for detailed explanation of benefits.

Here are some additional things to consider when choosing a plan:

- **Plan Options:** There are four plan options provided by Channel Partners Solutions. The health plan option you choose determines how you and your plan share the costs of care.
- **Payroll Contributions:** This is the amount that is deducted from your paycheck based on the plan you select, whether you use medical services or not. Payroll contributions are important, but they're not all you need to consider.
- **Benefits:** All plans provided cover pre-existing conditions and offer free preventive services.
- **Out-of-Pocket Costs**: It's important to know how much you have to pay out of your pocket for services when you get care. You pay these out-of-pocket costs in addition to your payroll contributions.
- **Type of Insurance Plan and Provider Network:** Different plan types provide different levels of coverage for care, contingent on the plan's network and non-network of doctors, hospitals, pharmacies and other medical service providers.

MEDICAL AND PRESCRIPTION DRUGS - *CIGNA*

The grid below provides highlights of your in-network medical plan options. Out-of-network benefits are available, but your benefits are reduced when using an out-of-network provider. For full plan details, please refer to your Certificate of Coverage.

Channel Partners Solutions is now contributing to the two HSA plans. $500 Individual and $1,000 Family. The HSA employer contribution will be prorated if you are hired after January 1st.

CIGNA	OAP 750		OAP 2500		HDHP 1750		HDHP 4000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible (Individual/Family/ Individual within Family***)**	$750/$1,500	$1,500/$3,000	$2,500/$5,000	$5,000/$10,000	$1,750/$3,500/ $3,300	$3,500/$7,000/ $5,600	$4,000/$8,000/ $4,000	$8,000/$16,000/ $8,000
Out-of-Pocket Maximum (Individual/Family/ Individual within Family***)**	$3,500/$7,000	$7,000/$14,000	$5,000/$10,000	$10,000/$20,000	$6,000/$12,000/ $6,000	$12,000/$24,000/ $12,000	$6,750/$13,500/ $6,750	$13,500/$27,000/ $13,500
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Coinsurance	15%	50%	25%	50%	25%	50%	30%	50%
Physician Services								
Doctor's Office Visit	$20	50% AD	$30	50% AD	25% AD	50% AD	30% AD	50% AD
Specialist Office Visit	$40		$60					
Preventive Care	Covered 100%		Covered 100%		Covered 100%		Covered 100%	
Lab & X-ray Services	15% AD		25% AD		25% AD		30% AD	
Hospital Services								
Inpatient	15% AD	50% AD	25% AD	50% AD	25% AD	50% AD	30% AD	50% AD
Emergency Care								
Urgent Care Copay	$50	50%	$100	50% AD	25% AD	50% AD	30% AD	50% AD
Emergency Room Copay (Waived if admitted)	$150		$300		25% AD		30% AD	
PRESCRIPTION DRUGS								
Annual Pharmacy Deductible	Medical Deductible applied to Rx		Medical Deductible applied to Rx		Medical Deductible applied to Rx		Medical Deductible applied to Rx	
Retail (30-Day Supply)								
Generic	$10	50%	$15	50%	$15 AD	50% AD	$15 AD	50% AD
Preferred	$50		$60		$40 AD		$40 AD	
Non-Preferred	$100		$120		$60 AD		$60 AD	
Specialty	30% ($250 Max)		30% ($250 Max)		30% AD ($250 Max)		30% AD ($250 Max)	
Mail Order (90-Day Supply)								
Generic	$20	50%	$30	50%	$30 AD	50% AD	$30 AD	50% AD
Preferred Brand	$100		$120		$120 AD		$120 AD	
Non-preferred Brand	$200		$240		$180 AD		$180 AD	
Specialty	30% ($250 Max)		30% ($250 Max)		30% AD ($250 Max)		30% AD ($250 Max)	

NOTE: Your medical plan options must offer certain preventive care benefits to you in-network without cost sharing and these preventive care benefits generally are updated annually. Under the Affordable Care Act, the medical plans generally may use reasonable medical management techniques to determine frequency, method, treatment or setting for a recommended preventive care service. You may obtain a list of preventive care services at www.mycigna.com.

- *AD = After Deductible.
- **Individual/Family: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.
- ***Individual within Family: After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.

SEMI-MONTHLY CONTRIBUTIONS FOR SEMI-MONTHLY PAID EMPLOYEES

PAYROLL CONTRIBUTIONS	OAP 750		OAP 2500		HDHP 1750		HDHP 4000	
	MONTHLY	SEMI-MONTHLY	MONTHLY	SEMI-MONTHLY	MONTHLY	SEMI-MONTHLY	MONTHLY	SEMI-MONTHLY
Employee	$577.32	$288.66	$418.50	$209.25	$153.52	$76.76	$75.00	$37.50
Employee + Spouse	$1,333.90	$666.95	$1,000.36	$500.18	$521.95	$260.98	$384.82	$192.41
Employee + Child(ren)	$1,206.85	$603.43	$905.08	$452.54	$401.61	$200.81	$287.09	$143.55
Family	$1,905.57	$952.79	$1,429.06	$714.53	$650.00	$325.00	$500.00	$250.00

GENERIC MEDICATIONS THEY KEEP YOUR WALLET HEALTHY

An effective way to save on your out-of-pocket health care costs is to consider switching to generic drugs, when appropriate. Generic medicines are approved to be as safe and effective as their brand-name counterparts and on average cost 50 percent less than brand-name drugs.

Generic drugs contain the same active ingredients and are available in the same strength and dosage form as their brand-name counterparts. The US Food and Drug Administration (FDA) regulates the manufacture of all generic drugs, which helps ensure their strength, quality and purity. The FDA also requires generic drugs to be absorbed into the body at the same rate and to the same extent as the branded product, which ensures that generic and branded products provide the same effectiveness in children, adults and the elderly. You can save the most money by choosing generic medicines when available. Ask your doctor to authorize generic substitutions when medically appropriate.

$4 GENERICS! FREE ANTIBIOTICS! SHOP AROUND FOR MEDICATIONS

Another smart way to save on medication costs is to shop around and look for the best price! Cost of a prescription medication can vary greatly from one pharmacy to another, even within the same store chain. For example, your medication at one CVS or Walgreen's is not always the same cost at a different CVS or Walgreen's, right across the street! Before you drop off the prescription to be filled, call ahead or check the pharmacy website to find out the cost.

Several pharmacies now offer special prescription programs, including $4 generic drugs and free antibiotics. For a list of the medications included in the programs, please visit the pharmacy's website.

PHARMACY INFORMATION

FREE MEDICATION

Several retailers, including those listed below, offer low or no cost generic medications. Please check the websites listed to see what special offers are available at retailers near you.

Your company is providing you with additional information on generic drugs to help facilitate your search for the best deals to lower your prescription drug costs. As you conduct your own research, you may find many other cost-saving alternatives not listed in this benefit guide. The purpose of this section is not to instruct you to utilize these alternatives, but to enlighten you on various options available to you to help decrease costs and improve your health.

WALMART AND SAM'S CLUB

- $4 generic medications per 30-day supply
- $10 generic medications per 90-day supply
- www.walmart.com

PUBLIX PHARMACY

- Free antibiotics, several to choose from
- A wide variety of medications for diabetes, cholesterol and more! 90-day supply for just $7.50
- www.publix.com

TARGET AND WINN-DIXIE

- $4 generic medications per 30-day supply
- $10 generic medications per 90-day supply
- www.target.com | www.winndixie.com

HEALTH SAVINGS ACCOUNT (HSA) - *WEX*

Available to Participants in The HSA High-Deductible Plan

A Health Savings Account (HSA) is a tax-advantaged savings account that can be used for your qualified health care expenses. You own your HSA and can contribute to the account with pre-tax payroll deductions based on your needs.

Did you know an HSA provides triple tax benefits? The money you contribute is pre-tax, and the interest that accumulates in the account is tax-free. In addition, money withdrawn from an HSA isn't taxed, provided you use it for qualified health care expenses. Like a savings account, you will only be able to withdraw funds that are in the account.

HSA ADVANTAGES

You can use the account to pay for qualified health care expenses.

Unspent dollars roll over each year and are yours to keep if you retire or leave the company.

You can invest your HSA funds, so your available health care dollars can grow over time.

You are Eligible If...

HOW DO I ACCESS/MAKE CONTRIBUTIONS TO MY HSA?

You are enrolled in the HDHP

You are not covered by a spouse's plan

No one else can claim you as a dependent

You are not enrolled in Medicare, TRICARE, or TRICARE for life

You have not received VA benefits in the past 3 months

You can manage your HSA at your ADP portal. You'll set up your payroll contributions during your enrollment period and can make changes at any time throughout the year (although it may take between 1–2 payroll periods for any changes to be processed).

New for 2025! Channel Partners Solutions will contribute $500 into each Individual HSA and $1,000 into each Employee + Dependent HSA annually. Your contributions are deducted from your paycheck on a before-tax basis in equal installments throughout the calendar year. The HSA employer contribution will be prorated if you are hired after January 1st.

HOW MUCH CAN BE DEPOSITED INTO AN HSA IN 2025?

HOW MUCH CAN YOU CONTRIBUTE?	ANNUAL IRS CONTRIBUTION LIMIT	ANNUAL CHANNEL PARTNERS SOLUTIONS CONTRIBUTION	YOUR MAXIMUM CONTRIBUTION AMOUNT
Individual Coverage	$4,300*	$500	$3,800
Family Coverage	$8,550*	$1,000	$7,550

<55*

- Up to $4,300 for individual.
- Up to $8,550 for family.

*Not enrolled in Medicare.

The maximum contribution increases by $1,000.

*Not enrolled in Medicare.

55+*

NOTE: Amounts change yearly per IRS guidelines.

FLEXIBLE SPENDING ACCOUNT (FSA) - *WEX*

A Health Care FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. This plan is available to employees enrolled in the High-Deductible Plan with Copays, or the Low Deductible Plan, and can be used to pay for medical, dental and vision expenses.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay Federal Income tax, Social Security taxes, and state/local income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period. You will have the choice to carry forward up to $660 of your FSA money if you maintain a balance as of December 31, 2025.

ELIGIBLE EXPENSES

Eligible health care expenses for the FSA include more than just your deductible and copayments. Generally, any medically necessary health care expense that you can deduct on your tax return is considered an eligible expense.

Some examples include:

- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Dental services and orthodontia

All over-the-counter medicine or drugs require a prescription in order to receive reimbursement from an FSA.

HEALTH CARE FSA

A Health Care FSA reimburses employees for eligible medical expenses, up to the amount contributed for the plan year. Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. Visit irs.gov for a full list of eligible expenses.

You may contribute up to $3,300 annually (funds will be available as of the election effective date).

IS THE FSA PROGRAM RIGHT FOR ME?

Flexible Spending Accounts are beneficial for anyone who has out-of-pocket medical, dental, vision, hearing, or dependent care expenses beyond what his or her insurance plan covers.

It's easy to determine if a FSA will save you money. At enrollment time, you will need to determine your annual election amount. Estimate the expenses that you know will occur during the year. These includes out-of-pocket expenses for yourself and anyone claimed as a dependent on your taxes. If you had $100 or more in recurring or predictable expenses, the accounts can help you stretch your dollars.

HOW DO THE ACCOUNTS WORK?

If you decide to enroll in the FSA account, your contribution is taken out of each paycheck – pre-taxed – in equal installments throughout the plan year. These dollars are then placed into your FSA. When you have an eligible health care expense, your FSA debit card may be used to pay for these expenses. In many cases, this automatic service may eliminate the need to file claims for reimbursement. Your account must be pre-funded 1/12th of the total annual elections before you can use your debit card.

NOTE: Please note that the Health Savings Account and Flexible Spending Account are separate options – if eligible, you may choose to participate in either the HSA or the FSA, not both.

DID YOU KNOW?

You have until December 31st 2024 to use your FSA funds. Any remaining funds left (over the $660 carryover limit) will be forfeited.

EXAMPLE

The following example shows how you can save money with a flexible spending account.

Bob and Jane's combined gross income is $30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend $4,000 in adult orthodontia and vision care next plan year, they each decide to direct a total of $2,000 per person into their FSAs.

	WITHOUT FSA	WITH FSA
Gross Income	$30,000	$30,000
FSA Contributions	$0	$-4,000
Gross Income	$30,000	$26,000
Estimated Taxes		
Federal	$-2,550	$-1,755
State	$-900**	$-741**
FICA	$-2,295	$-1,890
After-Tax Earnings	$24,255	$21,614
Eligible Out-of-Pocket		
Medical Care Expenses	$-4,000	$0
Remaining Spendable Income	$20,255	$21,614
Spendable Income Increase		$1,359

*Assumes standard deductions and four exemptions.

**Varies, assume 3%.

NOTE: The example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice.

IMPORTANT:

USE IT OR LOSE IT!

- **Health Care FSA:** You can carry over up to $660 of the unused funds to the next plan year.
- Any unused funds over the rollover amount will be forfeited. Please plan wisely!

DENTAL - *CIGNA*

Channel Partners Solutions offers you two PPO dental plans through Cigna. You can visit any dentist, but you pay less out of pocket when you choose a Cigna in-network dentist. Dependent age limit is 26. Visit www.mycigna.com to find a participating provider.

BENEFIT	CIGNA HIGH PPO	CIGNA LOW PPO
Annual/Calendar Year Maximum	$2,000	$1,500
Annual/Calendar Year Deductible (Individual/Family)	$50/$150	$50/$150
Preventive Services	Covered 100%	Covered 100%
Basic Services	10% AD	20% AD
Major Services	40% AD	50% AD
Orthodontia Services	50%	Not Covered
Orthodontia Lifetime Maximum	$2,000	Not Covered

Plan includes out-of-network benefits, see plan summary for additional details.

PAYROLL CONTRIBUTIONS	MONTHLY	SEMI-MONTHLY	MONTHLY	SEMI-MONTHLY
Employee	$37.86	$18.93	$26.37	$13.19
Employee + Spouse	$79.96	$39.98	$54.23	$27.12
Employee + Child(ren)	$98.00	$49.00	$53.72	$26.86
Family	$148.28	$74.14	$98.26	$49.13

VISION - *CIGNA*

Channel Partners Solutions offers you a group vision plan through Cigna using the EyeMed Network of providers. Please refer to the chart below for the vision benefits. As a member, you have access to consumer education tools and claims information to help you manage your vision care. Log into www.mycigna.com to find a participating provider and tour the site for additional information.

CIGNA	IN-NETWORK	OUT-OF-NETWORK
Examination (Once per Calendar Year)	$10 copay	Reimbursed up to $45
Lenses (Once per Calendar Year)		
Single	$20 copay	Reimbursed up to $32
Bifocal	$20 copay	Reimbursed up to $55
Trifocal	$20 copay	Reimbursed up to $65
Contact Lenses (Once per Calendar Year)		
Elective	$250 allowance	Reimbursed up to $205
Medically Necessary	Covered 100%	Reimbursed up to $250
Frames	$130 allowance	Reimbursed up to $71

Employees can elect dental and/or vision regardless of whether they are enrolled in medical.

To claim your Out-of-Network Reimbursement: Send a completed Cigna Vision service by EyeMed claim form and itemized receipt to: Cigna Vision, Claims Dept. c/oFAA PO Box 8504, Mason, OH. 45040 -7111.

PAYROLL CONTRIBUTIONS	MONTHLY	SEMI-MONTHLY
Employee	$8.94	$4.47
Employee + Spouse	$17.87	$8.94
Employee + Child(ren)	$18.06	$9.03
Family	$28.80	$14.40

NOTE: Additional rate information can be found in your enrollment portal.

LIFE AND DISABILITY INSURANCE - *LINCOLN FINANCIAL*

LIFE AND AD&D

Channel Partners Solutions provides a Basic Life and Accidental Death & Dismemberment (AD&D) benefit at no cost to you in the amount of $50,000. At age 65 this benefit will reduce by 35% of the original amount, and at age 70 the benefits will reduce an additional 50% of the original amount. Your AD&D benefit is equal to your life benefit.

VOLUNTARY LIFE AND AD&D INSURANCE

For You

- Coverage in increments of $10,000 up to lesser of 5x your annual salary or $500,000 maximum.
- Guaranteed Issue up to $150,000; any amount in excess of $100,000 will require an Evidence of Insurability (EOI) form completed.

For Your Spouse

- Coverage in increments of $5,000 up to lesser of 50% of employee amount to a maximum of $500,000.
- Guaranteed Issue up to $30,000; any amount in excess of $30,000 will require an Evidence of Insurability (EOI) form completed.

For Your Dependent Child(ren)

- Coverage in increments of $2,000 not to exceed 50% of employee amount or $10,000 of Life benefit only.
- Children 14 days to 6 Months: $250 maximum benefit. (Newborn children under 14 days are not eligible for coverage.)

New Hires: If you do not elect Supplemental Life coverage when you are first eligible, Evidence of Insurability will be required for the entire amount of coverage for future enrollment.

Voluntary Life and AD&D Coverage Monthly Rate

AGE AS OF JANUARY 1, 2024	EMPLOYEE/$10,000	SPOUSE/$5,000
<29	$0.81	$0.41
30-34	$0.91	$0.46
35-39	$1.11	$0.56
40-44	$1.61	$0.81
45-49	$2.61	$1.31
50-54	$4.71	$2.36
55-59	$7.21	$3.61
60-64	$8.41	$4.21
65-69	$15.01	$7.51
70-74	$29.31	$14.66
75-79	$78.71	$39.36
80+	$178.41	$89.21
Child(ren) Life: $2.00 per $10,000 benefit (Life only).		

- New Hire/newly eligible:
  - **Employee:**
    - The employee is able to enroll up to the guaranteed issue up to $150,000 (or less if more than 5x salary).
    - If they enroll in more than $150,000 (plan maximums of 5x salary and/or plan maximum of $500,000) than they are required to complete an EOI and receive an approval.
  - **Spouse:**
    - The spouse is able to enroll up to the guaranteed issue up to $30,000 (or less if more than 50% of the employee volume).
    - If the spouse enrolls in more than $30,000 (plan maximum of 50% of employee coverage and/or plan maximum of $500,000) than they are required to complete an EOI and receive an approval.
- Annual Enrollment (currently show an open enrollment period from November 25 to December 9, this can be alerted on an annual basis if needed).
  - **Employee:**
    - The employee, who is in 'good standing', can increase their coverage by 2 increments of $10,000 (total of $20,000) without an EOI approval.
      - This includes employees that previously waived the coverage and would like to increase their coverage from $0 to $20,000.
      - The incremental increases can continue until the employee hits the plan maximums of either 5x salary or $500,000.
    - The spouse, who is in 'good standing', can increase their coverage by 2 increments of $5,000 (total of $10,000) without an EOI approval.
      - This includes spouses that previously waived the coverage and would like to increase their coverage from $0 to $10,000.
      - The incremental increases can continue until the spouse hits the plan maximums of either 50% of employee coverage of $250,000.

Good Standing: Members (employee and/or spouses) that have not been previously denied or previously requested a volume that required an EOI approval and the application was either not received/completed or when additional medical information was requested, was not received.

CALCULATING VOLUNTARY LIFE AND AD&D PREMIUMS

Example – You are 45-years-old and you elect $50,000 of coverage:

- Find your rate per $10,000 in the table - $2.61.
- Divide your total amount of coverage by $10,000: $50,000 / $10,000 = 5.
- Multiple the number you get in #2 by the rate found in #1: 5 X $2.61 = $13.05 monthly premium.

Spouse rate based on employee's age.

DISABILITY - *LINCOLN FINANCIAL*

VOLUNTARY SHORT-TERM DISABILITY (STD)

Eligible employees may purchase Short-Term Disability coverage through Lincoln Financial. The cost for this benefit can be found in the ADP portal.

Short-Term Disability covers 60% of your current weekly salary if you suffer from a non work- related disabling accident or illness. The maximum weekly benefit covered under this plan is $1,000 per week. Benefit payments will begin on the 15th day after you have been unable to work due to an accident or sickness. You will receive benefit payments for up to 11 weeks while you are disabled. The Long-Term Disability plan is designed to pick up benefits when this period is exhausted.

Monthly Short-Term Disability Rates

AGE RANGE	PREMIUM RATE
0-24	$0.280
25-29	$0.280
30-34	$0.270
35-39	$0.260
40-44	$0.260
45-49	$0.290
50-54	$0.340
55-59	$0.430
60-64	$0.520
65-69	$0.590
70+	$0.710

The chart below provides step-by-step instructions on how to calculate your monthly cost for Short-Term Disability coverage.

EXAMPLE: 44 YEAR OLD EMPLOYEE, EARNING $681 PER WEEK		CALCULATIONS	YOU
Step 1	Enter the monthly rate per $10 of weekly benefit.	$0.26	
Step 2	Enter your weekly earnings. *Divide you annual earnings by 52.*	$681.00	
Step 3	If your weekly earnings are greater than the **maximum weekly covered earnings** of $1,667, indicate $1,667. *Otherwise, indicate the amount from Step 2.*	$681.00	
Step 4	Calculate your weekly benefit. *Multiply Step 3 by $0.60.*	$408.00	
Step 5	Enter your weekly benefit in increments of $10. *To calculate, divide the amount in Step 4 by 10*	$40.80	
Step 6	Calculate your monthly cost. *Multiply Step 1 by Step 5.*	$10.60	

DISABILITY - *LINCOLN FINANCIAL*

VOLUNTARY LONG-TERM DISABILITY (LTD)

You have the option to purchase Voluntary Long-Term Disability through Lincoln Financial.

Long-Term Disability covers 60% of your monthly salary, up to $10,000 per month if you are disabled due to a non-work related accident or illness. There is a 90-day waiting period, and you may not be eligible for benefits if you have received treatment for the disabling condition in the 3 months prior to the effective date of this benefit.

Your benefit may be paid for two years if you are unable to perform the material and substantial duties of your own occupation. Your benefit will be payable through age 65 if you are disabled prior to age 60. If disabled at age 60 or after, the maximum benefit period can be found in the contract.

Monthly Long-Term Disability Rates

AGE RANGE	PREMIUM RATE
0-24	$0.140
25-29	$0.140
30-34	$0.270
35-39	$0.410
40-44	$0.860
45-49	$1.280
50-54	$1.590
55-59	$1.670
60-64	$1.670
65-69	$1.300
70-74	$0.800
75-79	$0.800

Maximum Benefit Period for Long-Term Disability, Your Social Security Normal Retirement Age, or the Maximum Benefit Period Shown Below.

AGE RANGE	PREMIUM RATE
Age at Disability	Maximum benefit period
Less Than Age 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 & over	12 months

The chart below provides step-by-step instructions on how to calculate your monthly cost for Long-Term Disability coverage.

EXAMPLE: 38 YEAR OLD EMPLOYEE, EARNING $34,500 PER YEAR		CALCULATIONS	YOU
Step 1	Enter the monthly rate per $100 of monthly covered payroll for their age range.	$0.410	
Step 2	Enter your monthly earnings. *Divide your annual earnings by 12.*	$2,950.00	
Step 3	If your monthly earnings are greater than the **maximum monthly covered earnings** of $16,667, indicate $16,667. *Otherwise, indicate the amount from Step 2.*	$2,950.00	
Step 4	Calculate your monthly benefit. *Multiply Step 3 by $.60.*	$1,770.00	
Step 5	Enter your monthly earnings in increments of $100 of monthly covered payroll. *To calculate, divide the amount in Step 3 by $100.*	$29.50	
Step 6	Calculate your monthly cost. *Multiply Step 1 by Step 5.*	$12.09	

DID YOU KNOW?

U.S. health care spending averaged $13,493 per person in 2022.

Centers for Medicare & Medicaid Services, National Health Expenditure Fact Sheet, 2023

SUPPLEMENTAL MEDICAL BENEFITS

Medical insurance does not prevent all of the financial strain of a major illness or injury. Many families don't have enough in their savings to cover the deductible and coinsurance of a major medical event. Supplemental medical benefits can help cover this out-of-pocket financial exposure for a reasonable cost.

The benefits are paid directly to you, allowing you to use the funds however you choose. You receive the full benefit even if you have other insurance. Channel Partners Solutions offers critical illness insurance, accident insurance, and hospital indemnity insurance.* **Please note: These plans are not replacements for medical insurance.**

NOTE: The policies/certificates of coverage have exclusions and limitations which may affect any benefits payable. The policies/certificates of coverage or their provisions, as well as covered illnesses, may vary or be unavailable in some states for supplemental medical benefits. Please see your Summary Plan Description (SPD) for complete details.

CRITICAL ILLNESS INSURANCE

Critical illness insurance helps take some of the worry out of getting sick. How many of you know someone who has been diagnosed with cancer, or has suffered a heart attach or stroke? Had a major organ transplant? Or been diagnosed with advanced Alzheimer's?

No one likes to think about it, but a critical illness can strike at any time and at any age. Compounding the challenges of an illness are the financial hardships it can bring.

Consider all the expenses you may face during an illness, such as:

- Health insurance deductibles and copays
- Child care
- Living expenses — mortgage, utilities, groceries, and others

Critical illness insurance from Lincoln Financial Group can help. Think of this as a supplement to your health insurance plan. The cash benefit you receive from this plan can help with copays, deductibles, treatments not covered by health insurance, or even living expenses while you are recovering.

If you or a loved one is diagnosed with a covered illness or event, you receive a cash benefit to use however you wish. It's that simple, and so very important.

What is covered?

If you or a loved one is diagnosed with a covered critical illness or event, you receive a lump sum cash benefit. This is in addition to any other insurance you may have. The standard core plan includes diagnoses for the top health concerns of consumers:

- Heart conditions, such as heart attack, sudden cardiac arrest resulting in death, or mitral or aortic valve disease
- Renal failure
- Kidney failure or major organ transplant
- Stroke or arterial/vascular disease
- Cancer, such as invasive cancer, non-invasive cancer and skin cancer

If, over time, you are diagnosed with more than one critical illness or event, you may receive more than one cash benefit.

Be ready for whatever comes your way.

Critical illness insurance includes Health Advocate services for you and your family. These services can be accessed at any time 24/7 and include:

- Personal health advocate who can help you manage health care services – even if you never get sick
- Services available to you and your family
- Finding the right doctors
- Help in finding second opinions
- Coordination of care among different providers
- Assistance in understanding medical information
- Coordination of hospice, adult day care, and other services
- Assistance with health insurance benefit coordination
- Assistance negotiating medical bills of $400 or more
- Up to three in-person or video conference counseling sessions
- Unlimited telephonic counseling

It's affordable and convenient.

Group rates are typically more affordable than what you might pay for an insurance plan on your own. And with payroll deduction, no money is due now – your premium simply comes out of your paycheck.

Cost:

- Available at group rates — often less expensive than rates for individual policies.
- Add your loved ones to the plan for just a little more.

Convenience:

- Payroll deduction is easy.
- You can continue coverage if you leave your job.

NOTE: If you elect coverage for your dependent children, you must provide notification to your employer when all of your dependent children exceed the dependent child age limit or no longer otherwise meet the definition of a dependent child. If you elect coverage for your spouse, you must provide notification to your employer if your spouse no longer meets the definition of a spouse.

NOTE: This plan is not a replacement for medical insurance.

SUPPLEMENTAL MEDICAL BENEFITS

ACCIDENT INSURANCE

Accident insurance can make mishaps a little less painful.

Accident insurance from Lincoln Financial Group can help. If you or a loved one is injured in an accident, you get a cash benefit. So even though you can't see an accident coming, you can still plan for one.

For example, if you sustain a covered injury and are admitted to the hospital, your accident insurance sends you a check that you can use however you like — to cover a copay or deductible, pay for everyday living expenses, or even make a purchase.

Receive a check if a covered injury results in any of the following:

- Initial physician office visit/urgent care center
- Physician follow up visits
- Emergency Room
- X-ray
- Major diagnostic exams
- Physical, occupational, and chiropractic therapy
- Lacerations
- Dislocations and fractures

What is covered?

You receive a cash benefit if a covered injury results in any of the following:

- Emergency room visits
- Surgeries
- Ambulance transportation
- Fractures and dislocations
- Hospital admission and confinement
- Lacerations
- Intensive care
- Concussions

And if you have multiple injuries from the same accident, you may receive a separate cash benefit for each of your injuries and covered treatments.

It's affordable and convenient.

Group rates are typically more affordable than what you might pay for an insurance plan on your own. And with payroll deduction, no money is due now — your premium simply comes out of your paycheck.

This plan requires **no** medical underwriting.

Cost:

- Available at group rates — often less expensive than rates for individual policies.
- Add your loved ones to the plan for just a little more.

Convenience:

- Payroll deduction is simple.
- You can continue the coverage if you leave your job.

NOTE: If you elect coverage for your dependent children, you must provide notification to your employer when all of your dependent children exceed the dependent child age limit or no longer otherwise meet the definition of a dependent child. If you elect coverage for your spouse, you must provide notification to your employer if your spouse no longer meets the definition of a spouse.

NOTE: This plan is not a replacement for medical insurance.

SUPPLEMENTAL MEDICAL BENEFITS

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance can make a difference when it matters most.

Hospital indemnity insurance from Lincoln Financial Group can help with expenses incurred from a hospitalization. Think of this as a supplement to your health insurance plan. The cash benefit you receive from this plan can help with copays, deductibles, treatments not covered by health insurance, or even living expenses while you are recovering.

This benefit includes coverage for hospitalizations due to sickness or injury, and include child-specific benefits. You receive a cash benefit to use however you wish. It's that simple, and so very important.

- Coverage is portable for employees who leave their company.
- Benefits are paid directly to employees to help with their expenses.
- And no medical questions are required to receive this coverage.

Receive a check for the following related to a hospitalization:

- Hospital admission
- Hospital confinement

Hospital indemnity benefits in action:

Here's how our hospital indemnity benefits work. Anita goes to the hospital for a routine delivery, but she and her baby both have complications, resulting in a longer-than-expected stay for her and her baby. As you can see, Anita gets cash benefits for each admission and confinement, adding up to $4,800 to help with her expenses.

Employer plan design: (High Plan)

Effective day: 1/1/25

Hospital Admission benefit: $1,000
(2 day per calendar year)

Hospital Confinement benefit: $200
(30 days per calendar year)

- Benefit paid on 2nd day of confinement

Hospital ICU Admission benefit: $1,000
(1 day per calendar year)

Hospital ICU Confinement benefit: $400
(15 days per calendar year)

- Benefit paid on 2nd day of confinement

Hospital NICU Admission: 25%

Hospital NICU Confinement: 25%

February 1, 2025
An insured mom goes into the hospital for routine childbirth but has complications, and the newborn child is admitted to the NICU. The insured mom stays in a standard hospital bed for five full days, and the baby is in NICU for four full days.

Claim paid:

Hospital Admission	$1,000
Hospital Confinement (mom four days)	$800
Hospital ICU Admission (newborn child)	$1,000
Hospital ICU Confinement (newborn child three days)*	$1,200
Hospital NICU Admission Child	$500
Hospital NICU Confinement	$300
Mom =	$1,800
Child =	+ $3,000
Total claim paid benefits =	**$4,800**

*Hospital Confinement begins on the 2nd day and requires a minimum of 23 hours confined to qualify.
NOTE: Standard provisions apply. Fictional example, demonstrating how hospital indemnity insurance works. Exact premium and benefits may vary by plan.

It's affordable and convenient.

Group rates are typically more affordable than what you might pay for an insurance plan on your own. And with payroll deduction, no money is due now – your premium simply comes out of your paycheck.

Cost:

- Available at group rates — often less expensive than rates for individual policies.
- Add your loved ones to the plan for just a little more.

Convenience:

- Payroll deduction is easy.
- You can continue coverage if you leave your job.

NOTE: If you elect coverage for your dependent children, you must provide notification to your employer when all of your dependent children exceed the dependent child age limit or no longer otherwise meet the definition of a dependent child. If you elect coverage for your spouse, you must provide notification to your employer if your spouse no longer meets the definition of a spouse.

NOTE: This plan is not a replacement for medical insurance.

VALUE ADDED BENEFITS

LIFEKEYS® SERVICES HELP YOU MEET LIFE'S CHALLENGES - *Lincoln Financial*

When you choose life insurance, you're planning for your family's future - assuring their comfort and securing their plans. With Lincoln Term Life Insurance, you can also access services that make a real difference now as well as in the future. LifeKeys services, included with all Lincoln Term Life and Accidental Death and Dismemberment Insurance policies, provide assistance to you, your family and your beneficiaries.

For You and Your Family…

EstateGuidance® Will Preparation

Create your will online – easily and economically. Follow a step-by-step guide through the entire process, and then use online instructions to execute your will.

You can:

- Name an executor to manage your estate.
- Choose a guardian for your children.
- Specify wishes for your property.
- Provide funeral and burial instructions.

GuidanceResources® Online

GuidanceResources® Online is the place to go for articles, tutorials, streaming videos and "Ask the Expert" personal responses on topics such as:

- Law and regulations
- Money and investments
- Health and wellness
- Work and education
- Leisure and home

Identity Theft

Identity theft is one of the fastest-growing crimes in the U.S. Be sure you have the information you need to recognize and prevent it. Our online resource helps you:

- Spot the warning signs.
- Take steps to protect your cell phone, computer and tax records from fraud.
- Lessen the damage and repair your credit, if identity theft occurs.
- Link to essential resources such as credit reporting bureaus, the FBI Internet Crime Complaint Center, ID Theft Resource Center, and more.

For You and Your Beneficiaries…

Services are available for up to one year after a loss, and include:

- A combination totaling six in-person sessions for grief counseling, or legal or financial information and...
- Unlimited phone counseling.

Assistance at a Difficult Time

Make sure your loved ones have the support they need, should you pass away. Unlimited phone contact with master's level grief counselors lets your beneficiaries access information, advice and referrals for topics such as:

- Grief and loss
- Stress, anxiety and depression
- Memorial planning information
- Concerns about children and teens

Financial Services

Your beneficiaries can call one of our certified financial specialists or use online tools and resources whenever they need help with essential topics such as:

- Bankruptcy
- Estate planning
- Debt
- Investments
- Budgeting

Legal Support

If your beneficiaries need quick legal information, they can call one of our in-house attorneys. Or, if they need in-depth information, guidance or representation we'll refer them to a qualified attorney in their area. They will be eligible for a free 30-minute consultation as well as a 25% reduction in customary legal fees thereafter. They'll get expert guidance on areas such as:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents beneficiaries need

Support With Day-to-Day Concerns

Through good times and bad, everyone can use assistance. LifeKeys® services provide in-depth information and guidance - on virtually any topic you can name. Your beneficiaries can call for a quick answer or take advantage of specialists who will do the research for them and provide a comprehensive, customized booklet of information. Topics include:

- Planning a memorial service.
- Finding child care or elder care.
- Selecting a mortgage.
- Moving and relocation.
- Making major purchases.

DID YOU KNOW?

A program description is available at www.lincoln4benefits.com.

To use TravelConnect℠ services, call 1-866-525-1955 or 1-603-328-1955.

Group ID: LFGTravel123

VALUE ADDED BENEFITS CONTINUED

Your comprehensive coverage includes…

Medical Emergency Evacuation and Transportation

Includes arrangement and payment for transportation of the patient to the nearest medical facility able to treat the injury or illness. Once the patient can travel home, includes arrangement and payment for the trip.

Dependent Child Transportation

If a medical emergency leaves no covered parents available, includes arrangement and payment for a dependent child's trip home or arrangement and payment for a family member to travel to and care for the child.

Travel Treatment Monitoring

Includes care management when a traveler has a medical emergency; services are available until the traveler is released or sent to a hometown hospital. Services vary from case to case but can include: medical record requests and reviews to ensure treatment is appropriate; intermediary services; medical translation services for the patient and/or the family; and communication between the patient and family back home.

And Much More ...

Identity theft is one of the fastest-growing crimes in the U.S. Be sure you have the information you need to recognize and prevent it. Our online resource helps you:

- Destination info – weather, currency and more
- Emergency travel arrangements and funds transfer
- Lost or stolen travel documents assistance
- Language translation services
- Medical and dental referrals
- Assistance with corrective lenses or medical device replacement
- Arrangement for the delivery of medications, vaccines or blood
- Updates to family, employer and/or home physician
- Repatriation of a deceased traveler
- Security and political evacuation assistance

For a complete list of services provided, please reach out to your benefits department.

YOU MAY ALSO BE ELIGIBLE FOR BENEFICIARY SERVICES

If you develop a terminal illness and access your Accelerated Death Benefit, you will be able to use beneficiary services shown on the next page.

EMPLOYEE ASSISTANCE PROGRAM (EAP) EMPLOYEE CONNECT℠ SERVICES - *LINCOLN FINANCIAL*

We offer confidential guidance and resources for you or an immediate household family member.

- In-person help for short-term issues; up to four* sessions with a counselor per person, per issue, per year.
- Toll-free phone and web access 24/7.
- Unlimited phone access to legal, financial, and work-life services.
- A 25% discount on in-person consultations and referrals.
- Work/life services for assistance with child care, finding movers, kennels and pet care, vacation planning, and more.

To learn more about the Lincoln Financial EmployeeConnect program, visit **www.guidanceresources.com** (username = LFGsupport; password = LFGsupport1), or talk with a specialist at **1-888-628-4824**.

*In California, up to three sessions in six months, starting with initial contact by employee.

GLOSSARY OF TERMS

COPAYMENT

A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a PPO-type plan. In some cases, you may be responsible for coinsurance after a copay is made.

COINSURANCE

Your share of the costs of a health care service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

DEDUCTIBLE

A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits that require copays do not apply to the deductible. For example, if your plan's deductible is $1,000, you'll pay 100 percent of eligible health care expenses until you have met the $1,000 deductible. After that, you share the cost with your plan by paying coinsurance.

FORMULARY

A list of prescription drugs covered by the plan, also called a drug list.

IN-NETWORK

A group of doctors, clinics, hospitals and other health care providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

OUT-OF-NETWORK

Care received from a doctor, hospital or other provider that is not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays for those services.

OUT-OF-POCKET MAXIMUM

This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)

This is a type of medical plan that requires the member to reach a deductible prior to having services covered by coinsurance. All expenses paid by the member count toward the deductible and out-of-pocket maximum.

CONTACTS

BENEFIT	WHO TO CALL	WEBSITE/EMAIL	PHONE NUMBER
Medical Plan	Cigna	mycigna.com	1-866-494-2111
Dental Plan			
Vision Plan			
Spending Accounts	WEX Benefits	wexinc.com/solutions/benefits/	1-866-451-3399
Life & Disability	Lincoln Financial	lfg.com	1-800-423-2765
Employee Assistance Plan		guidanceresources.com Username: LFGsupport; Password: LFGsupport1	1-888-628-4824
Voluntary Benefits		lfg.com	1-888-628-4824
Advocacy	Health Advocate	HealthAdvocate.com/members	1-866-695-8622
Online Enrollment Portal	ADP	hr@apolloretail.com	1-877-215-1998
Open Enrollment Support	Cigna One Guide		1-888-806-0594

ABOUT THIS GUIDE: Actual plan provisions for Channel Partners Solutions ("the Company") benefits are contained in the appropriate plan documents, including the Summary Plan Description (SPD) and incorporated benefit/carrier booklets. The Benefit Enrollment Guide is a summary only and does not describe each benefit option. This Benefit Enrollment Guide provides updates to your existing SPD as of the first day of plan year, which describes your health and welfare benefits in greater detail. Until the Company provides you with an updated SPD, this guide is intended to be a Summary of Material Modification (SMM) and should be retained with your records along with your SPD. As always, the official plan documents determine what benefits are available to you. If any discrepancy exists between this guide and the official documents, the official documents will prevail. The Company reserves the right to amend or terminate any of its plans or policies, make changes to the benefits, costs, and other provisions relative to benefits at any time with or without notice, subject to applicable law.

Updated: May 2025

IMPORTANT NOTICES

Important Notice from Channel Partners Solutions About Your Prescription Drug Coverage and Medicare — Medicare Part D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Channel Partners Solutions** 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. **Channel Partners Solutions** have determined that the prescription drug coverage offered through **Cigna** 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.

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 through 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. However, you also may pay a higher premium (a penalty) because you did not have creditable coverage if you were enrolled under the American Worker MEC 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 **Channel Partners Solutions** coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current **Channel Partners Solutions** coverage, be aware that you and your dependents may not be able to get this coverage back.

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 **Channel Partners Solutions** 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 **Channel Partners Solutions** 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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: **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: 01/01/2025
Name of Entity/Sender: **Channel Partners Solutions**
Contact: **Channel Partners Solutions** Privacy Officer
Address: Human Resources Department
3802 Corporex Park Dr., Suite 225
Tampa, FL 33619

HIPAA PRIVACY NOTICE REMINDER

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require **Channel Partners Solutions** to periodically send a reminder to participants about the availability of the Plan's Privacy Notices and how to obtain that notice. The Privacy Notice explains participants' rights and the plan's legal duties with respect to protected health information (PHI) and how the plan may use and disclose PHI. You can obtain a copy of the Privacy Notice by contacting **Channel Partners Solutions**. Please refer to the Summary Plan Description for additional information.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Cigna and Kaiser are required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

Cigna and Kaiser provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description, Cigna and Kaiser, or contact your Plan Administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a normal vaginal delivery, or
- 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) COMPLIANCE DISCLOSURE NOTICE

Channel Partners Solutions is complying with recent legislation that removes limits on mental health benefits. For example, there must be equality between medical benefits and mental health benefits as to financial requirements (such as deductibles, copayments, coinsurance, and out-of-pocket maximums) and quantitative treatment limitations (such as number of treatments, visits, or days of coverage)

GENERAL NOTICE OF ERISA RIGHTS AND PROTECTIONS

As a participant in the **Channel Partners Solutions** benefits program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). If you would like more information about ERISA, or if you have any questions, you may contact the Human Resources Department or the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20220.

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA")

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Generally, employees must give 30 days advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For More Information

For more information about FMLA, contact the US Department of Labor at **1-800-4USWAGE** (**1-800-487-9243**) or log onto the Department of Labor website at **www.dol.gov/agencies/whd/fmla**.

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days aft your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 Department
Email: **hr@apolloretail.com**
Phone: **1-877-215-1998**
Address: 3802 Corporex Park Dr., Suite 225
Tampa, FL 33619

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Channel Partners Solutions Human Resources Department **hr@apolloretail.com**.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

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

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

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

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

For further information regarding the plan and COBRA continuation, please contact:

Human Resources Department
Email: **hr@apolloretail.com**
Phone: **1-877-215-1998**
Address: 3802 Corporex Park Dr., Suite 225
Tampa, FL 33619

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

PATIENT PROTECTION MODEL DISCLOSURE

Cigna and Kaiser generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Cigna or Kaiser directly.

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

You do not need prior authorization from Cigna or Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Cigna or Kaiser directly.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

You may buy health insurance on the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

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

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Department **hr@apolloretail.com**.

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

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "Balance Billing" (Sometimes Called "Surprise Billing")?

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance**, or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're Protected From Balance Billing For:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When Balance Billing Isn't Allowed, You Also Have These Protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. The federal phone number for information and complaints is: **1-800-985-3059**.

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

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.

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 July 31, 2024. Contact your State for more information on eligibility –

1. ALABAMA – Medicaid
   Website: http://myalhipp.com/
   Phone: 1-855-692-5447
2. ALASKA – Medicaid
   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
3. ARKANSAS – Medicaid
   Website: http://myarhipp.com/
   Phone: 1-855-MyARHIPP (855-692-7447)
4. CALIFORNIA – Medicaid
   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
5. COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
   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
6. FLORIDA – Medicaid
   Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
   Phone: 1-877-357-3268
7. GEORGIA – 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
8. INDIANA – Medicaid
   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
9. IOWA – Medicaid and CHIP (Hawki)
   Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
   Medicaid Phone: 1-800-338-8366
   Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
   Hawki Phone: 1-800-257-8563
   HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
   HIPP Phone: 1-888-346-9562
10. KANSAS – Medicaid
    Website: https://www.kancare.ks.gov/
    Phone: 1-800-792-4884
    HIPP Phone: 1-800-967-4660
11. KENTUCKY – 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
12. LOUISIANA – Medicaid
    Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
    Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
13. MAINE – Medicaid
    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
14. MASSACHUSETTS – Medicaid and CHIP
    Website: https://www.mass.gov/masshealth/pa
    Phone: 1-800-862-4840
    TTY: 711
    Email: masspremassistance@accenture.com
15. MINNESOTA – Medicaid
    Website: https://mn.gov/dhs/health-care-coverage/
    Phone: 1-800-657-3672
16. MISSOURI – Medicaid
    Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
    Phone: 573-751-2005
17. MONTANA – Medicaid
    Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
    Phone: 1-800-694-3084
    Email: HHSHIPPProgram@mt.gov
18. NEBRASKA – Medicaid
    Website: http://www.ACCESSNebraska.ne.gov
    Phone: 1-855-632-7633
    Lincoln: 402-473-7000
    Omaha: 402-595-1178
19. NEVADA – Medicaid
    Medicaid Website: http://dhcfp.nv.gov
    Medicaid Phone: 1-800-992-0900
20. NEW HAMPSHIRE – Medicaid
    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
21. NEW JERSEY – Medicaid and CHIP
    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)
22. NEW YORK – Medicaid
    Website: https://www.health.ny.gov/health_care/medicaid/
    Phone: 1-800-541-2831
23. NORTH CAROLINA – Medicaid
    Website: https://medicaid.ncdhhs.gov/
    Phone: 919-855-4100
24. NORTH DAKOTA – Medicaid
    Website: https://www.hhs.nd.gov/healthcare
    Phone: 1-844-854-4825
25. OKLAHOMA – Medicaid and CHIP
    Website: http://www.insureoklahoma.org
    Phone: 1-888-365-3742
26. OREGON – Medicaid
    Website: http://healthcare.oregon.gov/Pages/index.aspx
    Phone: 1-800-699-9075
27. PENNSYLVANIA – Medicaid and CHIP
    Website: https://www.pa.gov/en/services/dhs/apply-formedicaid-health-insurance-premium-payment-program hipp.html
    Phone: 1-800-692-7462
    CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html
    CHIP Phone: 1-800-986-KIDS (5437)
28. RHODE ISLAND – Medicaid and CHIP
    Website: http://www.eohhs.ri.gov/
    Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
29. SOUTH CAROLINA – Medicaid
    Website: https://www.scdhhs.gov
    Phone: 1-888-549-0820
30. SOUTH DAKOTA – Medicaid
    Website: http://dss.sd.gov
    Phone: 1-888-828-0059
31. TEXAS – Medicaid
    Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
    Phone: 1-800-440-0493
32. UTAH – Medicaid and CHIP
    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/
33. VERMONT – Medicaid
    Website: https://dvha.vermont.gov/members/medicaid/hipp-program
    Phone: 1-800-250-8427
34. VIRGINIA – Medicaid and CHIP
    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
35. WASHINGTON – Medicaid
    Website: https://www.hca.wa.gov/
    Phone: 1-800-562-3022
36. WEST VIRGINIA – Medicaid and CHIP
    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)
37. WISCONSIN – Medicaid and CHIP
    Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
    Phone: 1-800-362-3002
38. WYOMING – Medicaid
    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 July 31, 2024, 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