MICHIGAN
BENEFIT GUIDE
2024

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- **If you require further assistance,** contact the Epitec Human Resources Team. The Epitec Human Resources Team will provide benefits administration assistance for benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Group #	Web / email	Phone
Medical			
Blue Cross Blue Shield of Michigan	007020292	www.bcbsm.com	1-800-752-1455
Blue Care Network	00262833	www.bcbsm.com	1-800-662-6667
Priority Health SE MI Partners HMO	796732	www.priorityhealth.com	1-800-446-5674
Health Savings Account HealthEquity		www.healthequity.com	1-866-346-5800
Dental Blue Cross Blue Shield of Michigan	00702092	www.mibluedentist.com	1-888-826-8152
Vision Blue Cross Blue Shield of Michigan	00702092	www.vsp.com	1-800-877-7195
Basic Life and AD&D Insurance **Voluntary Life Insurance** UNUM	947095	www.unum.com	1-800-275-8686
Short-Term Disability **Long-Term Disability** UNUM	947097	www.unum.com	1-800-275-8686
Employee Assistance Program UNUM		www.unum.com/lifebalance	1-800-854-1446
Epitec Human Resources Team		https://portal.epitec.com/	1-248-864-7215

Welcome to your 2024 Employee Benefits!

Epitec, Inc. takes into consideration our employees' evolving needs, as well as ensuring a level of security and protection when making decisions regarding the benefits program being offered.

We recognize the important role employee benefits play as a critical component of an employee's overall compensation. We also strive to maintain a benefits program that is competitive within our industry.

This benefits guide, together with other enrollment materials, are provided to help you understand your benefit choices and navigate through the Open Enrollment / New Hire process.

Before you enroll, please read this guide to become familiar with the benefit options. Your decisions will impact your benefit selections and what you pay for these benefits.

If you have any benefits related questions or concerns, please do not hesitate to call the Epitec Human Resources Team.

Epitec Human Resources Team

1-248-864-7215

https://portal.epitec.com/

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PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Epitec, Inc. reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

How to Enroll

Open Enrollment Period

For 2024 Epitec will have a **ACTIVE** enrollment. This means that all current enrollment elections for 2023 will roll over to 2024. If you wish to make any changes, please log in during the open enrollment period. If you are a new-hire, please follow the instructions below to enroll in your benefits.

Log in to your website:

Access the Employee Self-Service* website. **https://workforcenow.adp.com**

Enter your User ID and Password, and then click **Sign In**.

Note: If this is your first time logging in, click the Sign Up button. If you are unsure of the registration code, please contact your HR team.

Upon logging in, you will be presented with a splash page showing important information about this Open Enrollment period. You may click Start This Enrollment or Remind Me Later. The splash page will continue to be displayed each time you log in for the duration of the Open Enrollment Period until you complete your selections.

- **To Start -** Click **Enroll Now** in the Open Enrollment box. You will be brought back to the Welcome Note and Introduction screen. Please review all information on this screen, as there are often important references for your Open Enrollment options. If any tobacco attestation requirements are in place, you must populate the information as indicated before clicking Continue.

  The left side of the screen will indicate the different plan types that are available to enroll in. When you are viewing the selected plan type, all enrollment options will be displayed on screen.

- **Select Plan -** You may choose to click **Select Plan** for the desired enrollment or **Waive This Benefit**. If you chose to waive a benefit, you may be required to select a waive reason.

  When you choose to enroll in a plan, you may review your costs on a Per Pay Period, Monthly, or Annual basis by selecting the desired view in the calculator drop-down. The rate displayed to the left will be updated based on your selection, and it will also be updated if dependents are added for coverage.

- **Manage Dependents -** While enrolling in a plan, please be sure to indicate which dependents should be covered in Step 2, if applicable. If you need to update or add a dependent, you may click the **Manage Dependents** link in step 2.

  *Please note: The coverage level for your enrollment (Employee Only, Employee + Spouse, Employee + Child(ren), Employee + Family) is driven by which dependents you select to enroll.

- **Click Continue to Preview**- Review your enrollment, costs and covered individuals carefully. Then click **Save and Continue to Next Benefit** to continue making your desired selections.

- **Company-Paid/Voluntary Life Elections and Beneficiaries** - When electing Voluntary Life, you will need to select your beneficiaries as well.

  Start by clicking **Select Plan**, and then choose the amount of coverage you would like to elect.

  If the amount selected is over the Guarantee Issue amount or if you previously declined this benefit, an approval will be required and you will be asked to complete an **Evidence of Insurability (UNUM)** and submit it to UNUM. Your full election amount will not be approved until this is received. Click **Continue to Preview** and review your selection and beneficiary delegations. Then click **Save and Continue to Next Benefit**

- **Continue through each step** until all elections are complete and the **Continue to Summary** button is activated.

  Review all selections. When you are ready to confirm your selections, click **Submit Enrollment**. ***Please note that your benefit elections will not be processed until you click Submit Enrollment.*** If **Save for later** is selected, these enrollments will not be submitted to your HR team until you fully submit the enrollment.

Please ensure you receive the confirmation note indicating your elections have been submitted.

If you would like to make additional changes or modifications during the Open Enrollment Period, you may log in and navigate to **Myself > Benefits > Enrollments** and click the ***Enroll Now*** option again in the Open Enrollment box, which will bring you back to the beginning of the profile to make any desired election changes.

Eligibility

Full-time employees with a schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Benefits are effective the first day of the month following 60 days of employment. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in Epitec Inc.'s benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Medical coverage will terminate at the end of year of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance.

For all benefits, you must enroll within 30 days from your date of hire by going to **https://portal.epitec.com/**.

Pre-Tax Benefits: Section 125

Epitec Inc.'s benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, vision and flexible spending accounts, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

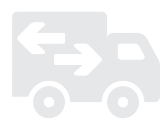
You must notify the Epitec Human Resources Team at 1-248-864-7215 or https://portal.epitec.com/ within 30 days from the life event status change in order to make a change in your benefit selections.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.



Benefit Changes continued...

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact Epitec Human Resources Team to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If You Experience a Life Event Status Change

Log onto **https://portal.epitec.com/** to add or drop dependents from your coverage if you experience a life event status change. Your username and password will be the same as you used during open enrollment. Click on "Life Events" and a series of easy-to-follow instructions will lead you through the enrollment process.

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to Epitec Human Resources Team. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can call the Epitec Human Resources Team at 1-248-864-7215 or visit **https://portal.epitec.com/**.

Medical Coverage

Epitec, Inc. is proud to offer you a choice between four different medical plans. Coverage under these plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

Blue Care Network / Priority Health HMO

The Blue Care Network (BCN) and Priority Health SE Michigan Partners each have an entire network of health care providers. You will have to select a primary care provider (PCP) who will coordinate all of your health services and care.

Blue Care Network PCP Focus network is a slightly narrower network for your PCP only. You will still have access to the broader BCN HMO network of specialists and hospitals.

Priority Health's S.E. Michigan Partners HMO Plan is a 2 Tier Network. Your out-of-pocket costs are much less if you see a Tier 1 provider. We encourage you to go to Priority Health's website to look-up which tier the providers are in. Be sure to select the SEMP HMO Plan Network. The tiers are shown next to the providers names.

Under the HMO Plan, you have a $0 copay for most types of preventative care and have coverage for a variety of specialist visits, but specialist visits are only covered when your PCP makes a referral. Additionally, you will pay copayment fees for every non-preventive medical visit. BCN requires referrals to specialists. THC only requires referrals to podiatrists, physical therapists and chiropractors.

There are no out-of-network benefits with the HMO.

To locate BCN PCP Focus HMO participating doctors or hospitals, please visit www.bcbsm.com.

- Click on the **Doctors & Hospitals** tab at the top of the page
- Click **Find a doctor or hospital**
- Select **I want to find a Primary Care Physician (HMO)** from the drop down menu
- At Step 2, select **Blue Care Network PCP Focus (HMO**) from the drop down menu

To locate a PH SEMP participaing doctor or hospital, please visit www.priorityhealth.com

Blue Cross Blue Shield of Michigan PPO

A Preferred Provider Organization (PPO) offers you the freedom to receive care from any provider—in or out of your network. This means you can see any doctor or specialist, or use any hospital.

In addition, PPO plans do not require you to choose a Primary Care Physician (PCP) and do not require referrals. For example, if you already have a doctor you like, you can continue receiving care from that provider as long as that doctor is in the PPO network.

If you need to see a specialist, you do not have to first consult with a PCP. No referrals are required for any doctor, specialist or hospital.

To locate a BCBSM PPO participating doctor or hospital, please visit www.bcbsm.com.

Build a Strong Relationship with Your Primary Care Physician

Most doctors went into the practice of medicine so that they could build strong emotional bonds with patients and guide them through health challenges.

Here are 3 tips to building a strong relationship with a new primary care physician, or improving the bond with your current one:

1. **Know what's important to you in a physician.**

   If you're looking for a new doctor, be sure this is someone with whom you will have good interpersonal chemistry, that they're committed to your well-being, and that their office is well organized.

2. **Get your doctor familiar with your health history.**

   Help your doctors to get to know you better by collecting your medical records, writing down your family's health history, and sharing this information with every new physician you meet.

3. **Ask the right questions to build rapport and get on the road to better health.**

   To maximize the time you have together, write down your health questions for your physician beforehand.

Medical Plan Comparison

	Blue Care Network PCP Focus HMO In-Network Only	PriorityHealth HMO In-Network Only	Simply Blue PPO HSA	BCBSM $4,000 PPO
Deductible (Individual / Family)	**$6,350 / $12,700**	Tier 1 **$5,000 / $10,000** Tier 2 **$8,550 / $17,100**	**$4,000 / $8,000**	**$4,000 / $8,000**
HSA Eligible?	Yes	No	Yes	No
Coinsurance	0%	Tier 1 - 30% Tier 2 - 50%	50%	30%
Out-Of-Pocket Maximum (Individual / Family)	$6,850 / $12,700	Tier 1 - $8,550 / $17,100 Tier 2 - $8,550 / $17,100	$6,350 / $12,700	$6,350 / $12,700
Preventive Services Well-Child Care Adult Physical Examination Cancer Screenings	No charge No charge No charge	No charge No charge No charge	No charge No charge No charge	No charge No charge No charge
Office Visits	0% after Deductible	Tier 1 - $30 PCP / $60 Specialist Tier 2 - $60 PCP / $90 Specialist	50% after Deductible	$40 PCP / $60 Specialist
Allergy Testing **Allergy Shots**	0% after Deductible 0% after Deductible	No charge No charge	50% after Deductible 50% after Deductible	70% after Deductible 70% after Deductible
Urgent Care Centers	0% after Deductible	Tier 1 - $60 Copay Tier 2 - $120 Copay	50% after Deductible	$60 Copay
Diagnostic Services Diagnostic Tests and X-rays Imaging (MRI, MRA, CAT, PET)	0% after Deductible 0% after deductible	Tier 1 - 30% after Deductible $150 Copay Tier 2 - 50% after Deductible $300 Copay	50% after Deductible 50% after Deductible	70% after Deductible 70% after Deductible
Hospital Emergency Room	0% after Deductible	$250 Copay	50% after Deductible	$250 copay
Ambulance Services	0% after Deductible	$150 Copay	50% after Deductible	70% after Deductible
Hospital Care	0% after Deductible	Tier 1 - 30% after Deductible Tier 2 - 50% after Deductible	50% after Deductible	70% after Deductible
Surgical Services	0% after Deductible	Tier 1 - 30% after Deductible Tier 2 - 50% after Deductible	50% after Deductible	70% after Deductible
Maternity Prenatal care visits Delivery and nursery care	No charge 0% after Deductible	Tier 1 - No charge 30% after Deductible Tier 2 - No charge 50% after Deductible	No charge 50% after Deductible	No charge 70% after Deductible
Chiropractic (Limits apply)	0% after Deductible	Tier 1 - $30 Copay (max 30) Tier 2 - $60 Copay (max 30)	50% after Deductible	$40 copay
Mental Health & Substance Abuse Treatment Inpatient Outpatient	0% after Deductible 0% after Deductible	Tier 1 - 30% after Deductible $30 Copay Tier 2 - 50% after Deductible $60 Copay	50% after Deductible 50% after Deductible	70% after Deductible 70% after Deductible
Out of Network Benefits	**HMO**	**HMO**	**PPO HSA**	**PPO $4000**
Deductible (Individual / Family)	In-Network Only	In-Network Only	**$8,000 / $16,000**	**$4,000 / $8,000**
Coinsurance	N/A	N/A	50%	50%
Out-Of-Pocket Maximum (Individual / Family)	N/A	N/A	$12,700 / $25,400	$12,700 / $25,400
Office Visits	Not Covered	Not Covered	50% after Deductible	50% after Deductible
Hospital Emergency Room	Not Covered	Not Covered	50% after Deductible	$250 copay

Prescription Coverage

Your prescription drug benefit is part of your medical plan and is based on a tier drug system. Copayments and/or coinsurance are determined by the tier in which the Prescription Drugs are assigned. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.bcbsm.com**.

Prior authorization/step therapy: A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

IMPORTANT: If you are enrolled in the HSA plan, your prescription drug plan IS NOT creditable. Medicare eligible participants will need to enroll in a separate Medicare drug plan.

Prescription Drug	Blue Care Network HMO	PriorityHealth HMO	Simply Blue PPO HSA	BCBSM $4,000 PPO
Retail Copay - 30-day supply				
Tier 1: Generic	$10 copay	$10 copay	$15 after ded.	$20 copay
Tier 2: Preferred Brand	$30 copay	$40 copay	$50 after ded.	$60 copay
Tier 3: Non-Preferred Brand	$60 copay	$80 copay	$70 copay or 50% after ded. up to $100	$80 copay or 50%
Tier 4: Specialty Drugs	20% Coinsurance up to $100	20% Coinsurance up to $100	Not Applicable	20% Coinsurance up to $200
Tier 5: Nonpreferred brand-name specialty drugs	Not Applicable	20% Coinsurance up to $200	Not Applicable	25%Coinsurance up to $300
Mail Order Copay - 90-day supply				
Tier 1: Generic	$20 copay	$20 copay	$35 copay after ded.	$50 copay
Tier 2: Preferred Brand	$80 copay	$80 copay	$140 copay after ded.	$170 copay
Tier 3: Non-Preferred Brand	$170 copay	$160 copay	$200 copay or 50% after ded. up to $290	$230 copay or 50%
Tier 4: Specialty Drugs	20% Coinsurance	No coverage	Not Applicable	Not Applicable

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Save Money with Generic Drugs

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

Blue Cross Online Visits

Online medical and behavioral care

You and your dependents may* have access to online medical and behavioral health services anywhere in the United States. You and your covered family members can see and talk to:

- A doctor for minor illnesses such as a cold, flu or sore throat when your primary care physician isn't available
- A behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression and grief (Behavioral health visits are available by appointment only.)

While online health care shouldn't replace your relationship with your primary care physician, it can be invaluable when:

- Your doctor isn't available.
- You can't leave home or your workplace.
- You're on vacation or traveling for work.
- You're looking for affordable after-hours care.

How do I get started?

Start by doing one of the following:

- **Mobile** – Download the BCBSM Online Visits℠ app
- **Web** – Visit **bcbsmonlinevisits.com**
- **Phone** – Call **1-844-606-1608**

No service key is required.

Share information with your primary care physician

To ensure that your primary care physician knows about all of your medical care, let them know when you use online health care. At the end of your visit, check the box to share your visit summary report with your family doctor or other health care providers.

How much does it cost?

For medical services, an online visit is based on your office visit cost share. Costs for behavioral health services vary depending on the type of provider and service received. You'll be charged using your existing outpatient behavioral health benefits.

Questions?

For questions regarding online health care, contact:

1-844-606-1608

bcbsmonlinevisits.com

*Not all plans cover all services. Log in to your Blue Cross member account to see what your plan covers.

The information included on this document doesn't apply to Medicare members.

The website and app use the American Well® technology platform and provider network. Online visits are powered by American Well, an independent company that provides online visits for BCN members.

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Blue Cross Blue Shield of Michigan

The most convenient way to stay informed about your plan

Ever been surprised by your bill at the doctor or pharmacy? You can use the BCBSM mobile app to find out what you'll owe ahead of time. It connects you securely to the health plan info on your **bcbsm.com** account when you need it. The app is available through the App Store® and Google Play™.

What you can do with the app

The more you know about your health plan, the more prepared you are when you need care. Depending on your plan*, you can use the app to:

- View your deductible and other plan balances
- See and search for services your plan covers
- Research drug prices
- Check claims and explanation of benefits
- Find doctors and hospitals
- Compare procedure costs
- Access the Health & Wellness site to take your health assessment and use valuable tools like the Personal Health Record, Digital Health Assistant programs and Health Trackers
- View and share your virtual ID card
- Easily call customer support and our nurse line
- Pay your monthly bill if you buy your own insurance from us
- Use Touch ID® to log in if you have an iPhone or your fingerprint if you have an Android phone (version 6.0 or higher)
- Get Blue365® member discounts
- Manage your primary care providers if you have an HMO or Personal Choice PPO plan
- Use our app on your iPad or Android tablet
- Easily register for a member account by snapping a picture of your Blue Cross ID card
- View all your referrals and authorizations in one place (excluding Medicare Advantage and Rx)
- Receive notifications on your phone when a new explanation of benefits statement, or EOB, is available
- Recover your forgotten username and password through a simplified account recovery process

24/7 Virtual care

When it's not convenient to go to the doctor, bring a doctor to you.

What is virtual care?

Virtual care gives you access to board-certified doctors on nights, weekends and even holidays for health issues that aren't an emergency. Virtual care connects you with a doctor over the phone, through video, or simply by filling out an online questionnaire. Depending on your condition and the type of virtual care you choose, a doctor can:

- Prescribe a medication and send it to your preferred pharmacy
- Develop a treatment plan
- Notify your primary care doctor with current information
- Make follow-up recommendations, including referrals to see a specialist

What conditions can it treat?

Virtual care is great for non-emergencies, like:

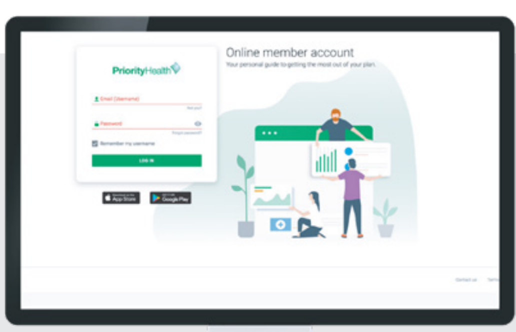
- Cough, cold and flu
- Fever, nausea and vomiting
- Sinus problems
- Pink eye
- Allergies, bites and stings
- Rash, hives and more

How much does it cost?

We offer our members 100% coverage ($0 copay) for in-network virtual care. It is included in your benefits at no cost to you.

Talk to your doctor.

Ask your doctor about what virtual care options are available to you.



Priority Health members who live in the state of Michigan can access video visits and eVisits with Michigan-based, board-certified providers through the new Priority Health member app. Download the Priority Health app to get started.

Health Savings Accounts

Available if enrolled in a HDHP

If you enroll in the HDHP, you will be eligible to open and contribute to an Health Savings Account (HSA) through HealthEquity. An HSA is financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service.

The HSA is similar to a regular savings account with a debit card and accrues interest. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

How you save with an HSA

As an HSA user, you will save in several ways:

- HSA contributions are not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed

HSA funds remain yours to grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave Epitec, Inc..

Supplement your retirement

Once your HSA balance reaches $2,000, you may invest your funds for increased earning potential that is also tax-free. After age 65, you can use your HSA much like a 401(k) and withdraw funds for any purpose. Qualified medical expenditures remain tax-free even into retirement.

You can win with an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future.

Using your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses; for yourself, your spouse, and your qualified dependents. Eligible expenses include:

- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Hearing aids
- Physical exams
- Prescriptions
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- and more...

2024 HSA Annual Contribution Limit:

$4,150 for individual coverage

$8,300 for all other coverage tiers

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

Dental Coverage

Epitec, Inc. offers you the choice of two options when it comes to dental coverage through Blue Cross Blue Shield of Michigan:

- Blue Dental EPO
- Blue Dental PPO Plus

Dental Plan Option 1	BCBSM EPO - Low Option	
	In-Network	Out-of-Network
Calendar Year Maximum	$1,000 per Member	
Calendar Year Deductible Applies to Class II and Class III services only	$25 Individual / $75 family	N/A
Class I services - Preventive Oral Exams, Cleanings, X-Rays, Fluoride Treatment	Covered 100%	Not Covered
Class II services- Basic Fillings, General anesthesia, Root Canal Therapy, Repairs Dentures, Oral surgery	Covered 80%	Not Covered
Class III services - Major Crowns, Inlays, Onlays, Dentures, Bridges, Endosteal implants	Covered 50%	Not Covered
	12 Month Waiting Period on Major Services	
Class IV services - Orthodontia Dependents under age 19	Not Covered	Not Covered

Network access information: With Blue Dental EPO, members must choose a dentist who is a member of the Blue Dental PPO network. Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.

Blue Dental PPO network: Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance amounts. Members also receive discounts on non covered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.
Note: If you go to a non-PPO (out-of-network) dentist, you are responsible for all costs for services rendered.

Dental Plan Option 2	BCBSM PPO - High Option	
	In-Network	Out-of-Network
Calendar Year Maximum	$1,000 per Member	
Calendar Year Deductible Applies to Class II and Class III services only	$25 Individual / $75 family	$25 Individual / $75 family
Class I services - Preventive Oral Exams, Cleanings, X-Rays, Fluoride Treatment	Covered 100%	Covered 100%
Class II services- Basic Fillings, General anesthesia, Root Canal Therapy, Repairs Dentures, Oral surgery	Covered 80%	Covered 80%
Class III services - Major - Crowns, Inlays, Onlays, Dentures, Bridges, Endosteal implants	Covered 50%	Covered 50%
	12 Month Waiting Period on Major Services	
Class IV services - Orthodontia Dependents under age 19	Not Covered	Not Covered

Network access information: With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network: Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on non covered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

Blue Par Select℠ arrangement: Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit mibluedentist.com. **Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.**

Vision Coverage

Blue Vision benefits are provided by Vision Service Plan (VSP). To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**. At your appointment, tell them you have VSP. There's no ID card necessary. VSP will handle the rest—there are no claim forms to complete when you see a VSP doctor!

Benefit	VSP network doctor	Non-VSP provider
Eye exam	$10 copay	$10 copay applies to charge
Prescription Glasses (lenses and/or frames)	Combined $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Lenses and frames Standard lenses	$10 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
Standard frames	$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to both frames and lenses)	Reimbursement up to $70 less $10 copay (member responsible for any difference)
Contact Lenses Medically necessary	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
Elective contact lenses (instead of glasses)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$85 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)

Eye Exams, lenses and frames are covered once in every 12 consecutive months.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Life and AD&D Insurance

Basic Life and AD&D Insurance through UNUM

Life insurance provides financial protection for your family in the event of your death. Epitec, Inc. offers all employees life and accidental death and dismemberment insurance through Unum with an issue amount of $15,000. Epitec, Inc. covers the cost of this benefit.

Your benefit amount will reduce at age 65.

Voluntary Life and AD&D Insurance through UNUM

Increase Your Coverage. You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by UNUM. This coverage comes in the following increments:

Employee Voluntary Life

Benefit Amount: increments of $10,000
Guarantee Issue: $200,000
Maximum Benefit with UNUM: $200,000

Spousal Voluntary Life

Benefit Amount: increments of $5,000
Guarantee Issue: $30,000
Maximum Benefit with UNUM: $100,000
Spouse amount cannot exceed 50% of the employee's Supplemental Life benefit.

Dependent Child Voluntary Life

Benefit Amount: Increments of $1,000
Guarantee Issue: $10,000
Maximum Benefit with UNUM: $10,000

Benefit amounts will reduce at age 65.

Voluntary Life elections after the initial eligibility period, or above the guarantee issue amount (employee: $200,000; spouse: $30,000) will be subject to Evidence of Insurability (UNUM).

Spouse rates are based on Employee age.

Plan Cost: 100% Employee Paid

Portability and Conversion Privilege — Basic and Voluntary Life and AD&D

Portability

The basic and voluntary group life insurance plans are fully portable, which means employees may keep coverage for themselves, their spouse and their dependents at affordable group rates when they leave the Company, retire or reduce work hours. Portable coverages remain active as long as your premiums are paid timely. Coverages can be increased at any time, with evidence of insurability. You cannot be sick or injured when porting coverage.

Conversion

The basic and voluntary group life insurance plans are also fully convertible. This allows an employee to convert all or part of the employee life insurance coverage to an individual policy when insurance is terminated or reduced under certain circumstances. Evidence of insurability is not required, however application must be made to UNUM within 31 days of the qualifying event to be eligible for conversion.

Voluntary Short-Term Disability

To ensure your income will continue if you are unable to work due to a disability that extends for more than 14 consecutive days, Epitec, Inc. provides short-term disability (STD). Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Start After: 14 days
Benefit Amount: 60% of basic weekly earnings up to $1,150 / week
Benefit Duration: 24 weeks

Plan Cost: 100% Employee Paid

Voluntary Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you become disabled for an extended period of time. Epitec, Inc. offers Long-Term Disability to all employees. Eligibility for long-term benefits is generally defined as if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment and you are unable to earn more than 80% of your predisability earnings at your own occupation for any employer in your local economy.

Benefits Start After: 180 days
Benefit Amount: 60% of predisability monthly earnings
Maximum Benefit: $5,000 per month
Benefit Duration: The later of your SSNRA* or the Maximum Benefit Period.

**SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.*

Plan Cost: 100% Employee Paid

Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months (for Short-Term Disability) or 6 months (for Long-Term Disability) before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months (for Short-Term Disability) or 24 months (for Long-Term Disability) after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Employee Assistance Program

unum®

Help, when you need it most

With your Employee Assistance Program and Work/Life Balance services, confidential assistance is as close as your phone or computer.

Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems
- And more

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

Ask our Work/Life Specialists about:

- Child care
- Elder care
- Financial services, debt management, credit report issues
- Identity theft
- Legal questions**
- Even reducing your medical/dental bills!
- And more

Who is covered?

Unum's EAP services are available to all eligible partners and employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver™ — helps you save on medical bills

Help is easy to access:

Phone support: 1-800-854-1446

Online support: unum.com/lifebalance

In-person: You can get up to three visits, available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

Better benefits at work.™

unum.com

Not available in all states

* The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

**State mandated restrictions for legal services in WA apply.

Unum's Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

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Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

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

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

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

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

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

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

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

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

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

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

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

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

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

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

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

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

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

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

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of Federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in Epitec, Inc.-sponsored health and welfare benefit plan are reminded that Epitec, Inc.'s Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. 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 provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, Epitec, Inc. asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices continued...

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses/domestic partners or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be cancelled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

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, 2023. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Medicare Part-D Creditable Coverage Notice

Important Notice from Epitec About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the health plan 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. We have determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage [will or will not] be affected.

Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents [may or 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 health plan coverage 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 please contact the plan administrator indicated on the first page of this notice.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through your current health plan provided by the current insurer changes. You also may request a copy of this notice at any time.

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

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

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

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

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

Date: January 1, 2024
Name of Entity/Sender: Epitec, Inc
Contact--Position/Office: Human Resource Department
Address: 24800 Denso Drive, Suite 150
Phone Number: (248) 353.6800

Health Insurance Marketplace

The Patient Protection Affordability Care Act (“PPACA”) was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace (“Marketplace”), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company’s medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in the Company’s medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse’s medical plan, your parent’s medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 800-318-2596.

Your Human Resources Team: 1-248-864-7215 https://portal.epitec.com/