Louisiana CAT

SEPTEMBER 1, 2024 – AUGUST 31, 2025

EMPLOYEE BENEFIT GUIDE

Louisiana CAT | Louisiana CAT Rental Store | Resource Power Group RPG | Force Power Systems FPS | NAPA AUTO PARTS

	COMPANY PAYS	YOU PAY	COST SHARED	
Medefy	■			7-8
Medical Plan 1: Value-Based Payments			■	9-15
■ How the VBP Plan Works				10
■ HST Connect				11
Medical Plan 2: HDHP			■	16-19
■ Plan Provisions				17
■ Medical ID Cards				19
Health Savings Account (HSA)			■	20-22
Ochsner Digital Medicine – Diabetes Wellness Management	■			23
Accarent Health – Complex Care Provider	■			24
Medical: Plan Comparison				25
Employee Contributions			■	26
Preventive Care / Glossary				27-28
Prescription Drug Programs – ServeYou Rx, Rx Manage, ScriptCo			■	29-31
Tobacco Cessation				32
Employee Assistance Program	■			33
Voluntary Dental – Companion Life		■		34
Voluntary Vision - EyeMed		■		35
Basic Life, AD&D: Companion Life	■			36
STD and LTD: Companion Life			■	37-38
Voluntary Supplemental Benefits			■	39-40
Voluntary Life: Companion Life		■		41-42
Voluntary Worksite Coverages		■		43-51
QHDHP and HSA (FAQs)		■		52-61
Info to Know / Legislative Notices				62-66

CARRIER CONTACT INFORMATION

FUNCTION	CARRIER	PHONE	WEBSITE
Third Party Administrator (Medical)/ Precertification	United Medical Resources (UMR)	(800) 826-9781	www.umr.com
Value-Based Payments Patient Advocacy	Healthscope Benefits	(888) 713-8808	www.healthscopebenefits.com
Employee Assistance Program	Interface EAP	(800) 324-4327	www.4eap.com
Telemedicine	Medefy / MediOrbis	Connect through the Medefy mobile app or call (866) 633-4672	https://mediorbis.com
Digital Medicine	Ochsner	(866) 273-0548	Connectedhealth.ochsner.org
Complex Care Provider	Accarent	(866) 771-0697	Accarenthealth.com
Retail/Mail-Order Prescriptions	ServeYouRx	(800) 759-3203	serve-you-rx.com/members/
$0 Copay Mail-Order Rx	GlobalRx Manage	(800) 883-8841	https//my.globalrxmanage.com/customers/louisiana-machinery-company/sign-up
Maintenance Generic Drugs	ScriptCo	(888) 201-0334	www.scriptco.com
HSA	UMB	(866) 520-4472	www.hsa.umb.com
Voluntary Dental	Companion Life Dental	(877) 676-5789	https://companionlife.go2dental.com/member/dental_search/proxinp.cgi
Voluntary Vision	EyeMed	(800) 638-3120	eyemed.com
Basic Life/AD&D, Voluntary Life, Short Term Disability, Long Term Disability	Companion Life	(877) 676-5789	MyOnlineBenefit.com
Legal Assistance	MetLaw	(800) 438-6388	Info.legalplans.com
Identity Theft Protection	Aura Identity Guard	(855) 443-7748	www.identityguard.com
Voluntary Critical Illness, Hospital Indemnity, Accident, Cancer	APL	800-256-8606	https://www.ampublic.com/
Voluntary Universal Life	Transamerica	(800) 797-2643	www.transamerica.com

WHAT YOU NEED TO KNOW ABOUT OPEN ENROLLMENT

TAX TREATMENT OF EMPLOYEE BENEFIT CONTRIBUTIONS

Some of your benefits are deducted from your pay on a pre-tax basis. This means you make your contributions before you pay federal or state taxes, as well as Social Security taxes. Lower taxes mean you keep more of what you earn.

Benefits deducted before taxes:

- Medical
- Voluntary Dental
- Voluntary Vision
- Health Savings Account (HSA)
- Voluntary 24-Hour Accident
- Voluntary Critical Illness
- Voluntary Cancer
- Voluntary Hospital Indemnity

Benefits deducted after taxes:

- Short Term Disability
- Long Term Disability
- Voluntary Life
- Voluntary Universal Life
- Identity Theft Protection

SEPTEMBER 1, 2024 – CHANGES/ADDITIONS

- **Voluntary Term Life**- we are offering a new voluntary term life insurance product through APL with Guarantee Issue Amounts of up to $150,000 for employees, $100,000 for your spouse, and $50,000 for your children.

SEPTEMBER 1, 2024 – WHAT IS NOT CHANGING

- The HSA eligible embedded medical plan will remain with UMR
- We will continue to offer the Value-Based Payments Medical Plan.
- Companion Life will continue to offer Dental, Basic Life Insurance, Vol Life, STD and LTD
- APL will once again be offering Hospital Indemnity, Accident, Critical Illness and Cancer plans.
- The Voluntary Universal Life with continue to be offered through Transamerica.

BENEFIT BASICS

TYPES OF BENEFITS ENROLLMENT

Your benefits are in effect for one full Plan Year—September 1, 2024 through August 31, 2025. During this time, you **cannot** make changes to your benefit elections without a qualified status change (refer to the next page for details).

Please Note: ***Even if you do have a qualified status change during the year, you are never permitted to switch medical plan elections, (i.e. from VBP to HDHP or vice versa).***

There are three types of benefit enrollment:

- **Open Enrollment:** Occurs once a year and is your opportunity to change your benefit elections or add/change dependents. Coverage begins on September 1, 2024.
- **New Hire/Newly Eligible Enrollment:** For new employees, coverage begins on the 1st of the month coinciding with or following 30 days of hire. You have 30 days from your date of hire to elect your benefits. Coverage is effective retroactive to your eligibility date.
- **Qualified Status Change:** Other than during Open Enrollment or when you are newly hired (or newly benefits-eligible), you can only make changes to your benefits elections if you experience a qualified status change, as mandated by the IRS. Coverage begins on the date of the event. For example, newborn/ adoption coverage begins on the date of your child's birth/adoption. *Refer to the right for details.*

ELIGIBILITY

If you are employed with LA Machinery and are over the age of 18, you are eligible for company benefits if you are a regular full-time employee working at least 30 hours/week.

Termination: Coverage terminates the ***last day of the month*** in which the termination date occurs for Medical, Dental, and Vision, Basic Life, Voluntary Life, and Voluntary Worksite products. STD and LTD terminate the **date of termination**.

REMINDERS

Please refer to the Eligibility and Enrollment Section at the end of this Benefit Guide

- Current contributions **WILL NOT** roll over. You MUST speak with an enroller **to enroll or waive your coverage** otherwise all coverages will terminate;
- Only employees electing the EHSA Option are permitted to have a HSA;
- Any covered non-essential health benefit drugs (non-EHB) will not count towards your OOP.
- For Voluntary Life you may elect an additional $10,000 of coverage for yourself, and $5,000 for your spouse, up to the Guarantee Issue Amount during Open Enrollment, without completing Evidence of Insurability. The actively-at-work provision will apply.
- For Voluntary Life/AD&D: Your employee election includes AD&D, however, spouses and children are not eligible for AD&D;
- Since Louisiana Machinery offers affordable coverage as defined under the Affordable Care Act, you are not eligible for any subsidies should you wish to purchase coverage in the Health Insurance Marketplace.

BENEFIT BASICS

ENROLLING YOUR DEPENDENTS

You may enroll your:

Spouse to whom you are legally married ***ONLY IF*** he/she does not have access to his/ her employer-sponsored coverage (medical only);

Natural, step or legally adopted child(ren) up to the age of 26*, who:

- Do not need to be full-time students or an eligible dependent on your tax return;
- Are not required to live with you;
- May be married or unmarried

Disabled child(ren) age 26 or older, who are mentally impaired, physically handicapped or totally disabled. You must periodically provide medical documentation of such disability.

**Coverage terminates the last day of the month in which your child(ren) turns 26 years old.*

Please Note: The spouse and/or child(ren) of your dependent child(ren) are not eligible for coverage.

QUALIFIED STATUS CHANGE

Based on IRS rules, you can only change certain benefits during the Plan Year with a qualified status change that is consistent with your plan change. *For example, you can add your spouse to your plan when you get married.*

If you experience a qualified status change, you may:

- ✓ Enroll for coverage (if you previously waived coverage);
- ✓ Add newly eligible dependents;
- ✓ Remove dependents who are no longer eligible; or
- ✓ Change your coverage level (for example, change "Employee Only" coverage to "Employee + Spouse")

Qualified Status Changes Include:

- ♦ Work schedule change (for example, from full- time to part-time or vice versa);
- ♦ Birth, adoption, placement for adoption or
- ♦ death;
- ♦ Marriage or divorce;
- ♦ Change in employment status for you or your spouse;
- ♦ Change in dependents eligibility (for example, your child reaches age 26 or your spouse becomes eligible for Medicare or Medicaid); or
- ♦ Gain or loss of eligible dependents through custody, court order or guardianship.
- ♦ Qualified Status Changes may be made by advising Human Resources of the event and providing any necessary documentation **within 31 days of the event.**

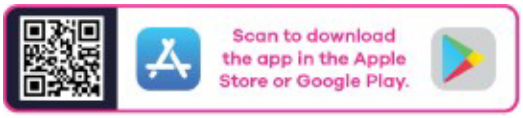
If you do not notify Human Resources within 31 days of a qualifying event, you must wait until the next Open Enrollment period to add, drop, or change coverage.

MEDEFY: YOUR BENEFITS AND TELEMEDICINE

Louisiana Machinery will continue to use Medefy to help you navigate your employee healthcare benefits and save money in the process. The Medefy app will help you find the best cost provider for the services that you need with around-the-clock access to Care Guides and availability to view your deductible/Out-of-Pocket accumulators.

Your Benefits	Direct access to all of your digital insurance cards, benefit summaries, Employee Benefit Guide, direct contact with all carriers, provider search tools, compare prescription drug costs, estimate procedure costs, and chat with a Care Guide.
Telemedicine	Connect to an on-call physician from our global provider network for time- sensitive medical needs. MediOrbis On-Demand Urgent Care connects top-tier physicians and patients within 10-minutes or less on average. With MediOrbis, patients can leverage 'new telemedicine' to access the care they need anytime, anywhere.

medefy MediOrbis



FACT: 70% of doctor's visits are for informational purposes only, or are for matters that could easily be handled over the phone or via video.
FACT: 66% of all emergency room visits are for non-emergencies.
FACT: 36 million Americans have been treated through telemedicine tele-consultations.

SCENARIO: *Jane Doe wakes up in the middle of the nightto find that her young daughter has a fever. Jane is concerned and wants to consult with a physician.*

Her options?

Visit Urgent Care or Emergency Room – Both Urgent Care (if she can find one open late) and the ER will be expensive options since any costs incurred will go towards the deductible first. If the deductible has already been met, she will still need to pay her portion (coinsurance) of the costs.
Wait until morning and schedule a doctor's appointment – Even if she feels the matter can wait the several days that it will take her to get an appointment with her physician, she will still need to meet her deductible and pay her coinsurance portion before the visit will be covered.

Use MediOrbis through the Medefy app or call (866) 633-4672 – Jane can consult a qualified physician, receive a diagnosis, and even have a prescription instantly dispatched to the nearest pharmacy...all without leaving her home or paying any additional costs.

Your Benefits at Your Fingertips - Download the app for free!

medefy

Welcome to Medefy

In-the-Moment Healthcare Guidance to Save You Time & Money

Download the App to Get Help in Less Than 60 Seconds.

Benefits Simplified.

Experience the difference — download the Medefy app and our Care Guides are available 24/7 to help you save time and money on your healthcare. From MRIs to CT scans, surgeries, and much more — Medefy provides the in-the-moment guidance when you need it most.

Concierge Service At Your Fingertips.

- Schedule appointments with low-cost, high-quality, and in-network providers.
- Get answers to benefits, claims, and bill questions from live, benefits experts.
- Access digital insurance cards, incentives, and much more.

Provided by

Louisiana CAT

Scan Below or Search 'Medefy' in the App Store to Get Started.

Google play | Download on the App Store

PLAN OPTION 1:

VALUE- BASED PAYMENTS (VBP)

ADMINISTERED BY

HEALTHSCOPE BENEFITS

How The Value-Based Payments (VBP) Plan Works

Louisiana Machinery has joined with HealthScope Benefits (HSB) to bring you a Value-Based Payment plan.

Value-Based Payments works just like a Classic PPO plan in some regards; members will still only be responsible for copays at primary care physician and specialist offices ($25), but Value-Based Payments does not have a traditional network of facilities like a Classic PPO. Value-Based Payments is open access, and you may choose any hospital to receive care, but your costs will be lower if you follow HealthScope Benefits' recommendations. Before you receive treatment at a hospital, please use the HST Connect mobile app or call HealthScope's Patient Advocacy Center (PAC) to verify that the facility has contracted prices for its services. HealthScope must first verify that the facility you plan to receive treatment is charging a reasonable price above Medicare referenced price. If you do not verify your facility with HealthScope, you may be subject to prices over 500% of Medicare price, depending on the facility.

Since Louisiana Machinery's Plan is self-insured, any claim incurred on covered participants is technically paid by Louisiana Machinery, it benefits both Louisiana Machinery and the employees to be educated in how VBP works.
This, in turn, will better control claim costs so that Louisiana Machinery can continue to sustain a comprehensive and competitive healthcare plan for employees.

Contact PAC via:

Phone: (888) 837-2237

Fax: (949) 891-0420

Email: pac@hstechnology.com

Monday - Friday 7:00AM-5:00PM PST

HSTConnect (mobile app)

How is the price determined?

Value-Based Payments' pricing methodology uses Medicare plus a percentage and cost information to determine a fair and reasonable price for your medical services.

Not all facilities charge the same amount for their services. It is imperative that employees contact HealthScope in order to verify that their facility is charging a reasonable price for services.

HST Connect

Access to quality, cost-effective healthcare is now in the palm of your hand.

Mobile app features:

- Find hospitals and other healthcare services, either In-Network or with high acceptance rates
- Compare quality ratings and pricing for specific procedures
- View deductibles, copays and other plan information
- Direct dial healthcare providers and get driving directions
- Prescription pricing estimates
- Look up information about procedures
- Communicate and receive notifications from HST's Patient Advocacy Center and submit balance bills directly through the app
- Access to HST's Provider Acceptance Rates help minimize the risk of balance billing.

Scan here to download, or find it in the App Store for **iOS** or **Android**

HST
A MULTIPLAN COMPANY

HealthScope Benefits

HealthScope Benefits, a UMR affiliate, educates and negotiates with health care providers before your procedure is performed. This is paramount in eliminating the potential for a balance bill. However, if a provider does bill you, HealthScope will work on your behalf to get the bill resolved. By choosing wisely, you can keep your costs as low as possible.

HealthScope Services Include:

- Patient Support
- Pre-Service Negotiations
- Scheduling of Services
- Manage Certifications & Referrals
- Confirmation of Pricing
- Assistance with Balance Billing

Have Billing Issues? As with any plan, you may occasionally receive a hospital bill above and beyond what was agreed on your statement (this is known as "balance billing"). If a balance bill occurs, **DO NOT PAY IT**. Contact HealthScope immediately and a patient advocate will work directly with the hospital on your behalf. **Call HealthScope toll free at (888) 713-8808**

By Louisiana Machinery participating in Value-Based Payments (VBP) for hospital or facility charges, it allows you to have a transparent method of determining how much you will pay for hospital/facility services. It works by reimbursing hospitals based on a reference price: Medicare plus a percentage.

***Value-based payments provides open access to facilities with no network restrictions*.**

Louisiana Machinery's Health Plan continues to cover eligible charges related to inpatient/outpatient hospital, ambulatory/surgical facilities, emergency room, skilled nursing, home health care, physician visits, X-ray/ Laboratory facilities and prescription drug charges.

Situations may occur when the Plan will recommend alternate facilities……this sometimes happens if the hospital and the plan cannot agree on a price. When possible, you should choose one of the recommended facilities since your costs will be lower.

Example: *You need an elective procedure performed in the hospital. Medicare would pay $10,000 for that particular procedure (and the hospital accepts the Medicare allowable charge). However, the hospital/ facility will charge you a mark-up price of $50,000, or 500% of the Medicare allowable charge. Using the Medicare guide as a reference, our Plan may offer to pay $15,000 or 150% of Medicare, thus reducing the price of the procedure significantly (and lowering your costs accordingly).*

FAQ: VBP Frequently Asked Questions

What is Value-Based Payments (VBP)?

Value-Based Payments is a transparent way to determine how hospitals will be paid for medical services. It works by reimbursing hospitals based on a reference price: Medicare (plus a percent). Because it is fully transparent and based on cost, the result is a price that is fair to both you and the provider. VBP provides open access to facilities with no network restrictions.

Does VBP apply to all procedures?

VBP only applies to procedures rendered at hospitals, surgery centers, outpatient facilities and dialysis centers. Physicians and other non-hospital providers are covered under your (PPO) network.

Will my provider accept VBP?

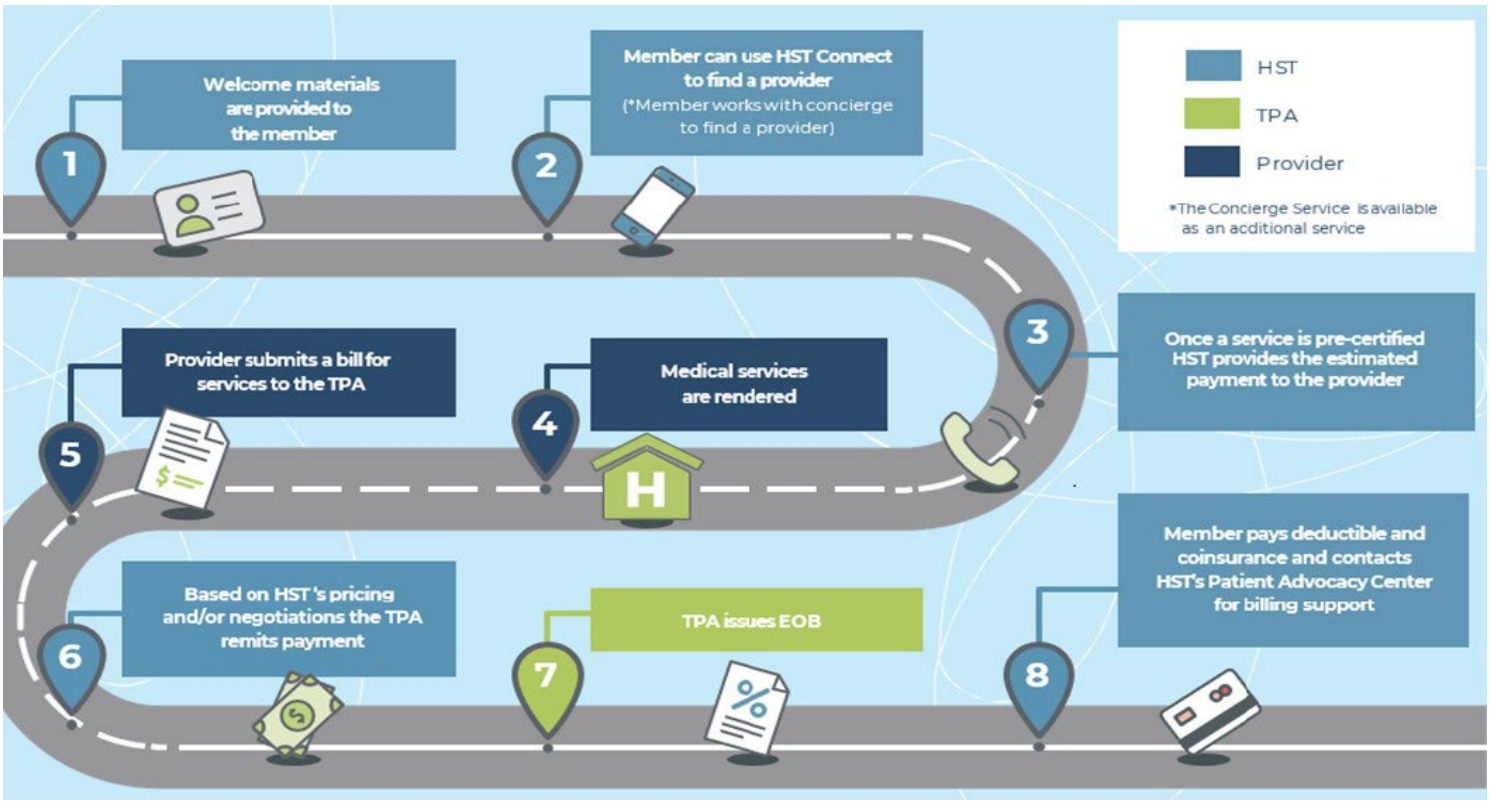
Providers are required to adhere to your benefit plan. If a hospital has questions, they will confirm your coverage by calling the telephone number on your identification card.

How does it work with my doctors?

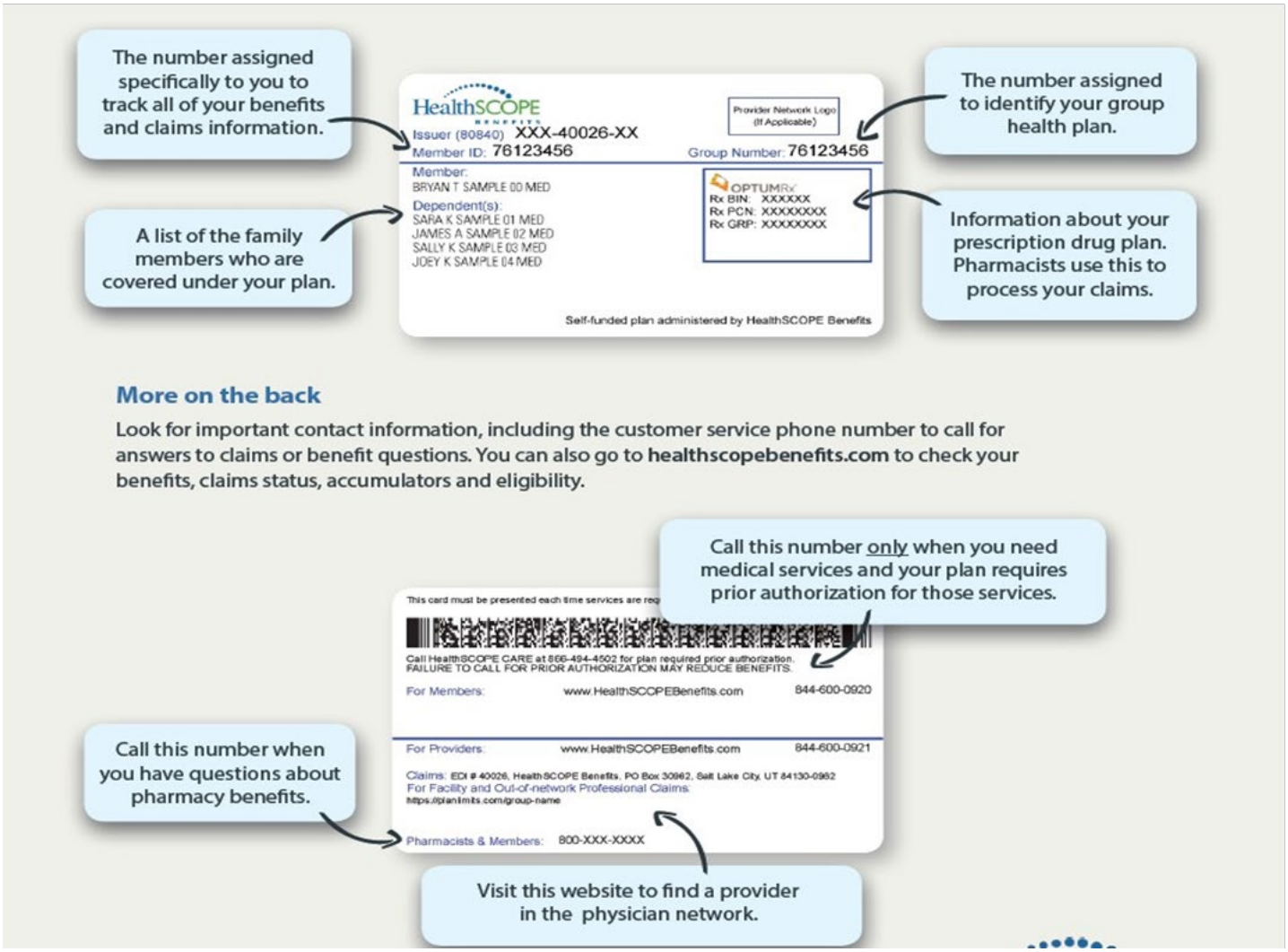
VBP only affects care at hospitals. Physicians, specialists, and other non-hospital providers are covered under your PPO network and are unchanged. Your PPO plan gives you access to a wide network of physicians, and you will pay the lowest rates when you use In-Network physicians. You are covered when you go Out-of-Network, although your costs may be higher.

How do I know how much I will be charged for my procedure?

By utilizing HSTConnect (our mobile app) you can view your estimated costs up front. As usual, you will be responsible for your copay, deductible, and coinsurance up to the annual out-of-pocket maximum.



HEALTHSCOPE MEDICAL: ID CARD



What is Double Insurance?

Double insurance is when you have two different health insurance plans. This may happen if you have coverage through your job and your spouse's plan. The benefit of double insurance is that you have two health plans that can help pay for care. The downside is that you have to pay two premiums, two deductibles, and deal with the potential confusion that comes with having two health plans.

When you have a primary and secondary health plan, the insurers use a framework to work together, so both health plans pay their fair share. Coordination of Benefits (COB) decides which plan pays first (primary plan) and which pays second (secondary plan.)

Here's how COB works when there is a health insurance claim:

1. It first goes to the primary plan. Insurer pays what it owes.
2. If there's money still left on the bill, it then goes to the secondary insurer.
3. After that, if there's still money left on the bill, the member gets a bill for the remaining balance.

What is Balance Billing?

"Balance bills" primarily occur in two circumstances: 1) when an enrollee receives emergency care either at an Out-of- Network facility or from an Out-of-Network provider, or 2) when an enrollee receives elective non-emergency care at an In-Network facility but is inadvertently treated by an Out-of-Network provider. Since the insurer does not have a contract with the Out-of-Network facility or provider, it may decide not to pay the entirety of the bill.

In that case, the Out-of-Network facility or provider may then bill the enrollee for the balance of the bill. Recent legislation has addressed balance billing at the Federal level and 32 states have enacted laws to protect enrollees from balance billing at the state- level.

Starting in 2022, when the law goes into effect, consumers won't get balance bills when they seek emergency care, when they are transported by an air ambulance, or when they receive non-emergency care at an In- Network hospital but are unknowingly treated by an Out-of-Network physician or laboratory. Payments will now be negotiated by providers and health plans. Insurers and providers have 30 days to try to negotiate payment of Out-of-Network bills. If that fails, the claims would go through an independent dispute resolution process with an arbitrator, who would have the final say.

Value Based Payments and Balance Billing

I have paid my required copay, deductible, or out-of-pocket maximum reflected on my EOB; however, I have still received a bill from the provider of service.

This is referred to as balance billing. Balance billing is when a health care provider accepts the allowed amount from an insurance plan, and then bills the patient for the difference between the charge and the allowed amount. HealthScope Benefits has you covered in case you receive a balance bill.

What should I do if I receive a balance bill from a provider of care?

If you receive a balance bill, simply contact a HealthScope Benefits Customer Care representative at the number on your ID card. You can follow the phone prompts to be connected to the appropriate team to handle your balance billing situations. Customer Care will need a copy of the balance bill so have your statement ready.

It is important to contact HealthScope Benefits as soon as you get your first balance bill. If a provider bills you for an amount above the patient responsibility identified on your Explanation of Benefits (EOB), **don't pay the bill**!

Contact HealthScope's Patient Advocacy Center (PAC) and an Advocate will take over your case and deal directly with the hospital on your behalf. The provider may be directed to provider portal for virtual negotiation. If necessary, they will send you an authorization form which allows HealthScope to engage with the provider.

PLAN OPTION 2:

EMBEDDED HIGH DEDUCTIBLE HEALTH PLAN with HSA (EHDHP)

ADMINISTERED BY UMR

EHDHP (PLAN OPTION 2)

LA Machinery is pleased to continue to offer an HSA qualified, Embedded HDHP (EHDHP) administered by UMR that meet the health care needs of you and your covered dependents.

- ✓ Comprehensive medical and prescription drug coverage
- ✓ A combined medical/pharmacy Out-of-Pocket maximum that limits your financial exposure
- ✓ The "Plan Year Maximum" listed on page 22 are the total for In-Network and Out-of- Network expenses. ***For example***, if a maximum of 30 visits is listed twice under a service, the Plan Year maximum is 30 visits total, which may be split between In-Network and Out- of-Network providers
- ✓ Emergency Room charges covered at In-Network level for emergency purposes only
- ✓ All Out-of-Network charges subject to Reasonable & Customary
- ✓ Has a higher deductible and Out-of-Pocket maximum than the VBP Option
- ✓ For non-preventive services and prescriptions, you must first satisfy your deductible before the plan pays its share of covered expenses
- ✓ Comes paired with a Health Savings Account (HSA), to which you can contribute to pre-tax, and that Louisiana Machinery also contributes.

MEDICAL: UMR SUMMARY OF BENEFITS

Plan Provisions	
Deductibles, Out-of-Pocket Maximums, and Annual Limits are on a **Plan Year basis, (i.e. September 1 through August 31)**. NOT Calendar Year In-Network, Out-of-Network Deductibles, and Out-of-Pocket Maximums are separate and **do not** cross apply.	
Network	United Healthcare (UHC) Choice Plus
Pharmacy Benefit Manager	ServeYou Rx, RxManage and ScriptCo for all medical options
Embedded HDHP Deductible	**EHDHP** – The embedded family deductible. The 1st $4,000 in eligible claims made by one member will be applied to the $8,000 family deductible. The 2nd $4,000 can be satisfied by the other covered individuals in any combination. The individual total deductible is $4,000.
• Pre-existing condition limitations not applicable • Dependent children covered to age 26, regardless of full-time student/marital status or access to other group coverage.	
• Emergency Room charges covered at In-Network level for emergency purposes. Out-of-Network charges subject to a percentage of Medicare Allowable.	
• PPACA Preventive care services covered in full (In-Network only)	

TIPS TO SAVE ON YOUR MEDICAL

Go Generic: Generic drugs are the same as other medications, just without the brand name. The biggest difference is the price. Generics usually cost you 30% to 70% less than brand names.

Review your Explanation of Benefits (EOB) to make sure you are properly billed. Contact your doctor or other care provider if you suspect an incorrect charge.
If you are enrolled in the HDHP option, when you visit the doctor do not pay the full cost up front, since covered charges have not yet been filed for a network discount. Tell the doctor you will pay 20% of your bill up front, and that you will pay the remaining balance once you receive your EOB.

Remember to bring the following to your first appointment with a new doctor:

Medical Records & Insurance Card

Medications

Special Needs

When visiting a hospital, always ask for an itemized hospital bill for each item of care. If you see a line item for "medical facility fee," put in writing that you will not pay this fee. Under the Affordable Care Act, Section 2718(e), hospitals are required to disclose the medical facility fee price tag before the time of service. In addition, any hospital that charges a medical facility fee is in violation of the False Claims Act. Paying close attention to your itemized bill can save you money in the medical fees. For example, a follow up doctor visit is often paid at $80, and a medical facility fee is often $150, resulting in a total amount of $230.

HOW TO CONFIRM A PROVIDER IS IN UNITEDHEALTHCARE'S CHOICE PLUS PPO NETWORK:

1. Go to www.UMR.com.
2. Click "Find a Provider"
3. Click on "Medical"
4. Scroll down to "U" and click on"United Healthcare Choice Plus"
5. You will be redirected to show the results

This will lead you to the UnitedHealthcare Web site, where you can choose to search by physician, hospital, or other facilities. Or you can call UMR customer service at (800) 826-9781.

PLEASE CONTACT UMR WITH ANY ELIGIBILITY OR BENEFITS QUESTIONS

UMR MEDICAL: ID CARD

UMR EHDHP: If you are not making any changes to your medical plan this Open Enrollment, you will NOT be receiving new medical ID cards for the 2023-2024 Plan Year. If you are a new employee or have chosen to make changes to your medical coverage and have not yet received your ID card for the EHDHP options by September 1, 2023, please provide the following information to your doctor or pharmacy:

MEDICAL CLAIMS
Claim Filing Address: UMR
PO Box 30541
Salt Lake City, UT 84130-0541
EDI Payor # 39026
Group Plan Number: 76413049
Medical Customer Service: (800) 826-9781
UMR Medical Provider Line: (877) 233-1800

ServeYou Rx Pharmacy Claims
Rx Group #: 7603 or 7604
RxBin#: 610548
RxPCN#: SERVU
Rx ID#: Contact ServeYouRx at (800) 759-3203

If your pharmacist has questions or concerns they may contact ServeYouRx at the Pharmacy Helpdesk line (800) 759-3203.

HEALTH SAVINGS ACCOUNT (HSA) - UMB BANK

When you enroll in Louisiana Machinery's High Deductible Health Plan, you have the option to open a Health Savings Account (HSA). HSA funds can be used to pay for eligible medical, dental and vision expenses for you and your eligible dependents, including deductibles, coinsurance, prescriptions, acupuncture and more, tax-free, now and in the future. Family members do not need to be covered under your plan in order to use the HSA funds.

HOW IT WORKS

With the HSA, you are in charge. You decide:

- How much you'll contribute;
- When to pay for eligible expenses with HSA funds directly (*you can also reimburse yourself from the account*);
- How and if you want to invest your HSA funds (*a balance of at least $2,000 is required to invest*); and
- Whether to save HSA funds for future expenses or retirement.

The HSA offers significant tax savings: Contributions are exempt from federal income tax (state tax treatment varies), payments/ withdrawals for eligible expenses are tax-free and earned interest is not taxed. Your HSA funds be- long to you even if you change jobs or retire and unused funds roll over from year to year.

IRS REGULATIONS

- Must be enrolled in an IRS-qualified High Deductible Health Plan
- You cannot be covered by any other medical plan, entitled to Medicare benefits or be eligible to be claimed as a dependent on another person's tax return
- See **Publication 502** at www.IRS.gov for eligible expenses
- For proof of expense eligibility, save receipts

CONTRIBUTIONS

To contribute to your HSA, you can:

- Elect an annual contribution that will be divided into equal amounts and withdrawn, before taxes, from your paycheck all year; and/or
- Make a deposit of your own using post-tax funds at any time during the year (and claim a tax credit)

You are not required to contribute to your HSA.

ANNUAL IRS CONTRIBUTION LIMITS

The IRS limits the total amount that can be contributed to your HSA from all sources.

For 2024, IRS contribution limits are:

- *Employee Only Coverage: $4,150*
- *Family coverage levels: $8,300*
- Age 55+ catch up contributions are $1,000

For 2025, IRS contribution limits are:

- *Employee Only Coverage: $4,300*
- *Family Coverage: $8,550*
- Age 55+ catch up contributions are $1,000

If you are enrolled in the EHDHP Option 2, Louisiana Machinery will match dollar for dollar up to $62.50 per month into your HSA account

NOTE: HSA Contribution Limits are Calendar Year, NOT Plan Year (IRS Guidelines).

If you are "enrolled" in Medicare, you are able to enroll in the EHDHP, however, you are NOT eligible to contribute to the HSA.

HSA Beneficiaries

QUESTION: Do I need to designate a beneficiary for my HSA account?

ANSWER: You are **not required** to name a beneficiary; however, you should name a beneficiary for your HSA, just as you would for your company retirement plan. After your death, any funds remaining in your HSA are payable to the beneficiary you named on the account. If one is not designated it will be transferred to the spouse. For someone other than a spouse, the tax benefits of account ownership do not transfer.

Naming Your Spouse
If you name a spouse as your HSA beneficiary, at your death the HSA will become your spouse's own HSA. They can maintain the HSA in their own name and can continue to access the funds. Distributions for qualified medical expenses will be income tax free. The spouse does not need to have HSA-eligible health insurance to continue to hold the HSA. However, if they do and they are eligible, they may make contributions to the HSA.

Naming Your Children
You may also name children or other non-spouses a beneficiary. However, the account value of the HSA account becomes taxable to the non-spouse beneficiary in the year of the account holder's death. That means the entire account will be taxable in one year.

The amount taxable to the beneficiary is reduced by any qualified medical expenses for the deceased HSA owner that are paid by the beneficiary within one year after the date of death.

Naming Your Estate
It is also possible to name an estate as an HSA beneficiary. There is a special rule that applies if the beneficiary of an HSA is the estate. If the estate is the beneficiary, then the total distribution is included on the deceased HSA owner's final tax return.

HEALTH SAVINGS ACCOUNT (HSA) – UMB BANK

		Employee				
		No Coverage	**Self-Only Non-HDHP**	**Self-Only HDHP**	**Family Non-HDHP**	**Family HDHP**
Spouse	**No Coverage**	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to $4,150, but spouse 2 is not eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to $8,300, but spouse 2 is not eligible to contribute to an HSA unless he/she is covered under spouse 1's HDHP. In this case the maximum combined contribution of $8,300 must be divided between them based on agreement.
	Self-Only Non-HDHP	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to $4,150, but spouse 2 is not eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to $8,300, but spouse 2 is not eligible to contribute to an HSA.
	Self-Only HDHP	Spouse 2 is eligible and may contribute up to $4,150 but spouse 1 is not eligible to contribute to an HSA.	Spouse 2 is eligible and may contribute up to $4,150, but spouse 1 is not eligible to contribute to an HSA.	Both people are eligible to have their own HSA and the maximum that can be contributed to each HSA is $4,150.	Neither is eligible to contribute unless spouse 2 is not covered under spouse 1's non-HDHP plan. In that case spouse 2 may contribute up to $4,150 to an HSA.	Both people are eligible and treated as if they have family coverage. Their maximum combined contribution of $8,300 must be divided between them based on agreement.
	Family Non-HDHP	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Neither is eligible to contribute unless spouse 1 is not covered under spouse 2's non-HDHP plan. In that case spouse 1 may contribute up to $4,150 to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is only eligible to contribute up to $8,300 if he/she is not covered under spouse 2's non-HDHP plan. Spouse 2 is not eligible to contribute to an HSA.
	Family HDHP	Spouse 2 is eligible and may contribute up to $8,300, but spouse 1 is not eligible to contribute to an HSA unless he/she is covered under spouse 2's HDHP. In this case the maximum combined contribution of $8,300 must be divided between them based on agreement.	Spouse 2 is eligible and may contribute up to $8,300, but spouse 1 is not eligible to contribute to an HSA.	Both people are eligible and treated as if they have family coverage. The maximum combined contribution of $8,300 must be divided between them based on agreement.	Spouse 2 is only eligible to contribute up to $8,300 if he/she is not covered under spouse 1's non-HDHP plan. Spouse 1 is not eligible to contribute to an HSA.	Both people are eligible and treated as if they have family coverage. The maximum combined contribution of $8,300 must be divided between them based on agreement.

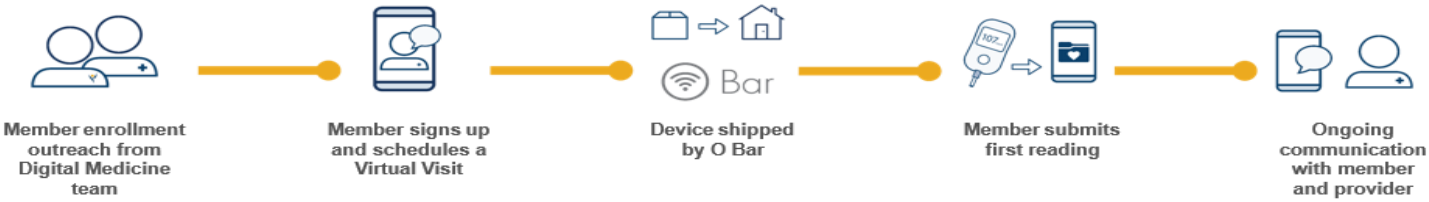
Ochsner digital medicine

What if you could get the one-on-one, personalized care you need to manage your high blood pressure or Type 2 diabetes without having to make multiple trips to the doctor? Today, thanks to your specialized care team and easy-to-use Bluetooth technology, it's possible!

Ochsner Digital Medicine helps patients manage their chronic conditions from home while staying connected to a dedicated care team. Using advanced analytics, our care team is able to create a personalized plan for you. Our convenient programs are designed to help you take control of your health. Whatever your goals, we'll help you reach them – one small, manageable step at a time.

Member Enrollment Is Seamless

Dedicated **Digital Medicine** support is available to guide members through the process step-by-step.



Enroll today.
Visit **ochsner.org/join-LouisianaCat** or call Digital Medicine Concierge Kayla at **888-675-0045.**

NO COST TO YOU!

Benefits of Ochsner Digital Medicine

- Know you're on a medication you'll actually want to take because it makes YOU feel better.
- Receive personalized care using your smartphone from a team that specializes in high blood pressure and Type 2 diabetes.
- Learn how to adopt healthier habits that fit your busy lifestyle.

How do I sign up?

Visit **ochsner.org/join-LouisianaCat** or call Digital Medicine Concierge Kayla at **888-675-0045.**

How do the programs work?

- Take readings from home with a digital blood pressure cuff or glucometer that connects to your smartphone.
- Get treatment from a licensed clinician who monitors your readings and adjusts medications as needed.
- Create healthy habits with advice and support from your health coach.

What does the program cost?

The high blood pressure and Type 2 diabetes programs are covered by the Louisiana Cat insurance at **no cost to you.**

Who is eligible to participate?

- Your company's health plan members age 18+ with a smartphone (Android or iOS).
- Existing diagnosis of high blood pressure and/or Type 2 diabetes.[1]

Accarent HEALTH

Healthcare Centers of Excellence Program Summary

QUALITY HEALTHCARE

You and your dependents now have access to Accarent's Centers of Excellence network of highly-rated medical providers specializing in complex care.

MEDICAL CASE MANAGEMENT

Accarent will support your care journey with concierge services and nurse case management when navigating a difficult diagnosis or medical procedure.

Cancer Diagnosis Confirmation and Recommended Treatment Plan:

The Cancer Diagnosis Confirmation and Recommended Treatment Plan program is designed to confirm a cancer diagnosis and provide a recommended treatment plan for adult and pediatric patients with a preliminary cancer diagnosis. The patient collaborates with a multi-disciplinary team to address their unique oncologic needs and provide a custom treatment plan to take home to their local oncologist or remain with Accarent's center of excellence for treatment.

Organ and Bone Marrow Transplant Management

Accarent's certified nurse case managers and concierges make up the Accarent Care Team–which has over 20 years of experience in assisting transplant patients in navigating a complex process. To help the patient during this difficult time in their life, Accarent's Nurse Case Managers answer any questions, coordinate care with providers, facilitate medical records transfer, and assist with lodging and transportation.

LOUISIANA CAT MEMBER BENEFITS

- PEDIATRIC & ADULT SPECIALIZED CARE
- NO OUT-OF-POCKET COST
- NURSE CASE MANAGEMENT
- TRAVEL AND LODGING ASSISTANCE AVAILABLE

CONTACT ACCARENT FOR ASSISTANCE

casemanagement@accarenthealth.com

www.accarenthealth.com

1-866-771-0697

MEDICAL: Plan Comparison

	VBP Option 1 (Healthscope)	EHDHP OPTION 2 (UMR)	
Plan Provision	**Value-Based Payments (VBP)**	**In-Network**	**Out-of-Network**
Lifetime/ Plan Year Max **Unlimited -** *Includes Prescription Drugs, Mental & Nervous/ Substance Abuse benefits*			
Individual Deductible (Plan Year) *In-Network and Out-of-Network deductibles are separate and DO NOT cross apply*	$1,250	$4,000	$6,000
Family Deductible (Plan Year) *In-Network and Out-of-Network deductibles are separate and DO NOT cross apply*	$2,500	$8,000	$12,000
Individual Out-of-Pocket Maximum (Plan Year)	$6,000, *Including Deductible and coinsurance*	$4,000, *Including Deductible and coinsurance*	$10,000, *Including Deductible and coinsurance*
Family Out-of-Pocket Maximum (Plan Year)	$12,000, *Including Deductible and coinsurance*	$8,000, *Including Deductible and coinsurance*	$20,000, *Including Deductible and coinsurance*
Coinsurance	80%	100%	80%
Primary Care Physician & Specialist Visit	100% after $25 copay	100% after Deductible	80% after Deductible
Other Practitioner Office Visit	100% after $25 copay	100% after Deductible	80% after Deductible
Inpatient Hospital	80% after Deductible	100% after Deductible	80% after Deductible
Hospital Emergency Room	$100 copay	100% after Deductible	
Prescription Drugs:			
Tier 1	$10 copay	100% after Deductible	80% after Deductible
Tier 2	$30 copay	100% after Deductible	80% after Deductible
Tier 3	$50 copay	100% after Deductible	80% after Deductible
Mail Order	3x copayment amount	100% after Deductible	80% after Deductible

MEDICAL: EMPLOYEE CONTRIBUTIONS

Contributions are tiered by Tobacco / Non-Tobacco, and you are required to complete the Tobacco questions when enrolling in medicalcoverage.

FULL-TIME EMPLOYEES NON-TOBACCO
Monthly/ Bi-Weekly Medical Contributions - PRE-TAX

Coverage Level	VALUE-BASED PAYMENTS	EHDHP OPTION Embedded HDHP
Employee Only	$25.00 / $12.50	$27.00 / $13.50
Employee + Spouse	$175.00 / $87.50	$207.00 / $103.50
Employee + Child(ren)	$150.00 / $75.00	$196.00 / $98.00
Employee + Family	$300.00 / $150.00	$360.00 / $180.00

REMEMBER: Your Medical, Dental, and Vision contributions are deducted from your paycheck on a **pre-tax** basis, which means that your taxable pay is lower - and so is the amount you pay for Social Security, Medicare, federal and state income taxes. Employees can choose to have the full amount of HSA contributions deducted pre-tax from the 1st pay check, or to have pre-tax deductions spread over 26 pay periods. You may also elect not to fund your HSA contributions pre- tax and file these contributions on your tax returns. If you chose to add additional funds throughout the year, these will be added post-tax.

FULL-TIME EMPLOYEES TOBACCO
Monthly/ Bi-Weekly Medical Contributions – PRE-TAX

Coverage Level	VALUE-BASED PAYMENTS	EHDHP OPTION 2 Embedded HDHP
Employee Only	$42.00 / $21.00	$44.00 / $22.00
Employee + Spouse	$250.00 / $125.00	$294.00 / $147.00
Employee + Child(ren)	$225.00 / $112.50	$279.00 / $139.50
Employee + Family	$400.00 / $200.00	$515.00 / $257.50

MEDICAL: PREVENTIVE CARE

Patient Protection and Affordable Care Act (PPACA) implemented a provision to offer certain health preventive services from network providers at no out-of-pocket cost to you or your family. *All Preventive Care Services are subject to age limits and limits per year. See Plan Document for details.*

- Routine Adult Physical Exam/Immunizations
- Routine Well Child Exams/Immunizations
- Routine Gynecological Care Exams
- Routine Mammograms
- Routine Digital Rectal Exams/ Prostate-Specific Antigen Test
- Colorectal Cancer Screening

Please Note: You may need to pay all or part of the costs when services are completed to diagnose, monitor, or treat illness, pregnancy or injury, rather than prevent an illness, pregnancy or injury.

Medications and Supplements (covered with a doctor's prescription):

- Aspirin
- Colonoscopy preparation
- Smoking Cessation
- Statin
- Vitamin D
- Fluoride chemoprevention—supplements starting at age 6 months for children without fluoride in their water sources
- Gonorrhea preventive medicine for the eyes of all newborns
- Iron supplements for children ages 6-12 months at risk for anemia
- Children's immunizations such as Chickenpox, Rota- virus, tetanus, Tdap, meningococcal, pneumococcal, Hepatitis A, Hepatitis B, inactivated poliovirus, etc.

Adult Preventive Care:

- Colorectal cancer screening for adults at 45-75
- Diabetes screening for adults 40-70 at higher risk
- Lung cancer screenings for adults at all specified ages who smoke or have quit within the past 15 years
- Tuberculosis screening for latent infection for adults at higher risk
- Abdominal aortic aneurysm one time screening for men of specified ages who have ever smoked
- Low to moderate dose statin use for adults 40-75 at higher risk
- Vitamin D supplementation to prevent falls in community dwelling for adults age 65 and older
- Over the counter and prescription smoking cessation medications for members 18 years and older

Women Preventive Services (includes pregnant women):

- Genetic counseling for women who have tested positive for BRCA
- Breast cancer chemoprevention
- Domestic and interpersonal violence - screenings & referral for intervention services
- HIV screenings for pregnant women
- Preeclampsia screening for all pregnant women
- Breast cancer mammography screenings every 1-2 years for women age 40 or older
- Bacteriuria - urinary tract or other infection screenings for pregnant women
- HPV-DNA test - high risk testing every 3 years for women with normal cytology results who are age 30 or older
- Prenatal vitamins/folic acid for women who are, may become pregnant, or are capable of pregnancy
- Osteoporosis (bone density) screening for women age 65 and over and women at higher risk
- Gestational diabetes screenings for women after 24 weeks of gestation
- Hepatitis B screening for younger women and other women at higher risk
- Cervical cancer screening for women at specified ages and intervals

TERMS TO KNOW

Beneficiary: The person who receives the insurance proceeds at the death of the insured.

Claim: An itemized statement of healthcare services and their costs provided by a hospital, physician's office, or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

Coinsurance: A percentage owed by employee after deductible is met up to the maximum out-of-pocket stated by a plan.

Copay: The amount of money a patient will pay out of their pocket each time they seek medical service.

Deductible: A flat amount of a group member must pay before the insurer will make any benefit payments.

Disability: A physical or mental condition that makes an insured person incapable of performing one or more duties of his or her occupation.

Explanation of Benefits (EOB): A statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. This will also indicate the patient responsibility.

Formulary: A list of generic and brand name prescribed medications covered by your health plan that treat the same conditions but cost less.

In-Network: UMR negotiates wholesale prices with providers across the country. Providers willing to accept wholesale prices sign a contract with UMR as "In-Network" providers. Since costs are lower with In-Network providers, your benefits are richer In-Network. You can log on to www.umr.com to find a provider in UMR's network or call the toll-free number on your ID card.

Out-of-Network: These are providers who are not contracted with UMR, thus charging higher prices for their services.

Out-of-Pocket Maximums: Dollar amounts set by the plan that limits the amount a member pays out of his or her own pocket for healthcare services during a plan year. This includes deductible, copays and coinsurance.

Premium: A prepaid payment or series of payments made to a health plan by purchasers, and often plan members, for medical benefits.

Provider: A provider may be a physician, hospital facility, urgent care center, emergency room, etc.

Taxable Benefits: Employer-provided non-cash compensation that is subject to income tax.

TPA (Third Party Administrator): An organization that processes claims and performs other administrative services for the medical plan.

This is not intended to serve as a complete list of commonly used employee benefit terms.

PRESCRIPTION DRUGS: SERVE YOU RX

Prescription Drug benefits are handled differently between the two medical plans:

- **Value-Based Payments:** Expenses count toward your Out-of-Pocket maximum but not your deductible.
  Be sure to review the $0 Copay Traditional PPO ACA Preventive Drug List associated with this Plan.
- **Qualified High Deductible Health Plan:** You pay the full cost for prescriptions until you reach your medical plan deductible. Expenses count toward your medical plan deductible and Out-of-Pocket

Refer to your **SERVEYOU Rx MEMBER PORTAL** at **serve-you-rx.com** to make the most of your prescription benefit. Click on 'Members' then 'Serve You Rx Members' for helpful tools including Member Forms, Preferred Drug Lists, Exclusions, etc.

There is also a drug list pricing tool to compare drug costs, drug information (side effects, missed dosage instructions, etc)

ServeYouRx offers a Free Meter Program for diabetes care. If you would like a new free OneTouch meter, call the OnceTouch Service Center at (866) 355-9962, order code: 594PRX100.

Serve You Rx is your prescription drug vendor. You can contact Serve You Rx at **(800) 759-3203** or **serve-you-rx.com/members/**

Why are certain medications chosen for Prior Authorization Review?

- May have high potential for serious side effects or adverse interaction with other drugs
- May have the potential to be frequently used incorrectly
- May have better alternatives
- May have high potential for abuse
- Should be used only for very specific conditions

SERVE YOU Rx

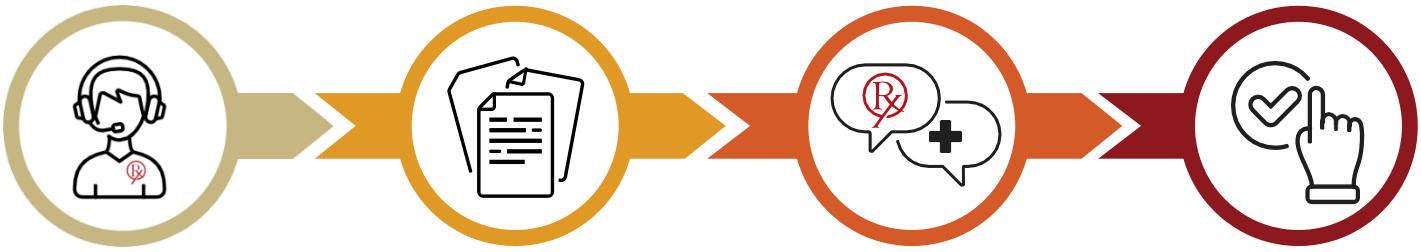
EMPHASIS ON GENERICS

Prescriptions are filled with a generic medication whenever possible, unless otherwise indicated by your physician ("Dispense as Written"). These are generally available at the lowest out-of-pocket cost, are just as effective as brand name drugs and meet FDA standards.

If you or your doctor choose a brand name medication when a generic is available, you are responsible for the brand copay PLUS the difference in cost between the brand name and generic drug.

For certain medications, you must try a generic drug or receive prior approval for coverage of a non-preferred brand drug. If you do not, coverage will be denied, and you will pay the full cost of the brand drug.

HOW THE SPECIALTY DRUG ACCESS PROGRAM WORKS



If you are taking a specialty medication, a member of the ServeYou Rx patient access support team will contact you to describe the Specialty Drug Access Program and answer your questions about the program

ServeYou Rx's patient access support team will work with you to complete the financial assistance application(s). Be prepared to provide information from your most recent tax return, W2 form, or pay stub.

ServeYou Rx works directly with your prescriber to complete the doctor or prescriber section of the paperwork

ServeYou Rx works directly with the assistance program to confirm program participation, if qualified, and schedule delivery of the medication to your preferred location.

What if I don't qualify? If you do not qualify for a drug manufacturer or patient assistance program, a member of the ServeYou Rx patient access support team will contact you to discuss other options for access to your specialty drug treatment.

Questions about the ServeYou Rx Specialty Drug Access Program? Call **800-759-3203, press option 2**. To view the ServeYou Rx Specialty Drug List, visit **serveyourx.com.**

How to Save Money on your Prescriptions

Louisiana Machinery offers you several ways to save you money on your prescription drugs. Take advantage of the programs below:

ServeYou Rx manages Louisiana Machinery's overall prescription drug program. **Contact Customer Service at (800) 759-3203** for any general questions regarding the pharmacy program, prior authorization, the Specialty Assistance, or Patient Assistance Program.

Global RxManage offers international sourcing of certain Brand-Name medications that could save you significant cost. **Contact Customer Service (800) 883-8841** to see which Brand-Name medications qualify or a list medication on the Formulary.

ScriptCo Pharmacy is Louisiana Machinery's new cost saving program. For certain generic maintenance medications, that you take on a regular basis, you can have these prescriptions shipped to your home at NO COST for a 90-day supply on the Copay plan (VBP) only. **Contact Customer Service at (888) 201-0334** for additional information.

INTERNATIONAL BRAND-NAMED DRUGS: Rx MANAGE

Rx Manage is a voluntary program, where you have access to several high-cost medications at $0 copay. This program allows you to order from a formulary of 250 brand medications from pharmacies in New Zealand, Australia, Canada, and England. The medication will be exactly the same as what you currently take; to be on the formulary, a medication must be available from the same manufacturer internationally as the U.S. brand, or from the international license holder.

How to Place an Order on the Personal Importation Program:

- You can place your first order online at **https://my.globalrxmanage.com/customers/louisiana-machinery-company/signup**, or by phone at **(800) 883-8841.**
- Once established, your online account is available 24 hours a day, 7 days a week. Login to your computer or mobile device using your Account ID and password at **https//my.globalrxmanage.com/customers/login**
- It will take 10-15 working days for you to receive the medication after it has shipped. Please make sure you have a 30 day supply on hand before placing your first order for each medication.

IF YOU HAVE QUESTIONS: Call Rx Manage call center that is open 9 am to 9 pm (EST) Monday through Friday and 9 am to 4 pm (EST) Saturday and Sunday to answer questions and take your orders. You can also email Rx Manage at **inquiries@rxmanage.com**

GENERIC MAIL ORDER DRUGS: ScriptCo Rx

ScriptCo Rx Pharmacy is a voluntary mail-order prescription drug program that gives you access to generic maintenance drugs at no cost for a 90-day supply on the copay plan (RBP) only. **NOTE:** If a generic is a controlled substance, you will continue to receive these prescriptions through ServeYou Rx. If you have any questions or need help, call ScriptCo Pharmacy at (888) 201-0334.

TOBACCO CESSATION: LA SMOKING CESSATION TRUST

Important Smoking Cessation Trust Program Changes

Per a Court Judgement, enrollment into the Smoking Cessation Trust Program ended July 11th, 2022, at 11:59pm. SCT Management Services will not be taking any new applications into the smoking cessation program. However, eligible smokers across Louisiana who enrolled into the smoking cessation trust program before the 7/11/2022 deadline may continue to receive all the free products and services offered by the smoking cessation trust for a period that could be up to five years.

Please call us if you have any questions:

Toll Free (855) 259-6346

Get Help Quit Smoking

SMOKING CESSATION TRUST

EMPLOYEE ASSISTANCE PROGRAM - IEAP

Employees and their families often face challenging daily demands, including issues at work, with family, finances and more. Louisiana Machinery will continue to offer an Employee Assistance Program (EAP) for you, your spouse, and your eligible dependents. With the EAP, you are provided with free, confidential counseling by experienced licensed counselors.

There is NO COST to you and nothing to sign up. Enrollment is automatic for all eligible employees.

All services are **FREE** and **CONFIDENTIAL**.

SERVICES OFFERED

Access to a network of providers with expertise in:

- Marriage & Family Issues
- Adolescent Counseling
- Social Workers
- Therapists
- Legal and Finance
- Substance Abuse

Issues covered through EAP benefits are:

- Stress management
- Depression/Anxiety
- Family/Parenting
- Emotional Issues
- Alcohol/drug abuse
- Community Referral Services
- Legal Referrals
- Financial Referrals

Regardless of the plan you choose, all plan members have access to a **free** and **confidential** Employee Assistance Program provided by Interface EAP. IEAP allows you (and your spouse and children if applicable) to see a mental health therapist for 8 free, face-to-face visits for each issue each year provided you call Interface EAP first.

You can also request to speak with a lawyer or a financial advisor. Call 800-324-4327 to access your EAP or visit www.4eap.com

Access to the EAP is 24 hours a day, 365 days a year.

VOLUNTARY DENTAL – Companion Life

The Louisiana Machinery Employee Dental Plan provides you and your family with coverage for preventive dental care and both major and minor dental procedures to improve overall oral health.

To locate a provider, go to https://companionlife.go2dental.com/member/dental_search/proxinp.cgi

Plan Provision	In-Network	Out-of-Network
Plan Year Deductible	$50 Individual/ $150 Family	Services covered at the 90th percentile of UCR
Plan Year Maximum	$3,000 per person per year	
Class I – Diagnostic/Preventive Oral exams, X-rays, Cleanings (**3 times** per benefit year), Fluoride Treatments, Sealants, Space Maintainers, Palliative Treatment	100% **Deductible Waived**	
Class II – Basic Services Endodontics, Periodontics, Fillings, Simple and Surgical Extractions, Anesthesia, Other Oral Surgery,	80% after Deductible	
Class III – Major Services Denture Relines and Rebases/Adjustments, Repairs to Dentures, Crowns, and Bridges, Crowns (Post and Core), Onlays (Post and Core), Complete and Partial Dentures, Fixed Bridge Work, Implants, Perio Trays	50% after Deductible	
Orthodontia (Dependent Children to age 19)	50%	
Lifetime Orthodontia Maximum	$1,000 per person	

MONTHLY CONTRIBUTIONS

Coverage Level	FULL-TIME EMPLOYEES
Employee Only	$ 29.01
Employee + Spouse	$ 56.89
Employee + Child(ren)	$ 71.09
Employee + Family	$101.13

BI-WEEKLY CONTRIBUTIONS

Coverage Level	FULL-TIME EMPLOYEES
Employee Only	$ 14.50
Employee + Spouse	$ 28.44
Employee + Child(ren)	$ 35.54
Employee + Family	$ 50.56

NOTE: *Please refer to your Companion Life Dental Certificate of Coverage for details. If this summary conflicts in any way with your Companion Life Dental Certificate of Coverage, the Certificate of Coverage shall prevail.*

VOLUNTARY VISION - EyeMed

The Louisiana Machinery Employee Vision Plan provides you and your family with coverage for eye exams, lenses and frames. This coverage is offered to you on a voluntary basis.

(Plan allows member to receive either contacts and frame, or frame and lens services. Contacts are only in lieu of spectacle lenses.)

Plan Provision	In-Network	Out-of-Network
Eye Exams ***(once every plan year)***	$10 Copay	Covered up to $40
Standard Plastic Lenses ***(once every plan year)*** **> Single, Bifocal, Trifocal or Lenticular Prescription;** and/or **> Additional Lens Options**	$10 Copay Additional Copays Apply	Single: up to $30 Bifocal: up to $50 Trifocal: up to $70 Lenticular: up to $70
Frames ***(once every other plan year)*** ➢ **Retail Allowance**	$0 Copay; 20% off balance over $130 allowance	Covered up to $91
Contacts Lenses ***(once every plan year)*** **> Retail Allowance;** or **> Medically Necessary Contacts**	$0 Copay; 15% off balance over $130 allowance $0 copay; paid-in-full	Up to $91 Up to $300

To Find a Provider, visit **eyemed.com**, select "Find an Eye Doctor" then select the Insight Network, and enter your zip code. Remember to provide your member ID# or social security number, name, and date of birth when you make an appointment.

Coverage Level	Monthly Rates	Bi-Weekly Rates
Employee Only	$6.68	$3.34
Employee + Spouse	$11.99	$6.00
Employee + Child(ren)	$12.67	$6.34
Employee + Family	$20.01	$10.00

NOTE: *Please refer to your EyeMed Vision Certificate of Coverage for details. If this summary of benefits conflicts in any way with your EyeMed Vision Certificate of Coverage, the Certificate of Coverage shall prevail.*

BASIC LIFE/AD&D – COMPANION LIFE

The Louisiana Machinery Basic Life/AD&D plan is a 100% employer-paid benefit that provides your family with financial protection in the event of your death or the death of a covered dependent (as long as you are enrolled in medical).

The Accidental Death & Dismemberment (AD&D) plan protects you and your family in the event of your death or injury due to a covered accident in addition to the benefit provided by your Life coverage.

Plan Provision	Coverage / Description
Benefit Amount	$50,000
Accidental Death Benefit	$50,000
Accidental Dismemberment Benefit	Percent of benefit based on dismemberment
Age Reduction	Reduces 33% at age 65 Reduces 45% of the original amount at age 70 Benefits terminate at retirement
Waiver of Premium	To age 60 (12-month waiting period) Terminates at age 65 if disabled before age 60
Accelerated Life Benefit	Included
Actively at Work Provision	You must be actively at work on your effective date of coverage in order for your policy to be in force

Be sure to designate your beneficiaries during enrollment.

NOTE: *Please refer to the Companion Life Certificate of Coverage for details. If this summary of benefits conflicts in any way with Companion Certificate of Coverage, the Certificate of Coverage shall prevail.*

SHORT TERM DISABILITY (STD) – COMPANION LIFE

LA Machinery's Short Term Disability plan provides a weekly benefit for expenses incurred if you cannot work several weeks due to an illness or injury. Your doctor must certify that you are unable to return to work on a full-time or partial basis.

Plan Provision	Coverage / Description
Weekly Benefit	60% of weekly earnings
Maximum Weekly Benefit	$1,500
Maximum Benefit Duration	Salaried Employees: 26 weeks Hourly Employees: 25 weeks
Elimination Period (Accident and Sickness)	Salaried Employees: Benefits begin on 8th day Hourly Employees: Benefits begin on 15th day
Pre-existing Condition Limitation	None for initial enrollees
Partial Disability	Included

EMPLOYEE CONTRIBUTIONS

Employees contribute **40%** of the cost of this coverage.
Your monthly rate: $0.092 per $10 of covered benefit

Disabilities caused by an occupational injury or illness are not covered.

Benefit Duration is until the earliest of:

- Your disability is resolved; or
- You reach a total duration of 25 or 26 weeks; or
- In the event of your death

Follow these steps to calculate your **monthly** premium:

1. Divide your annual salary by 52 =_____.
2. Multiple the result of Step 1 by .60 (If this amount is greater than $1,500/week, use $1,500) =_____.
3. Divide the result of Step 2 by 10 =_____.
4. Multiply the result of Step 3 by $0.23_____.
5. Any salaries in excess of $130,000 will have a monthly premium of $34.50/month.

STD Benefits Include: Maternity Benefits, Minimum Weekly Benefit of $25, Continuation of Coverage Under FMLA, Partial Disability Benefits

LONG TERM DISABILITY (LTD) – COMPANION LIFE

LA Machinery's Long Term Disability plan provides a monthly benefit in the event that you become disabled and are unable to work. Long Term Disability provides replacement income to give you financial security.

Plan Provision	Coverage / Description
Monthly Benefit	Salaried Employees: 60% of Monthly Earnings Hourly Employees: 50% of Monthly Earnings
Maximum Monthly Benefit	Salaried Employees: $15,000 Hourly Employees: $8,000
Minimum Monthly Benefit	$100
Elimination Period	180 days
Pre-existing Condition Limitation	3/3/12 *If you were treated or diagnosed for a medical condition 3 months prior to your coverage or hire date, you will be eligible for LTD benefits after 3 months free of treatment period followed by a 12-month waiting period*
Social Security Integration	Primary and Family
Own Occupation	2 Years
Maximum Duration of Benefits	Social Security Normal Retirement Age (SSNRA)
Mental & Nervous/Substance Abuse	2 Years (24 Months Per Occurrence)
Partial Disability	Included

You contribute 40% of the cost of this coverage. Your monthly rate: ***$0.176 per $100 covered payroll***

REMEMBER: YOU CANNOT ELECT LONG TERM DISABILITY WITHOUT ALSO ELECTING SHORT TERM DISABILITY, AND VICE VERSA.

Coordination With Other Disability Benefits

If you qualify for disability benefits from any other sources, your LTD benefit will be reduced so as not to exceed your elected coverage amount. Other sources of LTD benefits may include: Disability benefits from Social Security, State-compulsory benefit act or law, Retirement plan, and Worker's Compensation.

VOLUNTARY IDENTITY THEFT PROTECTION – AURA IDENTITY GUARD

Louisiana Machinery's IdentityTheft Protection plan includes comprehensive identity monitoring, fraud remediation and restoration, and identity theftreimbursement.

This benefit is 100% voluntary and paid for by you.

- Industry-leading alert speeds[1]
- Personalized threat alerts
- Cyberbullying alerts and social media monitoring
- Safe browsing tools
- Secure VPN connection
- Helps stop unauthorized data use
- Removes personal data
- Reduces spam + robocalls

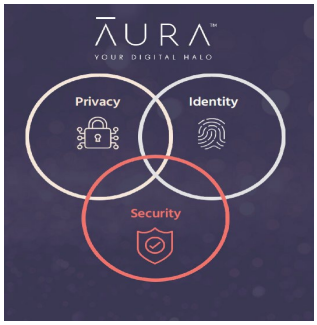
Coverage includes:
Identity monitoring and alerts;
24/7 Privacy Advocate support, and more

Pricing:
- ✓ $11.95/month for Individual coverage
- ✓ $20.95/month for Family coverage

ONE-STOP-SHOP FOR CYBER WELLNESS

Aura's integrated platform provides a Digital Halo of security to monitor, manage, and help protect personal information. This easy, cost-effective approach empowers employees with a robust suite of tools to meet the diverse needs of their digital lives.*

Using adaptive and innovative technology — including IBM® Watson™ AI — enables us to quickly evolve our solution to ensure that we're always providing the most comprehensive cyber protection available in today's market.



Visit IdentityGuard.com or call (855) 443-7748 for more details.
This benefit is portable.

NOTE: *Please refer to the Aura Identity Guard Certificate of Coverage for details. If this summary of benefits conflicts in any way with the Aura Identity Guard Certificate of Coverage, the Certificate of Coverage shall prevail.*

VOLUNTARY LEGAL ASSISTANCE - METLAW

Louisiana Machinery is continuing to provide you with a voluntary plan that offers convenient access to legal services you may not be able to afford on your own. This plan provides access to legal representation for you and your family at only **$21.00 a month**. The Nationwide network includes over 15,000 attorneys.

To access legal advisors call (800) 821-6400 or visit the website ***info.legalplans.com*** *with the password* ***LEGAL.***

Coverage	Benefit
Consumer Protection	Small Claims Assistance, Personal Property Protection
Debt Matters	Debt Collection Defense, Identity Theft Defense, Personal Bankruptcy or Wage Earner Plan, Tax Audits
Defense of Civil Lawsuit	Administrative Hearing Representation, Civil Litigation Defense, Incompetency Defense
Document Preparation	Affidavits, Deeds, Demand Letters, Mortgages, Promissory Notes, Document Review, Elder Law Matters
Family Law	Name Change, Prenuptial Agreement, Protection from Domestic Violence, Adoption and Legitimization (Contested and Uncontested), Guardianship or Conservatorship (Contested or Uncontested)
Immigration	Immigration Assistance
Personal Injury	Personal Injury (25% Network Maximum)
Real Estate Matters	Zoning Applications, Boundary or Title Disputes (Primary Residence), Primary Residence – Tenant Only: (1) Eviction and Tenant Problems, (2) Security Deposit Assistance, Primary, Secondary or Vacation Homes: (1) Home Equity Loans, (2) Property Tax Assessment, (3) Refinancing of Home, (4) Sale or Purchase of Home
Traffic and Criminal Matters	Juvenile Court Defense, Traffic Ticket Defense (No DUI), Restoration of Driving Privileges
Wills and Estate Planning	Trusts, Living Wills, Powers of Attorney, Probate (10% Network Discount), Wills and Codicils, Dependent Definition

To continue coverage, terminated and retired employees must apply for portable enrollment within 30 days of their last day of employment by calling **(800) GET-MET8**. Portable enrollment remains in effect for a 30-month period and is non-renewable. Enrollment is prepaid and the cost is equal to the enforce group rate x30.

VOLUNTARY LIFE/ AD&D – COMPANION LIFE

The Louisiana Machinery Voluntary Term Life plan allows employees to elect additional life and dependent life coverage to supplement the Basic Life policy. This coverage is entirely optional and is paid for by the employee. Spouse and dependent child coverage is only available if the employee is insured for Voluntary coverage.

EMPLOYEE SUMMARY OF BENEFITS

Plan Provision	Coverage/Description
Benefit Amount	7x annual salary in $5,000 increments to a maximum of $500,000
Minimum Benefit Amount	$10,000
Age Reduction	Reduces to 67% of the original amount at age 65 Reduces to 45% of the original amount at age 70
Guarantee Issue	$225,000
Waiver of Premium	To age 65 (6 month waiting period) if disabled prior to age 60
Accelerated Death Benefit	Included
Portability	Included
Actively at Work Provision	Included

SPOUSE SUMMARY OF BENEFITS

Plan Provision	Coverage/Description
Benefit Amount	In $5,000 increments up to $150,000, not to exceed 50% of employee's voluntary life benefit amount.
Minimum Benefit Amount	$5,000
Age Reduction	Reduces to 67% of the original amount at spouse age 65 Reduces to 45% of the original amount at spouse age 70
Guarantee Issue	$50,000

CHILD(REN) SUMMARY OF BENEFITS

Plan Provision	Coverage/Description
Benefit amount (live birth to 26 years)	$10,000
Guarantee Issue	$10,000

Employee election includes AD&D. Spouses and children are not eligible for AD&D.

VOLUNTARY LIFE - COMPANION LIFE

Enrolling Your Child(ren)

- You may enroll your eligible child(ren) up to age 26 (if they are not in the military);
- Your cost per paycheck does not vary by your child(ren)'s age or by the number of children covered

Evidence of Insurability (EOI)

When enrolling for Voluntary Employee Life Insurance, Evidence of Insurability (EOI) is required when you:

- Elect more than $225,000 in employee coverage;
- Elect more than $50,000 in spouse coverage;
- Increase your current coverage amount by more than $10,000 (employee) or $5,000 (spouse);
- Do not enroll when first eligible.

Employees that are already enrolled in the Voluntary Life program, may elect an additional $10,000 of voluntary coverage and spouses an additional $5,000 up to the Guarantee Issue (GI) during Open Enrollment without Evidence of Insurability (EOI).

Employees/spouses maxed out on the GI are subject to EOI for any additional amounts.

If you did not enroll when you were first eligible to do so and want to enroll now, any amount you apply for will be subject to Evidence of Insurability (EOI).

Spouse Monthly contributions (regardless of age): $0.14 per $1,000 of coverage
Child Monthly contributions (regardless of number of children): $1.10 per $10,000 of coverage

AGE-BANDED EMPLOYEE MONTHLY CONTRIBUTIONS (POST-TAX PAYROLL DEDUCTIONS)

Age Category	Monthly Premium Rate/ $1,000 of Ins. Coverage	Coverage Amount and Monthly Premium (12 pay periods) – Custom Rates								
		$10,000	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000
15-34	$.13	$1.30	$3.25	$6.50	$9.75	$13.00	$16.25	$19.50	$22.75	$26.00
35-39	$.15	$1.50	$3.75	$7.50	$11.25	$15.00	$18.75	$22.50	$26.25	$30.00
40-44	$0.19	$1.90	$4.75	$9.50	$14.25	$19.00	$23.75	$28.50	$33.25	$38.00
45-49	$0.26	$2.60	$6.50	$13.00	$19.50	$26.00	$32.50	$39.00	$45.50	$52.00
50-54	$0.38	$3.80	$9.50	$19.00	$28.50	$38.00	$47.50	$57.00	$66.50	$76.00
55-59	$0.61	$6.10	$15.25	$30.50	$45.75	$61.00	$76.25	$91.50	$106.75	$122.00
60-64	$0.72	$7.20	$18.00	$36.00	$54.00	$72.00	$90.00	$108.00	$126.00	$144.00
65-69	$1.19	$11.90	$29.75	$59.50	$89.25	$119.00	$148.75	$178.50	$208.25	$238.00
70-74	$1.90	$19.00	$47.50	$95.00	$142.50	$190.00	$237.50	$285.00	$332.50	$380.00
75 +	$2.50	$25.00	$62.50	$125.00	$187.50	$250.00	$312.50	$375.00	$437.50	$500.00

ADDITIONAL VOLUNTARY PLANS:
American Public Life (APL) & Transamerica

Your 2023 Worksite Benefits details and rates of the voluntary coverages being offered effective September 1, 2024 can be found below.

- APL Hospital Indemnity
- APL 24-Hour Accident
- APL Critical Illness
- APL Cancer Coverage
- ***NEW***APL Voluntary Term Life
- Transamerica Universal Life

Please Note: Louisiana Machinery Company, LLC is not endorsing the policy, contributing towards premium payments, or receiving any form of payment for allowing APL/Transamerica to offer this policy. All questions regarding these benefits should be directed to the APL/Transamerica.

MedChoice™ Group Hospital Indemnity Insurance

Hospital indemnity insurance may help cover the costs of an unexpected illness or serious accident that results in a hospital stay, outpatient surgery or treatment in a doctor's office. Focus on recovery, not your finances, with a hospital indemnity plan from APL.

Summary of Benefits for Louisiana MachineryCompany, LLC	
	Plan 1
HSA Compatible	No
Spouse Coverage	Available
Dependent Child(ren) Coverage	Available
Pregnancy Coverage/Waiting Period	Included/10 months
Hospital Admission Benefit	$1,000 per day; max of 1 day(s)
Hospital Confinement Benefit	$150 per day; max of 10 day(s)
Intensive Care Unit Admission Benefit	$1,000 per day; max of 1 day(s)
Intensive Care Unit Benefit	$300 per day; max of 10 day(s)
Rehabilitation Benefit	$25 per day; max of 5 day(s)
Additional Rider(s)	
Portability Option Rider	Included

Plan 1 - Monthly Premium*				
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18+	$13.00	$38.09	$15.34	$43.03
Plan 1 – Bi-Weekly Premium*				
18+	$6.50	$19.04	$7.67	$21.51

Accident Insurance can provide protection to help with the high cost of a covered accidental injury. From a simple physician's office visit, to x-rays, ambulance transportation or an intensive care admission due to an accidental injury — unexpected expenses can add up.

Summary of Benefits for Louisiana Machinery Company LLC

	Plan 1 Insured Benefit
Type of Coverage	24-Hour Coverage
Spouse or Partner Coverage	Spouse or Partner benefit amounts are 100% of the insured's benefit amount, unless otherwise stated.
Dependent Child(ren) Coverage	Dependent child(ren) benefit amounts are 100% of the insured's benefit amount, unless otherwise stated.
Continuation Coverage Based on defined qualifying events defined in your certificate	Coverage will be continued for 12 months following the date the insured ceased active employment.
Portability Coverage	Included, age 79 or younger
Post-Accident Time Frame Requirement Unless otherwise defined, confinement, stay, treatment, therapy, diagnosis, surgery, paralysis, dismemberment, death or prescription of covered items must occur within the defined number of days after a covered accident or for inpatient rehabilitation, if applicable to the plan, within the defined number of days after the date of discharge from the hospital.	90 day(s)
Hospital Benefits	
Hospital Admission Pays only once per day, even if the confinement or observation long stay is the result of more than one injury.	$2,000/1 day(s)
Hospital Confinement Pays once per ay	$350/365 day(s)
ICU Admission Pays only once per day, even if the confinement is the result of more than one injury.	$2,000/1 day(s)
ICU Confinement Pays once per day	$700/30 day(s)
Severe Burn Benefits	
2nd degree & 3rd degree Burns Pays once per covered accident based on degree and size of burn	$200 to $10,000
Skin Graft[1]	50% of severe burn benefit amount
Lodging and Travel Benefits	
Transportation for treatment for the injured covered person by train, bus, coach or plane must be at least 100 miles from the covered person's primary residence. Not payable if ambulance benefit is payable.	
Non-Local Transportation	$375/up to 3 round trip(s)
Family Lodging	$150/30 night(s)
Ambulance Benefits	
Air Ambulance	$600/3 day(s)
Ground or Water Ambulance	$200/3 day(s)
Emergency Dental & Vision Treatment Benefits	
Emergency dental extraction of a broken sound, natural tooth	$200
Emergency repair of a broken sound, natural tooth with a crown	$150
Eye surgery or removal of a foreign object	$150
Appliance and Prosthesis Benefits	
Wheelchair, motorized scooter, walker, walking boot, any other medical device used for mobility, including a brace, cane and crutches - based on type of appliance	$200/1 day(s)
Prosthesis Pays once per covered accident, per plan year based on number of devices	$750 to $1,500
Other Benefits	
Blood/Plasma/Platelets	$450/1 day(s)

Accident Screening Benefit	
Accident Screening[1]	$50/1 per covered person, up to 4 per family. Additional screening tests included
Initial Treatment Benefits	
Emergency Room Treatment Pays once per day	$300/3 day(s)
Urgent Care Treatment Pays once per day	$150/2 day(s)
Physician's Office Treatment Pays once per day	$100/3 day(s)
Telemedicine Pays once per day	$25/5 day(s)
Diagnostic Benefits	
X-ray	$200/5 day(s)
Major Diagnostic Exam	$75/1 day(s)
Therapy Benefits	
Inpatient Rehabilitation	$200/30 day(s)
Physical Therapy	$50/10 day(s)
Extended Treatment	$50/5 day(s) Benefits includes Chiropractic Therapy, Acupuncture Therapy
Coma and Paralysis Benefits	
Coma Must continue for at least 7 day(s) before a benefit is payable. Pays once per covered accident.	$15,000
Paralysis Must continue for at least 90 day(s) before a benefit is payable	Quadriplegia - $22,500 Paraplegia - $11,250
Accidental Death Benefits	
Accidental Death	Insured - $25,000 Spouse or Partner - $15,000 Dependent Child(ren) - $5,000
Common Carrier Accidental Death	Insured - $100,000 Spouse or Partner - $50,000 Dependent Child(ren) - $20,000
Accidental Death Seatbelt	Insured - $5,000 Spouse or Partner - $2,500 Dependent Child(ren) - $1,250
Dismemberment Benefits	
Dismemberment - Single, Double, Finger/Toe	$2,000 to $20,000
Dislocation Benefits	
Dislocation (open reduction) - based on joint involved	$375 to $5,000
Dislocation (closed reduction) percentage[1]	50% of open reduction benefit amount
Partial dislocation percentage[1]	25% of open reduction benefit amount
Fracture Benefits	
Fracture (open reduction) - based on bone involved	$375 to $5,000
Fracture (closed reduction) percentage[1]	50% of open reduction benefit amount
Chip fracture percentage[1]	25% of open reduction benefit amount
Laceration Benefits	
Based on length of laceration	$75 to $100/3 day(s)
Inpatient Surgery Benefits	
Pays once per covered accident based on type of surgery	$1,500
Outpatient Surgery Benefits	
Tendon/ligament/rotator cuff/torn knee cartilage - based on type of surgery	$750 to $1,000/1 day(s)
Brain Injury Benefits	
Concussion	$450/1 day(s)
Severe Traumatic Brain Injury (TBI)	$2,500/1 day(s)

Plan 1 - Monthly Premium*				
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18+	$12.82	$19.95	$26.21	$36.00
Plan 1 – Bi-Weekly Premium*				

18+	$6.41	$9.97	$13.10	$18.00

Group Critical Illness Insurance

Critical Illness insurance from APL can help you prepare for the financial impact you may face after a heart attack, stroke, invasive cancer or other covered critical illnesses.

Summary of Benefits for Louisiana Machinery Company, LLC

Critical Illness Covered Conditions	Plan 1 Insured Benefit Amount[2]	Plan 2 Insured Benefit Amount[2]	Plan 3 Insured Benefit Amount[2]
Nicotine Class	Non-Nicotine/Nicotine -Nicotine rates apply to all family members if any family member applying for coverage uses nicotine products.	Non-Nicotine/Nicotine -Nicotine rates apply to all family members if any family member applying for coverage uses nicotine products.	Non-Nicotine/Nicotine -Nicotine rates apply to all family members if any family member applying for coverage uses nicotine products.
Spouse Coverage	Available	Available	Available
Dependent Child(ren) Coverage	Available	Available	Available
Pre-Existing Condition	Waived	Waived	Waived
Pre-Existing Condition Limitation	Not applicable	Not applicable	Not applicable
Benefit Waiting Period	30 days	30 days	30 days
Tier 1 Cancer[3]			
Invasive Cancer	$10,000	$20,000	$30,000
Non-Invasive Cancer	$2,500	$5,000	$7,500
Benign Brain Tumor	$10,000	$20,000	$30,000
Skin Cancer	$250	$250	$250
Tier 1 Vascular[3]			
Heart Attack	$10,000	$20,000	$30,000
Coronary Artery Disease (Bypass Surgery)	$2,500	$5,000	$7,500
Stroke	$10,000	$20,000	$30,000
Tier 1 Other[3]			
Bone Marrow Transplant	$10,000	$20,000	$30,000
Major Organ Failure	$10,000	$20,000	$30,000
End Stage Renal Failure	$10,000	$20,000	$30,000
Tier 2 Vascular[3]			
Sudden Cardiac Arrest	$2,500	$5,000	$7,500
Tier 2 Other[3]			
Acute Respiratory Distress Syndrome (ARDS)	$2,500	$5,000	$7,500
Addison's Disease	$2,500	$5,000	$7,500
Advanced Alzheimer's Disease	$10,000	$20,000	$30,000
Advanced Parkinson's Disease	$10,000	$20,000	$30,000
Amyotrophic Lateral Sclerosis (ALS)	$2,500	$5,000	$7,500
Coma	$10,000	$20,000	$30,000
Complete Loss of Sight	$10,000	$20,000	$30,000
Complete Loss of Speech	$10,000	$20,000	$30,000
Complete Loss of Hearing	$10,000	$20,000	$30,000
Diphtheria	$2,500	$5,000	$7,500
Encephalitis	$2,500	$5,000	$7,500

Huntington's Disease	$2,500	$5,000	$7,500
Legionnaire's Disease	$2,500	$5,000	$7,500
Lyme Disease	$2,500	$5,000	$7,500
Malaria	$2,500	$5,000	$7,500
Meningitis	$2,500	$5,000	$7,500
Multiple Sclerosis (MS)	$2,500	$5,000	$7,500
Myasthenia Gravis	$2,500	$5,000	$7,500
Necrotizing Fasciitis	$2,500	$5,000	$7,500
Occupational Hepatitis	$2,500	$5,000	$7,500
Occupational HIV	$2,500	$5,000	$7,500
Osteomyelitis	$2,500	$5,000	$7,500
Permanent Paralysis	$10,000	$20,000	$30,000
Poliomyelitis	$2,500	$5,000	$7,500
Pulmonary Embolism	$2,500	$5,000	$7,500
Pulmonary Fibrosis	$2,500	$5,000	$7,500
Rabies	$2,500	$5,000	$7,500
Rocky Mountain Spotted Fever	$2,500	$5,000	$7,500
Ruptured Aneurysm	$2,500	$5,000	$7,500
Severe Arthritis	$2,500	$5,000	$7,500
Severe Mental Illness	$2,500	$5,000	$7,500
Severe Osteoporosis	$2,500	$5,000	$7,500
Sickle Cell Anemia	$2,500	$5,000	$7,500
Systemic Lupus	$2,500	$5,000	$7,500
Systemic Sclerosis (Scleroderma)	$2,500	$5,000	$7,500
Tetanus	$2,500	$5,000	$7,500
Tuberculosis	$2,500	$5,000	$7,500
Type I Diabetes	$2,500	$5,000	$7,500
Childhood Conditions[3]			
Cerebral Palsy	$2,500	$5,000	$7,500
Cleft Lip and/or Cleft Palate	$2,500	$5,000	$7,500
Cystic Fibrosis	$2,500	$5,000	$7,500
Down Syndrome	$2,500	$5,000	$7,500
Muscular Dystrophy	$2,500	$5,000	$7,500
Spina Bifida	$2,500	$5,000	$7,500
Tay-Sachs Disease	$2,500	$5,000	$7,500
[2,3]Spouse critical illness benefit amounts are 50% of the insured's critical illness benefit amounts shown. Dependent child(ren) critical illness benefit amounts, except for Childhood Conditions, are 50% of the insured's critical illness benefit amounts shown. Childhood Conditions are paid at 100% of the amounts shown.			
Additional Occurrence	Included	Included	Included
Recurrence Benefit	Included, 100%	Included, 100%	Included, 100%
Recurrence Separation Period	12 months	12 months	12 months
Wellness Benefits[8]	Maximum of 1 per covered person, up to 4 per family	Maximum of 1 per covered person, up to 4 per family	Maximum of 1 per covered person, up to 4 per family
Health Screening	$50, payable for a wellness test; or routine physical exam; or any additional generally medically accepted screening test used to evaluate risk or promote prevention of a covered condition.	$50, payable for a wellness test; or routine physical exam; or any additional generally medically accepted screening test used to evaluate risk or promote prevention of a covered condition.	$50, payable for a wellness test; or routine physical exam; or any additional generally medically accepted screening test used to evaluate risk or promote prevention of a covered condition.
Mammography	$50, payable once every 2 Years	$50, payable once every 2 Years	$50, payable once every 2 Years
[2,8]Spouse wellness benefit amounts are 100% of the insured's wellness benefit amounts shown. Dependent child(ren) wellness benefit amounts are 100% of the insured's wellness benefit amounts shown.			
Continuation Coverage	Included	Included	Included

Portability Coverage	Included, age 79 or younger	Included, age 79 or younger	Included, age 79 or younger

Non-Nicotine Plan 1 Monthly Age Based Premium**			Nicotine Plan 1 Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	$4.25	$7.07	18-29	$5.16	$8.45
30-39	$8.63	$13.78	30-39	$11.66	$18.38
40-49	$16.77	$26.22	40-49	$25.09	$38.70
50-59	$28.95	$44.77	50-59	$44.38	$67.86
60-69	$38.44	$59.24	60-69	$59.41	$90.70
70-79	$58.00	$88.08	70-79	$163.38	$255.23
Non-Nicotine Plan 1 Bi-Weekly Age Based Premium**			Nicotine Plan 1 Bi-Weekly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	$2.12	$3.53	18-29	$2.58	$4.22
30-39	$4.31	$6.89	30-39	$5.83	$9.19
40-49	$8.38	$13.11	40-49	$12.54	$19.35
50-59	$14.47	$22.38	50-59	$22.19	$33.93
60-69	$19.22	$29.62	60-69	$29.70	$45.35
70-79	$29.00	$44.04	70-79	$81.69	$127.61
Non-Nicotine Plan 2 Monthly Age Based Premium**			Nicotine Plan 2 Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	$7.11	$11.40	18-29	$12.09	$14.17
30-39	$15.60	$24.23	30-39	$21.76	$33.46
40-49	$31.51	$48.32	40-49	$48.15	$73.28
50-59	$55.34	$84.33	50-59	$84.06	$130.48
60-69	$73.23	$112.37	60-69	$115.83	$175.29
70-79	$114.95	$174.06	70-79	$323.81	$504.35
Non-Nicotine Plan 2 Bi-Weekly Age Based Premium**			Nicotine Plan 2 Bi-Weekly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	$3.55	$5.70	18-29	$6.04	$7.08
30-39	$7.80	$12.11	30-39	$10.88	$16.73
40-49	$15.75	$24.16	40-49	$24.07	$36.64
50-59	$27.67	$42.16	50-59	$42.03	$65.24
60-69	$36.61	$56.18	60-69	$57.91	$87.64
70-79	$57.47	$87.03	70-79	$161.90	$252.17
Non-Nicotine Plan 3 Monthly Age Based Premium**			Nicotine Plan 3 Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	$8.15	$14.95	18-29	$9.49	$17.16
30-39	$17.21	$28.60	30-39	$23.97	$39.22
40-49	$39.87	$63.01	40-49	$66.65	$104.70
50-59	$81.51	$127.23	50-59	$154.18	$239.38
60-69	$159.51	$246.35	60-69	$320.50	$494.39
70-79	$172.44	$260.68	70-79	$485.77	$755.36
Non-Nicotine Plan 3 Bi-Weekly Age Based Premium**			Nicotine Plan 3 Bi-Weekly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	$4.07	$7.47	18-29	$4.74	$8.58
30-39	$8.60	$14.30	30-39	$11.98	$19.61
40-49	$19.93	$31.50	40-49	$33.32	$52.35
50-59	$40.75	$63.61	50-59	$77.09	$119.69
60-69	$79.75	$123.17	60-69	$160.25	$247.19
70-79	$86.22	$130.34	70-79	$242.88	$377.68

Group Cancer Insurance

If you or a family member are diagnosed with cancer, APL's Cancer Insurance may help cover the costs associated with the detection and treatment of cancer and help you be more financially prepared.

Summary of Benefits for Louisiana Machinery Company

	Plan 1 Insured Benefit	Plan 2 Insured Benefit
Spouse Coverage	Available	Available
Dependent Child(ren) Coverage	Available	Available
Pre-Existing Condition Period/Pre-Existing Condition Exclusion Period	12 months/12 months	12 months/12 months
Cancer Treatment Benefit	Level 2	Level 2
Radiation Therapy, Chemotherapy, Immunotherapy Maximum per 12-month period	$10,000	$10,000
Hormone Therapy Maximum of 12 treatments per calendar year	$50 per treatment	$50 per treatment
Experimental Treatment	paid in same manner and under the same maximums as any other benefit	
Benefit Riders		
Cancer Screening Benefit Rider	Level 1	Level 4
Diagnostic Testing 1 test per calendar year	$50 per test	$100 per test
Follow-Up Diagnostic Testing 1 test per calendar year	$100 per test	$100 per test
Medical Imaging	$500 per test; 1 test(s) per calendar year	$500 per test; 2 test(s) per calendar year
Surgical Benefit Rider	Level 2	Level 2
Surgical Operation	$30 unit dollar amount; Max $3,000 per operation	$30 unit dollar amount; Max $3,000 per operation
Anesthesia	25% of amount paid for covered surgery	25% of amount paid for covered surgery
Bone Marrow Transplant Maximum per lifetime	$6,000	$6,000
Stem Cell Transplant Maximum per lifetime	$600	$600
Prosthesis, Surgical implantation, Non-surgical (not hair piece) 1 device per site, per lifetime	$1,000 per device $100 per device	$1,000 per device $100 per device
Patient Care Benefit Rider	Level 1	Level 3
Hospital Confinement	Insured or Spouse: $100 per day of hospital confinement, days 1-30; $100 per day of hospital confinement, days 31+ Eligible Dependent Child(ren): $200 per day of hospital confinement, days 1-30; $200 per day of hospital confinement, days 31+	Insured or Spouse: $200 per day of hospital confinement, days 1-30; $400 per day of hospital confinement, days 31+ Eligible Dependent Child(ren): $400 per day of hospital confinement, days 1-30; $800 per day of hospital confinement, days 31+
Outpatient Facility	$200 per day surgery is performed	$400 per day surgery is performed
Attending Physician	$30 per day of hospital confinement	$40 per day of hospital confinement
Dread Disease	$100 per day of hospital confinement, days 1-30; $100 per day of hospital confinement, days 31+	$200 per day of hospital confinement, days 1-30; $400 per day of hospital confinement, days 31+
Extended Care Facility	$100 per day	$200 per day
Donor	$100 per day	$200 per day
Home Health Care	$100 per day	$200 per day
Hospice Care	$100 per day; maximum of 365 days per lifetime	$200 per day; maximum of 365 days per lifetime

US Government, Charity Hospital or HMO	$100 per day of hospital confinement, days 1-30; $100 per day of hospital confinement, days 31+	$200 per day of hospital confinement, days 1-30; $400 per day of hospital confinement, days 31+
Miscellaneous Benefit Rider	Level 1	Level 2
Cancer Treatment Center Evaluation or Consultation - 1 per lifetime	Not included	$750
Evaluation or Consultation Travel and Lodging - 1 per lifetime	Not included	$350
Second / Third Surgical Opinion Per diagnosis of cancer	$300 / $300	$300 / $300
Drugs and Medicine	$150 per inpatient confinement; $50 per outpatient prescription, maximum $150 per month	
Hair Piece (Wig) - 1 per lifetime	$150	$150
Transportation and Lodging Transportation - maximum 12 tripsper calendar year for all modes of transportation combined Lodging - up to a maximum of 100 days per calendar year	actual coach fare or $0.40 per mile for travel by bus, plane or train; $0.40 per mile for travel by car; $50 per day for lodging	actual coach fare or $0.75 per mile for travel by bus, plane or train; $0.75 per mile for travel by car; $100 per day for lodging
Family Member Transportation and Lodging Transportation - maximum 12 trips per calendar year for all modes of transportation combined Lodging - up to a maximum of 100 days per calendar year	actual coach fare or $0.40 per mile for travel by bus, plane or train; $0.40 per mile for travel by car; $50 per day for lodging	actual coach fare or $0.75 per mile for travel by bus, plane or train; $0.75 per mile for travel by car; $100 per day for lodging
Blood, Plasma and Platelets	$300 per day	$300 per day
Ambulance Maximum of 2 trips per hospital confinement for all modes of transportation combined	Ground: $200 per trip Air: $2,000 per trip	Ground: $200 per trip Air: $2,000 per trip
Inpatient Special Nursing Services	$150 per day of hospital confinement	$150 per day of hospital confinement
Outpatient Special Nursing Services	$150 per day	$150 per day
Medical Equipment Maximum of 1 benefit per calendar year	Not included	$150
Physical, Occupational, Speech, Audio Therapy and Psychotherapy	$25 per visit; maximum of $1,000 per calendar year	$25 per visit; maximum of $1,000 per calendar year
Waiver of Premium	Included	Included
Internal Cancer First Occurrence Benefit Rider	Not included	Level 1
Lump Sum Benefit Maximum 1 per lifetime	Not included	Insured or Spouse: $2,500 Eligible Dependent Child(ren): $3,750
Increase in Coverage	Only available at annual renewal. Must be approved by APL and premium rates will be based upon the insured's attained age. Subject to the Time Limit on Certain Defenses and Pre-Existing Condition provisions, as defined in the policy.	
Additional Rider(s)		
Portability Amendment Rider	Included	
Continuity of Coverage Amendment Rider (Takeover)	Included, credit given for time served under prior coverage for: Pre-Existing Condition Limitation Eligibility Requirements	

Plan 1 - Monthly Premium*				
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
18+	$14.00	$24.50	$16.60	$27.00
Plan 1 – Bi-Weekly Premium*				
18+	$7.00	$12.25	$8.30	$13.50
Plan 2 - Monthly Premium*				
18+	$22.30	$38.90	$26.30	$42.90
Plan 2 – Bi-Weekly Premium*				
18+	$11.15	$19.45	$13.15	$21.45

Louisiana Machinery
Portable Term Life Insurance

Help provide financial protection for your loved ones

Will your loved ones be afforded the same lifestyle and opportunities after you're gone? Whether you've never had life insurance or simply want more coverage, you can help protect your family's future with APL's Portable Term Life Insurance.

Key features

- Portable coverage goes with you, through the end of the term, if you change jobs or retire
- You choose the period of time ("term") that best suits your current stage of life
- Insure your family with options for your spouse and child(ren) (employee coverage required)
- No health questions or exams at initial enrollment*

Family Coverage

Spouse Life Benefit

- Term (period of time) is the same length as yours

Child Life Benefit

- Children ages 14 days to 26 years old
- One rate insures all eligible children in your household

Summary of Benefits

	Plan 1	Plan 2
Certificate Term	20 Years	30 Years
Benefit Amounts *All face amounts may not be available for all ages.*	Employee: $10,000 to $150,000 in $1,000 increments Spouse: $10,000 to $100,000 in $1,000 increments Child(ren): $50,000	Employee: $10,000 to $150,000 in $1,000 increments Spouse: $10,000 to $100,000 in $1,000 increments Child(ren): $50,000
Insured Guarantee Issue	$150,000	$150,000
Spouse Guarantee Issue	100% of Insured Amount to a maximum of $100,000	100% of Insured Amount to a maximum of $100,000
Child(ren) Guarantee Issue	$50,000	$50,000
Accidental Death Benefit Rider	Included	Included
Certificate Portability	Included	Included

Louisiana Machinery Life Rates

Issue Age	APL 20 Year Uni-Nicotine Premium Per $1000 No Policy Fee Face Amount $10,000 - $150,000 Monthly	Annual	APL 30 Year Uni-Nicotine Premium Per $1000 No Policy Fee Face Amount $10,000 - $150,000 Monthly	Annual
17	0.31	3.66	0.35	4.19
18	0.31	3.66	0.35	4.19
19	0.31	3.66	0.35	4.19
20	0.31	3.66	0.35	4.19
21	0.31	3.66	0.35	4.19
22	0.31	3.66	0.35	4.19
23	0.31	3.66	0.35	4.19
24	0.31	3.66	0.35	4.19
25	0.31	3.66	0.35	4.19
26	0.31	3.66	0.35	4.19
27	0.31	3.66	0.35	4.19
28	0.31	3.66	0.35	4.19
29	0.31	3.66	0.35	4.19
30	0.31	3.66	0.35	4.19
31	0.31	3.66	0.35	4.19
32	0.31	3.66	0.35	4.19
33	0.31	3.66	0.35	4.19
34	0.31	3.66	0.36	4.32
35	0.31	3.66	0.38	4.58
36	0.31	3.66	0.40	4.84
37	0.32	3.79	0.44	5.23
38	0.34	4.05	0.46	5.49
39	0.36	4.32	0.49	5.89

Issue Age	APL 20 Year Uni-Nicotine Premium Per $1000 No Policy Fee Face Amount $10,000 - $150,000 Monthly	Annual	APL 30 Year Uni-Nicotine Premium Per $1000 No Policy Fee Face Amount $10,000 - $150,000 Monthly	Annual
40	0.38	4.58	0.53	6.41
41	0.41	4.97	0.57	6.80
42	0.45	5.36	0.62	7.46
43	0.48	5.76	0.68	8.11
44	0.52	6.28	0.74	8.89
45	0.58	6.93	0.81	9.68
46	0.62	7.46	0.86	10.33
47	0.66	7.98	0.94	11.25
48	0.72	8.63	1.02	12.30
49	0.77	9.29	1.11	13.34
50	0.84	10.07	1.20	14.39
51	0.89	10.73	1.29	15.43
52	0.96	11.51	1.38	16.61
53	1.04	12.43	1.49	17.92
54	1.11	13.34	1.61	19.36
55	1.20	14.39	1.73	20.80
56	1.30	15.57	1.89	22.63
57	1.41	16.87	2.05	24.59
58	1.53	18.31	2.22	26.68
59	1.67	20.01	2.42	29.04
60	1.82	21.84	2.63	31.52
61	2.01	24.07		
62	2.20	26.42		
63	2.43	29.17		
64	2.68	32.18		
65	2.96	35.58		
66	3.25	38.98		
67	3.56	42.77		
68	3.89	46.70		
69	4.27	51.27		
70	4.69	56.24		

CHILD(REN) RATE PER MONTH
0.52

Portable Term Life Insurance

Eligible dependent(s) means your lawful spouse or any other person lawfully defined as the spouse; and/or your child (natural, step, adopted or placed for adoption, and any other child lawfully defined as a child) who is at least 14 days old and under 26 years of age. Lawfully means as defined under the civil union, domestic partnership, marriage or other family or domestic relations laws, including case law, of the state where the policy is delivered or issued for delivery. You must be actively at work on the effective date or coverage will be deferred until you return to work. Dependent coverage will not become effective while the dependent is confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or hospitalized.

Limitations

If a covered person commits suicide, while sane or insane, within two years from the covered person's certificate effective date, APL will not pay the benefit proceeds. Instead, APL's liability will be limited to a return to the beneficiary of all premiums paid by you and a return to the policyholder of all premiums paid by the policyholder, less any indebtedness.

Accidental Death Benefit Rider

If applicable to the plan, death must result from and occur within 180 days of a qualifying accidental bodily injury as defined in the rider. No benefits will be payable under this rider if the covered person's death results from, or is contributed to, whether directly or indirectly from war or any act caused by war while the covered person is in military service (the term "war" includes declared or undeclared war or any conflict between the armed forces of any country or countries); intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; participating in a riot, insurrection or terrorist activity; voluntarily taking any drug (unless administered by a physician and taken according to the physician's instructions or an over the counter drug taken in accordance with instructions); poison, gas or fumes, unless a direct result of an occupational accident; committing or attempting to commit an illegal act, which would constitute a felony; or air travel, except while riding as a fare-paying passenger on a regularly scheduled commercial airline, or as a passenger for transportation only and not as a pilot or crew member.

Termination of Insurance

Insurance coverage under this certificate, including any attached riders, will end on the earliest of these dates: the date the grace period ends if the premium remains unpaid; the date the term period expires, as shown on the certificate schedule of insurance; the date you convert coverage to an individual plan; the date in which you request to terminate the coverage for an eligible dependent; the date the covered person no longer qualifies as an insured or eligible dependent; the date the policy terminates if portability coverage has not been elected or the date of the covered person's death. APL may terminate the coverage of any person who submits a fraudulent claim.

Continuation of Coverage

Coverage under the certificate will continue for all covered persons under the certificate if the insured is totally disabled on the date coverage ends if the insured notifies APL of their total disability on the date coverage ends, the insured provides acceptable documentation of their total disability and the policyholder continues to pay the due premium. The benefits continued will be the same as those that were in force under the certificate on the day before total disability. Continuation of coverage will end on the earliest of six months, the duration of the insured's total disability or the date the insured elects portability or conversion.

Portability

If your coverage terminates for reasons other than non-payment of premium, you may be eligible to port coverage. The requirements for election of portability, election of dependent portability and termination of portability are defined in your certificate. If you are not eligible for portability coverage, then you may be eligible to convert to an individual policy.

Conversion

If your coverage ended for any reason other than non-payment of premium, you may be eligible to convert coverage during one of the conversion periods. The conversion periods, requirements for election of conversion and election of dependent conversion are defined in the your certificate.

Frequently Asked Questions QHDHP and HSA

QHDHP Questions

Q: WHAT IS A QHDHP?
A: Qualified High Deductible Health Plan (QHDHP) is a plan that meets certain IRS criteria. You must be covered by a Qualified High Deductible Health Plan to contribute to a Health Savings Account (HSA). Here are the basic requirements:

- For 2024, the plan deductible must be at least $1,600 for single or $3,200 for family coverage.
- For 2024, the plan's maximum out-of-pocket must be less than or equal to $8,050 for single or $16,100 for family coverage, including the deductible.
- All covered medical services, including prescriptions, are integrated with the medical deductible and out- of-pocket maximum.

Q. CAN A HEALTH PLAN THAT DOESN'T HAVE A DEDUCTIBLE FOR PREVENTIVE CARE STILL QUALIFY AS A QHDHP?
A. Yes, a plan can still be considered a Qualified High Deductible Health Plan even if it doesn't have a deductible or has just a small deductible or Copayment – for preventive care. Preventive care may include periodic health evaluations, routine prenatal and well-childcare, child and adult immunizations, and certain screening services.

Q. IF MY HEALTH PLAN HAS A LIFETIME MAXIMUM LIMIT ON CERTAIN BENEFITS, DOES IT STILL QUALIFY AS A QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN?
A. Yes. A lifetime maximum limit on certain benefits does not keep a plan from qualifying as a Qualified High Deductible Health Plan.

Q. IS IT MORE EXPENSIVE UNDER THE QHDHP TO USE OUT-OF-NETWORK PROVIDERS?
A. Yes. You will be responsible for a larger portion of the costs with out-of-network providers.

Q. CAN I BE COVERED BY ANOTHER HEALTH PLAN AND STILL BE ELIGIBLE FOR AN HSA?
A. The answer depends on the type of coverage you have with the other plan:

- If the other plan is not a Qualified High Deductible Health Plan or you have a Flexible Spending Account (FSA) or a Health Reimbursement Arrangement (HRA) under the other plan that pays for medical expenses, you're not eligible for an HSA.
- If the other plan is a Qualified High Deductible Health Plan, you are eligible for an HSA. And it's OK if you have an FSA or HRA with this second qualified high deductible plan as you can't use the FSA or HRA to pay for medical expenses until you satisfy the deductible. However, you can use these spending accounts to pay for vision, dental care, and preventive services at any time.

Q. WHAT OTHER TYPES OF HEALTH COVERAGE CAN I HAVE AND STILL HAVE AN HSA?
A. You can have an HSA if you have one or more of the following types of coverage in addition to a Qualified High Deductible Health Plan:

- Insurance under which most of the coverage relates to workers' compensation laws, lawsuits, property ownership, or use of property, such as automobile insurance
- Insurance for a specified disease or illness, like a cancer policy
- Insurance paying a fixed amount per day – or other period – of hospitalization coverage – whether through insurance or otherwise – for accidents, disability, dental care, vision care, or long-term care, Employee Assistance Program, disease management, wellness programs, Drug discount cards, Eligibility for Veterans Affairs (VA) benefits, unless you have received VA health benefits in the last three months.

Frequently Asked Questions QHDHP and HSA

Establishing an HSA

Q: AM I ELIGIBLE FOR AN HSA?
A. To be eligible, the following must be true:

- You must be covered by a Qualified High Deductible Health Plan
- You cannot be claimed as someone's dependent
- You are not covered by other disqualifying insurance as described in the previous questions
- You are not enrolled in Medicare

Q. WHOSE RESPONSIBILITY IS IT TO SET UP AN HSA ACCOUNT?
A. It is solely your responsibility. This account belongs to you, not your employer.

Q. HOW CAN I SET UP AN HSA?
A. If you are eligible for an HSA, you can open one with a qualified HSA trustee or custodian, such as a bank or insurance company. You don't need permission from the IRS.

Contributions to HSAs

Q. WHO CAN CONTRIBUTE TO MY HSA?
A. Any person – an eligible individual, an employer, a family member, or any other person – can contribute to your HSA. Each contribution counts toward the maximum amount you can contribute to the HSA in the year. See your tax advisor for details.

Q. IS THERE A LIFETIME MAXIMUM CONTRIBUTION LIMIT FOR THE HSA?
A. No. Contribution limits only apply to the annual IRS allowed amount.

Q. HOW MUCH CAN I CONTRIBUTE TO AN HSA?
A. The maximum amount you can contribute to an HSA in any year is dependent on whether you have single coverage or family coverage. The IRS-allowed amounts for 2024 are $4,150 for single coverage and $8,300 for family coverage.

Q. WHEN CAN I MAKE "CATCH-UP" CONTRIBUTIONS TO AN HSA?
A. If you are age 55 and older, or turning 55 during the calendar year, you can make additional catch-up contributions to your HSA. For 2024, the maximum additional catch-up contribution is $1,000. If you have QHDHP coverage for the full year, you can make the full catch-up contribution, no matter when your 55th birthday falls during the year. If you do not have QHDHP coverage for the full year, you must prorate your catch-up contribution for the number of full months you're eligible – i.e., had QHDHP coverage. However, if you are covered on December 1, you are treated as an eligible individual for the entire year and you can make the full contribution.

Q. HOW DO I MAKE CONTRIBUTIONS TO MY HSA?
A. You can contribute through payroll deductions, which are tax-free contributions. You also can make cash contributions directly into your HSA. Banks typically accept rollovers or transfers of assets from an Archer Medical Savings Account (MSA), Individual Retirement Account (IRA), or another HSA – in accordance with the IRS requirements – as long as these rollover contributions are made in cash.

Q. HOW ARE MY HSA CONTRIBUTIONS TREATED ON MY FEDERAL TAXES?
A. When you contribute to an HSA, you can deduct the amount – up to the maximum contribution limit discussed above – from your adjusted gross income. You can deduct your contributions even if you don't itemize. Banks typically send required forms annually to the IRS and to you for year-end tax preparation. State tax treatments may vary. You should consult a tax advisor to address specific circumstances.

Q. WHAT IF MY EMPLOYER MAKES A CONTRIBUTION TO MY HSA, BUT I NEVER SET UP MY HSA ACCOUNT?
A. You will forfeit the employer contribution.

Q. HOW ARE EMPLOYER CONTRIBUTIONS TO MY HSA TREATED ON MY TAXES?
A. If your employer makes a contribution to your HSA, the contribution is not taxable to you. The contribution is excluded from your income. You should consult a tax advisor to address specific circumstances.

Frequently Asked Questions QHDHP and HSA

Contributions to HSAs *(cont.)*

Q. WHEN IS THE YEARLY DEADLINE FOR CONTRIBUTIONS TO MY HSA?
A. You can make HSA contributions for a particular year no later than the deadline, without extensions, for filing your federal income tax return for that year. For example, you can make contributions for 2024 until April 15, 2025. This information is only applicable to individual contributions, not your regular payroll deductions.

Q. WHO IS RESPONSIBLE FOR DETERMINING THE AMOUNT OF ELIGIBLE CONTRIBUTIONS?
A. Under IRS rules, as the account holder, you are responsible for determining the amount of eligible HSA contributions each year. Check with your tax advisor about your personal situation.

Q. WHAT HAPPENS IF MY HSA CONTRIBUTIONS EXCEED THE AMOUNT THAT MAY BE DEDUCTED OR EXCLUDED FROM MY GROSS INCOME?
A. Contributions you or anyone else, such as your employer, make to your HSA that exceed the amount allowed by law, or which are made during any year when you're not eligible to contribute, are called "excess contributions." You cannot deduct these excess contributions, and they are included in your gross income. There is also a 6% penalty on the excess funds, including any earnings through interest or investments, for each year they remain in your HSA. However, you can avoid this tax on excess contributions if you don't deduct the contributions on your taxes, and you take them out of your HSA along with any interest or capital gains they've earned, before the due date for filing your federal income tax return, including extensions, for the year in which you made the excess contributions. If you take the excess funds out of your HSA, the funds and any net income from the excess contribution is taxable as income for the year in which the contribution was made. Rollover contributions from a previous year or from an Archer MSA don't count when determining if you've made an excess contribution. Funds transferred from an Individual Retirement Account (IRA) do apply to the maximum contribution limit.

Note: if you roll over HSA funds from another HSA, and those contributions were made in the same calendar year, the rollover would apply to the limit.

Q. WHEN CAN I BEGIN MAKING CONTRIBUTIONS?
A. If you just signed up for the Qualified High Deductible Health Plan and HSA, you are required to wait until after the effective date of the plan before contributing to the HSA. If you contribute before the effective date, you are essentially contributing without Qualified High Deductible Health Plan coverage, and the contributions would then be subject to a penalty.

Using HSA Funds

Q. DOES MY ENTIRE YEARLY HSA CONTRIBUTION HAVE TO BE IN THE ACCOUNT BEFORE I CAN USE THE FUNDS?
A. No. You don't have to wait until all the funds are deposited to start making withdrawals, but you can only spend money actually in the account.

Q. HOW DO I ACCESS MY HSA FUNDS?
A. You will receive a debit card (thru most banks) that you can use to pay expenses directly from your account. Swipe the card at the provider's office or pharmacy. Or write the card number on your provider's bill to pay directly from the HSA.

***Q. CAN MY HSA COVER EXPENSES THAT ARE NOT COVERED UNDER MY QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN*?**
A. Yes. In addition to using the HSA for expenses that count toward your deductible, you can use it for expenses like over-the-counter drugs (with a written prescription), vision care, dental services, and even long-term care insurance.

Q. WHAT HAPPENS IF ALL MY HSA FUNDS ARE GONE, BUT I STILL HAVE A DEDUCTIBLE LEFT TO SATISFY?
A. You are responsible for paying your medical expenses until you reach the deductible. Even if you put enough in your HSA to cover your deductible, you may come up short if you use HSA funds for over-the-counter drugs (with written prescription), dental services, or vision expenses.

Q. DO I HAVE TO USE ALL MY HSA FUNDS EACH YEAR?
A. No. Your HSA is like a savings account. The funds remain in your account until you spend them.

Frequently Asked Questions QHDHP and HSA

Using HSA Funds *(cont.)*

Q. HOW CAN I FIND OUT HOW MUCH IS IN MY HSA?
A. To view the current balance and account activity, you can go online to your bank's website and review your account summary. It's a good idea to check your balance just to be sure you have sufficient funds to cover the entire expense.

Q. WHAT HAPPENS IF I USE HSA FUNDS FOR NON-QUALIFIED EXPENSES?
A. If you use HSA funds for expenses the IRS doesn't allow, you could be charged tax and penalties by the IRS. You should check with a tax advisor for advice on handling this situation. It's best to pay the funds back to the HSA account by filling out a deposit slip with the payment and checking the "redeposit" box.

Q. IF MY DEBIT CARD DOESN'T WORK, WHAT COULD BE WRONG?
A. The most common reasons a Debit Card is declined are:

- The card hasn't been activated
- You are using the card at a non-qualified location
- You don't have enough money in the HSA to cover the expense

Q. HOW DO I PAY FOR PRESCRIPTIONS AND OTHER MEDICATIONS WITH THE DEBIT CARD?
A. Present the card for payment or swipe it through the credit card machine at the pharmacy counter. The funds are automatically taken out of your HSA. You can also buy qualified over the counter (OTC) medications with the card.

Q. HOW DO I PAY DOCTORS' BILLS USING MY HSA?
A. Unless the doctor requires payment at the time of service, wait until the doctor sends a bill showing what is owed after the claim is processed. Then check the box on the bill to include the 8–16-digit debit card number, and send the bill back to the provider. You can also give the doctor the account number over the phone.

Q. IF I OVERPAY A DOCTOR, WHAT'S THE PROCESS FOR REIMBURSEMENT?
A. Ask the doctor's staff to credit the HSA account by swiping the debit card and reversing the charge for the overpayment. If the doctor sends you a check instead, endorse the check and send it to your HSA Bank with a deposit slip. Be sure to mark the "Redeposit" box on the deposit slip.

Q. WHAT SHOULD I DO WITH MY RECEIPTS FOR HSA TRANSACTIONS?
A. Save all receipts and documentation for all HSA transactions in case the IRS asks for verification that a distribution was for a qualified medical expense. It is your responsibility to maintain records in case of an IRS audit.

Q. WHAT HAPPENS IF MY HEALTHCARE EXPENSE IS MORE THAN THE AMOUNT IN THE HSA?
A. If the expense is more than the current HSA balance, use the debit card to pay the exact amount left in the account and pay the remaining cost by some other means. Once more funds are added to the HSA, you can request reimbursement.

Q. CAN I SAVE MY HSA FUNDS FOR RETIREMENT HEALTHCARE EXPENSES RATHER THAN USING THEM NOW?
A. Yes, you can save your HSA funds for future healthcare expenses.

Frequently Asked Questions QHDHP and HSA

Investments and HSAs

Q. IS THE HSA AN INVESTMENT ACCOUNT?
A. Think about your HSA as two accounts. First and foremost, the HSA is an interest-bearing savings account that allows you quick and easy access to pre-tax dollars to help you pay for healthcare expenses. Your employer's contribution and any contributions you make go into this savings account. Once you reach a minimum balance to keep as a reserve in your savings account for healthcare expenses, you can invest the remaining dollars in a self-directed brokerage account, or a money market fund sweep account. You have a wide range of nationally recognized funds to choose from.

Q. WHAT IS THE MINIMUM BALANCE I MUST HAVE IN MY HSA TO HAVE AN INVESTMENT ACCOUNT?
A. Different banks have different criteria for minimum balances. Transaction fees may apply if you elect to invest your HSA money in mutual funds or other investments. Check with your respective bank for specific information.

Dependents and HSAs

Q. I AM DIVORCED AND COUNT MY DAUGHTER AS A DEPENDENT ON MY TAX RETURN EVERY OTHER YEAR. CAN I COVER HER UNDER MY QHDHP AND USE HSA FUNDS TO PAY FOR HER MEDICAL EXPENSES?
A. Yes. The IRS allows divorced parents to use HSA dollars to pay for dependent expenses as long as the child is a qualified dependent under Internal Revenue Code Section 152. A child of divorced or separated parents can be treated as a dependent of both parents. Each parent can use their HSA funds to pay for the child's qualified medical expenses, even if the other parent claims the child's dependency exemption, if:

- The child is in the custody of one or both parents for more than half the year;
- The child receives over half of his/her support during the year from his/ her parents; and

The child's parents:

- Are divorced or legally separated under a decree of divorce or separate maintenance;
- Are separated under a written separation agreement; or
- Live apart at all times during the last 6 months of the year.

Q. IF BOTH SPOUSES ARE COVERED INDIVIDUALLY BY THEIR RESPECTIVE EMPLOYER, WHO DETERMINES WHO COVERS CHILDREN?
A. If dependents are covered under both policies, the dependents will be primary on the plan for the parent who has a birthday first in the calendar year. Example: if you and your spouse both cover your children and your birthdays are March 10 for mom and July 9 for dad, the dependents would be primary on mom's plan. This is a standard practice among all insurers.

Q. IF I COVER MY CHILD AND MYSELF ON MY PLAN, AND MY EX-HUSBAND COVERS HIMSELF AND OUR CHILD ON HIS PLAN, CAN I ELECT THE HAS (if our child is claimed as a dependent on his taxes)?
A. Yes. You can have a Qualified High Deductible Health Plan covering employee and child. Your husband can continue to cover your child as well. The IRS rule revolves around who is the owner of the HSA. Since you, and not your child, own the HSA, you can elect the HSA and your child can still be covered under both plans.

Q. IF MY CHILD HAS ACADEMIC COVERAGE FOR SPORTS, CAN I STILL COVER HIM OR HER AS A DEPENDENT UNDER MY QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN WITH HSA?
A. Yes. You can still cover the child on the Qualified High Deductible Health Plan and use HSA dollars for the child's medical expenses.

Rollovers and Transfers from HSAs or MSAs

Q. WHAT ARE THE RULES ABOUT ROLLOVERS AND TRANSFERS OF HSAS?
A. If you have HSAs or Archer MSAs with other financial institutions, you can transfer these funds into your HSA, either by rollover or transfer.

- Rollovers –The current trustee of the funds – the custodian – writes a check to you. You have 60 days to deposit the check into your HSA or you'll be subject to taxes and penalties. By law, this method is limited to one rollover per calendar year per account.
- Transfers –The current trustee sends the money directly to your trustee on your behalf. The law permits multiple transfers, but trustees aren't obligated to do multiple transfers. Either trustee can put limits on sending or receiving fund transfers, and bank fees may be applied to the transactions. You may have to pay an account-closing fee to the current account trustee.

Frequently Asked Questions QHDHP and HSA

Rollovers from an Individual Retirement Account (IRA)

Q. DO I HAVE TO KEEP QHDHP COVERAGE TO AVOID TAXES ON THE TRANSFER OF IRA FUNDS TO AN HSA?
A. To avoid taxes and penalties, you must be covered by an QHDHP and remain a qualified individual for 12 months after the transfer of funds.

Q. WHEN AND HOW CAN I TRANSFER FUNDS FROM MY IRA TO MY HSA?
A. The IRS allowed IRA-to-HSA transfers starting January 1, 2007.You can do this kind of transfer only one time. However, if you change coverage from single to family in the same year, you may elect to transfer additional funds from the IRA, as long as you don't exceed the maximum annual contribution limit.

Q. WHAT TYPES OF IRAS ARE ALLOWED TO TRANSFER TO AN HSA?
A. An individual can transfer funds from Traditional or Roth IRAs only. SEP and Simple IRAs do not qualify for transfer.

Tax Treatment of HSAs

Q. HOW ARE EARNINGS ON HSA FUNDS TREATED FOR FEDERAL TAX PURPOSES?
A. Earnings on amounts in an HSA are not taxable unless the earnings are used for ineligible expenses - generally something other than healthcare. Some states do tax HSA funds, so check with your tax advisor.

Q. ARE THERE ANY TAX ISSUES IF I PLEDGE MY HSA AS SECURITY FOR A LOAN?
A. Any portion of your HSA that you pledge as security for a loan is treated as being distributed to you in that year. In addition to any regular income tax you owe, you may also be liable for a 20% penalty for ineligible distribution.

Q. WHAT TAX FORMS RELATE TO HSA's?
A. HSA-related forms include:

- Form 1099-SA – your account custodian, sends this form to you by January 31. The form reports all distributions from your account.
- Form 5498-SA – your account custodian sends this form to you by May 31. The form reports all contributions, rollovers, and transfers to your account. You can also view your paycheck deductions on the W-2 form your employer sends.
- Form 8889 –You or your tax preparer complete this form when you file your taxes. The form reports all HSA contributions and distributions – information shown on your 1099-SA and W-2.

Distributions from HSAs

Q. WHEN CAN I WITHDRAW FUNDS FROM MY HSA?
A. You can withdraw funds from your HSA at any time.

Q. HOW ARE DISTRIBUTIONS FROM MY HSA TAXED?
A. Distributions from your HSA are generally excluded from federal income tax if you are using the money for healthcare expenses not covered by insurance. If you use the funds for anything other than healthcare expenses, the distribution is included in your taxable income, and you may incur an additional penalty.

If you are under age 65 and use your HSA funds to pay for a non-qualified medical expense, you will pay income taxes and a 20% (10% for distributions before 2011) excise tax on that amount. If you are over 65, or become disabled at any age, and use your HSA funds to pay for a non-qualified medical expense, you will pay ordinary taxes (but not excise tax) on that amount. It is your responsibility to pay the taxes and/or penalties on HSA withdrawals used for non-qualified medical expenses and report them on your tax return. Failure to do so may result in additional penalties.

Q. WHAT HAPPENS IF I RECEIVE AN HSA DISTRIBUTION AS THE RESULT OF A MISTAKE?
A. If the IRS is satisfied that there is clear and convincing evidence that amounts were distributed from your HSA because of a reasonable mistake, you may repay the mistaken distribution no later than April 15 following the first year you knew, or should have known, about the mistake. Under these circumstances, the distribution isn't included in your gross income or subject to the 20% penalty (10% for distributions before 2011). The repayment is not subject to the 6% penalty for excess contributions, but it will be subject to payroll and income taxes.

Frequently Asked Questions QHDHP and HSA

Distributions from HSAs (*continue*)

Q. WHAT EXPENSES ARE ELIGIBLE FOR TAX-FREE DISTRIBUTION FROM MY HSA?
A. Distributions made for "qualified medical expenses" are generally excluded from your taxable income. "Qualified medical expenses" means amounts paid for healthcare, as defined in Section 213(d) of the Code and Publication 969, for yourself, your spouse, or your dependents – but only if the care was not covered by insurance or another health plan, including a Limited Purpose FSA.

Qualified medical expenses include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, as well as for transportation primarily for and essential to such care. Qualified medical expenses don't include insurance premiums other than premiums for long-term care insurance, premiums on a health plan during any period of continuation coverage required by federal law, COBRA coverage, or premiums for healthcare coverage while an individual receives unemployment compensation.

Q. IS MY CUSTODIAN RESPONSIBLE FOR DETERMINING WHETHER HSA DISTRIBUTIONS ARE USED FOR HEALTHCARE EXPENSES?
A. No, it is your responsibility to determine the tax consequences of any distributions, to maintain adequate records for tax purposes, and to pay any taxes and penalties resulting from a distribution. Please consult your legal or tax advisor with any questions.

Q. IF I AM A RETIREE AND AGE 65 OR OLDER, MAY I RECEIVE TAX-FREE DISTRIBUTIONS FROM AN HSA TO PAY MY CONTRIBUTION TO MY EMPLOYER'S RETIREE HEALTH COVERAGE?
A. After age 65, you may receive tax-free distributions from an HSA to pay for your employer's retiree health insurance coverage.

Divorce or Death of HSA Accountholder

Q. WHAT HAPPENS IF MY HSA IS TRANSFERRED BECAUSE OF A DIVORCE DECREE?
A. If your HSA is transferred to your spouse because of a divorce decree, it's not considered a taxable transfer. After the transfer, your former spouse is the accountholder of the HSA, but the former spouse must ask your bank to transfer the account to his or her name, must provide the bank with a certified copy of the divorce decree and property settlement or transfer agreement, and must sign appropriate documents to establish the account in his or her name.

Q. WHAT HAPPENS TO MY HSA WHEN I DIE?
A. You can designate one or more beneficiaries to receive your HSA when you die. At any time you can also cancel a beneficiary designation and, if desired, designate different individuals as beneficiaries. If you don't have a valid beneficiary designation, the bank typically distributes your HSA assets to your estate. In certain states, you'll need your spouse's consent if you wish to name a person other than, or in addition to, your spouse as beneficiary or change an existing beneficiary designation. Consult with your attorney before making a beneficiary designation.

Q. WHAT ARE THE TAX CONSEQUENCES OF HSA DISTRIBUTIONS FOLLOWING MY DEATH?
A. If your spouse is the named beneficiary of your HSA, your HSA becomes your spouse's HSA. The surviving spouse is not required to include any HSA amount in gross income for tax purposes as a result of your death, and he or she is subject to income tax only on those distributions that are not made for qualified healthcare expenses.

If, at your death, your HSA passes to a named beneficiary other than your spouse, the HSA ceases to be an HSA as of the date of your death. The beneficiary is required to include the fair market value of the HSA assets
– at the date of your death – in his or her gross income for the taxable year that includes the date of death. The includable amount is reduced by the amount in the HSA used, within one year of your death, to pay your qualified healthcare expenses incurred before death. If there is no named beneficiary of your HSA, the HSA ceases to be an HSA as of the date of your death, and the fair market value of the HSA assets as of the date of death is included in your gross income for the year you died.

Frequently Asked Questions QHDHP and HSA

Statements and Filing Requirements

Q. WHAT INFORMATION DO I NEED TO FILE WITH THE IRS?
A. Your Bank typically sends a 1099 Form to the IRS and to you each year showing the value of your HSA as of December 31 of the previous year along with a report of the contributions to your HSA for the previous year. The Bank reports all contributions as tax-deductible contributions by you, unless they receive:

- Certification from your employer that the employer made contributions
- Notification from you that a contribution is a rollover or transfer contribution

Unless you give the bank written notice otherwise, the bank assumes that any distribution, whether by check, debit card, or otherwise, is a "normal distribution" for tax reporting. Normal distributions include distributions for qualified healthcare expenses and exclude:

- Return of excess contributions
- Distributions following your disability
- Distributions following your death
- Prohibited transactions

You or your tax preparer will complete Form 8889 when you file your taxes. The form reports all HSA contributions and distributions – information shown on your 1099-SA and W-2.

Mid-Year Enrollees to the QHDHP and HSA

Q. WHAT IS A MID-YEAR ENROLLEE?
A. A mid-year enrollee is anyone who enrolls in an QHDHP with an effective date other than January 1 or becomes eligible to contribute to the HSA after January 1.

Q. IF I ENROLL IN AN QHDHP AFTER JANUARY, HOW MUCH CAN I CONTRIBUTE FOR THE YEAR?
A. For 2024, you may contribute $4,150 for single coverage and $8,300 for family coverage – regardless of the enrollment date.

Q. IF I ENROLL AFTER JANUARY, DO I HAVE TO KEEP QHDHP COVERAGE TO AVOID TAXES ON A FULL-YEAR CONTRIBUTION?
A. You must be covered by an QHDHP and remain a qualified individual for the remainder of the current taxable year and the following year. If not, you will be subject to taxes for the months not covered by an QHDHP.

Miscellaneous

Q. SHOULD I KNOW ABOUT ANY OTHER LEGAL REQUIREMENTS?
A. In addition to the legal requirements mentioned in this question and answer document, your HSA is subject to the following rules:

- You can't invest your HSA funds in life insurance contracts
- Except for investments in a common trust fund or common investment fund, you can't mix your HSA assets with any other funds or accounts

Q. WHAT HAPPENS TO MY ACCOUNT IF I LEAVE MY CURRENT EMPLOYER?
A. Your HSA is yours forever and is portable, so it goes with you if you leave your employer. You can still use the funds even if you don't get an QHDHP elsewhere. However, you can keep contributing to the HSA only if you enroll in another QHDHP.

Q. WHERE CAN I GO TO FIND MORE INFORMATION ABOUT IRS REGULATIONS FOR HSA's?
A. Go to www.irs.gov and type "HSA" in the search box at the top of the home page.

Q. WHAT HAPPENS IF I HAVE A LIFE EVENT, LIKE GETTING MARRIED OR HAVING A CHILD?
A. Consult with your human resources representative. When you change your coverage type or deductible level, your maximum annual contribution limit may be affected.

Frequently Asked Questions QHDHP and HSA

Example 1 – How It Works – Single Coverage

Lucy enrolls in a Qualified High Deductible Health Plan with the following features:

- $2,500 single deductible
- 80% coinsurance for in-network providers

She also has a Health Savings Account. Even though Lucy can put up to $4,150 (in 2024) in a Health Savings Account, Lucy funds the account up to the $2,500 deductible.

Year 1	Year 2
Lucy's healthcare costs are higher than usual because she breaks her leg. Her expenses for the year total $10,865: • Hospital doctor's services ..... $650 • Hospital facility cost..... $7,500 • X-rays at hospital ..... $1,200 • Specialist Office visit ..... $315 • Six physical therapy sessions..... $1,050 • Two prescriptions $150	Lucy's healthcare costs aren't as high as last year. She has an illness that requires two visits to the doctor's office and two prescriptions. Her expenses for the year total $435: • Two doctor's office visits .....$200 • Two prescriptions..... $235
Here's how Lucy uses her HSA to pay for healthcare HSA fund .....$2,500 Total cost of services .....$10,865 Lucy uses HSA to pay deductible.....$2,500 Balance of cost of services.....$8,365 PPO plan pays 80% of costs .....$6,692 Lucy pays remaining 20%.....$1,673 HSA funds remaining $0	Here's how Lucy uses her HSA to pay for healthcare HAS funds.....$2,500 Total cost of services..... $435 Lucy uses HSA to pay..... $435 HSA funds remaining..... $2,065
Summary When the accident happened, Lucy used the HSA dollars deposited so far to cover her deductible. She wrote a check for the rest and then got reimbursed from her HSA when more money went into the account. After Lucy used the HSA to meet her $2,500 deductible, her health plan kicked in to help her pay the remaining $6,692. The plan paid 80% coinsurance, and Lucy paid the other 20% out of pocket. Because she used all the money in her HSA, Lucy has a zero balance at the end of the year.	Summary Because her healthcare expenses were only $435, Lucy didn't use all of her HSA funds. She also didn't have to use any of her take-home pay to cover out-of-pocket costs. At the end of the year, she has $2,065 left. She can use the money tax-free for healthcare expenses in the future and even invest it tax-free.

Frequently Asked Questions QHDHP and HSA

Example 2 – How It Works – Family Coverage

Doug chooses a Qualified High Deductible Health Plan that covers himself, his wife Tina, and their two children: 4-year-old John and newborn Julie. His family plan features:

- $5,000 family deductible
- 80% coinsurance for in-network providers

Even though Doug and his employer can put up to $8,300 (in 2024) in a Health Savings Account, Doug funds the account up to the $2,500 deductible.

Year 1	Year 2
Both children get sick once during the year. Not surprisingly, they spread the illness to their dad – but Tina manages to avoid it. Doug, John, and Julie each visit the doctor once. Doug and John need a prescription to treat the illness, and John gets some lab tests. The family's expenses for the year total $775: • Three doctor's office visits.....$300 • Lab tests.....$100 • Three prescriptions.....$375	This year, John is injured – leading to X-rays, a three-day hospital stay, knee surgery, and two prescription drugs. On top of that, both Tina and Julie get sick and have to go to the doctor. The family's expenses for the year total $7,710: • Hospital care..... $3,000 • X-rays .....$250 • Surgeon and anesthesiologist ..... $4,000 • Two doctor's office visits ..... $200 • Two prescriptions $260
Here's how Doug uses an HSA to pay for healthcare HSA fund .....$2,500 Total cost of services.....$775 Doug uses HSA to pay.....$775 HSA funds remaining.....$1,725	Here's how Doug uses an HSA to pay for healthcare.....$4,225 ($2,500 for Year 2 + $1,725 Rollover from previous year) Total cost of services ..... $7,710 Doug uses HSA to pay deductible ..... $2,500 Balance of cost of services..... $5,210 PPO plan pays 80% of costs ..... $4,168 Doug pays remaining 20% with HSA ..... $1,042 HSA funds remaining $683
Summary Because the family's healthcare expenses were only $775, Doug didn't use all of his HSA. At the end of the year, he's spent $775 on out-of-pocket costs, and he still has $1,725 left to use for future healthcare expenses.	Summary Doug used the $2,500 in his HSA to meet the plan's deductible, leaving $1,725 in his account. After meeting the deductible, the family's health benefits kicked in to pay 80% of the remaining healthcare costs. Doug paid the other 20% with his HSA, and he still has $683 left to use for future healthcare expenses.

INFORMATION TO KNOW / LEGISLATIVE NOTICES

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

WAITING PERIOD

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 30 calendar days of regular employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which is combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. COBRA is not applicable until short-term disability is exhausted.

Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether the employer agrees to such reclassification, will change a person's eligibility for benefits.

An **eligible Dependent** includes:

- Your legal spouse, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.
- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following

Dependents:
  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).

- A Dependent does not include the following:
  - A foster Child;
  - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - A Domestic Partner;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
  - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

To be an eligible **Totally Disabled Dependent Child**, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.
- A Totally Disabled Dependent Child age 26 or over must be unmarried.

NON-DUPLICATION OF COVERAGE

Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS

The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:
- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:
- If You have a Dependent Child covered under this Plan who is under the age of 26 and **Totally Disabled, either mentally or physically,** that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan.
- You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year.
- Coverage may continue subject to the following minimum requirements:
  - The Dependent must not be able to hold a self-sustaining job due to the disability; and

- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within Your Waiting Period, Your coverage will become effective the first day of the month coinciding with or following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will begin on that day; or

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 calendar days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 30 calendar days of acquiring the Dependent; or
- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 31 calendar days following the event; or
- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the Annual Open Enrollment period, eligible employees will be able to enroll themselves and their eligible dependents for coverage under this Plan. Covered employees will be able to make changes in coverage for themselves and their eligible dependents.

Coverage Waiting Periods are waived during the Annual Open Enrollment period for covered employees and covered dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the Annual Open Enrollment period, the following will apply:

- The employer will give eligible Employees written notice prior to the start of an Annual Open Enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage will be September 1 following the Annual Open Enrollment period.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
    - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months which runs concurrently with anytime taken under FMLA, provided the applicable Employee contribution is paid when due.
    - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The date of divorce in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or
- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or
- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 12 months from the date Your coverage ended, Your coverage will be reinstated. You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 12 months from the date Your coverage ended, and You did not perform any hours of service that were credited within the 12 month period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee.

REINSTATEMENT OF COVERAGE PROVISION FOR LAYOFF

An Employee that is laid off and recalled within one year will be reinstated and will not be required to satisfy any Waiting Periods. If it is after the one-year period, the Employee will be treated as a new hire and will be required to meet all the requirements of a new hire.