infinite

OptaFi
Accelerating your journey

Zyter TruCare

Aabaco Small Business

Attinio

BENEFIT GUIDE

JANUARY 1, 2025 – DECEMBER 31, 2025 PLAN YEAR

WELCOME TO YOUR 2025 BENEFITS GUIDE

The Companies offer a comprehensive suite of benefits to promote health and financial security for you and your family.

This interactive guide provides you with a summary of your benefits. Please review it carefully so you can choose the coverage that's right for you.

USE THIS INTERACTIVE GUIDE TO EXPLORE YOUR BENEFIT OPTIONS.

Just click on each section to quickly and easily find the benefit information you need.

BENEFIT BASICS

As an employee, you are eligible for benefits if you work at least 30 hours per week. Benefits are effective on the first day of employment, and you have 30 days to enroll following your date of hire. Benefits end on the last day of employment.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include:

- Your legal spouse (same or opposite gender)
- Your domestic partner (same or opposite gender)
- Your child(ren) or child(ren) of your domestic partner. For medical, child(ren) to age 26; for life to age 19.

Once your benefit elections become effective, they remain in effect until the end of the calendar year unless you become ineligible for the benefit, or have a Qualified Life Event.

QUALIFYING LIFE EVENTS

Generally, you may only make or change your existing benefit elections during the open enrollment window. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage
- Divorce or legal separation
- Birth of your child or your domestic partner's child
- Death of your spouse, domestic partner or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse/domestic partner or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

You must notify Human Resources within 30 days of a qualifying life event. Depending on the type of event, you may need to provide proof of the event, such as a marriage license. Human Resources will let you know what documentation you should provide. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next open enrollment window to make changes (unless you experience another qualifying life event).

WHAT IS A DOMESTIC PARTNER?

Your domestic partner (same or opposite gender) is eligible for benefits if s/he has lived with you for at least six months in a committed relationship and can meet certain other requirements. For more information about domestic partner benefits, contact the HR Department at **USHR@infinite.com**.

ENROLLMENT INSTRUCTIONS

ADP Workforce is our online enrollment tool. The site is accessible via the Internet at https://workforcenow.adp.com and can be accessed 24 hours a day, seven days a week. The following tips will help you prepare for and complete the online enrollment process.

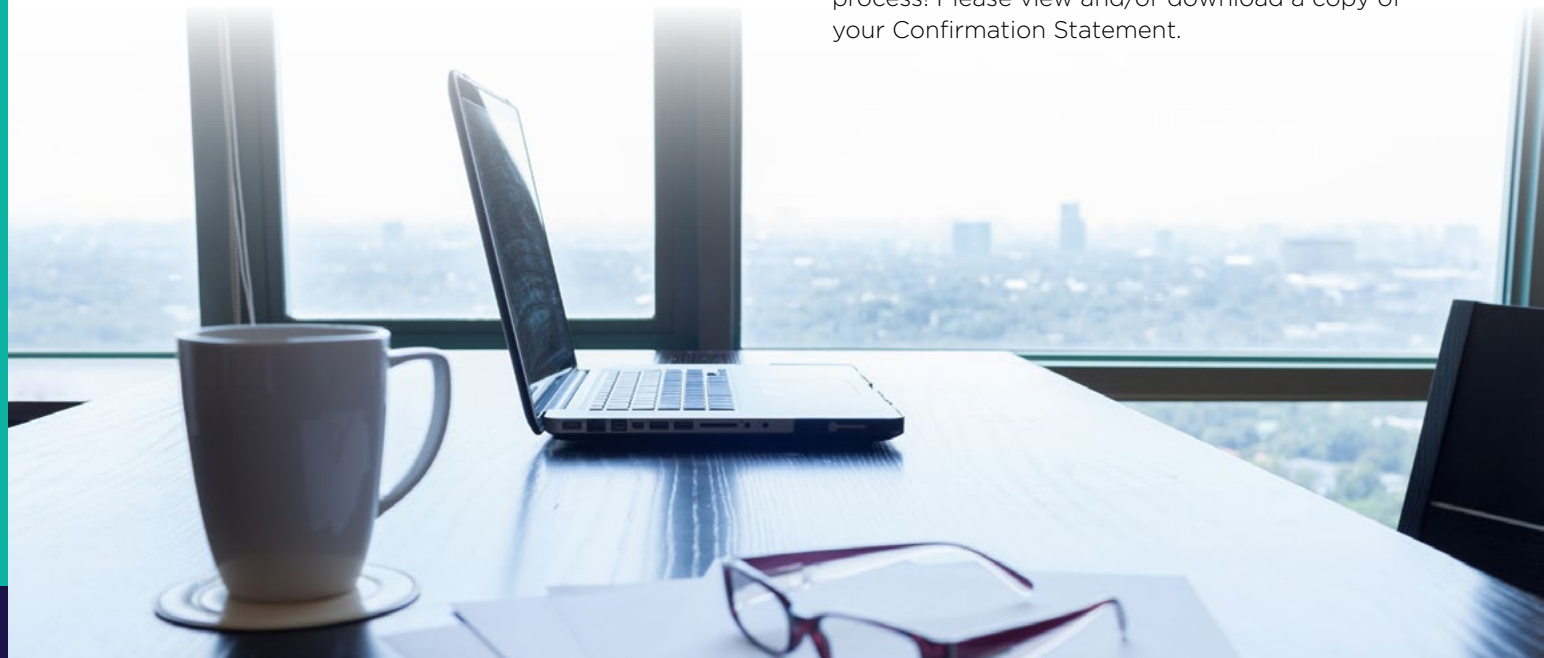
If you are a new hire or have experienced a qualified Life Event, you will need to log-on to your ADP Workforce account to enroll and/or make changes to your benefits elections such as plan and/or coverage level, dependent assignment, or beneficiary designation. These changes will then require HR approval to become effective.

BEFORE YOU ENROLL, REVIEW YOUR OPTIONS & MAKE YOUR CHOICES

Take time to review the information in the Plans section. It will help you understand your benefit choices. Discuss it with your family, too! Click on the Plans link at the top of your home page and select a plan to review the plan details.

STEPS TO COMPLETE YOUR ENROLLMENT

1. Log onto ADP Workforce (**workforcenow.adp.com**) by using your existing ADP login credentials. If you are new user to ADP, please select signup and complete your registration.
2. Once you log in, follow the prompts to enroll or waive the benefits. If you do not wish to enroll in the benefits, you must waive the benefits.
3. **For Life Events:** Log into ADP Workforce and click Report a Life Change and follow the prompts.
4. **Review Confirmation:** Review your elections thoroughly.
5. You have successfully completed the enrollment process! Please view and/or download a copy of your Confirmation Statement.



HEALTH CARE COVERAGE

Your health care coverage includes medical/Rx, dental and vision plans. Detailed information about each plan is in this section. If you have questions, please contact Human Resources.

YOUR MEDICAL/RX PLAN

You have two medical/Rx plan option: CareFirst BCBS BluePreferred HDHP 5000 & HDHP 2000

IN/OUT-OF-NETWORK COVERAGE

The Company offers two high deductible PPO Medical plans through CareFirst Blue Cross Blue Shield, and a Health Savings Account (HSA). Under these plans, you have the flexibility to manage your health care needs and referrals by primary care physicians are not required.

The Company's medical plans have high deductibles that apply to both in- and out-of-network services. The HDHPs require employees to make educated decisions about their health spending habits which, in turn, offers lower cost premiums with a high degree of cost sharing within the plan. Preventive care services are not subject to the deductible.

By staying in-network, you take advantage of special rates and discounts that have been negotiated with participating doctors and facilities which means a higher level of coverage and less out-of-pocket costs for you. Note that with the HSA, prescriptions are subject to the deductible and out-of-pocket maximum.

OUT-OF-POCKET MAXIMUM

This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will fully cover eligible medical expenses for the rest of the benefits plan year. If you see an out-of-network provider, you may be responsible for out-of-pocket costs that are considered above the "reasonable and customary" fees.

HEALTH SAVINGS ACCOUNT

If you are enrolled for family coverage in the plan using a Health Savings Account (HSA), you only need to satisfy the individual deductible before coinsurance would apply for the family member who has met the individual deductible. The family's medical costs may be combined to meet the out-of-pocket maximum.

Understanding the benefits available to you and how to manage your HSA funds puts you in charge of making more informed health care decisions, such as,

- Ensuring you seek preventive and wellness services
- Opting for generic medications where available and appropriate for your condition
- Using in-network providers if possible

FINDING A DOCTOR

To find a physician, facility or pharmacy, simply go to **www.bcbs.com**, enter your zip code to find your local: "Blue" and select "Find Providers." Then log in or register to get search results using your plan. More than just a source for locating an in-network provider, registering with your local "Blue" offers a wealth of benefits, from seeing which family members are covered under your plan, keeping track of your deductible, and viewing your Explanation of Benefits (EOBs), to a wealth of health care information and benefits. We also encourage you to register at **www.carefirst.com**.

MEDICAL COVERAGE

The Company offers two medical plans that allows you to manage your medical care needs and those of your family. The plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs. By enrolling in one of our medical plans you are eligible to open a personal Health Savings Account (HSA) at your bank of choice. See page 7 for additional information.

	CAREFIRST BCBS BLUEPREFERRED HDHP 5000		CAREFIRST BCBS BLUEPREFERRED HDHP 2000	
Plan Provision	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual / Family)	$5,000 / $10,000	$10,000 / $20,000	$2,000 / $4,000	$10,000 / $20,000
Out-of-Pocket Maximum (Includes Deductible) (Individual / Family)	$6,350 / $12,700	$12,700 / $25,400	$4,000 / $8,000	$12,700 / $25,400
Lifetime Maximum	None		None	
Preventive Care	No Charge	20% AD*	No Charge	20% AD*
Primary Physician Office Visit	0% AD*	20% AD*	20% AD*	40% AD*
Specialist Office Visit	0% AD*	20% AD*	20% AD*	40% AD*
Inpatient Hospital Services	0% AD*	20% AD*	20% AD*	40% AD*
Outpatient Hospital Services	0% AD*	20% AD*	20% AD*	40% AD*
Urgent Care	0% AD*	20% AD*	20% AD*	40% AD*
Emergency Room Care	$100 Copay AD*		$100 Copay AD*	
Prescription Drug Deductible	Integrated With Medical Deductible		Integrated With Medical Deductible	
Prescription Drug Out-of-Pocket Maximum	Integrated With Medical Out-of-Pocket Maximum		Integrated With Medical Out-of-Pocket Maximum	
Retail Prescription Drug (34-day supply)				
• Generic	$10		$10	
• Brand Preferred	$25		$35	
• Brand Non-Preferred	$45		$50	
• Retail Preferred Specialty	50% up to $75 AD*		50% up to $75 AD*	
• Retail Non-preferred Specialty	50% up to $75 AD*		50% up to $75 AD*	
Mail Order Prescription Drug (90 day supply)	2x Retail		2x Retail	

Note: This is a summary of your coverage only. Please refer to your summary plan description for the full scope of coverage. In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

*After deductible is satisfied.

HEALTH SAVINGS ACCOUNT

Health Savings Account is a tax-exempt account, and an excellent tax-free savings option to pay for health care expenses! You are eligible to contribute to an HSA **only** when you are enrolled in either of our high deductible health plans (HDHP), and you can use the money to pay qualified medical expenses as shown in the chart below. If you waive coverage in the medical plan you will not be able to make contributions to the HSA.

WHY DEFER MONEY INTO AN HSA?

Triple tax savings. You are not taxed on the money deposited into your HSA, money withdrawn for qualified expenses is also tax free, and any interest you earn is tax-free as well!

Portability - the HSA belongs to you. The money you save is deposited into your bank and will rollover from year to year. Even if you leave the company, your HSA balance will remain in your account and can be utilized for future health care needs, COBRA premiums, or be cashed out as retirement income (less applicable taxes).

Control. You make all the decisions about your account (deposits, withdrawals, banking institution, etc.).

To participate in this pre-tax benefit, you must:

1. Elect the annual amount you want to defer
2. Open an HSA checking account at a bank of your choice
3. Complete and return an HSA direct deposit form to USHR.

ACCOUNT TYPE	HEALTH SAVINGS ACCOUNT (HSA)
Eligible Expenses	Qualified medical expenses, Retiree health, COBRA, qualified long term care insurance, health insurance while receiving federal or state unemployment compensation, Medicare premiums. Note: When you have an HSA, you must file required form with tax return each year and you may be required to show that HSA funds were spent on qualified expenses only. So, keep your receipts!
2025 Annual Contribution Limits	• Individual: $4,300 • Family: $8,550 • Catch up: $1,000 (55 and older)
Benefit	Reduces your taxable income and unspent funds are rolled over to the next year.

SAVE ON YOUR TAXES

Here is an example of how much you can save when you use the HSA to pay for your qualified expenses.

	With HSA	Without HSA
Your taxable income	$50,000	$50,000
Pre-tax contribution to Health Savings Account	$2,000	$0
Federal and State taxes	$14,400	$15,000
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses	$33,600	$33,000
Tax savings with a Health Savings Account	$600	N/A
This chart is an example only, and may not reflect your actual experience. It assumes a 25% federal income marginal tax rate and a 5% state tax rate.		

CAREFIRST VALUE ADDED BENEFITS

CAREFIRST VIDEO VISIT

See a doctor 24/7

When your primary care provider (PCP) isn't available, CareFirst Video Visit allows you to securely connect with a doctor whenever and wherever you want on a smartphone, tablet or computer. Video Visits cost the same as your PCP sick office visit copay (up to a maximum of $60).

Get treatment for common health issues

CareFirst Video Visit is intended for the treatment of uncomplicated, non-emergency health concerns including, but not limited to:

- Bronchitis
- Cough/sore throat
- Sinus infection
- Diarrhea
- Fever
- Pinkeye
- Cold/flu
- Respiratory infection

Video Visit doctors provide consultation, diagnosis and even prescriptions (when available and appropriate). They are all U.S. board-certified, licensed, credentialed and have profiles so you can see their education and practice experience.

When to use Video Visit

- Your doctor's office is closed
- You are on business travel or vacation
- You have children at home and can't bring them to the doctor's office
- You feel too sick to drive

Register today so you'll be ready when you want to visit. There are two easy ways:

1. Visit **www.carefirst.com/needcare** and click on any of the Video Visit links, or
2. Download the CareFirst Video Visit app from your favorite app store

BLUE REWARDS

A Healthy Incentive for you

At CareFirst BlueCross BlueShield (CareFirst), your health matters to us, so we want to reward you for taking an active role in your health. At no additional cost to you, CareFirst presents Blue Rewards, an innovative program that offers you up to $300 per adult and $750 per family. The Blue Rewards program is available to eligible employees who are enrolled in the CareFirst medical plan. Blue Rewards offers you a financial reward for completing four steps and gives you the opportunity to earn an additional reward for meeting certain health measures.

Here's how it works:

Get rewarded!

Choose a CareFirst medical plan and reap the benefits of Blue Rewards, the innovative program that helps improve your health and rewards you for doing so. For more information, visit **www.carefirst.com/bluerewards**

DENTAL PLAN

Your dental plan provides coverage for routine exams and cleanings and pays for a portion of other services, as shown in the chart below.

You have a choice of two dental plans through MetLife: the Core Plan and the Core Plus Plan. This chart shows what the plans pay:

	CORE PLAN		CORE PLUS PLAN	
Plan Provision	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Individual / Family)	$50/$150	$50/$150	$50/$150	$50/$150
Annual Maximum per individual	$1,500	$1,000*	$2,500	
Diagnostic and Preventive, to include cleanings, fluoride treatments, sealants and x-rays	100%, no deductible		100%, no deductible	
Basic Services to include fillings, periodontics, scaling and root planning, oral surgery	90% after deductible	80% after deductible	90% after deductible	
Major Services to include crowns, bridges, full and partial dentures	60% after deductible	50% after deductible	60% after deductible	
Orthodontia (children only up to age 19)	50% after deductible, $1,250 lifetime maximum			

*Out-of-Network Annual Maximum per individual for employees in Texas is $1,500.

PRE DETERMINATION OF BENEFITS

To assist you with managing your total costs, MetLife recommends that a pre-determination of benefits occur if services are expected to exceed $300. During the Predetermination of Benefits, MetLife will advise the patient and the dentist of what services are covered and what the payment would be. The actual payment for these predetermined services depends on eligibility, plan limitations, coordination of benefits and the remaining maximum at the time services are performed. It is not a guarantee of payment but rather an estimate to assist you with planning for your out-of-pocket costs.

To receive a benefits estimate, have your dentist submit a request for pre-treatment estimate online at **www.metdental.com** or have him or her call **1-877-MET-DDS9**.

LOCATING A NETWORK PROVIDER

Locating a provider is easy! Simply login **www.metlife.com** and click on “Find A Dentist.”

VISION COVERAGE

Your vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses.

The Vision Plan is designed to help you take care of your eyes by offering two vision plans. The first is a discount plan offered by Davis Vision through CareFirst BlueCross BlueShield, and the buy up option is available through VSP.

The VSP plan provides coverage for routine eye exams and pays for a portion of the cost of glasses or contact lenses. You can see in- or out-of-network providers; however, you always save money if you see in-network providers.

	VSP VISION COVERAGE	
Benefit	**In-Network**	**Out-of-Network (reimbursement)**
Exam (every 12 months)	$10 copay	Up to $55
Lenses (every 12 months)		
• Single	$25 copay	Up to $50
• Bifocal	$25 copay	Up to $75
• Trifocal	$25 copay	Up to $100
Frames (every 12 months)	$25; $130 retail allowance 20% off amount over allowance	Up to $70
Medically Necessary Contact Lenses	Covered in full after materials copay ($25)	Up to $210
Elective Contact Lenses in lieu of Glasses (every 12 months)	$130 allowance	Up to $105

	DAVIS VISION DISCOUNT COVERAGE THROUGH CAREFIRST
Benefit	**In-Network**
Exam (every 12 months)	$10 copay
Lenses (every 12 months)	
• Single	$25 copay
• Bifocal	$25 copay
• Trifocal	$25 copay
Frames (every 12 months)	
• Priced up to $70 retail	$40 copay
• Priced above $70 retail	$40 plus 90% off the amount over $70
Medically Necessary Contact Lenses (every 12 months)	Covered at 80% of retail

TOTAL BODY WELLNESS INCLUDES KEEPING YOUR EYES HEALTHY.

In fact, through a basic eye exam, doctors can see not only if you have vision problems, but can also detect signs of other medical conditions such as diabetes, high blood pressure, and high cholesterol. That's why everyone, not just employees who wear glasses, should get regular vision check-ups by qualified vision doctors.

LIFE AND AD&D INSURANCE

LIFE INSURANCE

Life insurance is an important part of your financial security, especially if you support a family. The company provides basic life insurance to all eligible employees at no cost.

TYPE OF COVERAGE	BENEFIT
Employer-provided basic life insurance	Flat $50,000

If you are age 65, the amount of your Basic Life insurance will be reduced to 65% of the original amount. On and after you reach age 70, the benefit will reduce by 50%.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Accidental Death & Dismemberment (AD&D) Insurance provides a benefit in the event of your accidental death or dismemberment. The company provides basic AD&D coverage to all eligible employees at no cost.

TYPE OF COVERAGE	BENEFIT
Employer-provided basic AD&D insurance	Flat $50,000

SUPPLEMENTAL TERM LIFE INSURANCE

If you are undecided about your need for life insurance, consider how the following statements apply to you:

- I am married, have children or dependents
- I support someone else
- I have a business
- I am concerned that my retirement and savings plans will not provide sufficient funds for my beneficiaries

Consider the following expenses when deciding on the amount of life and AD&D insurance to purchase:

Major Expenses – medical bills, estate settlement costs and taxes, etc.

Income Replacement – how many years will your dependents need your income to maintain their present standard of living?

Housing – life insurance proceeds may be used to purchase a home or pay off an existing mortgage

Outstanding Debts – credit card balances, auto loans, student loans, etc.

College Fund – college tuition, including room and board and books for your children

CONT.

LIFE AND AD&D INSURANCE

EVIDENCE OF GOOD HEALTH

You may elect Voluntary Life Insurance, up to the Guaranteed Issue amount, in your first 30 days of hire without submitting Evidence of Insurability (EOI).

If you elect Voluntary Life Insurance outside of your first 30 days of hire, you will be required to complete an EOI application and/or exam to obtain the coverage.

Please note: If you do not return the EOI Application within the 30 days of election, your coverage request will be closed and you will not have Voluntary Life Insurance coverage.

SUPPLEMENTAL EMPLOYEE LIFE	SUPPLEMENTAL SPOUSE / DEPENDENT LIFE
Employee: • Lesser of five times your base annual earnings or $500,000 • Increments of $10,000 • Guaranteed Issue: $100,000	**Spouse:** Increments of $5,000 up to 50%of your election **Child(ren):** Increments of$1,000 up to$10,000 **Guaranteed Issue:** • Spouse: $25,000 • Child(ren): $10,000

DISABILITY INSURANCE

The Disability Insurance Plans offered through MetLife is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury.

SHORT-TERM DISABILITY

Short Term Disability is designed to provide you with income replacement in the event you are unable to work due to a disability. Some states (CA, HI, NJ, NY, PR and RI) require state mandated disability benefits and the state plan will pay you a portion of the benefit and MetLife benefit payment will be offset by payment under state disability plans. You may be responsible for paying the state mandated disability premium through payroll deductions in some cases.

Eligible Compensation

Eligible compensation under both the short and long term disability plans includes your gross earnings in effect immediately prior to the onset of disability. Earnings do not include any bonus payments.

	SHORT-TERM DISABILITY (STD):
Company-Paid	• Covers 60% of your weekly pre-disability earnings up to a $1,500 weekly maximum. • Benefits begin on the 14th day of injury or illness and continue to the earlier of recovery or eleven weeks.

LONG-TERM DISABILITY

If you elect Long Term Disability, you may qualify for long-term disability benefits if, after 90 days of disability, you are unable to perform the material duties of your regular occupation.

After 24 months, you are considered disabled if you are unable to do any job that is reasonably appropriate for you considering your education, training, and experience.

Pre-Existing Conditions

For the purpose of Long Term Disability, a pre-existing condition is any condition, illness, or injury for which you received treatment, medication, or diagnostic services during the three (3) months prior to being covered by the Plan. A condition is also considered pre-existing if a prudent person would have received treatment, medication, or diagnostic services, even if you chose not to.

	LONG-TERM DISABILITY (LTD):
Employee-Paid	• Covers 50% of your weekly pre-disability earnings up to a $10,000 monthly maximum. • Benefits begin after ninety days of disability or illness and continue until recovery or age 65.

ADDITIONAL BENEFITS

The Company offers you and your family additional benefits to enhance your benefits package.

RETIREMENT PLANNING

The 401(k) Retirement Savings Plan offers a convenient, pre-tax way to save for your future through payroll deductions.

Eligibility

You are eligible to participate in the 401(k) plan on the first day of the quarter following your month of hire. You will receive a letter in the USPS that will provide you with login information and a PIN so you can register and start deferring retirement dollars.

Employee Contributions

Contributions from your pay are made on a pre-tax basis or post-tax basis depending if you choose to enroll in the traditional or Roth 401(k) – up to the IRS annual limit. If you are 50 years of age or older, (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRS annual limit.

Up to 90% of your eligible compensation up to the IRS limit can be contributed under the 401(k) plan.

Enrollment

To enroll in or make changes to your 401(k), please login to **www.mykplan.com** or call **1 (866) MYKPLAN**.

GRIEF COUNSELING

Your MetLife employer-paid life insurance plan offers you, your dependents and your beneficiaries access to face-to-face grief counseling sessions and related concierge services to help cope with a loss. Grief counseling services provide valuable, confidential and professional support during a difficult time to help address personal and funeral planning needs – at no extra cost.

You may call to discuss any situation you perceive as a major loss, including but not limited to:

- Death of a loved one
- Divorce
- Receiving a serious medical diagnosis or critical illness
- Losing a pet

For assistance, please contact **888-319-7819** or **www.metlifegc.lifeworks.com** Username: metlifeassist; Password: support

CONT.

ADDITIONAL BENEFITS

The Company offers you and your family additional benefits to enhance your benefits package.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Sometimes life can be challenging. That's why the Company provides at no cost to you an Employee Assistance Program (EAP) to all eligible employees. The EAP is designed to provide prompt, confidential help with a range of personal and family issues that may affect all of us from time to time. You or a member of your household (spouse or domestic partner, dependent children, parents and parents-in-law) receive up to three free counseling sessions with an EAP Professional.

EAP counselors will assist you with concerns such as:

- Marital and relationship issues
- Alcohol and drug abuse
- Stress management
- Family/parenting problems
- Work relationships
- Legal assistance
- Wellness information
- Child and elder care

EAP services are provided by MetLife at no cost to you. If you need help or guidance, you may reach out to the EAP at **888-319-7819** or visit **metlifeeap.lifeworks.com**, user ID: metlifeeap / password: eap

AUTO AND HOME INSURANCE

The Company offers MetLife Auto & Home group insurance program as part of your employee benefits. With this program you can see how much you could save with the additional discounts for being an employee. Tenure and other group discount factors may apply. You can call **1-800-GET-MET8** to request a quote.

LEGAL

MetLaw, a legal plan from Hyatt Legal Plans, can be an easy and cost-effective way to seek legal assistance. MetLaw legal coverage provides you with full service to unlimited number of legal matters. You will have access to MetLife's national network of more than 13,000 attorneys.

CONT.

ADDITIONAL BENEFITS

The Company offers you and your family additional benefits to enhance your benefits package.

GROUP ACCIDENT

Group Accident Insurance, offered through MetLife, complements your medical coverage by helping to ease the financial impact of an accident or illness. It provides you with a payment to use as you see fit and can help with any of the out of pocket expenses you may incur as a result of an accident or illness, such as insurance deductibles, copays, and transportation to/from medical centers, childcare and more.

An accident or illness can happen anytime, anywhere. Today's active lifestyles may make you more susceptible too. You can't plan for accidents or illnesses, but you can be better prepared financially to handle them when they do occur. MetLife offers Accident Insurance so you can focus more on your recovery and less on your finances.

HOSPITAL INDEMNITY INSURANCE BENEFITS

With MetLife, you will have a choice of two comprehensive Hospital Indemnity plans (Low Plan/High Plan) which will provide lump sum cash payments in addition to any other payments. These plans complement your existing medical coverage. The difference between Indemnity plans and medical insurance, is that funds that are owed to you are paid directly to you and not the medical provider.

Here are some of the covered benefits/services, when an accident or illness puts you in the hospital.

Benefit Type[2]	Low Plan MetLife Hospital Indemnity Insurance Pays YOU	High Plan MetLife Hospital Indemnity Insurance Pays YOU
HOSPITAL COVERAGE (ACCIDENT)		
Admission must occur within 180 days after the accident	$500 per accident (non-Intensive Care Unit (ICU)) $1,000 per accident (ICU)	$1,000 per accident (non-ICU) $2,000 per accident (ICU)
Confinement must occur within 180 days after the accident	$100 a day (non-ICU) for up to 31 days $200 a day (ICU) for up to 31 days	$200 a day (non-ICU) for up to 31 days $400 a day (ICU) for up to 31 days
Inpatient Rehabilitation stay must occur immediately following hospital confinement and must occur within 365 days of accident	$100 a day, up to 15 days per accident but no more than 30 days per calendar year	$200 a day, up to 15 days per accident but no more than 30 days per calendar year
HOSPITAL COVERAGE (SICKNESS)[3]		
Admission Payable 1 time per calendar year	$500 (non-ICU) $1,000 (ICU)	$1,000 (non-ICU) $2,000 (ICU)
Confinement Paid per sickness	$100 a day (non-ICU) for up to 31 days $200 a day (ICU) for up to 31 days	$200 a day (non-ICU) for up to 31 days $400 a day (ICU) for up to 31 days

CONT.

ADDITIONAL BENEFITS

The Company offers you and your family additional benefits to enhance your benefits package.

CRITICAL ILLNESS

Critical Illness Insurance, offered through MetLife, complements your medical and disability income coverage, and can ease the financial impact of a critical illness by providing a lump-sum benefit to help you pay some of your additional expenses. Thanks to advancements in modern medicine, chances of recovery from a critical illness like a heart attack, cancer, or stroke have greatly improved. However, while most medical plans provide coverage for hospital and medical expenses arising from critical illnesses, there are still many expenses that are not covered, such as medical co-pays, transportation to treatment centers, childcare, and more. Can you withstand the potential financial impact of a critical illness?

The Critical Illness Insurance policies feature:

- A lump-sum benefit payment to use as you see fit
- Dependent coverage for your spouse/domestic partner and child(ren)
- Convenient payment options
- No obligation to submit expense receipts
- Coverage that can go with you if you leave your employer

Critical Illness Insurance complements your medical and disability income coverage. It can ease the potential financial impact of certain critical illnesses by helping you pay for some of the expenses associated with a covered condition.

Which Coverage is Right for You?

ACCIDENT INSURANCE	HOSPITAL INDEMNITY	CRITICAL ILLNESS INSURANCE
Make sure you're better prepared for more than 150 covered events, including injuries, hospitalizations and medical services.	Receive a flat amount when you're admitted to a hospital and a daily amount for each day of your stay	Ease the financial impact of a covered critical illness, including conditions such as a heart attack, cancer or stroke.

CONT.

ADDITIONAL BENEFITS

The Company offers you and your family additional benefits to enhance your benefits package.

TRAVEL ASSISTANCE

To complement your MetLife Group Life & Disability Insurance coverage, you have access to Travel Assistance, a comprehensive travel service provided and administered by AXA Assistance USA, Inc. through a marketing arrangement with MetLife. Travel Assistance offers you and your dependents access to medical, travel, and concierge services - 24 hours a day, 365 days a year when traveling more than 100 miles from home. One simple toll-free phone call to the Alarm Center puts you in touch with AXA Assistance's highly trained staff that can assist you in obtaining the help you need.

Use Travel Assistance if you....

- Plan a trip and need general travel information about visa, passport, inoculation requirements and local customs
- Need access to medical, travel, and concierge services
- Require medical assistance or medical evacuation
- Lose documents, credit cards or luggage while traveling

Coverage Includes

- Access to over 600,000 pre-qualified providers worldwide
- Mobile assist service for help with using your mobile device while traveling internationally
- Trained multilingual staff who can advise and assist you before and during your travels
- 24-hour pre-departure information about weather, local currency or holidays
- Access to emergency cash, bail assistance, legal referrals as well as air and ground ambulance service

For questions, call or visit **(800) 454-3679** or **(312) 935-3783 (collect)**

http://webcorp.axa-assistance.com Login: axa Password: travelassist

IDENTITY THEFT

Identity Theft and Fraud Protection insurance, offered through InfoArmor, provides protection to employees and their families from evolving cyber threats that cause data breaches and financial losses.

This protection helps detect identity theft and minimize damages to personal assets by actively monitoring and notifying you of suspicious activities. The solution includes proactive alerts for: credit cards, wireless carriers, utility accounts and non-credit accounts. This service also provides complete credit monitoring, access to monthly credit scores and annual credit reports.

ANNUAL NOTICES

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Company has determined that the prescription drug coverage offered by the CareFirst Medical Plan HSA 5000 and HSA 2000, for all plan participants, is expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Creditable Coverage if you are enrolled in the HSA 5000 plan or the HSA 2000 plan. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Company Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from CareFirst or enroll in Medicare. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

If you decide to join a Medicare drug plan, your current coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back. This determination depends on your specific circumstances and is subject to the terms of the group health insurance policies in effect under the medical plan.

CONT.

ANNUAL NOTICES

For More Information About This Notice Or Your Current Prescription Drug Coverage:

You'll receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare.

You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit **www.medicare.gov**

Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

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

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

Infinite Computer Solutions, Inc., (the "Plan") provides health benefits to eligible employees of Infinite Computer Solutions, Casenet and Zyter (the "Companies") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact Niti Prothi, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach this contact person at: 2600 Tower Oaks Blvd, Ste. 700, Rockville, MD 20852 or call **301-355-7766**.

CONT.

ANNUAL NOTICES

PATIENT PROTECTION DISCLOSURE

The Companies group health plan, administered by CareFirst, general allows (but do not require) the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from CareFirst or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact CareFirst at **877-691-5856** or Outside MD/DC/VA at **800-810-BLUE**.

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Human Resources.

CONT.

ANNUAL NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Human Resources.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

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

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

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

CONT.

ANNUAL NOTICES

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

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

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

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

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

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

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

CONT.

ANNUAL NOTICES

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: American Benefits Group.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

CONT.

ANNUAL NOTICES

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

CONT.

ANNUAL NOTICES

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTION AND YOUR HEALTH COVERAGE | PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or by contacting Infinite HR at **ushr@infinite.com** or by contacting Casenet or Zyter HR at **hrcasenet@zyter.com**.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor **www.askebsa.dol.gov or call 1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 1/31/2025)

ALABAMA – Medicaid
http://myalhipp.com | 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program:
http://myakhipp.com | 1-866-251-4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
http://myarhipp.com | 1-855-MyARHIPP (1-855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp | 1-916-445-8322
hipp@dhcs.ca.gov

CONT.

NOTICES

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com

Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711

CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991 / State Relay 711

Health Insurance Buy-In Program (HIBI): https://hcpf.colorado.gov/health-insurance-buy-program

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html | 1-877-357-3268

GEORGIA – Medicaid

HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
1-678-564-1162, Press 1

GA CHIPRA: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | 1-678-564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64:
http://www.in.gov/fssa/hip | 1-877-438-4479

All other Medicaid:
https://www.in.gov/medicaid | 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid: https://dhs.iowa.gov/ime/members | 1-800-338-8366

Hawki: http://dhs.iowa.gov/Hawki | 1-800-257-8563

HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
1-888-346-9562

KANSAS – Medicaid

https://www.kancare.ks.gov/ | 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
1-855-459-6328
KIHIPP.PROGRAM@ky.gov

KCHIP: https://kidshealth.ky.gov/Pages/index.aspx
1-877-524-4718

Medicaid: https://chfs.ky.gov

LOUISIANA – Medicaid

www.medicaid.la.gov or www.ldh.la.gov/lahipp
1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

https://www.maine.gov/dhhs/ofi/applications-forms
1-800-442-6003 TTY: Maine relay 711

Private Health Insurance Premium:
1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

https://www.mass.gov/masshealth/pa
1-800-862-4840 TTY: (617) 886-8102

MINNESOTA – Medicaid

https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/
1-800-657-3739

MISSOURI – Medicaid

http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
1-573-751-2005

MONTANA – Medicaid

http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084 | HHSHIPPProgram@mt.gov

CONT.

NOTICES

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov
1-855-632-7633 | Lincoln: 1-402-473-7000 | Omaha: 1-402-595-1178

NEVADA – Medicaid
http://dhcfp.nv.gov | 1-800-992-0900

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program | 1-603-271-5218
HIPP program toll free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
1-609-631-2392
CHIP: http://www.njfamilycare.org/Default.aspx
1-800-701-0710

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid
1-800-541-2831

NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov | 1-919-855-4100

NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid
1-844-854-4825

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org | 1-888-365-3742

OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
1-800-699-9075

PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx | 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov
1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
https://www.scdhhs.gov | 1-888-549-0820

SOUTH DAKOTA - Medicaid
http://dss.sd.gov | 1-888-828-0059

TEXAS – Medicaid
http://gethipptexas.com | 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov
CHIP: http://health.utah.gov/chip | 1-877-543-7669

VERMONT – Medicaid
http://www.greenmountaincare.org | 1-800-250-8427

VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid: 1-800-432-5924 **CHIP:** 1-800-432-5924

WASHINGTON – Medicaid
https://www.hca.wa.gov | 1-800-562-3022

WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms
http://mywvhipp.com
Medicaid: 1-304-558-1700
CHIP Toll-free: 1-855-MyWVHIPP (1-855-699- 8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility | 1-800-251-1269

IMPORTANT CONTACTS

PLAN	WHOM TO CALL	PHONE NUMBER	WEBSITE
Medical Plans	CareFirst	877-691-5856 Outside MD/DC/VA 800-810-BLUE	www.carefirst.com www.bcbs.com
Health Savings Account (HSA)	Bank of Your Choice	n/a	n/a
Dental Plan	MetLife	800-438-6388	www.metlife.com/mybenefits
Vision Plan	VSP Davis Vision	800-877-7195	www.vsp.com www.davisvision.com
COBRA	American Benefits Group	800-499-3539, option 3	cobrasuppot@amben.com
Life and AD&D Insurance	MetLife	800-638-6420	www.metlife.com/mybenefits
Disability Insurance	MetLife	800-275-4638	www.metlife.com/mybenefits
Grief Counseling	MetLife	888-319-7819	www.metlifegc.lifeworks.com User ID: metlifeassist Password: support
Critical Illness Accident Insurance Hospital Indemnity	MetLife	800-GET-MET8	www.metlife.com
Employee Assistance Program (EAP)	MetLife	888-319-7819	Metlifeeap.lifeworks.com User ID: metlifeeap Password: eap
401(k) Retirement Savings Plan	ADP Retirement Services	866-MYKPLAN	www.mykplan.com
Auto and Home Insurance Legal	MetLife	800-GET-MET8	www.metlife.com
Identity Theft	InfoArmor	800-789-2720	https://www.myprivacyarmor.com

infinite

OptaFi
Accelerating your journey

Zyter TruCare

Aabaco Small Business

Attinio

ABOUT THIS GUIDE

This benefit summary provides selected highlights of the our employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. The Company reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.