Infineum

2024 OpenEnrollment Benefits

FOR RETIREES

This is a summary of your benefits. Please refer to the Plan booklets for detailed information.
Infineum reserves the right to modify and/or terminate benefits at any time.

A MESSAGE FROM HUMAN RESOURCES

Infineum continuously seeks ways to provide colleagues with competitive and high quality health care options at a reasonable cost. As a self-funded medical plan sponsor, Infineum pays for actual medical costs rather than using an insured arrangement. This allows us to closely monitor and manage plan costs and design based on our own population's claims experience. You may recall that colleague contribution rates were held steady for the past two years. In 2023, Infineum's medical claims cost experience has increased significantly. As a result, Infineum will adjust colleague contributions for each medical plan effective 1/1/2024 to account for actual claims experience. In addition, Plan2 will be closed effective 1/1/2025. We encourage you to review your options and plan accordingly. Programs to further control prescription drug costs will be implemented in 2024.

Please continue to help us control Infineum healthcare costs by keeping up with preventive care services, choosing Aetna network providers, and by taking the following actions.

STAY WELL

- Enjoy a healthy lifestyle
- Avoid processed foods and maintain a healthy weight
- Get regular exercise (30 minutes/day, 3-5 days/week)
- Avoid smoking
- Limit alcohol consumption

USE PREVENTIVE CARE

- Choose a primary care physician (PCP) and get annual, no-cost well-visits
- Follow-up with age-appropriate diagnostic tests and vaccinations, as recommended by your PCP
- Maintain regular communication with your physician

AVOID THE EMERGENCY ROOM

- Use CVS Minute Clinics or Urgent Care centers (walk-in medical clinics) for non-life-threatening emergencies. These offer faster care at low or no-cost for basic services
- Use your PCP for general examinations and well-visits
- Continued access to telemedicine visits in 2024, with the same cost sharing as in-person visits

Retirees under age 65: You may be liable for charges from out-of-network providers (subject to deductible and co-insurance) related to an ER visit in a participating hospital, if the visit is not a true emergency.

UNDERSTAND THE COSTS OF YOUR MEDICAL CARE

Retirees under age 65:

- Use Aetna network providers whenever possible
- Use the provider directory at http://www.aetna.com/docfind/custom/mymeritain/
- Look for Aetna providers who meet quality and cost-efficiency measures
- Pay attention to Explanations of Benefits (EOBs) and associated provider statements

Infineum Benefits:
Transforming to Grow

WELCOME TO YOUR BENEFITS

Infineum offers a comprehensive, affordable benefits package to you and your family. Our benefits provide protection and support to help you achieve your health, financial, and wellness goals. This brochure outlines the benefits package and how you can take maximum advantage of all the benefits available. Please take the time to review your current coverage and to read the Open Enrollment materials. This will ensure that you can make an informed decision on the benefits and coverage levels that are best for you and your family. During our annual open enrollment period, retirees have the opportunity to enroll in, or make changes to their benefit plans.

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BENEFIT PLAN CHANGES FOR 2024 - RETIREES UNDER AGE 65

Medical Plans

- Based on actual claims cost experience.
  - Plan 1 contributions will increase by 8%
  - Plan 2 contributions will increase by 20%
- In-network out-of-pocket maximum for Plan 2 will increase to $3,000/$5,000 (Individual/ Famly).
- Plan 2 will be discontinued effective 1/1/2025
  - No new enrollments in Plan 2 will be allowed for 2024.

Dental Plan

- No changes to dental plan contributions for 2024.

Prescription Drug Plan

- Limited Step Therapy will be implemented for 2024. This program requires the use of less costly yet effective medications before more costly drugs are approved for coverage. Impacted members will receive letters from Express Scripts to notify them directly about the change.
- The list of drugs which require Prior Authorization will also be expanded.

Medicare Supplement Plan and Medicare Part D Plan

- The Medicare Supplement Plan currently covers the Medicare Part A deductible as well as the Medicare Part B deductible. This coverage will continue in 2024. Due to higher claims and prescription drug costs, Medicare Supplement Plan contributions will increase by 15%.

ALLOWABLE CHANGES DURING OPEN ENROLLMENT

Change	Action Required
Enroll in Medical Plan *(no previous coverage)*	Benefits Change Form
Change Medical Plan	No new enrollments in Plan2 will be permitted
Add eligible dependents to Medical Plan	Benefits Change Form
Drop eligible dependents from Medical Plan	Benefits Change Form
Drop Medical Coverage	Benefits Change Form
Enroll in Dental Plan *(no previous coverage)*	Benefits Change Form
Add eligible dependents to Dental Plan	Benefits Change Form
Drop eligible dependents from Dental Plan	Benefits Change Form
Drop Dental Coverage	Benefits Change Form

NOTE: All changes will take effect on January 1, 2024.

Complete and mail Benefits Change Form to:

Hedy DiSimoni, Infineum USA Inc. 1900 E. Linden Ave. Linden, NJ 07036

or, scan and email to Hedy.DiSimoni@Infineum.com

Forms must be received no later than November 30, 2023.

NO ACTION IS REQUIRED IF YOU WISH TO CONTINUE WITH YOUR CURRENT ENROLLMENT.

MEDICARE SUPPLEMENT PLAN – REMINDER

The Infineum Medicare Supplement Plan is a medical plan for retirees, survivors and eligible family members who are eligible for Medicare. Currently, it is designed to work with Medicare in order to provide coverage similar to that provided to colleagues and retirees who are not yet eligible for Medicare.

You must meet several conditions to be eligible for the Infineum Medicare Supplement Plan. You must: 1) be eligible for Medicare, and you must have retired from Infineum with retiree status; or 2) be an eligible family member of an Infineum retiree or an eligible family member of a deceased Infineum colleague/retiree. **In either case, the Infineum Medical Plan must have covered you immediately prior to your Medicare Supplement Plan eligibility in order to qualify.**

If you have not been contacted by the Plan Administrator regarding sign-up for the Medicare Supplement Plan before your 65th birthday, contact Infineum Human Resources at 908-474-2273 to start the process. You will also be provided with a revised coupon booklet from Infineum's Retiree Billing Administrator that includes the cost for the Medicare Supplement Plan.

Important Information: If you are a(n) Infineum Retiree, under age 65, and you receive disability benefits from Social Security for 24 months, you should automatically be enrolled in Medicare Part A and Part B effective on the 25th month of disability. While you are not required to enroll in Medicare Part B, your Infineum Medicare Supplement Plan will assume you are enrolled in Medicare Part B.

Things to Consider (when Medicare Disabled)...

1. Infineum, as well as your Medical Provider, will not be notified right away of your early Medicare Disability status. You MUST immediately notify Infineum Human Resources (908-474-2273) of your disability status to ensure that you are moved into the Infineum Medicare Supplement Plan on the date that coincides with your Medicare Part(s) A & B effective date.
2. If you decide to waive your Medicare Part B status upon disability, your Infineum Medicare Supplement Plan will still assume you are enrolled in Medicare Part B, and will process/pay claims as if Medicare is the "primary payer" and the Infineum Medicare Supplement Plan is the "secondary payer". Your out-of-pocket costs will increase if you make the decision to decline Medicare Part B.

MEDICAL PLAN COMPARISON CHART

MERITAIN HEALTH

Infineum offers employees medical plan(s) through Meritain Health. This chart shows a summary of those benefits. You will have lower out-of-pocket costs if you use in-network providers. Additional benefit information can be found in your Summary of Benefits (SBC).

Plan Name	Plan 1	Plan 2	Medicare Supplement*
IN-NETWORK BENEFITS			
Deductible *(Calendar year)*	$0	$250/$500	$0
Out-of-Pocket Maximum *(Calendar year)*	$5,000/$10,000	$3,000/$5,000	$2,000/$4,000
Coinsurance *(Patient pays)*	0%	20%	0%
Physician Services *Primary Care Physician (PCP)* *Specialist* *Preventive Care*	$25 copay $40 copay Covered 100%	$30 copay $50 copay Covered 100%	Deductible & Coinsurance
Routine Labs	*Office:* PCP $25, Specialist $40 *Outpatient/Independent Facility:* Covered 100%	*Office:* PCP $30, Specialist $50 *Outpatient/Independent Facility:* 20% after deductible	Deductible & Coinsurance
Routine X-Rays	*Office:* PCP $25 or Specialist $40 *Outpatient/Independent Facility:* Covered 100%	*Office:* PCP $30 or Specialist $50 *Outpatient/Independent Facility:* 20% after deductible	Deductible & Coinsurance
Inpatient Hospital	Covered 100%	20% after deductible	Deductible & Coinsurance
Outpatient Surgery	Covered 100%	20% after deductible	Deductible & Coinsurance
Emergency Room	$100 copay, waived if admitted	20% after deductible	Deductible & Coinsurance
Urgent Care	$25 copay	20% after deductible	Deductible & Coinsurance
PRESCRIPTION BENEFITS			
Retail (31 day supply) *Generic/Preferred Brand/* *Non-Preferred Brand*	$15/$40/$60	$15/$40/$60	Refer to page 15 for co-payments
Mail Order (90 day supply) *Generic/Preferred Brand/* *Non-Preferred Brand/Specialty*	$20/$60/$100/$100	$20/$60/$100/$100	Refer to page 15 for co-payments
OUT-OF-NETWORK BENEFITS			
Deductible *(Calendar/Plan year)*	$1,000/$2,000	$1,000/$2,000	N/A
Out-of-Pocket Maximum *(Calendar/Plan year)*	$5,000/$10,000	$5,000/$10,000	N/A
Coinsurance *(Patient pays)*	40%	30%	N/A

**No network applies to the Medicare Supplement Plan.*

DOC FINDER

MERITAIN® HEALTH

An Aetna Company

Your DocFind® Online Directory

Aetna Choice® Point of Service (POS) II

It's easy to find doctors and hospitals in your network

When you and your family need care, you can look for doctors and hospitals in the Aetna Choice POS II network. It's easy when you use the online DocFind directory from Aetna.* With up-to-date listings, you can search for providers by name, specialty, gender, hospital affiliations and more.

Find Aetna providers online in just a few quick steps

You can use the DocFind directory anywhere you have internet access. Just:

1. Visit **http://www.aetna.com/docfind/custom/mymeritain/**.
2. Key in the ZIP code, city, county or state of the desired geographical area in the *Enter location here* field. Click *Search*.
3. Key in *Aetna Choice® POS II (Open Access)* under *Select a Plan*. **Or** you can select *Aetna Choice® POS II (Open Access)* from the list of plans. Click *Continue.*
4. There are two options available to search for providers. The guided flow search uses some of our most commonly searched terms and easily organizes them for our users to find. To use the guided search flow, choose and click on one of the categories under *Find what you need by category*. **Or see step five.**
5. Use the search box, which includes type-ahead suggestions and will present provider, facility, specialty and condition search options based on what is entered. These suggested options will present an exact match or relevant providers. *What do you want to search for near* (will display your chosen location).
6. Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.
7. Narrow your search results by using the *Filter & Sort* option. Choices include Gender, Languages, Hospital Affiliations, Office Detail, Individual Practice Association Affiliations, Group Affiliations and Provider Type.

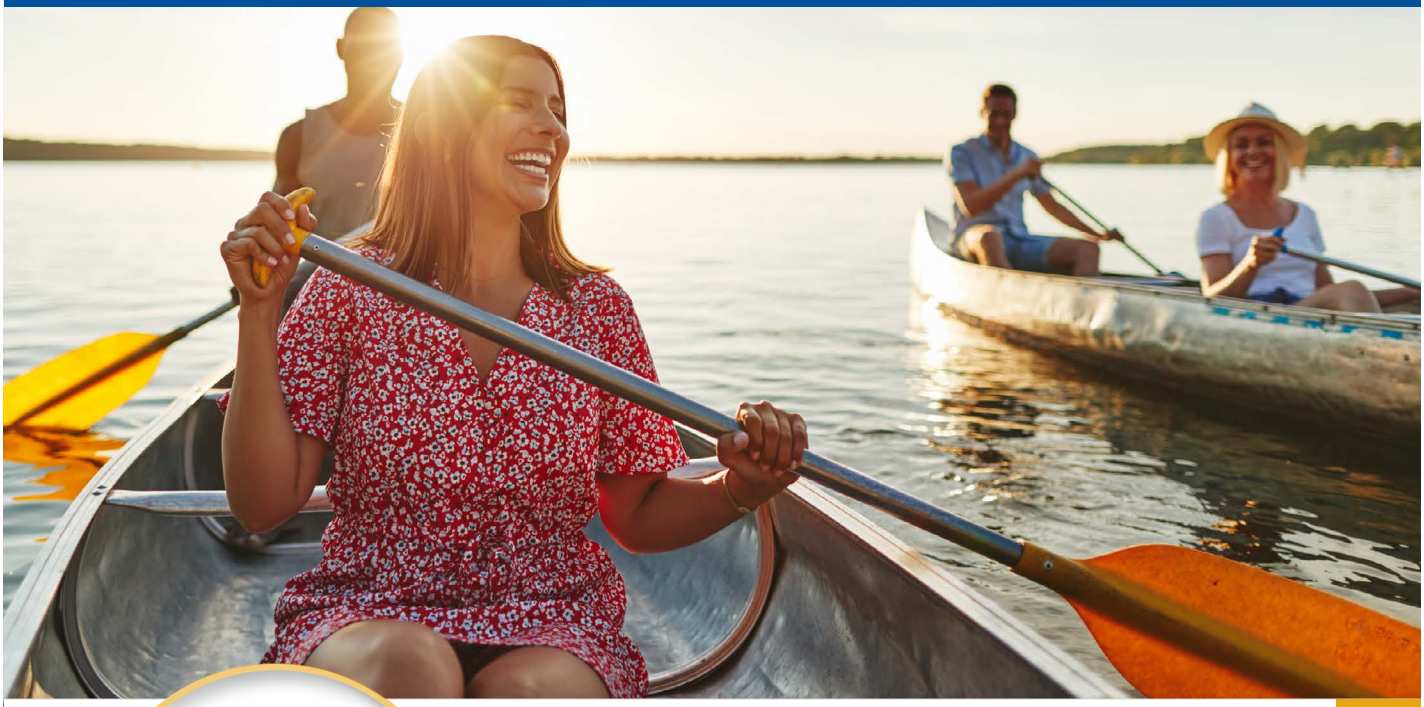
DOC FINDER

Why choose a primary care physician (PCP)?

Meritain Health® does not require you to choose a PCP, but we encourage you to choose one. Your PCP knows your health care needs, so they can help manage your health and coordinate your care. To find and choose a PCP, use the *Find Care & Pricing* tool on your member portal.

Find providers by phone

Need a provider when you're not near a computer? No problem. Simply call the Aetna Provider Line at **1.800.343.3140** from 8:00 a.m.–9:00 p.m. ET, Monday through Friday.



ADVOCATES FOR
HEALTHIER LIVING

We are Meritain Health

As Advocates for Healthier Living, we provide easy-to-use health care benefits you can use to live well. We also take steps to help you save on the cost of your care. Contact us at the number on your ID card if you have any questions about your plan.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates.*

Providers are independent contractors and are not agents of Aetna or Meritain Health. Provider participation may change without notice. Neither Aetna nor Meritain Health provides care or guarantees access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

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MERITAIN HEALTH

MERITAIN® HEALTH

An Aetna Company

A Quick Look at Your Health Plan

Infineum

Group #16985

When you enroll with Meritain Health®, you're taking the next step towards a healthier, more balanced you.

It's important for you to understand how your health plan works. This way, you can make the changes you want in your health and in your life.

Get the support you need for a healthy balance

Chances are, you try every day to keep a healthy balance in your life. But time can get away from you, or you might put other details first. That's why we're here: to help you focus and to support you each step of the way. You can think of your healthcare benefits as your resource to protect your body, mind and spirit.

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www.meritain.com

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MERITAIN HEALTH

Benefit Highlights

Protecting your healthy balance with preventive care

Question: Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?

Answer: Nothing makes more sense in these busy times than preventing illness before it happens. That's why your plan offers excellent benefits for preventive services.

Early detection, proper nutrition, and routine exercise are the keys to living a long and healthy life, and will also help to control long-term healthcare costs. Your employer encourages you to take the necessary steps—available to you right now—to ensure early detection and treatment of diseases.

Built into your health plan are preventive benefits that cover:

- Well-child care
- Physical exams
- Mammogram
- Bone density test
- Prostate blood exam
- Pap smear
- Fecal occult screening

Nationwide provider access at a discount

When you and your family seek healthcare services, you have access to Aetna's broad national provider network of healthcare providers and facilities. Aetna's network contains more than 664,000 participating physicians and ancillary providers, with 5,667 hospitals.[1] When you visit providers in the Aetna network, you will receive services at strong, negotiated rates, helping you to save on the cost of healthcare.

[1] *https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html*

Locate your preferred providers

With Aetna's comprehensive provider participation, many of your preferred doctors may already be in the Aetna network. To verify whether or not a doctor or healthcare facility participates, visit **http://www.aetna.com/docfind/custom/mymeritain/**.

Support for your health journey

Your employer wants you to get the best, most appropriate care, when and where you need it. That's why your plan includes the extra expertise of **Meritain Health's Medical Management program**. The Medical Management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Some of these services include:

- Before admission to the hospital for elective or non-emergency services
- Within 48 hours (two working days) after an emergency or urgent hospital admission.
- Before elective inpatient, outpatient or ambulatory surgery.
- Before inpatient substance-abuse treatment or treatment for a mental health disorder.
- Before entering an extended-care, rehabilitation or skilled-nursing facility.

Consult your Summary Plan Description for a complete listing of healthcare services that require precertification with a medical management nurse.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Providers are independent contractors and are not agents of Meritain Health. Provider participation may change without notice. Meritain Health and Aetna do not provide care or guarantee access to health services.

MERITAIN HEALTH

Your ID Card Information

Helpful Tips

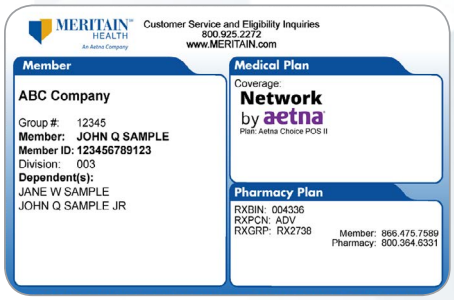
- Your healthcare plan includes a network of providers you can visit for healthcare services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents' benefits.
- Your medical copays are listed for you and your providers.
- Your pharmacy coverage information is listed on the front of your card, and includes the Express Scripts customer service number and prescription copays.
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.

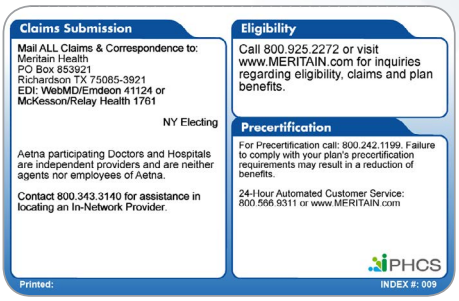
The final step toward better balance and better living

After you've completed enrollment, your employer has approved it and after any waiting period has passed, your benefits will be effective.

Your Meritain Health ID Card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you.

Sample ID Card





MERITAIN HEALTH

Convenient Tools and Resources

Your personalized member website

Once enrolled as a Meritain Health member, you will have access to the **Meritain Health Member Portal**. When you log in, you'll find everything you need to know about your benefits—from eligibility, to enrollment, to what's covered. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed.

Registration for the member website is easy

If you're already registered to access your online account, simply enter **www.meritain.com** into your browser and login from the homepage.

If you're not yet registered, it's OK. Registration is an easy three-step process.

1. Go to **www.meritain.com**.
   Then, in the top right corner, click *Register.*
2. Next, select *Member* under *I am a* and enter your group ID.
   You can find your group ID on the front of your member ID Card. (If you are new to the plan, you will soon receive your member ID Card in the mail.) Then, click *Continue.*

   Please note: you may set up a login for yourself, as well as any children under age 18 who are covered by your plan. For privacy purposes, your spouse and dependents over the age of 18, covered by the plan, must each establish logins to access their individual information.
3. You will need to fill in your:
   - Group ID (located on your member ID Card)
   - Member ID (located on your member ID Card)
   - Date of birth
   - Name
   - ZIP code
   - Email address

A username will be provided to you. After you create a password and confirm your email address—you're done! You'll automatically be logged into your new Meritain.com account. The next time you log in, just use the same username and password from Step 3.

Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their PHI for treatment, payment or healthcare operations; and (ii) the health plan's disclosure of their PHI to persons who may be involved in their healthcare or payment thereof (e.g., family members, close friends).

Important plan contacts

What do you need help with?

- My medical benefits
- In-network doctors or hospitals

  Meritain Health Customer Service
  1.800.925.2272 | www.meritain.com
- The Aetna Choice® POS II provider network

  Aetna provider line
  1.800.343.3140
  www.aetna.com/docfind/custom/mymeritain
- My prescription drug benefits

  Express Scripts
  Customer Service
  1.866.544.2891
- Precertification

  Meritain Health Medical Management
  1.800.242.1199
- My enrollment or benefit elections

  Infineum
  Human resources representative
  1.908.474.2273

CVS MINUTE CLINIC

MERITAIN® HEALTH

An Aetna Company

MinuteClinic®

Now offering access to MinuteClinic at no cost to you*

High-quality care that's affordable and reliable

MinuteClinic makes it easy for you to get the care you need, when and where you need it. And now you can get access to all covered MinuteClinic services at no cost—not just preventive care.*

- MinuteClinic is a walk-in clinic inside select CVS Pharmacy® and Target stores, and is the largest provider of retail health care in the United States—with over 1,100 locations in 33 states and the District of Columbia.
- It's open every day, including evenings. MinuteClinic offers both walk-in and scheduled appointment options.
- MinuteClinic health care providers treat a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate.

AFFORDABLE

CONVENIENT

Visit **minuteclinic.com for age and service restrictions. Video visits are not a covered service under this benefit. This is for informational purposes only. It is not medical advice and is not intended to be a substitute for proper medical care provided by a physician. Information is believed to be accurate as of the production date; however, it is subject to change. Includes access to all covered services at MinuteClinic.*

Members in Aetna Whole Health ACO, APCN Plus, HMO and indemnity plans may not be eligible for this benefit. Such members should refer to their benefit plan documents in order to determine coverage and applicable cost-share for walk-in clinic benefits and services, as applicable.

Meritain Health, Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are within the CVS Health family. Meritain Health is not responsible or liable in any manner for services received at CVS MinuteClinic locations.

Questions? Just call Meritain Health® at the number located on the back of your ID card.

COORDINATION OF BENEFITS

MERITAIN HEALTH
An Aetna Company

Coordination of Benefits

Primary and secondary coverage

Many families today carry more than one group health plan, often when both spouses are employed. If this is true in your case, the two plans will coordinate payment of your medical charges. This is based on a system that considers one of the plans to be the *primary plan* and the other the *secondary plan*.

Primary and secondary plans

A plan is primary if it covers the patient as an employee. A plan is secondary if it covers the patient as a dependent. This means that when you receive medical care, your Meritain Health plan is always primary and the other plan is always secondary. Also, when your covered spouse receives care, his or her employer's plan is always primary, and your Meritain Health plan is always secondary.

Birthday rule

But which plan is primary for your dependent children? The birthday rule makes the answer to this question simple.

Under the birthday rule, the parent who has the first birthday in the year carries the primary coverage for all dependent children. The parent whose birthday falls later in the year carries the secondary coverage.

So, if one parent's birthday is January 12 and the other parent's birthday is any date after January 12 (that is, a date between January 13 and December 31) the parent with the January 12 birthday will be the primary payer for the dependents. In the uncommon case that both parents have the same birthday, the policy that has been in effect the longest for the child will be primary.

Coordination of benefits under two plans

When you submit claims to your primary Meritain Health plan, it will pay benefits without considering benefits that may be provided by the secondary plan. Your Meritain Health plan then will send you an Explanation of Benefits (EOB), which you may submit with a claim form to your secondary plan.

In most cases, the secondary plan will pay an amount that, when combined with the amount paid by the primary plan, doesn't exceed the amount the secondary plan would have paid if it were primary.

For example, let's pretend that your employed spouse incurs a $100 medical charge. His or her medical plan is primary since he or she is the employee. Your Meritain Health plan is secondary.

- Your spouse's plan will cover 70 percent of the $100 charge, paying $70 to your spouse's doctor.
- Assume your Meritain Health plan would have covered 80 percent of the expense if it was the primary plan.
- As the secondary plan, your Meritain Health plan will cover the difference between the 70 and 80 percents. This 10 percent difference would be paid out as $10.

If you have questions, simply call Meritain Health Customer Service using the phone number on your member ID Card.

www.meritain.com

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COORDINATION OF BENEFITS

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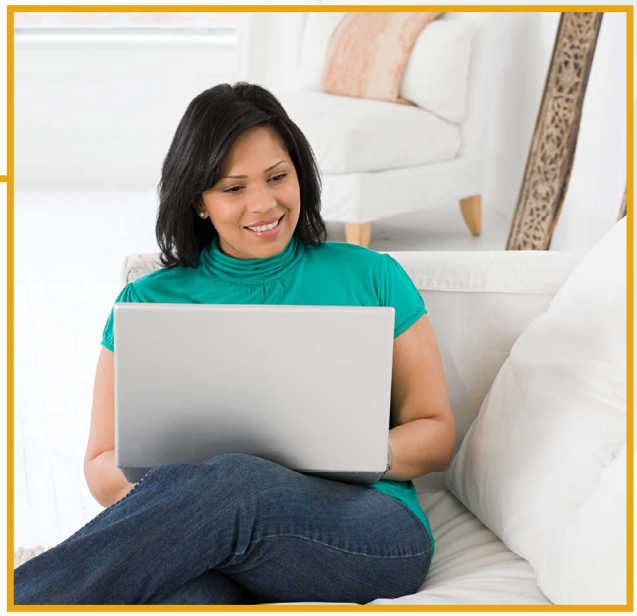

Accessing Other Insurance Coverage Online

Your healthcare benefits plan includes a provision called coordination of benefits. This means if one person is covered by two benefit plans, both plans share responsibility for covering that person's healthcare expenses. This helps prevent duplicate payments and helps hold down healthcare costs.

Examples of other coverage include: Medicare (due to age or disability), group coverage through a family member's employer, association coverage through a group you or a family member belongs to, student health coverage, or coverage mandated by a divorce decree.

Meritain Health may sometimes ask you to update this information so we can keep our records current.

You can now complete your Coordination of Benefits (COB) online:

1. From the *Benefits and Coverage* dropdown, select *Coordination of Benefits*.
2. You'll be asked if you or any dependents have other coverage, other Medicare coverage and/or other Medicaid coverage. Simply answer *Yes* or *No* to report if you or anyone in your family has other health coverage.
3. If you answer *Yes*, you'll be asked for information about the other coverage like start date, carrier name, policy holder name and date of birth, etc. Just fill out the forms that open when you select *Yes*.
4. After you complete the form, click *Next* to see a summary of the information.
5. If you agree with the summary, click *Submit* in the bottom right corner. If you need to make changes, click *Edit* at the top of the summary.

If you have any questions, you can call Customer Service at the number on the back of your ID Card for assistance.

Other COB options are available

For your convenience, please click here for a copy of the Other Insurance Coverage Form.

- You can *email* it to:
  Forms.Direct@meritain.com
- Or you can *mail* it to:
  Meritain Health
  Eligibility Department
  P.O. Box 27810
  Minneapolis, MN 55427-0810
- Or *fax* to **716.541.6672**.
  You should keep a copy of the fax confirmation record if you plan to call to confirm receipt.

ADVOCATES FOR HEALTHIER LIVING

Advocates for Healthier Living

Meritain Health provides easy-to-use healthcare benefits you can use to stay healthy and productive. Contact us at the number on your ID Card if you have any questions about your plan.

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PRESCRIPTION BENEFITS

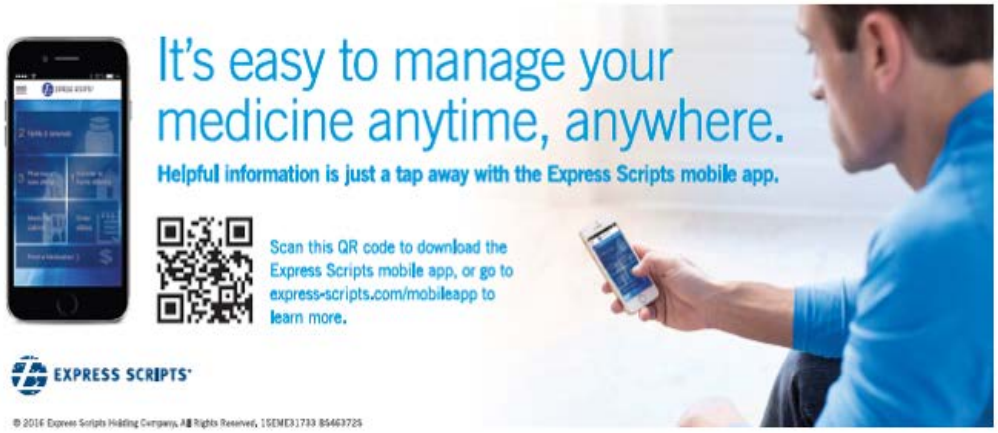
EXPRESS SCRIPTS

The plan provides coverage for generic drugs, brand name drugs on a formulary, and brand name drugs not listed on the formulary. Please be sure to provide your Express Scripts Pharmacy ID card to your pharmacy when filling prescriptions.

If you are taking any maintenance medications, it's beneficial to fill a 90 day prescription through the Mail Order service with Express Scripts. You will save money! Refer to the table on this page for details.

To get setup with Mail Order, you may call the Express Scripts customer service number listed on the back of your ID card. You will need to mail your completed Mail Order form in with your prescription and applicable payment. Within a couple of weeks, you will be setup in the system and then able to later request refills either online or over the phone.

Plan Name	Rx Copays
Retail (31 day supply) *Generic / Preferred Brand / Non-Preferred Brand / Specialty*	Preferred $20 / $50 / $70 / $70 Standard $25 / $55 / $75 / $75
Retail (32-60 day supply) *Generic / Preferred Brand / Non-Preferred Brand / Specialty*	Preferred $40 / $100 / $140 / $140 Standard $45 / $105 / $145 / $145
Retail (90 day supply) *Generic / Preferred Brand / Non-Preferred Brand / Specialty*	Preferred $60 / $150 / $210 / $210 Standard $65 / $155 / $215 / $215
Mail Order (90 day supply) *Generic / Preferred Brand / Non-Preferred Brand / Specialty*	$20 / $60 / $100 / $100



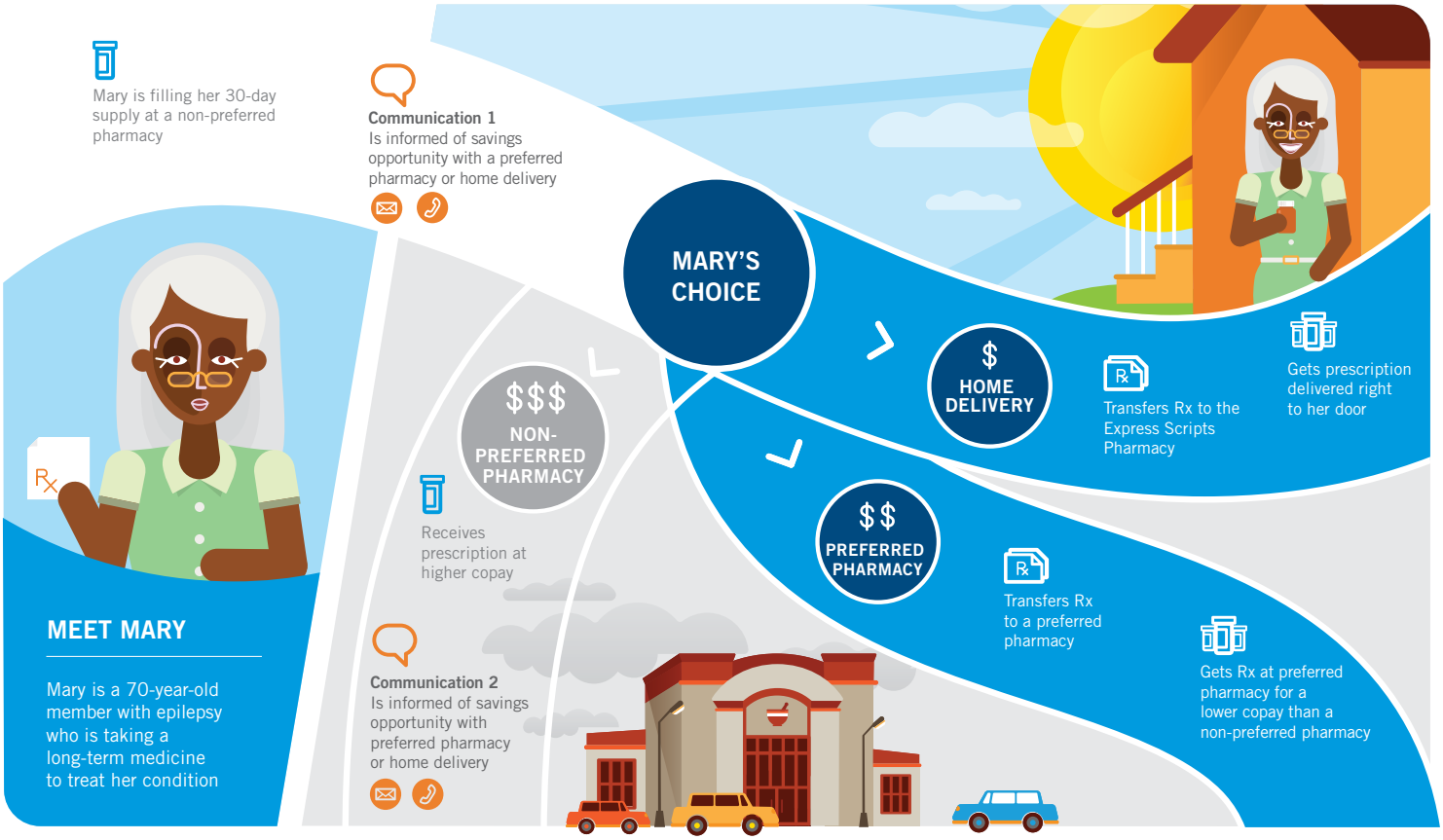
Express Scripts mobile app:

- Refill prescriptions
- See order status and claims
- Find and compare prices
- Access your ID card

MPVN CHAIN PHARMACIES

MEDICARE PREFERRED VALUE NETWORK

Comprehensive preferred provider network of 27k+ pharmacies. *Retail pharmacy participation is contracted and may be subject to change)*



- Offers convenience with choice of a preferred or non-preferred pharmacy, or home delivery from the Express Scripts Pharmacy℠
- Members are prompted to choose a preferred pharmacy or home delivery to increase savings

DENTAL PLAN

AETNA

Dental coverage is key to your overall health. Infineum offers you and your family a Dental plan through Aetna. This Dental plan offers coverage for the following expenses:

Network name: Dental PPO/PDN with PPO II and Extend		
Plan Features	**In-Network***	**Out-of-Network**
Deductible *(Calendar/Plan year)* *Waived on Preventive Services*	$25/$75	$25/$75
Benefit Maximum *(Calendar/Plan year)*	$1,250[1]	$1,250[1]
Preventive Services Routine exams and cleanings, fluoride treatments, sealants, and X-rays	100%	100%
Basic Services Simple fillings and extractions, root canals, oral surgery, and gum disease treatment	80%	80%
Major Restorative Services Crowns and dentures	50%	50%
Orthodontia Services	50% $1,000 maximum	50% $1,000 maximum

** You will pay less for services when you use in-network providers. The plan's level of reimbursement is lower for services provided by out-of-network providers. For more information about the network go to aetna.com.*

[1] Benefit Maximum increases to $1,500 with at least one dental visit each year.

Aetna Dental® plans

You don't need a dental ID card to get dental care

We want to make doing business with us easier than ever.

How will my dentist know I'm an Aetna Dental member? When you visit your dentist, simply tell the office your name, date of birth or member ID number.

But what if I want a card?

Easy — use our mobile app or go online. Log in to your secure member website at **aetna.com**.

You can print out an ID card for you and your dependents by selecting "ID Card" and then selecting "View ID Card." If your electronic ID card says **"No Election"** or **"Invalid Choice,"** then your plan requires you to choose a primary care dentist (PCD) who is in our network. Until you choose one, your benefits and claims may be affected.*

Here's what else you can do online:

- Find or select a dentist
- View claims and claim address
- Manage your health care spending

aetna®

Aetna Dental® plans

Log in to your secure member website at **aetna.com** to explore the resources available to you. Call **1-877-238-6200** if you have any questions — 24 hours a day, 365 days a year.

*California/Arizona DMO® plan participants: If you have not selected a PCD, one may have been selected for you. View your electronic ID card to determine if one was selected on your behalf.

aetna®

aetna.com

Aetna Mobile — find what you need, wherever, whenever

To learn how to download the free Aetna Mobile app to access your ID card or dental benefits information when you're on the go, visit us at **aetna.com/mobile.**

Aetna Dental® PPO plan

Choosing your dental plan

See if your dentist is in the network
You may want to see if your dentist is in our network. Go to **Aetna.com** to use our provider search tool.

Check your costs
Dental plans are all different. So you won't see cost information here. Instead, check your benefits summary to find your share of the costs.

This may include your:

Deductible — the dollar amount some plans require you to pay for services before coverage starts.

Coinsurance — the percentage of dental care expenses you pay after your deductible. Your dental plan pays the rest. For example, you pay 20%, and your plan pays 80%.

Your dental plan may have yearly and lifetime limits on coverage. There also may be age and frequency limits on some services.

FSA
HSA

If you have a health savings account (HSA) or a flexible spending account (FSA), you can use those funds to help with costs.

Sign up today! You can visit any licensed dentist — in or out of network.

Your options	Pick your dentist	How it works
In network No paperwork Lower costs	Visit a dentist in the Aetna Dental PPO* network.	• Network dentists offer special rates for covered services. So your share of the cost is usually lower. • Network dentists file claims for you.
Out of network Choices	Visit any licensed dentist outside the network.	• You may pay more when you get care from dentists who aren't in the network.** • You may have to file your own claims.

*In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN).
**Out-of-network benefits are paid based on recognized charge levels, as determined by Aetna and specified in your plan documents.

Dental PPO insurance plans are underwritten and/or administered by Aetna Life Insurance Company (Aetna).

Manage your benefits, connect to care, handle claims — from anywhere

The Aetna Health℠ app and your Aetna® member website are personalized, seamless and easy to use. Once you're a member, here's how you can connect:

Go to Aetna.com

Go to **Aetna.com** to create an account and log in to your member website.

Get the Aetna Health app

Get the Aetna Health app by texting "GETAPP" to **90156** for a link to download the app and create an account. Message and data rates may apply.*

VISION BENEFITS – FOR RETIREES UNDER AGE 65 ONLY

A Look at Your VSP Vision Coverage

With VSP and INFINEUM USA INC. 30072285, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER PROGRAM

Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

vsp vision care

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.
Contact us: **800.877.7195** or **vsp.com**

VISION BENEFITS

Your VSP Vision Benefits Summary

INFINEUM USA INC. 30072285 and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
01/01/2024

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$15	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$30**	
FRAME†	• $140 featured frame brands allowance • $120 frame allowance • 20% savings on the amount over your allowance • $65 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

COLLEAGUE ASSISTANCE

Infineum USA - Colleague Assistance Program

Call CAP at **800.554.6931** or visit us on the web at **www.myCigna.com**
Employer ID: infineum

Face-to-face assistance			
Service level	• 24/7 telephonic access	• Network health care professional referrals	
Participant services	• Telephonic consultation • Crisis intervention services • Community resources	• Healthy Rewards® discount program • Online assessment tools • Online article library	• Online access and referrals • Up to 8 sessions per issue, per member, per year
Organizational services	• Account management • Unlimited management consultation and referral	• Online management reporting	• 10 service hours annually per 1,000 employees for orientations, seminars or training, onsite crisis intervention
Full-service work/life support			
Telephone, click-to-chat, web mail	• **Child care** – Child care centers, family child care homes, in-home care, babysitting agencies and options, nanny agencies and options, au pair agencies and options • **Senior care** – Home health agencies, nursing homes, assisted living facilities, continuing care retirement communities, social and recreational programs • **Prenatal care** – Birthing methods, nutrition, exercise, diet and child care pre-planning • **Adoption** – State adoption specialist, adoption support groups, private adoption, national adoption organizations	• **Parenting** – Child development, sibling rivalry, separation anxiety, sleep and bedtime routines, toilet training • **Summer care** – Residential camps, day camps, traditional camp programs, specialized camp programs • **Special needs** – Common childhood illnesses, children with multiple disabilities, developmental delays • **Pet care** – Veterinarians, insurance, pet sitting resources, obedience training, pet stores, pet supply catalogs • **Education** – Kindergarten programs, public schools	• **Legal** – 30-minute free consultation, 25% discount on usual fees, referrals to local providers • **Identity theft** – 60-minute free consultation with a fraud resolution specialist • **Financial services** – 30-minute free phone consultation with a qualified specialist on issues such as tax preparation, debt counseling and planning for retirement. 25% off tax preparation.
Online resources and tools	• **Parenting** – Adoption, child care, developmental stages, kid's well-being, education • **Aging** – Adults with disabilities, aging well, planning for the future, U.S. systems for the elderly, housing options, home care, health, caregivers, grief and loss • **Balancing** – Personal growth, communication, families, relationship, grief and loss, mental health, addiction and recovery	• **Thriving** – Health tools, live healthy, healthy eating, medical care, infant and toddler health, child health, adolescent health, women's health, men's health, senior health, health challenges • **Working** – Accomplished employee, effective manager, career development, training and development, workplace productivity, workplace diversity, workplace safety • **Living** – Consumer tips, home improvement, home buying or selling, moving, financial, legal, legal ready docs, errands online, safety, pets, travel and leisure time, fraud and theft	• **Educational materials** • **Personal assessments** • **Interactive tools** • **Self-search resource locators** • **Email for consultant-assisted search** • **Live messaging for consultant-assisted search** • **Web seminars**
Referrals and fulfillment	• Up to three qualified referrals where available; if additional needed, participant calls back	• Turnaround Time: 12 business hours; emergency is six business hours	• Online and print fulfillment materials

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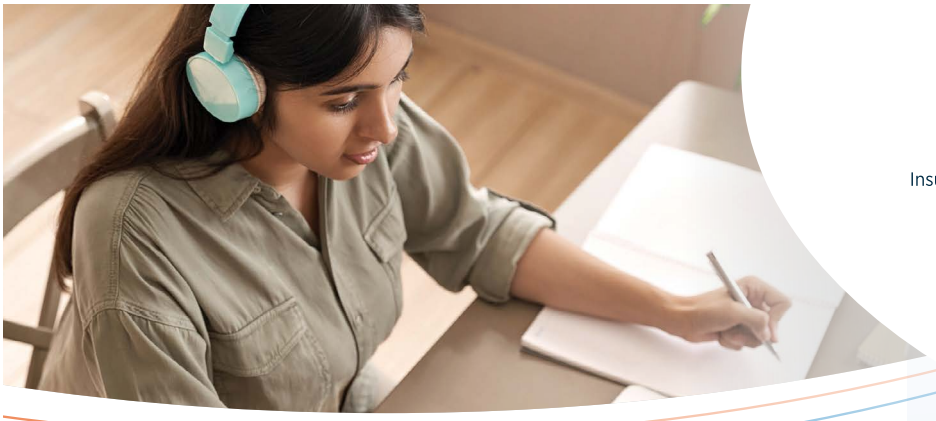
BENEFIT ADVOCATE CENTER



Gallagher

Insurance | Risk Management | Consulting

Ask Your Advocate Team

Put our team to work to maximize your healthcare benefits.

Gallagher is ready to help you get the most from your benefit program by providing support from an advocate at no cost to you. Get assistance with:

1. **Explanation of benefits**
   Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
2. **Prescription challenges**
   Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help with an authorization for a medication?
3. **Benefits questions**
   Are you unsure if the insurance company will pay for a certain procedure?
4. **Claim issues**
   Did you receive a bill from a doctor but don't know why?
5. **Difficult situations**
   Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

Connect with Us

Infineum USA Inc.
Advocate Center

833.525.7102
bac.infineum@ajg.com

Hours of operation

Monday – Friday

8 a.m. – 6 p.m.

ajg.com **The Gallagher Way.** Since 1927.

Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc. is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Neither Arthur J. Gallagher & Co., nor its affiliates provide accounting, legal or tax advice.
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CONTACTS

Contact Information			
Plan	**Carrier**	**Phone Number**	**Email/Website**
All Benefits	Gallagher Benefit Services	1-833-525-7102	bac.infineum@ajg.com
Medical	Meritain Health	1-800-925-2272	www.meritain.com
Prescription	Express Scripts	1-866-544-2891	www.express-scripts.com
Dental	Aetna	1-877-238-6200	www.aetna.com
Vision *(Under age 65)*	VSP	1-800-877-7195	www.vsp.com
Colleague Assistance Plan	Cigna	1-800-554-6931	www.mycigna.com

MONTHLY PLAN RATES

Monthly Plan Rates	Single		Individual + Adult		Individual + Child(ren)		Family	
	Retiree	Infineum	Retiree	Infineum	Retiree	Infineum	Retiree	Infineum
Plan 1* Meritain/Aetna	$225	$899	$428	$1,720	$383	$1,537	$572	$2,288
Plan 2* Meritain/Aetna	$320	$835	$637	$1,570	$556	$1,418	$848	$2,089
Medicare Supplement Meritain	$173	$296	$346	$587	N/A	N/A	N/A	N/A
Dental Plan PPO/PDN with PPO II	$26	$26	$47	$39	$47	$39	$75	$57

EXTENDED COVERAGE OF DEPENDENTS

UP TO AGE 26

You may recall that the Patient Protection and Affordable Care Act (PPACA), commonly referred to as "health care reform," was signed into law by President Obama on March 23, 2010. One of the provisions of this law required health care plans to extend dependent care coverage to eligible individuals through age 26, beginning no later than March 23, 2011. As a result of this legislation, dependent children who are under age 26, unless other coverage is available through his/her employer or spouse, may remain on the Infineum Medical Plan. Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer. Eligibility for this coverage does not depend on full time student status, marital status, financial dependency or residence in the parental home. Dependents with this new eligibility can be added to your Medical Plan option during the Open Enrollment period beginning on November 1, 2022 to start coverage on January 1, 2024. New Jersey retirees should note that, because the Infineum Medical Plan is self-funded, it is not subject to the expanded coverage provisions of the recently enacted N.J. Dependent Under 31 Law (DU31).

WOMEN'S PREVENTIVE CARE

WITH NO COST SHARING

On August 1, 2011, the Department of Health and Human Services (HHS) released an amendment to the Interim Final Regulations for preventive care under the Patient Protection and Affordable Care Act (PPACA). The amendment applies to non-grandfathered individual insurance policies as well as non-grandfathered insured and self-insured group health plans.

The amendment provides additional guidelines for women's preventive services. Health plans will need to cover women's preventive services, including birth control, without copayments or deductibles. The guidelines reflect the recommendations made in July 2011 by the independent Institute of Medicine.

For plan years beginning on or after August 1, 2012, non-grandfathered plans will be required to cover the following additional preventive care services for women with no cost sharing:

Plans may impose cost sharing on brand name preventive drugs if a generic version is available and is just as effective and safe for the patient to use. Cost sharing would not be permitted on the generic drug.

For more detail on the amendment and the additional preventive care services for women, visit:

www.hrsa.gov/womensguidelines/ or

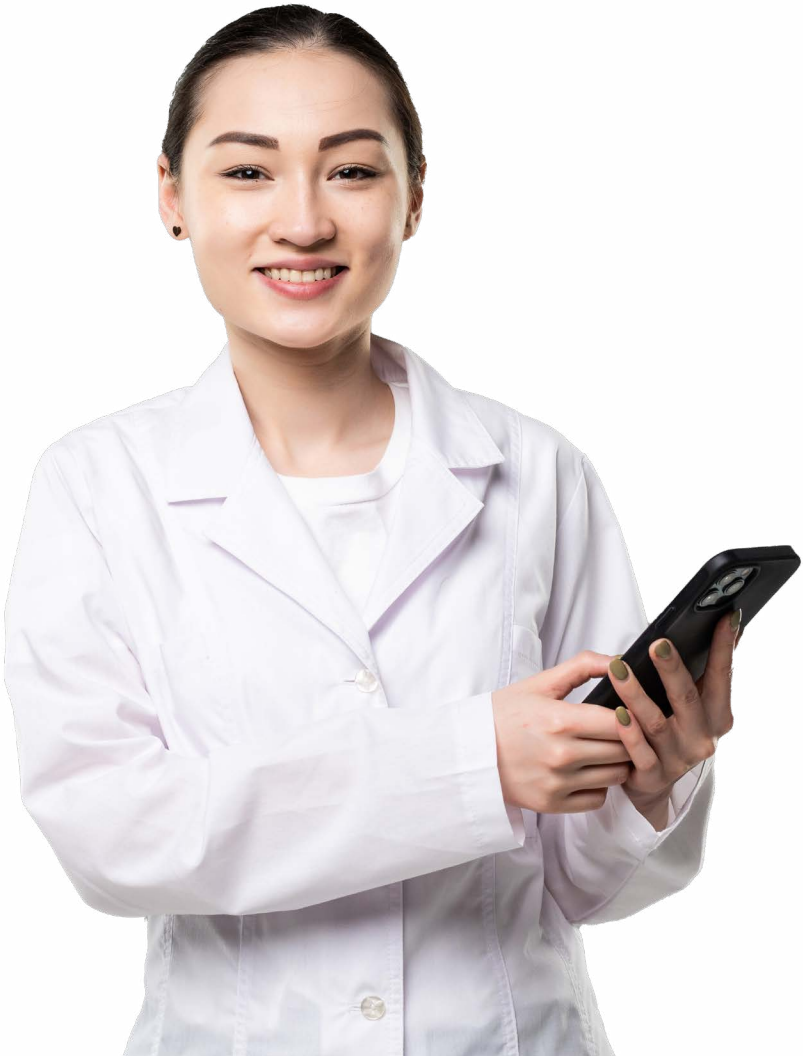
http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html

For more information on the existing PPACA preventive care guidelines, visit:

http://www.healthcare.gov/center/regulations/prevention/taskforce.html

Services include:

- Annual well-woman visits
- Screening for gestational diabetes
- HPV DNA testing for women 30 years and older
- Sexually-transmitted infection counseling
- HIV screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies, and counseling



SUMMARY ANNUAL REPORT

FOR INFINEUM HEALTH & WELFARE BENEFIT PLAN

This is a summary of the annual report of the Infineum Health & Welfare Benefit Plan, EIN 74-2890923, Plan No. 501, for period January 1, 2022 through December 31, 2022. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Information Regarding Your Medical and Dental Plans*

All participant contributions and employer contributions are used to pay benefit claims and administrative expenses. For the period January 1, 2022 through December 31, 2022 this included employer contributions of $12,224,206 for medical and $432,962 for dental. For this same period, participants contributed $3,397,131 for medical and $502,395 for dental.

Insurance Information

The plan has contracts with United of Omaha Life Insurance Company, ACE American Insurance Company, and Connecticut General Life Insurance Company to pay Life Insurance, Long-term Disability, Accidental Death & Dismemberment, and Employee Assistance Plan claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2022 were $980,939.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write Infineum USA Inc., 1900 East Linden Avenue, Linden, NJ 07036, (800) 441-1074.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan at Infineum USA Inc., 1900 East Linden Avenue, Linden, NJ 07036 and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

** Information provided in this paragraph is not required to be reported to the Department of Labor. It is provided for your information only.*

LEGAL NOTICES

Important Notice from Infinium 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 Infinium and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

- 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.
- Infinium has determined that the prescription drug coverage offered through the company-sponsored medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your Infinium coverage will not be affected. You can keep this coverage even if you elect Part D; the plan will coordinate with Part D coverage. If you are an active associate and decide to join a Medicare drug plan and drop your current Infinium coverage, be aware that you and your dependents will be able to get this coverage back, provided you are still eligible to participate in the Infinium Medical Plan.

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

You should also know that if you drop or lose your current coverage with Infinium and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage: Contact the person listed below for further information.

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Infinium changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

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

Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213

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

Date:	January 1, 2024
Name of Entity/Sender:	Infineum USA Inc. – HR Dept.
Contact:	Benefits Specialist
Address:	1900 E. Linden Ave. Linden, NJ 07036
Phone Number:	908-474-2273

LEGAL NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

Dear Infinium Associate:

Key parts of the Affordable Care Act, also known as the healthcare reform law, went into effect January 1, 2014. As of this date, the healthcare reform law will require almost all Americans to have healthcare coverage or be subject to a penalty tax. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace for buying health insurance and about health coverage at Infinium .

If you are eligible for health coverage through Infinium , your coverage will likely be more affordable through Infinium 's health plans, or if applicable and available, through your spouse's or your parent's employer plan (if you are under the age of 26).

If you are not eligible for Infinium health plans, you should consider other options available to you, such as coverage through your spouse's employer plan, your parent's employer plan (if you are under the age of 26), Medicaid, Medicare or your state's Marketplace. Enrollment in the Marketplace will begin in November. You may b e eligible for a federal subsidy (in the form of a tax credit) in order to make buying insurance through the Marketplace more affordable. The subsidy you may be eligible for depends on your household income. If you are eligible for health coverage from Infinium you will not be eligible for the subsidy (tax credit) through the Marketplace. Therefore, you may wish to enroll in Infinium 's health plan.

What Is The Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. It offers "one-stop shopping" to find and compare private health insurance options. All U.S. citizens and legal residents will have access to individual health insurance policies through their state's Marketplace. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014. To find out more about the Marketplace in the state where you live, visit www.healthcare.gov.

Can You Save Money On 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 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by Infinium , then you won't be eligible for Infinium 's contribution to the Company-offered coverage. Also, this Company 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.

Why Are You Sending This Information?

Most U.S. employers are required to send this notice to employees to raise awareness of the Marketplace and to help them understand how having access to their employer's healthcare plan may limit their eligibility for a subsidy in the Marketplace.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your HR Department.

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

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

Employer Name	Infineum
Employer ID:	74-2890923
Contact:	HR Department
Address:	1900 E. Linden Ave. Linden, NJ 07036
Phone Number:	908-474-2273
Email Address:	hedy.disimoni@infineum.com

LEGAL NOTICES

Women's Health and Cancer Rights Act (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator or contact your HR Department.

Notice Regarding the Newborns' Act

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

HIPAA Special Enrollment Rights

Infinium Health Plan Notice of Your HIPAA Special Enrollment Rights.

Our records show that you are eligible to participate in the Infinium Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction). A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the HR Department.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

LEGAL 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 at www.askebsa.dol.gov or call 1-866-444- EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January, 2023. Contact your State for more information on eligibility –

ALABAMA—Medicaid myalhipp.com 1-855-692-5447

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

ARKANSAS—Medicaid
myarhipp.com 1-855-MyARHIPP (855-692-7447)

COLORADO—Medicaid
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

FLORIDA—Medicaid flmedicaidtplrecovery.com/hipp
877-357-3268

GEORGIA—Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

INDIANA—Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479

All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA—Medicaid http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS—Medicaid www.kdheks.gov/hcf
Phone: 1-785-296-3512

KENTUCKY—Medicaid chfs.ky.gov/dms/default.htm
Phone:1-800-635-2570

LOUISIANA—Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE—Medicaid
www.maine.gov/dhhs/ofi/public-assistance/index.html
1-800-442-6003 TTY: Maine relay 711

MASSACHUSETTS—Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

LEGAL NOTICES

MINNESOTA—Medicaid
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI—Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA—Medicaid
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084

NEBRASKA—Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633 Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA—Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE—Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY—Medicaid and CHIP
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK—Medicaid
www.nyhealth.gov/health_care/medicaid
Phone: 800-541-2831

NORTH CAROLINA—Medicaid www.ncdhhs.gov/dma
919-855-4100

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

OKLAHOMA—Medicaid and CHIP
www.insureoklahoma.org
Phone: 1-888-365-3742

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

PENNSYLVANIA—Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND—Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA—Medicaid www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA—Medicaid dss.sd.gov
Phone: 1-888-828-0059

TEXAS—Medicaid gethipptexas.com
Phone: 1-800-440-0493

UTAH—Medicaid and CHIP
Medicaid: health.utah.gov/medicaid
CHIP: health.utah.gov/chip 1-877-543-7669

VERMONT—Medicaid www.greenmountaincare.org
Phone: 1-800-250-8427

VIRGINIA—Medicaid and CHIP
Medicaid: www.coverva.org/programs_premium_assistance.cfm
1-800-432-5924
CHIP: www.coverva.org/programs_premium_assistance.cfm
Phone: 855-242-8282

WASHINGTON—Medicaid
www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
1-800-562-3022 ext. 15473

WEST VIRGINIA—Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN—Medicaid and CHIP
www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800-362-3002

WYOMING—Medicaid wyequalitycare.acs-inc.com
Phone: 1-307-777-7531

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

LEGAL NOTICES

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service This is called "balance billing " This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit"Surprise billing" is an unexpected balance bill This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

For New Jersey residents: On June 1, 2018, New Jersey Governor Phil Murphy signed the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the NJ Surprise Bill Act) into law. This legislation, in part, prohibits the practice of balance billing patients and increases transparency in medical billing. The purpose of the law is to protect patients from unexpected or "surprise" medical bills that sometimes arise when a patient unknowingly receives treatment from an out-of-network provider and is then billed for the difference between the provider's billed charges and reimbursement received from payors for services performed in emergency room/urgent and/or inadvertent care settings. Generally, the NJ Surprise Bill Act applies to fully insured plans, the State Health Benefit plans, and self-funded plans that have opted into being governed by the NJ Surprise Bill Act. Beginning January 1, 2022, the new Federal No Surprises Act will govern self-funded surprise bill claims that have not opted into NJ law and those fully insured claims for services not covered by the NJ Surprise Bill Act, such as post-stabilization care

When balance billing isn't allowed, you also have the following protections:

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

If you believe you've been wrongly billed, you may contact Meritain Health Customer Service at 800-925-2272 or Infineum Human Resources at 908-474-2273

Visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/requirements-related-to-surprise-billing-final-rules-2022.pdf.

for more information about your rights under federal law

Visit https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork html for more information about your rights under New Jersey state laws.

2024 Open Enrollment Benefits for Retirees

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.