Hourly Employee Benefits Guide

2025 Plan Year

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you choices about your prescription drug coverage.

Constantia Flexibles

To All Our Employees:

Constantia Flexibles' success has been made possible by the efforts and loyalty of our employees. Constantia Flexibles; in turn, wants to provide the best working conditions and benefits possible. Your health, welfare, and security are of vital concern to all of us.

While it is our sincere hope that we will all enjoy good health and a long life, no one is immune to illness, accident, or death. To protect you and your family's financial security from these possibilities, we are happy to be able to offer you this Employee Benefit Plan. This plan provides financial assistance to enable you to better meet unforeseen bills arising from accident and illness.

Please review carefully the provisions of the benefit plan outlined in this booklet. You should be aware of the coverage and security it provides. However, note that this plan is designed for protection and purposes of defining what expenses are examined to be reimbursable under the plan. This, of course, does not take the place of you and your loved ones seeking the best treatment options after consulting with your physician. Keep this booklet with your other valuable papers as it summarizes the benefits available during a time of emergency.

Plan Year: January 1, 2025 – December 31, 2025

We are pleased to offer you our 2025 Benefits Package!

Benefits are payable to full-time associates working at least 30 hours. These benefits will become effective on the first of the month following a 30-day waiting period.

Each year we review the above benefits to determine feasibility of the current carrier. Please be assured that we will find the best benefits available to the company and to our employees. If you have any questions or comments about the benefit package, please consult the Human Resources Department.

The enclosed packet contains a brief outline for all of the above benefits. This outline will help you determine your insurance needs. Specific questions can be answered by the insurance policies once you have received them by mail. Our broker of insurance, GBS, will be more than happy to answer any questions to aide in your decision-making, feel free to call Alex Hawkins at 864-509-6501.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, then you may in the future be able to enroll yourself or your dependents in this plan due to losing that coverage. You would need to request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, then you may be able to enroll yourself and your dependents. You would need to request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Helpful Definitions:

In network - Providers that have contracted with a network to provide covered services at a negotiated rate (i.e. - hospitals, doctors, pharmacies, durable medical equipment suppliers, etc.)

Out of Network - Providers that have not contracted for reimbursement at a negotiated rate.

Copayment - A specified amount of money you pay each time certain covered services are preformed (i.e. - office visit or prescription, etc.). Your Copayment does not apply to your Deductible or Out of Pocket Maximum.

Coinsurance - A specified percentage share in which you and the plan pay toward the cost of covered services. Usually, you have to meet your deductible before coinsurance kicks in.

Deductible - Each year you must meet a plan year deductible. This means you must pay a certain amount of money towards covered expenses before the coinsurance kicks in.

Out of Pocket Maximum - Once you meet the out of pocket limit (by paying your part of the coinsurance), the plan pays 100% of any further covered medical expenses that you incur for the remainder of the plan year.

EMPLOYEE BENEFIT PORTAL

www.constantiahr.ajgportal.com

Don't forget to take advantage of the Benefits Portal we offer to all employees and their families. This portal contains enrollment instructions, eligibility requirements, and benefits information. If at any time you have questions regarding your benefits or how to navigate through the website, please contact Gallagher Benefit Services at 1-864-239-0544.

Using your Benefits Portal

Here, we **connect** you to information that supports your work-life at Constantia Flexibles.

- Take a tour through the portal and learn about what the Leadership Team has to say about our company.
- Check out the extraordinary programs and benefits that we offer.
- And make a note of where to locate the forms, tools and other information you may need during your work-life at the company.

We have developed this portal as your one-stop resource for timely information and updates, as well as those documents, forms and tools you may need. You can access the portal 24 hours a day, 365 days a year. You'll find a wealth of information along with easily accessible documents to make your life easier. We encourage you to explore the portal and hope you enjoy the convenience of having important information right at your fingertips.

BLUE CROSS BLUE SHIELD-MY HEALTH TOOLKIT®

These BCBS programs and services can help you make the most of your medical plan.

BCBS offers numerous tools to make it easy to manage and track your medical claims, search for in-network providers, and much more! Please review the information below to learn more about BCBS and their online tools!

Access to SouthCarolinaBlues.com and My Health Toolkit:

- Learn more about your plan, and the coverage an programs that come with it
- View claim history and account transactions; print claim forms
- Find information and estimate costs for medical procedures and treatments
- Compare hospitals by number of procedures performed, patients' average length of stay and cost.
- Tobacco Cessation

Make South Carolina Blues your personal health place:

Enjoy a simple way to personalize, organize and access your important plan information. Register on ***My Health Toolkit*** on www.SouthCarolinaBlues.com. Once you do, you can login anytime, any-where to:

- **Find** doctors and compare cost and quality ratings
- **Review** your coverage
- **Manage** and track claims
- **Access** temporary ID cards and find out how to order new ones
- **Track** your account balances and deductibles
- **Find** health information and resources
- **Browse** member perks and discounts
- **Compare** hospital quality

Download the My Health Toolkit App! With the app you can:

- Use your digital ID card wherever, whenever.
- Check the status of your claims fast.
- See what's covered by your health plan.
- Find a local provider who's right for you.

MEDICAL AND PRESCRIPTION DRUG

Blue Cross Blue Shield - Group # 25-53266

Co Pay Plan	In Network	Out of Network
Deductible – Calendar Year Individual Policy Family Policy **Employer Funded HRA** Individual Policy Family Policy	 $2,000 Single $4,000 per Family $501-$2,000 Individual $1,501-$4,000 per Family	 $10,000 Single $20,000 per Family $2,501-$4000 Individual $5,501-$8000 per Family
Coinsurance (after the deductible)	70% (Insurance pays 70%, you pay 30%)	50% (Insurance pays 50%, you pay 50%)
Coinsurance Maximum (excluding deductible)	$2,000 single (of allowable charges) $4,000 family (of allowable charges)	$10,000 single (of allowable charges) $20,000 family (of allowable charges)
Lifetime Maximum (per person)	Unlimited on mandated essential benefits	Unlimited on mandated essential benefits
Inpatient Hospital - preauthorization is required	Subject to coinsurance (30%)	Subject to a $100 per admission copayment and coinsurance (50%)
Physician Office Visits	$25 co-pay then 100% coverage	Subject to the deductible and coinsurance (50%)
Routine Physical as Mandated	Paid at 100%	Not covered
Well-Child Care as Mandated	Paid at 100%	Not covered
Routine Pap Smear/Prostate Screening – 1 per benefit year	Paid at 100%	Not covered
Routine Mammograms	Paid at 100% (one per year age 35 or older) in mammography network	Not covered
Sustained Health Services (Preventive Care benefits not mandated)	$25 co-pay up to $250 Annual Maximum	Not covered
X-ray and Laboratory	Subject to the deductible and coinsurance (30%)	Subject to the deductible and coinsurance (50%)
Emergency Room True Emergencies Non–True Emergencies	Subject to the deductible and coinsurance (30%) Subject to the deductible and coinsurance (30%)	Subject to deductible and in-network Co-ins. (30%) and balance billing Subject to deductible and co-insurance (50%)
Maternity – preauthorization is required for the hospital stay	Subject to the deductible and coinsurance (30%)	Subject to the deductible and coinsurance (50%)
Mental Health/Substance Abuse **Inpatient -** preauthorization is required **Outpatient Hospital/Clinic/ Outpatient Physician** **Emergency Room—**Facility and Physician Charges **Physician Services in the Office**	 Facility and Professional Charges- Subject to the coinsurance (30%) Subject to the deductible and coinsurance (30%) Subject to the deductible and co-insurance (30%) $25 co-pay, then 100%	 Facility and Professional Charges- Subject to the coinsurance 50%) Subject to the deductible and coinsurance (50%) Subject to deductible and in-network co-insurance (30%) Subject to deductible and co-insurance (50%)

MEDICAL AND PRESCRIPTION DRUG

Co Pay Plan	In Network	Out of Network
Home HealthCare – preauthorization is required (60 visits per year)	Subject to the deductible and coinsurance (30%)	Subject to the deductible and coinsurance (50%)
Chiropractic Care	Paid at 50% with an annual maximum of $1,000 per person after the deductible	Paid at 50% with an annual maximum of $1,000 per person after the deductible
Prescription Drugs (oral contraceptives are covered) Generic - Mandatory Preferred Name Brand Non-Preferred Name Brand	 $15 co-pay then paid at 100% level $40 co-pay then paid at 100% level $70 co-pay then paid at 100% level	 $15 co-pay then paid at 50% level $40 co-pay then paid at 50% level $70 co-pay then paid at 50% level
Specialty Drug - 1-855-811-2218 for inquires regarding this benefit	Optum Specialty Pharmacy Only $125 co-pay per 31 day supply	
Mail Order Service (90 day supply) Call (855) 811-2218 for additional information	$25 generic / $90 preferred name brand / $175 non-preferred name brand	Not Covered

A $100.00 spousal surcharge will be added to your health insurance payroll deduction each month if you have elected coverage for your spouse and your spouse is eligible for coverage through his/her employer but elects not to enroll with their employer. If your spouse is eligible for coverage as an employee, the spousal coverage surcharge is waived. See Spousal Surcharge Affidavit upon enrollment.

Those who do use tobacco/nicotine will receive a tobacco/nicotine surcharge of $43.33.See Smoking Surcharge Affidavit upon enrollment.

If you need help to quit smoking or using tobacco products, preventive medications are available at $0 cost share for members enrolled in Medical plans.

NO SURCHARGE	
RATES	**Weekly**
Employee Only	$29.70
Employee & Spouse	$80.49
Employee & Child(ren)	$64.83
Employee & Family	$99.96

SPOUSE SURCHARGE	
RATES	**Weekly**
Employee Only	$29.70
Employee & Spouse	$103.57
Employee & Child(ren)	$64.83
Employee & Family	$123.04

SMOKING SURCHARGE	
RATES	**Weekly**
Employee Only	$39.70
Employee & Spouse	$90.49
Employee & Child(ren)	$74.83
Employee & Family	$109.96

SPOUSE & SMOKING SURCHARGE	
RATES	**Weekly**
Employee Only	$39.70
Employee & Spouse	$113.57
Employee & Child(ren)	$74.83
Employee & Family	$133.04

BLUE CARE ON DEMAND

BCBS offers Blue Care on Demand. This service allows you access to a doctor when it's not an emergency, but you need urgent attention. BlueCare on Demand is there 24/7.

- Common Cold
- Flu Like Symptoms
- Pink Eye
- Strep Throat
- Ear Ache

Use a smart phone, tablet, or personal computer for easy access—no matter where you are! Download the My Health Toolkit app and create an account today.

BCBS MAIL ORDER PRESCRIPTION COVERAGE

As a BCBS customer, you'll have access to OptumRx's Mail Service Pharmacy. Please call OptumRx Home Delivery Customer Care at 855-811-2218 or visit My Health Toolkit with any questions.

You'll enjoy:

- Easy refills – up to a 90-day supply means fewer refills
- 24 hour, toll free hotline to speak to registered pharmacists about medication questions
- Convenient Internet and refill-by-phone services to order your refills any time, any day
- Helpful order updates and refill reminders, by e-mail, phone or text

Getting Started

Members can call OptumRx Home Delivery to enroll in its FastStart service. The representative will contact their doctors for their prescriptions. They'll need their member ID number, the name of their drug, doctor's name and phone number and their shipping address. They will also need to provide a credit card number to pay for their mail-order prescription, along with the expiration date for the card they use.

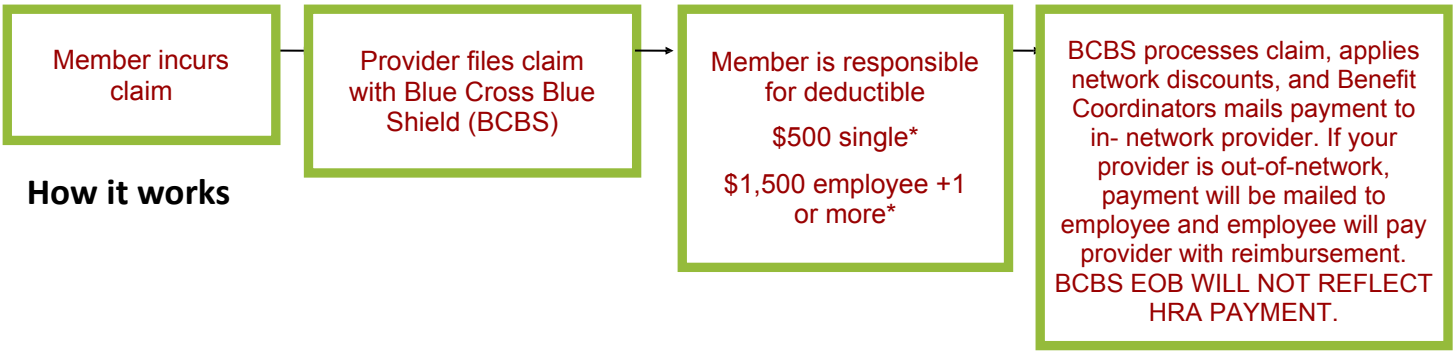
Prescription Refills

After you get your initial prescription, you may request a refill on the Internet, by phone or by mail. Have your prescription refill form with your prescription number close by when you reorder. For Internet refills, go to My Health Toolkit and click on the link to OptumRx. You may also call OptumRx Customer Care toll free at 855-811-2218 to refill your prescription by phone. If there are no refills available, OptumRx will call your doctor for authorization to refill your prescription(s). If your prescription is out of refills, please allow extra time to process your order.

Automatic Refills

Your medication will be refilled automatically if you sign up for the Optum automatic refill program. After you receive your first mail-service prescription, go to your My Health Toolkit portal or call OptumRx toll free at 855-811-2218. If you don't sign up for the automatic refill program, you'll need to request your refills each time you're ready for them, either on the OptumRx's web-site, by phone or by mailing in your refill form to OptumRx.

HEALTH REIMBURSEMENT ACCOUNT



How it works

HRA Case Studies

Mrs. Jones was hospitalized for gall bladder surgery. Her employer plan's annual deductible is $2,000 for single. Under the HRA, her single deductible is $500, the employer funds the next $1,500 in the HRA account, the rest is subject to co-insurance.

Employer covers claims in excess $500* up to $2,000 per year HRA contribution			
	Expense	**Member Responsibility**	**HRA**
Physician for Surgery	$2,000	$500	$1,500
Hospital Bill	$17,000	$2,000 (30% up to $2,000 out of pocket Maximum)	$0
Total	**$19,000**	**$2,500**	**$1,500**

Mrs. Jones' responsibility was her $500 single deductible. Also, Constantia Flexibles covered the remainder of the deductible from $501 to $2,000. The balance was subject to coinsurance, BCBS paid 70%, Mrs. Jones was responsible for $2,000, meeting all of the out of pocket maximum.

*If you choose not to participate in employee health screenings, you will have higher payroll deductions.

**These costs do NOT reflect the co-pays that are not included in the deductibles and out of pocket maximums.

The Hart family had some unexpected medical costs this year – wife Sheryl found out she was pregnant again and daughter Tara was hospitalized for pneumonia. Husband John's employer plan's annual deductible is $4,000 for family coverage. Under the HRA, the Hart family's deductible is $1,500, the employer funds the next $2,500 in the HRA account, the rest is subject to co-insurance.

Employer covers claims in excess $1,500* up to $4,000 per year HRA contribution			
	Expense	**Member Responsibility**	**HRA**
Physician	$4,000	$1,500	$2,500
Hospital Bill (Sheryl and Tara)	$25,000	$4,000 (30% up to $4,000 out of pocket maximum)	$0
Total	**$29,000**	**$5,500**	**$2,500**

The Hart family's responsibility was their $1,500 family deductible. Also, Constantia Flexibles covered the remainder of the deductible from $1501 to $4,000. The balance was subject to coinsurance, BCBS paid 70%, Mr. Hart was responsible for $4,000, meeting all of the out of pocket maximum.

*If you choose not to participate in employee health screenings, you will have higher payroll deductions.

**These costs do NOT reflect the co-pays that are not included in the deductibles and out of pocket maximums.

HEALTH REIMBURSEMENT ACCOUNT

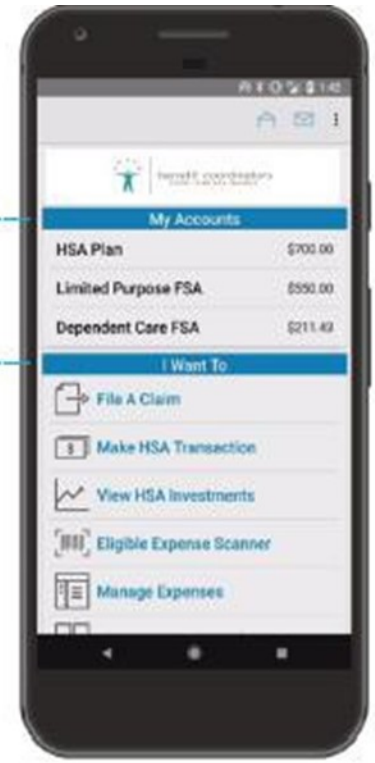
ADMINISTERED BY BENEFIT COORDINATORS, INC.

Manage your health benefits on the go.

Want a simple, easy way to check your healthcare account balances and submit receipts from anywhere? The BCI4me app lets you securely access your health benefit accounts with a touch of a finger. Designed so you can quickly find what you need most, our Mobile App provides easy, on-the-go access to all your health accounts.

View balance information for all your account(s) right away.

Use the "I Want To" section to quickly take any number of actions from making payments to viewing HSA investments to scanning items for eligibility and more.



Stay up to speed

With the BCI4me app, you can get to the healthcare account information you need—fast. Wondering whether you have enough money to pay a bill or make a purchase? BCI4me puts the answers at your fingertips*:

- Enjoy real-time access including an intuitive app design and navigation
- Log in to your account(s) with ease using your fingerprint
- Quickly check available balances and account details for medical and dependent care FSA, HSA, HRA, VEBA, transportation and premium reimbursement plans
- View charts summarizing account information
- View in-app messages and text alerts that provide instant notifications about your account(s)
- Link to an external web page to obtain helpful information such as a list of eligible expenses
- Retrieve a lost username or password
- Use your device of choice – including Apple® and Android™-powered smartphones

Get started with BCI4me in minutes.

Download on the App Store

ANDROID APP ON Google Play

Download the BCI4me app for your chosen device from the Apple App Store or Google Play and log in using the password you use to access the Benefit Coordinators, Inc. consumer portal.

HEALTH REIMBURSEMENT ACCOUNT

ADMINISTERED BY BENEFIT COORDINATORS, INC.

HRA ID CARD:

You will get an ID card from BCI that explains to providers your HRA plan through your employer. Providers will not be filing claims with us directly, but you will still want to give them your HRA ID card so they know you are not responsible for your entire BCBS deductible.

HOW ARE CLAIMS PAID:

BCI will receive your medical claims directly from BCBS so you don't need to file anything with us. Once claims are received and processed, the payments are issued directly to your provider. As long as you have setup your email address in our online portal, the system will email you when a payment is made prompting you to login to the portal and view the details. You can match that to your BCBS Explanation of Benefits (EOB) and your provider bills to ensure that you are only paying your correct patient responsibility after BCBS and BCI have processed your claim.

ONLINE ACCOUNT ACCESS:

You can view your HRA online 24/7 through www.bci4me.com. By accessing your account you can view claims submitted, funds available and payments issued.

1. Open your internet browser and go to www.bci4me.com.
2. Under the "New User?" heading, click the "Create your new username and password" link.
3. Follow the prompts to setup your login. You will need your first and last name, zip code and SSN.

Once your login ID and password are setup, you can also access your account through our mobile app – BCI4me.

Best Practice: Setup your login before you have any claims! Make sure to provide your email address and check your notification preferences – click the Message Center Tab, then Update Notification Preferences. Make sure the email notification for payments is allowed.

QUESTIONS: Contact us!

Phone:	800-951-1012 x120
Email:	hra@benefitcoordinators.com
Mailing Address:	Benefit Coordinators, Inc. PO Box 197 Irmo, SC 29063

benefit coordinators

VISION · STRATEGY · BALANCE

BCBS MY HEALTH TOOLKIT

Make the most of your medical plan

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- **Review** your coverage
- **Manage** and track claims
- **Access** temporary ID cards and find out how to order new ones
- **Track** your account balances and deductibles
- **Find** health information and resources
- **Browse** Member Perks and Discounts
- **Compare** hospital quality

To register at www.southcarolinablues.com, you will need your ID number or SSN, as well as your date of birth.

Remember, you can start using **www.southcarolinablues.com and My Health Toolkit** beginning on your coverage's start date.

MY HEALTH NOVEL: HOW IT WORKS

With My Health Novel, you can access health management mobile apps and programs at no cost to you. Whether you're interested in starting new healthy habits or improving your current ones, My Health Novel connects you to the best tools, programs, and apps.

When you qualify and sign up, you can take advantage of a virtual network of resources, group support and more to keep you on track.

Enjoy access to programs and specialists who can help you answer questions and support you on your health journey.

Simple survey through My Health Toolkit® matches to best program

LOGIC BEHIND PROGRAM TRIAGE APPROACH

Member experience is streamlined, with a comprehensive clinical logic behind the scenes

PROGRAM	DESCRIPTION	QUALIFYING CRITERIA
Healthy Weight Management	*For members who are interested in improving their lifestyle habits or maintaining their weight.*	• BMI <25 OR • BMI ≥25 and ≤29.9 with no cardiovascular disease risk factors
Diabetes Prevention Program	*Created by the CDC and tailored towards those who are at higher risk for developing Type 2 Diabetes. A type of intensive behavioral counseling.*	• BMI ≥25 + diagnosis of pre-diabetes or self-reported lab results in pre-diabetic range OR • Meeting CDC risk criteria
Intensive Behavioral Counseling	*A variety of programs designed to improve diet, promote exercise and achieve clinically meaningful weight loss.*	• BMI ≥30 OR • BMI ≥25 + diagnosis of Type 1 or Type 2 Diabetes OR • BMI ≥25 + a cardiovascular disease risk factor

ESSENTIAL ADVOCATE

While many people look for health information on the internet, you have a better and more reliable choice. You can call Essential Advocate to get answers to your health care questions.

Care coordinators are on staff to take your call 24 hours a day. Knowledgeable health advocates will offer guidance and support — or connect you with a registered nurse to advise you.

You can call and talk with them about any of these matters and more:

- **Health problems or concerns:** Nurses can assist you with minor illnesses and injuries, answer questions about your treatment plans from your doctor or address concerns you might have before or after surgery.
- **Medications:** Ask about medication side effects or drug combinations.
- **Appointment scheduling:** Get assistance setting up appointments with doctors or specialists.
- **Cost and quality research:** Ask for help using our online tools, including cost estimates and quality ratings.
- **Find a provider:** Get help locating a doctor, hospital, urgent care center or other health services.
- **Assisted living or elder care:** Get reliable information about nearby facilities about which you may need more information.
- **Community resources:** Learn what resources may be available in your town or surrounding area.

Start by calling 888-521-2583

The care coordinator will ask you for your name and member ID number. Then you can ask your questions. A care coordinator will connect you with someone who can help you.

Essential Advocate is available to you at no cost as a service of your health plan.

Note: If you are in an emergency situation or have urgent medical needs, please call 911 or go to a hospital emergency room or urgent care center.

DENTAL

Delta Dental - Group # 2137-1000

Dental Benefits

Annual Deductible	$50 per person covered
Coverage A – Diagnostic and Preventive Services	100% (with no deductible)
Coverage B – Basic and Restorative Services	80% (after annual deductible)
Coverage C – Major Dental Services	50% (after annual deductible)
Coverage D – Orthodontics	50% (after annual deductible)
Benefit Maximum:	Coverages A, B & C - $1,500 annually, Coverage D - $1,500 lifetime maximum
Dependent Age Limit	To Age 26

Rollover Provision - If a covered person submits at least one claim for covered charges during a benefit year and receives benefits that are in excess of any deductible or co-pay fees and that in total does not exceed $700, they will have $500 of benefits rolled over to the next year if using in-network provider or $350 if using out of network provider. This can accrue up to $1,250. There is no rollover provision on orthodontic.

Diagnostic and Preventive Care (Coverage A)

- Prophylaxis (cleaning) and oral examinations (twice in any 12-month benefit period)
- Fluoride application (limited to age 19)
- X-rays: bitewings (as needed); complete mouth x-rays (once every three years)
- Space maintainers for prematurely lost teeth in children to age 16 (once every five years)
- Emergency treatment for pain

Basic and Restorative Services (Coverage B)

- Amalgam filings
- Composites on anterior (front) teeth
- Synthetic porcelain restorations
- Plastic restorations
- Extractions: simple and surgical extractions including pre- and post- operative care
- Endodontics (root canal therapy)
- Periodontics (treatment of gums and bones supporting teeth)
- Sealants for dependent children to age 19

Major Dental Services (Coverage C)

- Crowns and cast restorations
- Prosthodontics – complete or partial dentures, fixed bridges, repair to fixed bridges and dentures Inlays and onlays
- Oral surgery such as frenectomies, removal of cysts and neoplasms and other surgical procedures not covered under Basic and Restorative Services

Orthodontic Services (Coverage D)

- Preventive treatment procedures
- Comprehensive orthodontic treatment
- Post-treatment retentive appliances
- Orthodontic coverage is generally provided for dependent children to age 19

For benefit questions or for participating providers call (800) 335-8266 or go to their website: www.deltadentalsc.com

Rate	Weekly
Employee Only	$1.46
Employee & Child(ren)	$4.53
Employee & Spouse	$3.80
Employee & Family	$6.86

VISION

EyeMed Vision Care - Group #9778507

For benefit questions or for participating providers call **(866)392-6057** or go to their website: **http://portal.eyemedvisioncare.com/wps/portal/emweb/members**

Overview of Benefits

- A complete vision examination every twelve months; subject to $10 co-pay
- One pair of frames every twenty-four (24) months from EyeMed Vision Care's covered frames. If a frame is selected outside of EyeMed Vision Care's selection, an allowance will be provided towards the wholesale cost of the frame. Subject to $0 copay; $120 allowance, 20% off balance over $120.
- One pair of clear single vision or standard multifocal lenses every twelve (12) months subject to $25 co-pay.
- If interested in contact lenses in lieu of spectacle lenses and frames, an allowance of $135 for conventional or disposable lenses is provided toward the purchase of contact lenses.

Rate	Weekly
Employee	100% paid by employer
Employee & Child(ren)	$1.07
Employee & Spouse	$0.97
Employee & Family	$2.10

Travel Accident

The Hartford - Group # ETB111495

- $250,000 coverage for accidents while on business travel.
- Constantia Flexibles pays 100% of the employee premium cost.

LIFE INSURANCE AND DISABILITY COVERAGE

New York Life

Life Group #SGM608474 | Long Term Disability Group # SGD609019

Short Term Disability Group # SGD609018

Life and AD&D Insurance

- Employee receives two times annual salary rounded to highest $1,000 up to a maximum of $400,000 for Life and AD&D Insurance.
- There is a 35% reduction in benefit at age 65 and an additional 15% at age 70
- AD&D is 2 times your Basic Benefit Amount (which your basic is 2 times your salary).
- **Constantia Flexibles pays 100% of the employee premium cost**

Base Spouse and Child(ren) Life Insurance

- Spouse: $5,000 for Life
- There is a 35% reduction in benefit at age 65 and an additional 15% at age 70
- Children: Less than six months old - $1,000 of coverage. Six months to age 26 - $2,500.

Cost Per Pay Period	
Dependent Cost	$0.23

For benefit questions call
888-842-4462 or go to their website:
https:// www.mynylgbs.com/auth

Short Term Disability

- Covers 70% of your current weekly salary if you suffer from a disabling accident or illness that is not work-related.
- Maximum weekly benefit is $500 and will begin after you have been unable to work for 15 days due to an accident or 15 days due to a sickness.
- Benefit payments will be received for 11 weeks while you are disabled. If you continue to be disabled your long term disability coverage will begin.
- Maternity is covered as any other illness.
- Benefit payments will be reduced by any Social Security disability benefits that you or your family members are eligible to receive. Benefits will also be reduced by other forms of income that you may receive.
- Evidence of insurability (you will need to answer health questions) is required for late enrollees.
- **Constantia Flexibles pays 100% of the employee premium cost.**

Long Term Disability

- Covers 60% of your current monthly salary if you suffer from a disabling accident or illness on or off the job.
- Maximum monthly benefit is $5,000 and will be paid on a monthly basis.
- Minimum monthly benefit is $100.
- Benefit payments will begin after you have been unable to work for 90 days due to your disability.
- You will receive benefits if you cannot work in your occupation for 24 months.
- You will receive benefit payments until Social Security Normal Retirement Age while you remain disabled.
- Maternity is covered as any other illness.
- If an employee dies while disabled, eligible survivors will receive the employee's 3-month net disability benefit. In one lump sum.
- Both total and partial disabilities are covered. You will become eligible for partial disability after receiving one monthly benefit payment for total disability. Benefit payments are then reduced by 50% of your current monthly earnings.
- New York Life will waive your premium payment while you are disabled.
- Any condition treated prior to 3 months of the effective date, will not be covered for the first 12 months.
- **Constantia Flexibles pays 100% of the employee premium cost.**

FLEXIBLE SPENDING ACCOUNT (FSA)

ADP WageWorks

Flexible Spending allows you to set aside money from your paycheck on a pre-tax basis for your uncovered health care costs.

- The maximum contribution to the plan is $3,300 per year.
- You must use your account balance before March 15th of the following year or you forfeit the funds.

The following is a worksheet to help you determine if you should participate in Flexible Spending Account:

HEALTH CARE EXPENSED ITEMS	Actual Current Year Expenses	Estimated Upcoming Year Expenses
Deductibles for health insurance expenses	$_____	$_____
Co-payments for health insurance expenses	$_____	$_____
Routine physical	$_____	$_____
Pediatric visits / Well-baby care	$_____	$_____
Over-the-counter medications require script	$_____	$_____
Eye exams or Hearing exams	$_____	$_____
Eye glasses/Prescription sunglasses/Contact lenses	$_____	$_____
Dental deductibles and coinsurance expenses	$_____	$_____
Orthodontic (braces) expenses (adult and child)	$_____	$_____
Acupuncture	$_____	$_____
Physicians' fees	$_____	$_____
Transportation expenses for essential medical care	$_____	$_____
Long-term rehabilitation care / Convalescent care	$_____	$_____
Physical therapy / Special equipment	$_____	$_____
Treatment for alcoholism or substance abuse	$_____	$_____
Other Expenses	$_____	$_____
Total Annual Expenses	$_____	$_____
Total Pre-Tax Deduction Per Pay Period (divide by 52)	$_____	$_____

PLEASE NOTE: Cosmetic surgery or procedures, electrolysis, contact lens insurance, Rogaine, and nicotine patches are not eligible expenses per IRS. regulations.

Dependent Care Accounts allow you to set aside money from your paycheck on a pre-tax basis for your dependent day care costs.

- The maximum contribution to the plan is $5,000 per year.
- You must use your account balance before march 15th of the following year or you forfeit the funds.

For benefit questions call

866-618-1699

or go to their website:

https://myspendingaccount.wageworks.com/Welcome/PortalLandingPage.aspx

QUALIFIED RETIREMENT PLAN

401(K) AND PROFIT SHARING PLAN

Fidelity

Plan #28474

Constantia Flexibles offers a retirement savings plan for the employees. The plan is in two parts:

- 401K – Where employees can defer from 1-100% of their annual salary into the plan on either a Traditional Pre-tax or a Roth basis up to the maximum as defined by law. Constantia Flexibles will match dollar for dollar, for the first 3% an employee contributes. In addition, Constantia Flexibles LLC will contribute 50% on the next 2% the employee contributes with a maximum company match of 4%.

- Roth contribution - This source is deducted on a post-tax basis and allows more flexibility for participants when making their deferral sources. Please contact Fidelity with any questions by either calling 800-294-4015 or going online to www.netbenefits.com.

Profit Sharing Plan - the employer may make discretionary contributions, if any, in an amount to be determined by the Board of Directors at the end of the plan year. The administrator is Fidelity Investments. You must be 18 years of age or older to participate. You will enter the plan as of the first of the month following a one month waiting period which is similar to your other benefits which call for a 30 day service requirement.

All new employees will be auto enrolled in the 401K plan at 3%. Should you choose to opt out or change your contribution percentage, please contact Fidelity by phone or online at 1-800-294-4015 or www.netbenefits.com.

EMPLOYEE ASSISTANCE PROGRAM (LAP)

First Sun

FIRST SUN EAP

We Help People Be Better at Work

Counseling Services

5

You, your immediate family and members of your household are offered five free services to apply toward confidential counseling sessions or life management services.

Employee Assistance Program Services

Easy to Call. Easy to Use.

Through First Sun EAP you, your immediate family and members of your household have access to an award-winning Employee Assistance Program (EAP) with services specifically designed to enhance your wellbeing — both personally and professionally.

As our tagline states, "We Help People Be Better at Work." Our highly seasoned and credentialed staff are invested in you and personally handle your call. They are professionally trained to assess your needs and get you to the right resources that will make a difference in your situation. It's no wonder the First Sun client satisfaction rate is so high.

When you are challenged by personal or emotional issues, our licensed counselors* are here to help. Your sessions may be used for personal and workplace issues. We are just a phone call away, 24 hours a days, 7 days a week. Five free face-to-face and video counseling sessions are available to each employee, immediate family and members of your household.

When your personal or professional life becomes unbalanced, we are here to help you regain that balance. Here are some of the issues your EAP addresses:

- ***Grief and Loss***
- ***Stress Management***
- ***Alcohol/Substance Use***
- ***Marital/ Relationship***
- ***Anxiety***
- ***Depression***
- ***Personal Growth***
- ***Trauma***
- ***Anger Management***
- ***Family Conflicts***
- ***Spiritual Matters***
- ***Workplace Concerns***
- ***Work-life Balance***
- ***Behavioral Change***

** All counseling services are confidential in compliance with the law.*

You are eligible for five free counseling sessions and five life management services. *Your EAP services are made available to you, your immediate family and members of your household by your employer. You may use the services whether or not you have chosen to participate in an employer insurance plan..*

Please see next page for more services.

Call us 24/7/365 at 800-968-8143 or visit www.firstsuneap.com

EMPLOYEE ASSISTANCE PROGRAM (LAP)

First Sun

FIRST SUN EAP

We Help People Be Better at Work

3 EASY STEPS TO USING YOUR EAP

1 **Call 800-968-8143** or review online resourcesat www.firstsuneap.com.

2 **Speak confidentially** with an intake specialist about your situation or request.

3 **Receive professional support** to assist you in reaching your goals.

We Are Here for You

Our dedicated consultants are available 24 hours a day, 7 days a week to address your needs. Crisis calls are handled immediately and all appointments will be scheduled in a timely manner. Individual use of your EAP is confidential and is not reported to your employer.

Life Management Services

5 *You, your immediate family and members of your household are offered five free services to apply toward confidential counseling sessions or life management services.*

Financial Consultations — Financial counselors assist with planning for retirement, reorganizing the family budget and dealing with a financial crisis.

Legal Consultations and Documents — Our website holds a wealth of personal and legal documents, and legal information. You may also call for a free legal consultation. All legal services are provided by licensed attorneys.

Elder Care Resources and Assistance — Receive an assessment from our consultants for needs involving elderly and disabled adults. Get resources, referral information and support for caregivers.

Child Care Resources and Assistance — Consultants advise how to select child care resources and address child care needs including routine day care needs, special need care, swing shift needs and summer camps.

College Assistance — Consultants are available for students and working adults who desire assistance in the college search or identifying resources such as financial aid, test preparation and educational plans.

School Assistance — Resources are available to help parents choose an appropriate school, prepare children for school, and assist children with school achievement.

Adoption Assistance — For parents wanting to adopt, consultants can provide referrals to adoption attorneys, placement agencies, domestic and international adoption agencies, fertility specialists and clinics, etc.

Pet Care — Consultants offer comprehensive pet care referral services to assist with veterinary selection, emergency care, grooming, obedience classes, boarding, pet sitting, and the like.

The First Sun EAP website offers detailed information about your benefits as well as helpful articles, assessments, calculators, courses, webinars, videos and a resilience app for your personal and professional growth.

You are eligible for five free counseling sessions and five life management services. *Your EAP services are made available to you, your immediate family and members of your household by your employer. You may use the services whether or not you have chosen to participate in an employer insurance plan..*

Call us 24/7/365 at 800-968-8143 or visit www.firstsuneap.com

Blue Cross Blue Shield Global

As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global Core program, you have access to doctors and hospitals around the world.

To take advantage of the program:

- Always carry your current member ID card.
- Before you travel, contact your BCBS company for coverage details.
- If you need to locate a doctor of hospital, call the service center for Global Core at 1-800-673-1177. They are open 24 hours a day, 7 days a week.
- If you need inpatient care, call the Service Center to arrange direct billing. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses you normally pay. The in network hospital should submit the claim on your behalf.
- Always call the number on the back of your card to precertify or preauthorize.
- For outpatient and doctor care or inpatient care not arranged through the Service Center, you may need to pay upfront. Submit a manual claim for the benefits to apply.

To learn more about Blue Cross Blue Shield Global Core:

TheBlueCard®
Now, Home Is Where The Card Is®

- Visit www.bcbsglobalcore.com.
- Use the Blue Cross Blue Shield Global Core app for Android*, iPhone, and iPod touch.** (Rates from your wireless provider may apply).
- Call your BCBS company.
- Call the Service Center at 1.800.810.2583 or collect at 1.804.673.1177, 24 hours a day, seven days a week.

COBRA

ADP WageWorks COBRA

What is COBRA?
COBRA stands for the Consolidated Omnibus Budget Reconciliation Act (COBRA). The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

What does that mean for me?
COBRA gives certain former Constantia Flexibles' team members, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events.

Qualifying Events for Team Members:

Voluntary or involuntary termination of employment for reasons other than gross misconduct.

Reduction in the number of hours of employment.

How does a person become eligible for COBRA continuation coverage?
To be eligible for COBRA coverage, you must have been enrolled in the Constantia Flexibles' Medical, Vision and/or Dental Plans and the plans must continue to be in effect for active team members. COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her coverage.

How long after a qualifying event do I have to elect COBRA coverage?
Qualified beneficiaries must be given an election period during which each beneficiary may choose whether to elect COBRA coverage. Each qualified beneficiary may independently elect COBRA coverage. A covered team member or the covered team member's spouse may elect COBRA coverage on behalf of all other qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child. Qualified beneficiaries must be given at least 60 days for the election. This period is measured from the later of the coverage loss date or the date the COBRA election notice is provided by Constantia Flexibles' plan administrator.

When does COBRA coverage begin?
COBRA coverage begins on the date that medical/vision and/or dental coverage would otherwise have been lost by reason of a qualifying event.

How long does COBRA coverage last?
COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Medicare 101

If you're nearing retirement age, or are over 65 and still working, you may have questions about Medicare. Read on for the information you need to know.

What is Medicare?

Medicare is health insurance for people age 65 or older, under 65 with certain disabilities or any age with End-Stage Renal Disease (permanent kidney failure).

Types of Medicare

There are four types of Medicare - 2 parts are from the government (A & B) , 2 are private (C & D):

Medicare Part A helps cover inpatient care in hospitals, skilled nursing facilities, and hospice and home health care. Generally there is no monthly premium if you qualify and paid Medicare taxes while working.

Medicare Part B helps cover medical services like doctors' services, outpatient care and other medically necessary services that Part A doesn't cover. You need to enroll in Medicare Part B and pay a monthly premium determined by your income.

A Medicare Advantage Plan (like an HMO or PPO) is another Medicare health plan choice you may have as part of Medicare. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans", are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, the plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all types of Medicare Advantage Plans, you're always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the service that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you're in a Medicare Advantage Plan. Medicare Advantage Plans aren't supplemental coverage. Medicare Advantage Plans typically include Part D prescription drug coverage.

Medicare Part D is prescription drug coverage, and is available to everyone with Medicare. It is a separate plan provided by private Medicare-approved companies, and you must pay a monthly premium.

Many people also purchase a supplemental insurance policy, such as a Medigap policy to help cover the gaps not covered by Medicare. Medigap policies, aka Medicare Supplemental Policies, are sold by private insurance companies.

Getting Started

Medicare sends you a questionnaire about three months before you're entitled to Medicare coverage. Your answers to these questions, including whether you have group health insurance through an employer or family member, help Medicare set up your file and make sure your claims are paid correctly.

If your health insurance or coverage changes at any time after submitting the questionnaire, call the Medicare Coordination of Benefits Contractor at 800-999-1118 to update your file.

Coordination of Coverage

If you have Medicare and another type of insurance, the question of who should pay or who should pay first can be tricky. For example, generally a group health plan would pay before Medicare, but there are several exceptions. Contact the number above for specific answers for your situation, or visit www.medicare.gov for additional information.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Constantia Blythewood, LLC.

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Constantia Blythewood, LLC. has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Constantia Blythewood, LLC. coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current Constantia Blythewood, LLC. coverage, be aware that you and your dependents will not be able to get this coverage back by enrolling back into the Constantia Blythewood, LLC. benefit plan during the open enrollment period under the Constantia Blythewood, LLC. benefit 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 Constantia Blythewood, LLC. 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 Constantia Blythewood, LLC. changes. You also may request a copy of this notice at any time.

NOTICE OF CREDITABLE COVERAGE

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**January 01, 2025**
Name of Entity/Sender:	**Constantia Blythewood, LLC.**
Contact—Position/Office:	**Cheryl Turner - Payroll and Benefits Administrator**
Office Address:	**1111 N. Point Blvd.**
	Blythewood, South Carolina 29106
	United States
Phone Number:	**803.404.6581**

Legal Notices

Women's Health & 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 the plan. Therefore, the following deductibles and coinsurance apply:

Medical plan (Individual: 70% (Insurance pays 70%, you pay 30%) coinsurance and $2,000 deductible; Family: 70% (Insurance pays 70%, you pay 30%) coinsurance and $4,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 803.404.6581 or cheryl.turner@cflex.com.

HIPAA Special Enrollment Rights

Constantia Blythew ood, LLC. Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Constantia Blythew ood, LLC. 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 30 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 30 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 Cheryl Turner - Payroll and Benefits Administrator at 803.404.6581 or cheryl.turner@cflex.com.

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.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 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

Medical SBC

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2025 - 12/31/2025
Coverage for: Individual | **Plan Type**: Standard PPO

South Carolina **Constantia Blythewood, LLC : HRA Plan**

This Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call **1-800-922-1185.** For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary** or **www.cciio.cms.gov** or call **1-800-922-1185** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$2,000** person/**$4,000** family. Out-of-Network **$10,000** person/**$20,000** family.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services, prescription drugs and all In-Network inpatient facility services except hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network **$7,900** person/**$15,800** family. Out-of-Network **$20,000** person/**$40,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, chiropractic services, out-of-network copayments, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.SouthCarolinaBlues.com** or call **1-800-810-BLUE (2583)** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Medical SBC

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay/ visit; deductible does not apply	50% Coinsurance	Allergy injections, second surgical opinion, dialysis, office surgery, chemotherapy and radiation services are covered at 30% Coinsurance In-Network.
	Specialist visit	$25 Copay/ visit; deductible does not apply	50% Coinsurance	Allergy injections, second surgical opinion, dialysis, office surgery, chemotherapy and radiation services are covered at 30% Coinsurance In-Network.
	Preventive care/screening/ immunization	No Charge	Not Covered	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If you need drugs to treat your illness or condition	Generic drugs (Retail)	$15 Copay/ prescription; deductible does not apply	$15 Copay/ prescription then 50% of remaining cost; deductible does not apply	Limited to a 90 day supply with a Copay applying to each 31 day supply.
	Generic drugs (Mail Order)	$25 Copay/ prescription; deductible does not apply	Not Covered	90 day supply.
	Preferred brand drugs (Retail)	$40 Copay/ prescription; deductible does not apply	$40 Copay/ prescription then 50% of remaining cost; deductible does not apply	31 day supply.
More information about **prescription drug coverage** is available at www.SouthCarolinaBlues.com	Preferred brand drugs (Mail Order)	$90 Copay/ prescription; deductible does not apply	Not Covered	90 day supply.

Medical SBC

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Retail)	$70 Copay/ prescription; deductible does not apply	$70 Copay/ prescription then 50% of remaining cost; deductible does not apply	31 day supply.
	Non-preferred brand drugs (Mail Order)	$175 Copay/ prescription; deductible does not apply	Not Covered	90 day supply.
	Specialty drugs	$125 Copay/ prescription; deductible does not apply	Not Covered	31 day supply. Available at approved specialty pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	Pre-authorization is required for some outpatient surgeries. Penalty for not obtaining pre-authorization is 50% of the allowable charge.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	30% Coinsurance	30% Coinsurance	None
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	None
	Urgent care	$25 Copay/ visit; deductible does not apply	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance; deductible does not apply	$100 Copay/ admission then 50% Coinsurance; deductible does not apply	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	30% Coinsurance	50% Coinsurance	Pre-authorization is required for some outpatient services. Penalty for not obtaining pre-authorization is 50% of the allowable charge. In-Network office visits covered at $25 Copay; deductible does not apply.
	Substance use disorder outpatient services	30% Coinsurance	50% Coinsurance	

Medical SBC

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Mental/behavioral health inpatient services	30% Coinsurance; deductible does not apply	50% Coinsurance; deductible does not apply	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Substance use disorder inpatient services	30% Coinsurance; deductible does not apply	50% Coinsurance; deductible does not apply	
If you are pregnant	Office visits	$25 Copay/ visit; deductible does not apply	50% Coinsurance	Pre-authorization for facility services is required. Penalty for not obtaining pre-authorization is denial of room and board. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	30% Coinsurance; deductible does not apply	$100 Copay/ admission then 50% Coinsurance; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	50% Coinsurance	60 visits/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	30% Coinsurance	50% Coinsurance	30 combined visits/benefit year for Occupational Therapy & Physical Therapy. 20 visits/benefit year for Speech Therapy.
	Habilitation services	30% Coinsurance	50% Coinsurance	30 combined visits/benefit year for Occupational Therapy & Physical Therapy. 20 visits/benefit year for Speech Therapy.
	Skilled nursing care	30% Coinsurance; deductible does not apply	$100 Copay/ admission then 50% Coinsurance; deductible does not apply	60 days/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Durable medical equipment	30% Coinsurance	Not Covered	Purchase or rentals of $500 or more require pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges.

Medical SBC

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	30% Coinsurance	50% Coinsurance	6 months/episode. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	See your Employer for benefit details.
	Children's glasses	Not Covered	Not Covered	See your Employer for benefit details.
	Children's dental check-up	Not Covered	Not Covered	See your Employer for benefit details.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Eye Care (Child)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care (excludes office visit/unattended electrical stimulation)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa, the South Carolina State Department of Insurance at 1-800-768-3467 or visit www.doi.sc.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-922-1185 or visit us at www.SouthCarolinaBlues.com, the South Carolina State Department of Insurance at 1-800-768-3467 or visit www.doi.sc.gov, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

Medical SBC

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.
Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng *customer service* na makikita sa unang pahina ng paunawang ito.
Chinese: 如需中文服务，请致电列于本通知首页的客户服务号码。

Navajo: T'áá Dinéjí shił hane'go shiká i'doolwoł nínízingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'ígíí éí díí naaltsoos neiyi'nilígíí akáa'gi siłtsoozígíí bikáá' ííshjáąh.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medical SBC

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$2,000
■ Specialist Copayment	$25
■ Hospital (facility) Coinsurance	30%
■ Other Coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$3,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,270**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$2,000
■ Specialist Copayment	$25
■ Hospital (facility) Coinsurance	30%
■ Other Coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall deductible	$2,000
■ Specialist Copayment	$25
■ Hospital (facility) Coinsurance	30%
■ Other Coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$80
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,180**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact:**1-800-922-1185.**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Medical SBC

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Medical SBC

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید.
(Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ąąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Your Employee Benefit Package is Worth

The chart below represents the dollar value of your benefits package excluding the qualified retirement match and administration cost by Constantia Flexibles.

	Annually
Employee Only	$7,105
Employee & Child	$11,281
Employee & Spouse	$12,840
Employee & Family	$15,713

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 of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.