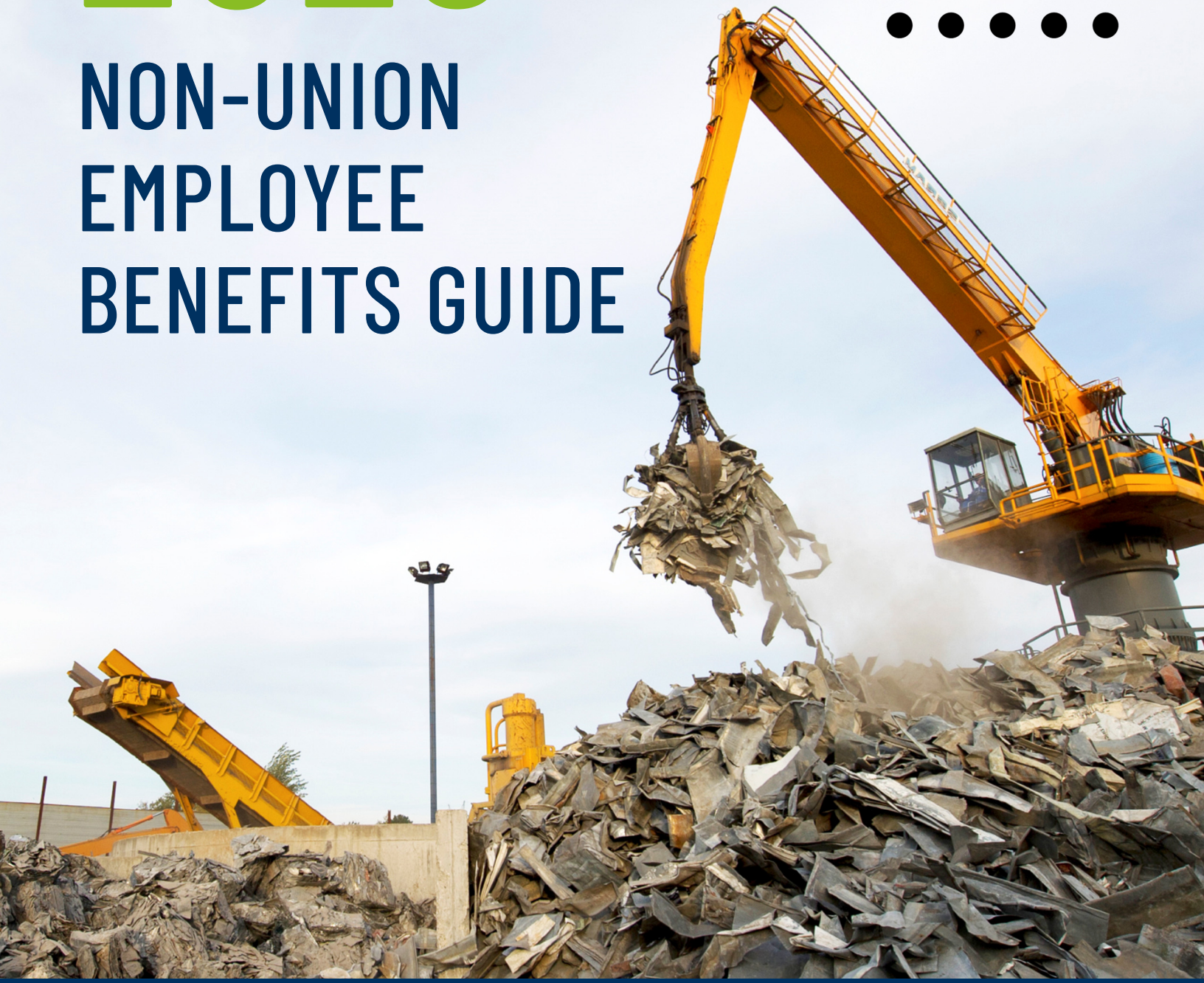
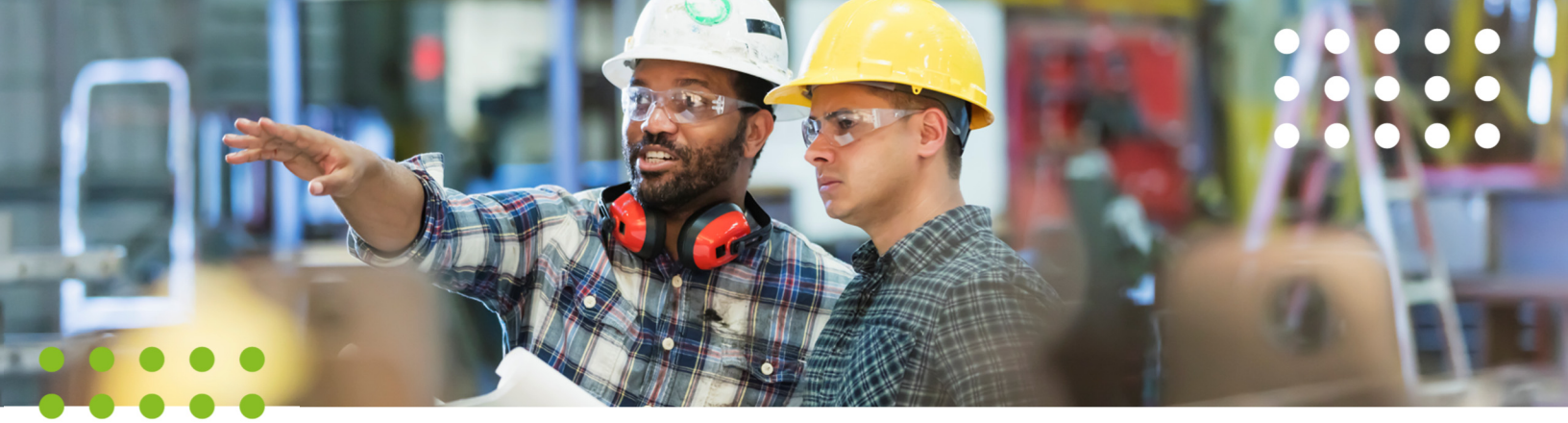
2025

NON-UNION EMPLOYEE BENEFITS GUIDE



emr METAL RECYCLING



Inside This Guide

Questions?

If you have questions about your benefits, contact your Human Resources representative or **USA.Benefits@emrgroup.com**.

You can also contact our outside benefits' consultant, Conner Strong & Buckelew. Their EMR Benefits Member Advocacy Center is reachable at **800-563-9929** (Mon-Fri, 8:30 am to 5:00 pm ET) or go to **www.connerstrong.com/memberadvocacy** to submit an inquiry online—anytime.

Visit our BenePortal at www.emrbenefits.com or by scanning the QR code. Use BenePortal to access benefit plan documents, insurance carrier, contacts, forms, guides, links, and other applicable benefit materials.

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

ELIGIBILITY & ENROLLMENT

New Employees

New, full-time, non-union employees who work at least thirty hours per week may enroll in benefits the first of the month following sixty calendar days of service. You have thirty days to enroll once your enrollment window opens.

Dependent Eligibility

You may enroll your eligible dependents when you enroll yourself. EMR will continue to confirm that any new dependents you enroll onto your coverage are eligible for benefits— you are required to provide valid documentation to Human Resources prior to the close of your eligibility window (e.g., birth certificate or marriage license). Dependents who are eligible for benefit coverage include:

- Your legally married spouse
- Your dependent children, including:
  - Your natural born child(ren), legally adopted child(ren), step-child(ren) or court-ordered dependent child(ren) for whom you are the court-appointed legal guardian
  - Your dependent child(ren) up to age 26. Coverage ends at the end of the month following the date they turn 26
  - Your continuously disabled dependent child(ren) [if disabled prior to age 26] who is incapable of self-sustaining employment and dependent upon you for support, regardless of age

Qualifying Life Events

The choices you make during your initial enrollment will be in effect until December 31, 2025. During the year, you may only make changes if you experience a qualified status change, known as a "life event". Some examples of qualifying life events are:

- Birth or adoption of a child
- Marriage
- Divorce and/or legal separation
- Death or loss of a dependent (including loss of dependent status)
- Change in your spouse's employment status causing loss or gain of benefits coverage
- Change in your own employment status causing a loss/gain of benefits coverage
- Eligibility for Medicare

You must notify EMR Human Resources as soon as a life event occurs. You only have 30 days from the date a life event occurs to make changes to benefits. If you have questions about your eligibility, contact your Human Resources representative at USA.Benefits@emrgroup.com.

CONTRIBUTIONS & RATES

WEEKLY EMPLOYEE MEDICAL/PRESCRIPTION CONTRIBUTIONS

TIER	HDHP	PPO
Employee	$26.07	$72.71
Employee + Spouse	$60.99	$164.02
Employee + Child(ren)	$48.64	$131.01
Family	$99.11	$268.20

WEEKLY EMPLOYEE DENTAL CONTRIBUTIONS

TIER	METLIFE DENTAL PLAN
Employee	$5.00
Employee + Spouse	$10.46
Employee + Child(ren)	$11.59
Family	$17.78

WEEKLY EMPLOYEE VISION CONTRIBUTIONS

TIER	UHC VISION PLAN
Employee	$0.00
Employee + Spouse	$1.10
Employee + Child(ren)	$1.49
Family	$2.60

MEDICAL & PRESCRIPTION DRUG PLANS

UNITED HEALTHCARE & EXPRESS SCRIPTS

You can choose from two medical plans through United Healthcare. Both use the Choice Plus network of highly qualified medical providers throughout the United States. Both plans include prescription drug coverage through Express Scripts.

REMINDER! You must complete Coordination of Benefits (COB) in your UHC member portal annually. If you have any questions, please call UHC at 800-611-8061.

COMPARING OUR PLANS

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)	Preferred Provider Organization (PPO) with Flexible Spending Account (FSA)
• The HDHP has lower employee contributions. You pay the full cost of services, including prescription drugs, until you meet the deductible. Then, you pay the coinsurance up to the plan out-of-pocket maximum, and the plan pays the rest. • Preventive care, like your annual physical, is covered at 100% in-network, with no deductible. • The HDHP includes a tax-advantaged HSA. Use your HSA to save money and help pay for eligible healthcare expenses.	• The PPO has higher employee contributions. The PPO includes a fixed copay for primary care and specialist office visits prior to reaching your deductible. • If you elect the PPO plan, you are not eligible to participate in an HSA. You may enroll in an FSA. Unlike an HSA, you must spend 100% of the money used in an FSA each year.

Smart90 Program

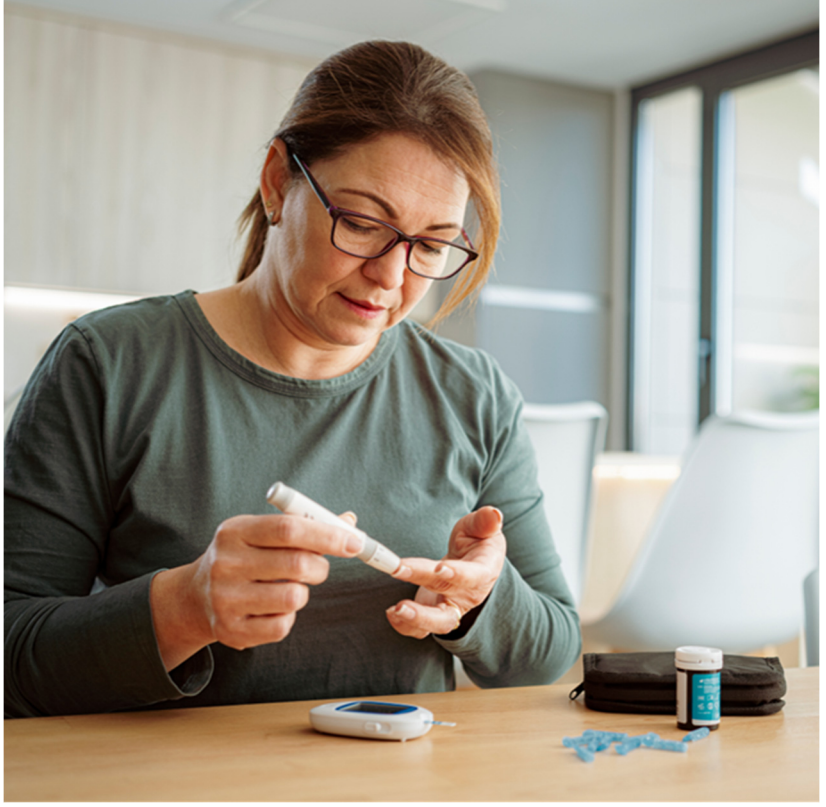
The Smart90 Program provides maintenance medications. Smart90 is a feature of your prescription benefit, managed by Express Scripts. With it, EMR employees and their family members have two ways to get up to a 90-day supply of long-term maintenance medication (those drugs you take regularly for ongoing conditions). You can conveniently fill those prescriptions either through home delivery from the Express Scripts Pharmacy, CVS or Walgreens.

To get started with Smart90, ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year (as appropriate). To fill your prescription:

- Mail your prescription(s) along with the required cost.
- Call Express Scripts toll-free at **800-282-2881**. Have your prescription number handy when you call.
- Order online at **www.Express-Scripts.com**
- Refill you prescriptions, track orders, check medication prices, and make payments anytime, anywhere with the Express Scripts mobile app. **www.express-scripts.com/mobile-app**

To find an in-network provider, go to the UHC website, https://www.uhc.com/, log into your account, and click, "Find a doctor". If you are using the UHC app, log in and click "Find a doctor". To download the UHC app, scan the QR code from your mobile device.

DIABETES MANAGEMENT
LIVONGO



EMR has partnered with Livongo, a digital diabetes management company. Livongo provides a state-of-the-art system to help you better manage your diabetes. If you are diabetic, you may qualify for this free program.

Who can join:

You and your family members with diabetes can join at no cost if you have medical coverage through EMR.

When you engage with Livongo, you get:

- **Unlimited Strips at No Cost to You:** When you are about to run out, Livongo ships more supplies, right to your door.
- **Connected Meter:** Automatically uploads your blood glucose readings to your secure online account and provides real-time personalized tips.
- **Support from Coaches When You Need It:** Communicate with a coach anytime about diabetes questions on nutrition or lifestyle changes.

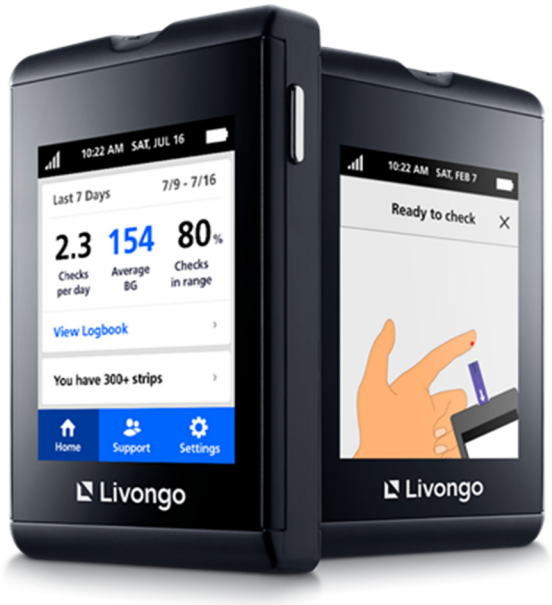
Take control of your health with Livongo's diabetes management program and discover effective tools and techniques that work for you!

Livongo®

Livongo for Diabetes—A Health Benefit at No Cost that Helps Make Living with Diabetes Easier

Get started with Livongo today

Visit **Join.Livongo.com/EMRUSA/Register**
or call **800-945-4355** or download the app
Use your registration code: **EMRUSA**



MEDICAL OPTIONS COMPARISON

WHAT YOU PAY FOR MEDICAL SERVICES

	HDHP	PPO PLAN
IN-NETWORK BENEFITS		
EMR Annual Contribution to HSA/FSA	HSA – $1,000	FSA – $500
Annual Deductible	$2,500 individual/$5,000 family	$2,000 individual/$4,000 family
Annual Out-of-Pocket	$7,000 individual/$14,000 family	$5,000 individual/$10,000 family
Preventive Care	Covered at 100% - Deductible, coinsurance, and/or copays do not apply for in-network only.	
PCP Visit	25% after deductible	$25 copay
Telemedicine	25% after deductible	100%
Specialist Visit	25% after deductible	$50 copay
Urgent Care Visit	25% after deductible	10% after deductible
Emergency Room	25% after deductible	10% after deductible
Diagnostic Radiology and Imaging	25% after deductible	10% after deductible
Hospital (Inpatient Stay)	25% after deductible	10% after deductible
Outpatient Surgery	25% after deductible	10% after deductible
OUT-OF-NETWORK BENEFITS		
Annual Deductible	$5,000 individual/$10,000 family	$4,000 individual/$8,000 family
Annual Out-of-Pocket	$14,000 individual/$28,000 family	$10,000 individual/$20,000 family
Coinsurance	50% after deductible	40% after deductible

PRESCRIPTION DRUG COMPARISON

WHAT YOU PAY FOR PRESCRIPTION DRUGS

	HDHP	PPO PLAN
EXPRESS SCRIPTS PRESCRIPTION DRUG BENEFITS (RETAIL: UP TO 30-DAY SUPPLY/MAIL ORDER: UP TO A 90-DAY SUPPLY)		
Retail Prescription Drugs		
Generic	25% after deductible	$10 copay
Formulary Brand	25% after deductible	$40 copay
Non-Formulary Brand	25% after deductible	$70 copay
Specialty	25% after deductible	$100 copay
Mail-Order Prescription Drugs		
Generic	25% after deductible	$25 copay
Formulary Brand	25% after deductible	$100 copay
Non-Formulary Brand	25% after deductible	$175 copay
Specialty	25% after deductible	$250 copay
Preventive Medications	25% (deductible does not apply)	Copay applies (see above)

TAX-ADVANTAGED SAVINGS ACCOUNTS: HSA & FSA

OPTUM BANK & WEX

Health Savings Account (HSA)

Administered by Optum Bank

If you elect the HDHP, you will be automatically enrolled in an HSA, which is a tax-advantaged account that is used to help pay for qualified medical expenses.

How do I contribute to an HSA?

You can contribute to your HSA account through payroll deductions or as a deposit directly through Optum Bank. **EMR will contribute $1,000 annually for the HDHP plan in 2025.** You can contribute as much as you like, provided the combined annual contribution limits do not exceed:

- $4,300 for individual coverage in 2025
- $8,550 for family coverage in 2025
- Annual catch-up contribution for age 55+: $1,000

When can I start using my HSA dollars?

You can use your HSA dollars immediately following your HSA account activation at Optum Bank, and once contributions have been made.

What if I enroll in the middle of the year?

If you enroll in an HSA in the middle of a year, you are allowed to make a full year's contributions, provided that you remain covered by the HSA for at least the 12 month period following that year.

Do HSA funds expire?

No, HSA funds do not expire. Unused funds will be available for your use in the next year.

To be eligible for an HSA, you:

- Must have coverage under an HSA-qualified HDHP
- Cannot have other first-dollar medical coverage (i.e. policy with no deductible)
- Cannot be enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return

You cannot contribute to your HSA if you are enrolled in Medicare. However, you can keep the existing money in your account to pay for medical expenses, tax-free.

Flexible Spending Accounts (FSA)

Administered by Wex

An FSA allows you to set aside a set amount of pre-tax dollars to cover certain out-of-pocket expenses for the plan year. Three types of accounts are available—Healthcare FSA, Limited Purpose FSA, and Dependent Care FSA. **EMR will contribute $500 annually to a Healthcare FSA for those enrolled in the PPO plan in 2025.**

Healthcare FSA

A Healthcare FSA can reimburse you for eligible medical, dental and vision expenses not covered by your insurance plan. The annual maximum contribution in 2025 for the Healthcare Spending FSA is **$3,300**.

Limited Purpose FSA

Those enrolled in an HSA may enroll in a **Limited-Purpose FSA to cover vision and dental expenses only**. The annual maximum contribution in 2025 for the Limited Purpose FSA is **$3,300**

Dependent Care FSA

The Dependent Care FSA lets you use pre-tax dollars for qualified dependent care, such as child or adult daycare. The annual household maximum amount you may contribute is **$5,000**.

Commuter Reimbursement Account

The Commuter Reimbursement Account can help pay for eligible transit and parking expenses. The 2025 maximum contributions for both transit and parking accounts are **$325** each per month.

Do FSA funds expire?

Any unused balances at the end of the year will be forfeited. EMR offers a 2-1/2 month grace period to allow you to continue to incur expenses against your FSA or Dependent Care account. As per IRS regulations, any contributions must be used within the plan year.

DENTAL BENEFITS

METLIFE

MetLife will provide your dental benefits in 2025. You can use in-network or out-of-network providers. Benefits are the same; however, you will maximize your benefits with in-network providers. If you use an out-of-network provider, the plan pays only the Reasonable and Customary ("R&C") amount, and you are responsible for any higher costs. For example, if the R&C amount for a cleaning is $100, but your out-of-network dentist charges $125, you will pay $25.

Find an In-Network Dental Provider:

With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching the online **Find a Dentist** directory.

1. Go to **www.mybenefits.metlife.com**
2. Select "**Find a Dentist**" next to "**How can we help you?**"
3. Select "**PDP Plus**" next to "**Choose your network**."
   - Enter you Zip, City, or State and select the "**Find a Dentist**" button.

MetLife Contact Information

- Group # 155136
- Phone: **800-942-0854**
- Website: **www.mybenefits.metlife.com**

MetLife Mobile app:

The MetLife mobile app is available in the Apple App Store and on Google Play. Download the app and use it to find a participating dentist, view your claims and access your ID card.

WHAT YOU PAY AT THE DENTIST

FEATURE/SERVICES	IN-NETWORK	OUT-OF-NETWORK
Annual Maximum (Per Person)*	$1,250	$1,250
Annual Deductible (Individual/Family)	$50 / $150	$50 / $150
Preventive & Diagnostic Services Oral exam, cleanings, full mouth x-rays, bitewing x-rays	Covered at 100% (Deductible does not apply)	Covered at 100% of R&C (Deductible does not apply)
Basic Services Fillings, basic extractions, root canals, periodontic treatments	Covered at 80%	Covered at 80% of R&C
Major Services Crowns, inlays and onlays, bridges and dentures, implants	Covered at 50%	Covered at 50% of R&C
Child Orthodontic Services** Diagnostic casts, fixed and removable appliances, cephalometrics film	Covered at 50% up to $1,250 lifetime max	Covered at 50% of R&C up to $1,250 lifetime max

***If you get a cleaning/exam in 2025, your annual maximum will increase by $100 in 2026. This will repeat annually till you reach $1,550 annual maximum.**

****Orthodontia services covered for dependent children up to age 26.**

VISION BENEFITS

UNITED HEALTHCARE VISION - SPECTERA

EMR employees may enroll in the UnitedHealthcare Vision Plan, which includes the Spectera network, for the 2025 plan year. You may also choose to cover dependents for an additional low cost. You may choose any vision provider for your care, but to keep your out-of-pocket costs down, consider an in-network provider. **The cost to enroll in employee-only coverage in EMR's vision plan is $0**.

Find an In-Network Eye Doctor:

When it comes to shopping for eye care, you've got plenty of choices. The United Healthcare Vision Network (Spectera) has over 165,000 access points for care nationally, from local doctors around the corner to well-known retail chains or specialty online retailers. Be sure to mention the **Spectera Network** when visiting the eye doctor.

Sign in to **www.myuhcvision.com** to search by provider name, specialty or location.

UHC Contact Information

- Group # 743813
- Phone: **800-638-3120**
- Website: **www.myuhcvision.com**

Scan the QR code to download the UHC app!

WHAT YOU PAY WHEN YOU VISIT THE EYE DOCTOR

FEATURE/SERVICES	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Exam (Every 12 months)	$10 copay	Up to $40
Frames (Every 12 months)	$130 allowance (30% off balance over $130)	Up to $45
Lenses (Every 12 Months)		
Single	$10 copay	Up to $40
Bifocal	$10 copay	Up to $60
Trifocal	$10 copay	Up to $80
Contact Lenses (Every 12 months-in lieu of glasses)		
Formulary contact lenses*	$10 copay	Up to $105
Non-selection contact lenses	$105 allowance	Up to $105
Medically-necessary lenses**	$10 copay	Up to $210
Prescription Safety Eyewear	$130 allowance	Not available

* Coverage for formulary contact lenses does not apply at all in-network providers. Visit **www.myuhcvision.com** to locate an in-network provider. If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider. The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.

** Medically necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts medically necessary, you should ask your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

BASIC LIFE AND AD&D AND DISABILITY

SYMETRA

Basic Life and AD&D Insurance

EMR provides all actively working employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance coverage **at no cost to you**. This benefit will be paid to your beneficiary in the amount equal to 3 times your annual salary, up to a maximum of $1 million.

Short and Long-Term Disability

Disability insurance is coverage that provides you with income protection should you lose time on the job due to a non-work related injury or illness. With disability coverage, you are compensated for a portion of your lost income. EMR provides short-term and long-term disability coverage through Symetra at **no cost to you**.

Short-Term Disability (STD)

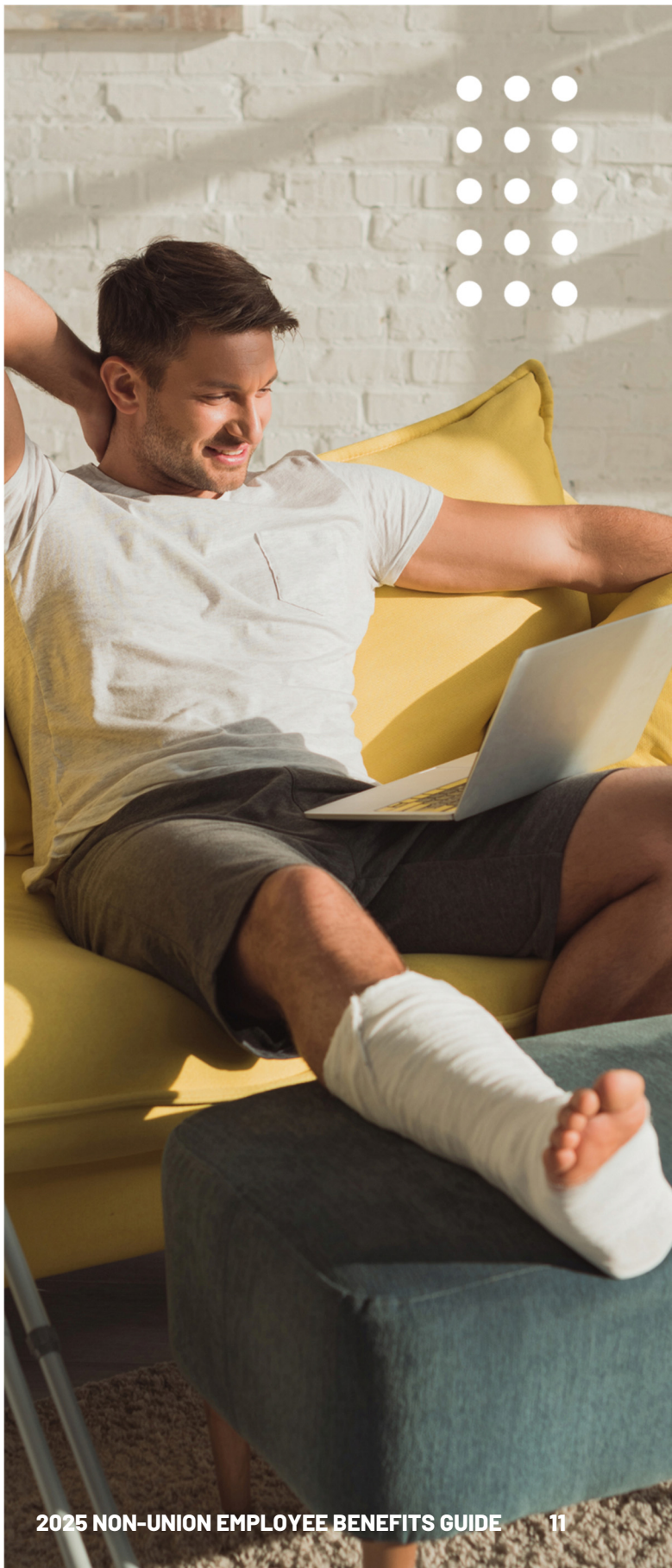
Short-Term Disability benefits begin 7 days after the date of disability. The benefit will pay at a rate of 60% of your standard 40 hour week income up to a maximum of $1,050 per week for 26 weeks.

The percentage of income may increase according to state regulations. If you continue to be disabled thereafter and are eligible, you may then apply for long-term disability benefits. Please ask your HR how to apply.

Long-Term Disability (LTD)

Long-Term Disability provides income during an extended period of disability once the STD benefit is exhausted.

The benefit available is dependent on your salary and employee classification. You may receive monthly LTD benefits as long as you are deemed disabled by the insurance provider, up to the Social Security retirement age.



EMPLOYEE WELLNESS SOLUTION

OPTUM

EMR USA Metal Recycling has partnered with Optum to provide all EMR employees access to personalized mental health support and work-life resources — confidentially and free.

EMR provides you and your dependents with Emotional Wellbeing Solutions. It's a modern and flexible employee assistance program ("EAP") that, together with WorkLife Services, offers support for everyday life. You and your dependents are provided with access to **six face-to-face or telephonic sessions** per incident, per year. The encounter with the counselor is completely confidential.

Emotional Wellbeing Solutions:

Financial coaching from experts

Up to 60 minutes of free consultation (provided in 30-minute increments) with a credentialed financial coach for each financial issue. Access to extensive legal and financial tools and libraries to help you take control of your finances.

Legal counseling and mediation services

No-cost 30-minute telephonic or in-person consultation with a state-specific attorney or qualified mediator per separate legal issue. Ongoing services are provided at 25% below the firm's current rates after the initial consultation.

Digital self-care tools

Visit liveandworkwell.com to access our digital suite of tools and resources. Discover the solutions and clinical techniques that best fit your needs to help manage stress, anxiety and other concerns all in one convenient location.

Virtual Visits

HIPAA-compliant technology delivers video services in the privacy and comfort of your home or wherever you choose, providing convenience and accessibility. Licensed telemental health providers are available in every state.

WorkLife Services:

- Adult care and eldercare support
- Child and family support
- Chronic illness and condition support
- Convenience services
- Educational resources

Optum's digital site provides you with self-care resources and tools to help manage stress, anxiety, and other concerns, all in one, convenient location. For personal and confidential support, contact Optum at 866.374.6061 or scan the QR code ! Company Access Code: EMR

Emotional Wellbeing Support Finder

Within the Live and Work Well site **www.liveandworkwell.com**, EWS offers a platform that allows employees and their dependents to explore Optum's additional comprehensive emotional wellbeing benefits, including:

- **Calm:** An evidence-based mental health app for self-care.
- **Talkspace:** Virtual one-on-one therapy sessions.
- **Uptime:** On-the-go digital training and self-care resources.
- **Provider Finder:** Access to the standard provider network.
- **LiveWell:** An international portal for emotional wellbeing solutions.

BENEFITS CONTACTS

Below is a list of important contacts for all of your employee benefits needs.

Questions? Contact USA.Benefits@emrgroup.com

BENEFIT	VENDOR	CONTACT
Medical Coverage Group #: 743813	United Healthcare	(800) 611-8061 www.uhc.com
Prescription Drug Coverage Group #: EMRRXS1	Express Scripts	(800) 282-2881 www.express-scripts.com
Dental Plan Group #: 155136	MetLife	(800) 942-0854 https://mybenefits.metlife.com
Vision Plan Group #: 743813	UnitedHealthcare Vision	(800) 638-3120 www.myuhcvision.com
Health Savings Account	OptumBank	(866) 234-8913 www.optumbank.com
Flexible Spending Account **Commuter Reimbursement Account**	Wex	(833) 225-5939 www.wexinc.com
Life Insurance and Disability	Symetra	(877) 377-6733 https://www.symetra.com/
Benefits Member Advocacy Center Group Name: EMR	Conner Strong & Buckelew	(800) 563-9929 www.connerstrong.com/memberadvocacy
BenePortal	Conner Strong & Buckelew	https://emrbenefits.com
Employee Wellness Solutions	Optum	866-374-6061 www.liveandworkwell.com

GLOSSARY OF KEY TERMS

Copayment (Copay)

A fixed dollar amount that you pay toward the cost of certain covered medical services under the health plan.

Deductible

The amount you pay for certain covered services before the health plan begins to pay.

Coinsurance

This is the percentage of healthcare expenses you pay after your deductible up to the out of pocket maximum. Your health plan pays the rest up to any benefit or lifetime maximum.

Out-of-Pocket Maximum

The maximum amount you will pay (excluding your payroll contributions) in a plan year for covered health services before the plan begins to pay 100% of costs. Deductibles, copays, and coinsurance all apply towards the out-of-pocket maximum.

High Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (also called your deductible). A high deductible plan can be combined with a health savings account (HSA), for you to pay for certain healthcare expenses with money you set aside in your tax-free HSA. This is why it's more commonly called an HSA-eligible plan.

Preferred Provider Organization (PPO)

A type of health insurance plan that offers a network of healthcare providers. Members can choose to receive care from any provider, but they will pay less if they use providers within the plan's network. PPOs do not require members to choose a primary care physician (PCP) or get referrals to see specialists. Members can still see out-of-network providers, but they will typically face higher out-of-pocket costs.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is a process that determines which health insurance plan is responsible for paying a medical claim when a person has more than one health plan. COB helps to ensure that patients receive the maximum benefit they are entitled to.

LEGAL NOTICES

Eligibility
An eligible employee with respect to the programs described in this Guide is any individual who is designated as eligible to participate in and receive benefits under one or more of the component benefit programs described herein. The eligibility and participation requirements may vary depending on the particular component program. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program. Certain individuals related to you, such as a spouse or your dependents, may be eligible for coverage under certain component benefit programs. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Plan Document for the applicable component benefit programs.

Patient Protection-Patient Access to Obstetrical and Gynecological Care
You do not need prior authorization from United Healthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact United Healthcare at 866-901-4409.

Availability of Summary Health
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: http://www.emrbenefits.com
A paper copy is also available, free of charge, by contacting Human Resources.

Women's Health and Cancer Rights Act
On October 21, 1998, the Women's Health and Cancer Rights Act became effective. This law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. As the Act requires, we have included this notification to inform you about the law's provisions. The law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the
mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed,
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance,
3. Prostheses,
4. Treatment of physical complications of all stages of mastectomy, including lymphedema.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Health Insurance Portability and Accountability Act (HIPAA) – State Children's Health Insurance Program (SCHIP)
Loss of other coverage: 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 Medicaid or SCHIP coverage: 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 you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New dependent: 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 Medicaid or SCHIP premium assistance:
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.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Coverage
CHIP is short for the Children's Health Insurance Program—a program to provide health insurance to all uninsured children and who are not eligible for or enrolled in Medical Assistance. CHIPRA is the reauthorization act of CHIP which was signed into law in February 2009. Under CHIPRA, a state CHIP program may elect to offer premium assistance to subsidize employer-provided coverage for eligible low-income children and families. All employers are required to provide employees notification regarding CHIPRA.

Summary of Benefits and Coverage
The Patient Protection and Affordable Care Act requires that health plans provide consumers with information about health plan benefits and coverage in a simple and consistent format called a Summary of Benefits and Coverage (SBC). The purpose of the SBC is to help consumers better understand the coverage they have and allow them to easily compare different coverage options. It summarizes key features of the plan, cost-sharing provisions, and coverage limitations and also provides coverage examples. A Uniform Glossary explaining the most common terms used in health insurance is also available. Employees receive SBCs when they are first eligible for coverage, each year during Open Enrollment, and upon request. To obtain a copy of the plan's summary of benefits and coverage, contact United Healthcare at 866-901-4409.

Notice of Privacy Practice
EMR (USA Holdings) Inc. provides health care benefits and related benefits to its eligible employees and their eligible dependents. By so doing, it creates, receives, uses, and maintains health information about plan participants which is protected by federal law (Protected Health Information/PHI). The Health Insurance Portability and Accountability Act(HIPAA) requires health plans to provide plan participants and others with a notice of the plan's privacy practices with regard to the health

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information it creates and maintains in the course of providing benefits. (Notice of Privacy Practice). This Notice of Privacy Practice describes the ways the plan uses and discloses PHI. To obtain a copy of the plan's Notice of Privacy Practices, contact Human Resources.

Important Notice About Your HDHP/PPO Plan 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 EMR (USA Holdings) Inc. 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. EMR (USA Holdings) Inc. has determined that the prescription drug coverage offered by EMR (USA Holdings) Inc. 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 EMR (USA Holdings) Inc. coverage will not be affected. Members can keep this coverage if they elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current EMR (USA Holdings) Inc. coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with EMR (USA Holdings) Inc. 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 EMR (USA Holdings) Inc. 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 http://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: September 2024
Name of Entity/Sender: EMR (USA Holdings) Inc.
Contact--Position/Office: Human Resources
Address: 201 N. Front St., Camden, NJ 08102
Phone Number: (800) 727-2748

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

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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
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
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
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID
Health Insurance Premium Payment (HIPP) Program
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+)
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

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid Website: https://www.in.gov/medicaid/
http://www.in.gov/fss/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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

MAINE – Medicaid
Enrollment Website: www.mymaineconnection.gob/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-495-1178

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

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NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 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)

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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: https://www.pa.gov/en/agencies/dhs/resources/chip.html
CHIP Phone: 1-800-986-KIDS (5437)

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

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

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

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
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
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-562-3022

VIRGINIA – Medicaid and CHIP
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
Phone: 1-800-432-5924

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

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

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

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 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
KCHIP Website: https://kynect.ky.gov

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Important Notice

This Guide is intended to provide you with the information you need to choose your 2025 benefits, including details about your benefits options and the actions you need to take during this year's Annual Enrollment period. It also outlines additional sources of information to help you make your enrollment choices. If you have questions about your 2025 benefits or the enrollment process, call Human Resources. The information presented in this Guide is not intended to be construed to create a contract between EMR and any one of EMR's employees or former employees. In the event that the content of this Guide or any oral representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document are controlling. EMR reserves the right to amend, modify, suspend, replace or terminate any of its plans, policies or programs, in whole or in part, including any level or form of coverage by appropriate company action, without your consent or concurrence.

Newborns' and Mothers' Health Protection Act Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, [or midwife], or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

The Genetic Information Nondiscrimination Act (GINA) Notice

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

Fixed Indemnity Insurance Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with job-protected leave for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees. Eligible employees can take up to 12 workweeks of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness may take up to 26 workweeks of FMLA leave in a single 12-month period to care for the servicemember. You have the right to use FMLA leave in one block of time. When it is medically necessary or otherwise permitted, you may take FMLA leave intermittently in separate blocks of time, or on a reduced schedule by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is not paid leave, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's

Am I eligible to take FMLA leave?

You are an eligible employee if all of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements. You work for a covered employer if one of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management

How do I request FMLA leave?

Generally, to request FMLA leave you must:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You do not have to share a medical diagnosis but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You must also inform your employer if FMLA leave was previously taken or approved for the same reason when requesting additional leave.

Your employer may request certification from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater

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family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress

What does my employer need to do?
If you are eligible for FMLA leave, your employer must:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your employer cannot interfere with your FMLA rights or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your employer must confirm whether you are eligible or not eligible for FMLA leave. If your employer determines that you are eligible, your employer must notify you in writing:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?
Call 1-866-487-9243 or visit dol.gov/fmla to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. Scan the QR code to learn about our WHD complaint process

Notice to Enrollees in a Self-funded Nonfederal Governmental Group Health Plan for Plan Years Beginning On or After September 23, 2010

[This notice is appropriate in the case of a collectively bargained plan ratified on or after March 23, 2010.]

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. (Name of plan sponsor) has elected to exempt (name of plan) from (all) (or specify which ones) of the following requirements:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the (plan year) (period of plan coverage) beginning (specify date) and ending (specify date). The election may be renewed for subsequent plan years.

[If the Plan provides protections similar to any of the exempted requirements, either voluntarily or in accordance with State law, those protections may be identified.]

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 0938-0702. The time required to complete this information collection is estimated to average 15 minutes 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.

Special Enrollment Notice

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 (including COBRA 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 Company 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). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility 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 (CHIP) 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 CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

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. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for 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 (CHIP) 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. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. To request special enrollment or obtain more information, contact HR.

INSURANCE MARKETPLACE NOTICE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health

be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage. Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll inthat health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility

INSURANCE MARKETPLACE NOTICE

for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact 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

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application

3. Employer Name EMR (USA Holdings) Inc.		4. Employer Identification Number (EIN) 14-1976472
5. Employer Address 201 North Front Street		6. Employer phone number 1-800-SCRAP-IT
7. City Camden	8. State NJ	9. Zip Code 08102
10. Who can we contact about employee health coverage at this job? HR Manager		
11. Phone number (if different from above)	12. Email address USA.Benefits@emrgroup.com	

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


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