HELPING YOU UNDERSTAND
Your Benefit Choices

2024-2025

This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your employers benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the "Notices" Section in the back of this benefits booklet.

**This guide may or may not be applicable to union employees.*

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WELCOME

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BENEFITS OFFERED

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HOW TO ENROLL

Enroll online, no later than Monday, November 4th at:
Stockmeister.com/open-enrollment

Your Open Enrollment Period
October 28, 2024 – November 4, 2024

Each year as our medical plan renews Foremost Management evaluates the plan with the intention of providing our employees with the most cost-effective pricing.

After careful consideration, the decision has been made to move the medical carrier to Anthem and moving the GAP Insurance carrier to MedMutual Protect. Also, a voluntary vision benefit will be available if you choose to elect. If you have any questions about these benefits, please contact your plan Administrator, Cora Willett at (740) 286 - 8000.

Employees who are enrolled in the company medical plan will receive $20,000 of employer paid Basic Life coverage with MetLife.

It is important to remind ALL providers, (including your physician's, lab & Xray, hospital, therapists) that a new carrier, with a new group number and new claim paying office will apply for services on 12/1/2024.

IMPORTANT:

- Please refill all existing prescriptions before 12/01/2024, so you have an ample supply of prescription drugs during the transition to the new carrier.
- If you are on a mail order prescriptions, you need to contact your physician to have a new mail order prescription written and submitted to the new carrier.
- DO NOT USE YOUR 90 DEGREE BENEFITS ID CARD FOR ANY SERVICES PROVIDED AFTER 11/30/2024.

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their 26 birthday this year?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

ELIGIBILITY
RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are full-time and work a minimum of 30 hours per week. Your coverage will be effective 1st of the month following 60 days from your date of hire.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner; or
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains who is eligible for coverage under each benefit plan type:

Line of Coverage	When coverage ends
Medical	The last day of the month the child turns age 26
Vision	The last day of the month the child turns age 26

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

HEALTH

MEDICAL | TERMS AND DESCRIPTIONS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

***OUT-OF-NETWORK** Any services received from an out-of-network provider, with the exception of a true emergency, will not be covered.

PPO | In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

TRADITIONAL DRUGS

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 | Highest copay: In this category are nonpreferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay. **Make sure to check for mail order discounts that may be available.**

SPECIALTY DRUGS

TIER 4 | Lowest specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than nonpreferred specialty drugs in tier 5.

Did You Know?

- ✓ **Preventive Services** are c**overed at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

How do I find an In-Network Provider?

Select In-Network providers can be found on your provider's website:

https://providers.anthem.com/ohio-provider/resources/provider-search-tool

MEDICAL
HEALTH | PLAN COMPARISON

MedMutual Protect GAP Plan Instructions

- Member's will have a $1,000 single/$2,000 family **IN-NETWORK** deductible. After that is met, you will not pay any additional deductible or coinsurance out of pocket, **only copays**.
- Members will receive **TWO** ID cards. One for Anthem and one for the GAP plan. **BOTH** must be shown at the time of your appointment to ensure claims are processed correctly.
- If you get a bill or have questions you can call Anthem. If your doctor's office asks you about the GAP ID Card, you can reply "please call the number on the card and they will explain the benefits".

	In-Network	Non-Network
DEDUCTIBLE		
Single Deductible	$1,000	$18,000
Two Person/Family Deductible	$2,000	$36,000
COINSURANCE *(applies after deductible is met)* **& Out of Pocket Max** *(includes coinsurance and deductible)*		
Plan Pays	80%	50%
Single Maximum	$6,000	$25,650
Two Person/Family Maximum	$15,100	$51,300
MEMBER COPAYMENT(S)		
Primary Care (PCP) - Office Visit	$30	50%
Preventive Services	$0 / 0%	50%
Specialist - Office Visit	$50	50%
Urgent Care Facility	$75	50%
Emergency Room Visit	$350	50%
To Search Providers	https://www.anthem.com/find-care/	

Your Care Options and When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

PRESCRIPTION DRUGS

Rx | PLAN COMPARISON

TRADITIONAL DRUGS

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 | Highest copay: In this category are nonpreferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay. **Make sure to check for mail order discounts that may be available.**

SPECIALTY DRUGS

TIER 4 | Lowest specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than nonpreferred specialty drugs in tier.

Rx Copays	Retail	Mail Order
TIER 1 (Value / Generic)	$15	$30
TIER 2	$50	$125
TIER 3	$90	$225
TIER 4	25% to $350/$450(L2)	Not Covered

Anthem Level 1 & Level 2 Pharmacies:

Level 1 (L1) retail copays apply at low cost pharmacies, higher copays apply at all other pharmacies. Low cost pharmacies include (CVS, Kroger, Walmart, Giant Eagle, Sam's Club, Target, and Costco).

Level 2 (L2) pharmacies include but are not limited to Walgreens, Kmart, Rite Aide, and all other retail pharmacies.

Your prescription drug coverage is important to your health. With pharmacy benefits from Anthem, powered by **CarelonRx**, you can track and manage all of your prescriptions in one convenient place. Refill and renew prescriptions, find a pharmacy, and check the cost of medications.

To get started, log in to anthem.com, go to My Plans, and then go to Pharmacy. You can also use the **Sydney Health** mobile app.

No-hassle refills and renewals - Refills and renewals are at your fingertips when you choose **CarelonRx Mail**. You can turn on automatic refills and renewals, check order status, get notices when your order ships or if something needs your attention, and manage your payments and account balance

Save Money With Generic (Tier 1) Drugs

Ask your doctor if it's appropriate to use a generic drug rather than a brand.

Generic drugs are less expensive, and according to the FDA, they contain the same active ingredients and are identical in dose, form and administrative method as a brand name.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER - Many drugs are available in a 90 day supply, rather than the 30 day retail supply. Typically, you will pay less if you choose to get a mail order 90 day supply.

GOOD Rx - There are many tools online that you can use in order to save on prescription costs. One being GoodRx.com, an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR – Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times there are generic or different manufacturers that will save you money at the pharmacy.

VISION

MetLife

The vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. We offer one vision plan choice through MetLife.

	IN-NETWORK Davis Vision	OUT-OF-NETWORK
PLAN FEATURES		
Vision Exam	**$10** copay	Up to **$45**
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	**$25** copay	Up to **$30**
Bifocals	**$25** copay	Up to **$50**
Trifocals	**$25** copay	Up to **$65**
Lenticular	**$25** copay	Up to **$100**
Frames	**$130 Allowance, then 20% of balance**	Up to **$70**
COVERED SERVICES		
Contact Lenses	**$130 Allowance** **Covered in full (medically necessary)**	Up to **$105**
Contact Lens Evaluation Fitting	**15% Discount**	**Included in allowance**
BENEFIT FREQUENCY		
Exams	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months
Contacts	Once every 12 months *(contacts in lieu of frames/lenses)*	Once every 12 months

ONLINE HEALTHCARE

24/7 | VIRTUAL DOCTOR VISITS

No crowded waiting rooms.
No Driving.
See a doctor when you need a doctor.

A virtual visit lets you see and talk to a doctor from your mobile device or computer. When you use one of the provider groups in our virtual visit network, you have benefit coverage for certain non-emergency medical conditions. Costs must be paid by you at the time of the virtual visit and will apply toward your deductible and out-of-pocket maximum.

To schedule a virtual visit, download the Sydney Health App or visit Anthem.com and select Find Care then Virtual Care

WHEN CAN I USE A VIRTUAL VISIT?

When you have a non-emergency condition and:

- your doctor is not available;
- you become ill while traveling;
- When you are considering visiting a hospital emergency room for a non-emergency health condition.

**Your covered children may also use Virtual Visits when a parent or legal guardian is present for the visit.*

Examples of Non-Emergency Conditions:

- ✓ Bladder infection
- ✓ Bronchitis
- ✓ Diarrhea
- ✓ Fever
- ✓ Pink eye
- ✓ Rash
- ✓ Seasonal flu
- ✓ Sinus
- ✓ Sore throat
- ✓ Stomach

HOW DOES IT WORK?

The first time you use a Virtual Visits provider, you will need to set up an account with that Virtual Visits provider group. You will need to complete the patient registration process to gather medical history, pharmacy preference, primary care physician contact information, and insurance information.

Each time you have a virtual visit, you will be asked some brief medical questions, including questions about your current medical concern. If appropriate, you will then be connected using secure live audio and video technology to a doctor licensed to deliver care in the state you are in at the time of your visit. You and the doctor will discuss your medical issue, and, if appropriate, the doctor may write a prescription* for you.

Virtual Visits doctors use e-prescribing to submit prescriptions to the pharmacy of your choice. Costs for the virtual visit and prescription drugs are based on, and payable under, your medical and pharmacy benefit. They are not covered as part of your Virtual Visits benefit.

**Prescription services may not be available in all states.*

HOW DO I GET ACCESS?

Learn more about Virtual Visits and access direct links to provider sites by logging into Anthem and select Find Care then Virtual Care.

DOWNLOAD THE APP

Get the information you need on the go by downloading **Sydney Health** App from the App Store for Apple℠ products or on the Google Play™ Store for Android products.

Download on the App Store

GET IT ON Google Play

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

IMPORTANT CONTACT INFORMATION

PROVIDER	CONTACT INFORMATION
Anthem	www.anthem.com 833-639-1634
Virtual Visits (Anthem)	Sydney Health App
MetLife	Find a Davis Vision provider at www.metlife.com/vision and select Davis Vision by MetLife'. For general questions, go to www.metlife.com/mybenefits. or call 1-833-EYE-LIFE (1-833-393-5433)

Have Questions?

Please see the chart above for provider customer service phone numbers and website addresses.

If you need any other assistance, contact HR Cora Willett (740) 286-8000 or email cwillett@stockmeister.com

For issues which require additional assistance, you may also contact our Account Management Team at NFP Corporate Services (OH) Inc.:

Danielle Kafantaris, Senior Account Executive -Phone (216) 816-0028 or email Danielle.Kafantaris@nfp.com

Jenna Cousino, Account Manager I - Phone (216)-264-5529 or email Jenna.Cousino@nfp.com

NOTES

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This Benefit Enrollment Guide Is Provided By:

NFP
An Aon Company