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Benefit Matters

HR News You Can Use

2025 Employee Benefits Guide

What's Inside

Your Health, Your Choice!

Welcome to your 2025 Benefit Enrollment Guide! We've prepared this Guide to serve as your roadmap through the benefit enrollment process. In it you will find an overview of changes made to the benefits program for 2025, as well as detailed descriptions of the individual benefit plans. Pricing schedules for each benefit are also included as are the contact information and website locations for all the carriers.

This guide summarizes the benefit plans that are available to eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict in this guide, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Important Note: Your enrollment is "ACTIVE" which means it requires you to either enroll or waive the medical, dental and vision benefits. Please take this opportunity to review your current benefits elections, update beneficiaries and make any changes necessary. All changes go into effect on January 1, 2025. **If you fail to actively enroll in each benefit, voluntary benefits will discontinue such as Dental, Vision Voluntary Life Insurance/AD&D, Critical Illness and Accident Insurance. Medical will default to Plan A (without employer HSA contribution).** Don't let this happen to you, act now!

Benefits Eligibility

Eligible Employees

You may enroll if you are a regular full-time employee who is actively working a minimum of 30 hours per week and are not covered by a union-sponsored healthcare plan.

Eligible Dependents

If you are eligible for our benefits, then your dependents are too. For medical, dental, vision, voluntary accident and voluntary critical illness, eligible dependents include your spouse and children up to age 26. If your child is developmentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, legally adopted, stepchildren and children placed through court-appointed legal guardianship.

For Life Insurance Benefits, dependents are eligible to be covered from live birth through age 25.

When Coverage Begins

Newly hired employees and dependents will be eligible on the 31st day following the employee's date of hire. All elections are in effect for the entire calendar year and can only be changed during Open Enrollment unless you experience a Qualifying Life Event.

Qualified Life Event Change

A Qualifying Life Event is a change in your personal life that may impact your eligibility or dependent's eligibility for Benefits. Examples of Qualifying Life Event changes include:

- Change of legal marital status (i.e., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 60 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 60 days of the event may result in your having to wait until the next open enrollment period to make your change. Log in to PlanSource to make your changes.

In the event of an employee's death, the company will continue to cover medical benefits for family members who are covered under the plan for 30 days after the date of death.

401k Employer Match Contribution and Financial Wellness - Eligible Employees*

- Milton CAT plays an important role in your financial future, and we want to help provide a plan to secure and enhance your next chapter in retirement.
- For eligible employees, our annual Employer 401k Contribution for 2025 is $5,000.

What's New For 2025

Medical Insurance

- Your Medical Employee Contributions will be increasing for the 2025 Plan Year, effective January 1st.
- New MSK program: Cigna Pathwell Bone & Joint.
- New Weight-Loss program: Encircle Rx available to all Cigna members effective 2/1.
- For Plan A & B to remain an HSA qualified plans, the embedded deductible feature will be slightly increasing from $3,300 to $3,500 for employee+1.
- Cigna's Carelink network will be replaced with Cigna's proprietary network. You will experience little to no impact with the providers you use today.

Pharmacy

- Certain non-specialty drugs will be subject to Prior Authorization and/or Quantity Limits. Those affected will be notified in advance by Cigna.

Health Savings Account (HSA) Contributions

- Employer contributions will be increasing for Plan A from $750/$1,500 to $1,000/$2,000.
- Increased IRS maximum annual contributions:
    - $4,300 (self-only)
    - $8,550 (family)
    - **Those over age 55 can contribute an additional $1,000 for catch up contributions.
- Total annual Employer HSA contributions for Plan A and B will be available to employees on the first payroll of January 2025. The HSA employer amount for New Hires will be prorated.

How To Enroll for 2025

MyMiltonCAT.com is your one stop access for Open Enrollment information and resources.

Before you enroll, be sure to review your Personal Information (Address, W-4, Direct Deposit, Pay Stub Info, Emergency Contacts, etc.) in UKG.

Visit www.MyMiltonCAT.com and click on UKG

Enter your username: [Employee last name + last 4 digits of your Social Security Number (SSN)]
Example: smith3579

Enter your password: [Initial Password: Birthdate in the format MMDDYYYY]
Example: 12011980

Password problems: Please call the IT Helpdesk at 508-634-5599

Important Note: Please be sure to add your physical address in UKG as some benefit cards cannot be mailed to a PO Box.

Once you're ready….. Log into PlanSource, review current benefits and make your 2025 selections.

Visit www.MyMiltonCAT.com and click on PlanSource

Enter your username: [First Initial of First Name + Up to six characters of your Last Name + last 4 digits of your Social Security Number (SSN)] Example: JSmith3579

Enter your password: [Password: Birthdate in the format YYYYMMDD] Example: 19750207

(Note: Every year during Open Enrollment your password will reset back to your birthdate in the YYYYMMDD format.)

Password problems: Please call PlanSource at 844-307-4868, Monday-Friday 8:00am to 8:00pm EST

Important Note:
Enrollment is "ACTIVE" and requires you to take action to enroll for employee benefits. Please take this opportunity to review your current benefits elections, update beneficiaries and make any changes. If you fail to take action, you will lose valuable benefits and company contributions and be defaulted into base Plan A's medical coverage

Review your current benefit selections to ensure dependent and beneficiary selections are accurate. This can be done once you log into Plansource by viewing Current Benefits in the top left-hand corner of the home page.

Have questions? Need Help? Please contact the HR Department at hr@miltoncat.com or 508-482-5740

Employee Contributions

The share of premiums that you pay for coverage is deducted on a pre-tax basis through payroll deductions.

	Salaried Employee Rates (Bi-Weekly)	Hourly Employee Rates (Weekly)
Medical: Cigna (Plan A)		
Employee Only	$0.00	$0.00
Employee + Spouse	$0.00	$0.00
Employee + Child(ren)	$0.00	$0.00
Employee + Family	$0.00	$0.00
Medical: Cigna (Plan B)		
Employee Only	$44.37	$22.18
Employee + Spouse	$86.08	$43.04
Employee + Child(ren)	$86.08	$43.04
Employee + Family	$112.60	$56.30
Medical: Cigna (Plan C)		
Employee Only	$129.67	$64.83
Employee + Spouse	$251.56	$125.78
Employee + Child(ren)	$251.56	$125.78
Employee + Family	$329.11	$164.55
Dental: Delta Dental of MA		
Employee Only	$8.68	$4.34
Employee + Spouse	$19.74	$9.87
Employee + Child(ren)	$18.42	$9.21
Employee + Family	$25.89	$12.95
Vision: EyeMed		
Employee Only	$3.18	$1.59
Employee + Spouse	$5.10	$2.55
Employee + Child(ren)	$5.20	$2.60
Employee + Family	$8.39	$4.19
Accident Insurance (Low): Voya		
Employee Only	$4.64	$2.32
Employee + Spouse	$7.79	$3.90
Employee + Child(ren)	$9.19	$4.60
Employee + Family	$12.35	$6.17
Accident Insurance (High): Voya		
Employee Only	$6.58	$3.29
Employee + Spouse	$10.95	$5.48
Employee + Child(ren)	$12.96	$6.48
Employee + Family	$17.33	$8.67
Critical Illness: Voya		
	See Following Page	

Reminder: If you opt-out of the Milton medical plan because you have medical coverage elsewhere (spouse, Military, etc.), you qualify up to $1,000 credit for single coverage or $2,500 for family coverage, which will be added to your paycheck as taxable income in equal installments.

Critical Illness

		Employee - $10,000 of Coverage				Spouse - $5,000 of Coverage				Child(ren) - $2,500 of Coverage	
Critical Illness (Low Plan)	Age-Bands	Non-Tobacco Biweekly	Weekly	Tobacco Biweekly	Weekly	Non-Tobacco Biweekly	Weekly	Tobacco Biweekly	Weekly	Bi-Weekly	Weekly
	< 30	$3.42	$1.71	$4.52	$2.26	$2.15	$1.07	$2.61	$1.30	$0.52	$0.26
	30 - 39	$4.48	$2.24	$6.37	$3.18	$2.72	$1.36	$3.69	$1.85		
	40 - 49	$8.58	$4.29	$13.06	$6.53	$4.62	$2.31	$6.83	$3.42		
	50 - 59	$15.46	$7.73	$24.83	$12.42	$7.04	$3.52	$10.87	$5.43		
	60 - 64	$20.86	$10.43	$34.85	$17.42	$9.16	$4.58	$14.65	$7.33		
	65 - 69	$27.69	$13.85	$42.55	$21.28	$11.95	$5.98	$17.63	$8.82		
	70+	$29.08	$14.54	$43.34	$21.67	-	-	-	-		

		Employee - $15,000 of Coverage				Spouse - $10,000 of Coverage				Child(ren) - $5,000 of Coverage	
Critical Illness (High Plan)	Age-Bands	Non-Tobacco Biweekly	Weekly	Tobacco Biweekly	Weekly	Non-Tobacco Biweekly	Weekly	Tobacco Biweekly	Weekly	Bi-Weekly	Weekly
	< 30	$4.52	$2.26	$6.18	$3.09	$3.09	$1.55	$4.02	$2.01	$1.04	$0.52
	30 - 39	$6.12	$3.06	$8.95	$4.48	$4.25	$2.12	$6.18	$3.09		
	40 - 49	$12.28	$6.14	$18.99	$9.50	$8.03	$4.02	$12.46	$6.23		
	50 - 59	$22.59	$11.30	$36.65	$18.32	$12.88	$6.44	$20.54	$10.27		
	60 - 64	$30.69	$15.35	$51.67	$25.83	$17.12	$8.56	$28.11	$14.05		
	65 - 69	$40.94	$20.47	$63.23	$31.62	$22.71	$11.35	$34.06	$17.03		
	70+	$43.02	$21.51	$64.41	$32.20	-	-	-			

Voluntary Life and AD&D Insurance

Age	Employee & Spouse Rate per $1,000
Through age-29	$0.05
30-34	$0.07
35-39	$0.10
40-44	$0.17
45-49	$0.26
50-54	$0.41
55-59	$0.73
60-64	$1.33
65-69	$2.19
70-99	$3.21
Child Life Rate	$0.17 per family unit
Voluntary AD&D Employee Rate	$0.03

Important Note: You must purchase coverage for yourself in order to purchase for your dependents.

Medical Insurance

Cigna Medical Plans

Milton offers three medical plan choices through Cigna. In-network preventive care visits and generic preventive prescriptions are covered in-full with no deductible or co-insurance.

We have two Choice Fund Consumer Driven Health Plans (CDHPs), Plan A and Plan B, and one Open Access Plus Copay Plan, Plan C. All three plans are a Preferred Provider Organization (PPO) where a referral to see a specialist for care is not required. The following page shows a side-by-side comparison of each of the plan offerings. Also, the CDHPs qualify for a Health Savings Account (HSA) for which most employees will qualify. Please refer to the Health Savings Account section for more details.

GLOSSARY OF TERMS

We realize healthcare can get complicated so here are some common medical plan terms you can reference as you prepare to make your medical plan election:

Deductible: An amount you pay out-of-pocket each year before Benefits are paid under the plan, outside of any copayments that may apply. All plans offered have a deductible. Here is a summary of the deductibles and what services are applied toward these deductibles:

Plan A: $3,000 individual / $6,000 family (both medical and RX costs apply)
Plan B: $3,000 individual / $6,000 family (both medical and RX costs apply)
Plan C: $1,000 individual / $2,000 family (medical costs apply)

- As a reminder, your in-network preventive visits and any preventive generic drugs are not subject to the deductible and are covered at 100%. A full listing of preventative generic drugs can be found in PlanSource under Benefit Documents 2025 or on mymiltoncat.com.
- Also, our plans have an embedded deductible feature which means no one person in a family will have to satisfy more than $1,000 (for Plan C) or $3,500 (for Plans A & B) in deductible expenses. Once one person in a family satisfies the individual deductible, the remainder of the family members' claims will all go into one bucket to accumulate toward the remainder of the deductible.

Copay: A fixed amount you pay for covered services, typically owed when you receive the service. Only Plan C has copays.

Coinsurance: The percentage of a claim you pay after the deductible has been met. Here is a summary of how coinsurance applies to each plan:

Plan A: 10% coinsurance in-network / 30% coinsurance out-of-network
Plan B: 0% coinsurance in-network / 30% coinsurance out-of-network
Plan C: 10% coinsurance (for some services) / 30% coinsurance out-of-network

In-Network: Providers of healthcare services, including but not limited to, physicians, hospitals and other healthcare facilities, that are under contract with Cigna to provide care to members at a reduced cost. Utilizing an in-network provider will result in lower costs to you.

Out-of-Network: Providers of healthcare services, which do not contract with Cigna to provide care to members. While the Cigna plans allow for out-of-network coverage, you typically have to pay more when using an out-of-network provider.

Out-of-Pocket Maximum: The maximum amount you and your family will pay out-of-pocket in a plan year. This includes any deductible, coinsurance and/or copays. Below is how this applies to each plan. Again, because the individual+1 and family deductibles are embedded, no one person in a family will satisfy more than the individual level out-of-pocket maximum.

Plan A: $6,000 individual / $12,000 family. Once you've met your deductible you will pay 10% coinsurance (in-network) or 30% coinsurance (out-of-network) up to the out-of-pocket maximum

Plan B: $6,000 individual / $12,000 family. Once you've met your deductible you will pay 0% coinsurance (in-network) or 30% coinsurance (out-of-network) up to the out-of-pocket maximum. If you stay in-network for all services, your out-of-pocket maximums will be $3,000 individual / $6,000 family. For EE+1 or more enrolled in the plan the in-network out-of-pocket maximum is $3,500. Once one person in a family reaches $3,500, remaining services for the year are covered at 100% for this individual.

Plan C: $3,000 individual / $6,000 family. Once you've met your deductible you will pay 10% coinsurance (in-network) or 30% coinsurance (out-of-network) up to the out-of-pocket maximum

Medical Insurance (continued)

MEDICAL PLAN OVERVIEW

The following chart provides a high-level overview of what you pay for covered services for each of the medical plans available to you.

Medical Plan Choices	Plan A	Plan B	Plan C
	Choice Fund Open Access	Choice Fund Open Access	Open Access Plus
In-Network Coverage	**You Pay**	**You Pay**	**You Pay**
Annual Deductible †			
Individual / Family	$3,000 / $6,000 ($3,500 embedded deductible for those enrolled as EE+1 or more)	$3,000 / $6,000 ($3,500 embedded deductible for those enrolled as EE+1 or more)	$1,000 / $2,000
Annual Out-of-Pocket Maximum			
Individual / Family	$6,000 / $12,000	$6,000 / $12,000 ($3,500 embedded out-of-pocket max for those enrolled as EE+1 or more)	$3,000 / $6,000
* Deductibles and Out-of-Pocket Maximums are combined both in and out of network. Each plan has an individual deductible that applies to both employee only enrolled or employee+1 or more enrolled. If you're enrolled in Plan A or B, your individual deductible is $3,000 (if enrolled as employee only) and $3,500 (if enrolled as employee+1 or more). For Plan C, your individual deductible is $1,000 regardless of your enrollment tier.			
You Pay After The Deductible			
Coinsurance	10%	0%	10%
Service Type			
Essential Preventive Care Visits	$0	$0	$0
General Practitioner Office Visit	Deductible, then 10%	Deductible, then 0%	$20 per visit
Specialist Visit	Deductible, then 10%	Deductible, then 0%	$40 per visit
Telemedicine (MD Live)	Cost varies based on type of service (see page 24 for more details)	Cost varies based on type of service (see page 24 for more details)	$20 per call
Urgent Care	Deductible, then 10%	Deductible, then 0%	$40 per visit
Emergency Room	Deductible, then 10%	Deductible, then 0%	$150 per visit
Outpatient Care	Deductible, then 10%	Deductible, then 0%	Deductible, then 10%
Diagnostic Lab/Xray - Outpatient Hospital / Facility	Deductible, then 10%	Deductible, then 0%	0%
CAT/PET Scan, MRI	Deductible, then 10%	Deductible, then 0%	0%
Hospital Admission / Inpatient Care	Deductible, then 10%	Deductible, then 0%	Deductible, then 10%
Prescription Drugs	**Retail / Mail**	**Retail / Mail**	**Retail / Mail**
Generic Preventive*	**$0 / $0**	**$0 / $0**	**$0 /$0**
Other Generic	Deductible, then 10%	Deductible, then 0%	$10 / $20
Brand	Deductible, then 10%	Deductible, then 0%	$20 / $40
Non-Preferred Brand	Deductible, then 10%	Deductible, then 0%	$50 / $100
Out-of-Network Coverage	**You Pay**	**You Pay**	**You Pay**
Annual Deductible			
Individual / Family	Combined with In-Network	Combined with In-Network	Combined with In-Network
Annual Out-of-Pocket Maximum			
Individual / Family	Combined with In-Network	$6,000 / $12,000	Combined with In-Network
You Pay After The Deductible			
Coinsurance	30%	30%	30%

Medical Insurance (continued)

Medical Plan Choices	Plan A	Plan B	Plan C
	Choice Fund Open Access	Choice Fund Open Access	Open Access Plus
In-Network Coverage	**You Pay**	**You Pay**	**You Pay**
Pre-Tax Funding Account Allowed ††			
General Purpose Health FSA			X
Limited Purpose Health FSA	X	X	
Health Savings Account (HSA)	X	X	
HSA Annual Contribution Maximums †††	**Yes**	**Yes**	**No**
Company Contribution - Individual / Family	$1,000 / $2,000	$750 / $1,500	N/A
Voluntary Employee Contribution - Individual / Family	$3,300 / $6,550	$3,550 / $7,050	N/A
Additional Contribution for those age 55+	$1,000	$1,000	N/A
† For employees who have 3 or more members covered under the medical plan, no 1 person will ever have to pay more than the individual deductible			
†† Each plan option is allowed one or both types of Pre-Tax Accounts that can help members pay for out-of-pocket costs:			
- GPFSAs and LPFSAs are funded by employees using pre-tax dollars. If funds are not used by the end of the calendar year then up to $500 can be rolled over into the next calendar year			
- A full list of qualified expenses for GPFSA, LPFSA and HSA can be found under IRS Publication 502 (see IRS Publication 502 https://www.irs.gov/pub/irs-pdf/p502.pdf)			
- Health Savings Accounts (HSAs) are funded partially by the employer and employees can also contribute to this account using pre-tax dollars. Employees own this account so any unused funds roll over year to year and can be taken with the employee if they leave the company			
††† Per IRS regulations, Medicare or Tricare enrollees and/or those who have an active General Purpose FSA (including spouses) are not eligible to open and actively contribute to an HAS			
* A full listing of preventative generic drugs can be found in PlanSource under Benefit Documents 2025 or on mymiltoncat.com.			

This summary is not a legal document and does not replace or supersede the “Evidence of Coverage”, policy, or the Summary Plan Description (SPD). Please refer to the Evidence of Coverage/Insurance Policy/Summary Plan Description (SPD) for a complete description of the coverage, eligibility criteria, controlling terms, exclusions, limitations, and conditions of coverage.

Milton reserves the right to terminate, suspend, withdraw, reduce, or modify the Benefits described in the Evidence of Coverage/Insurance Policy/Summary Plan Description (SPD) in whole or in part, at any time. No statement in this or any other document and no oral representation should be construed as a waiver of this right. This summary is the confidential property of Milton.

About Each Plan

ABOUT PLANS A and B

With health care costs continuing to rise, it is more important than ever to take responsibility for your health care choices. Plan A and Plan B are considered Consumer Driven Health Plans (CDHPs). With these plans you will pay no or lower per paycheck premiums in exchange for a higher deductible. All services, including prescriptions, are subject to the deductible.

These medical plans encourage you to think about your Benefits differently and maximize your available resources. Cigna provides tools that allow members to compare costs and quality of services they are seeking. Their tools even help members look up a prescription and then compare the cost at various pharmacies.

ABOUT PLAN C

Plan C is based on copayments. For common services such as office visits, urgent care, emergency room and prescription drugs you will pay a copay. Copays are paid per occurrence, and you continue to pay them until you reach your out-of-pocket maximum.

Other services such as inpatient and outpatient services are subject to the deductible and once the deductible is met you will pay 10% for future services up to the out-of-pocket maximum.

MEDICAL - CLAIMS PROCESS FOR SERVICES SUBJECT TO THE DEDUCTIBLE

- Since the amount you owe is not known until after the claim is processed by Cigna, you will generally not pay at time of services.
  - Some doctors/facilities do have a policy stating they expect some payment up front but most, especially Primary Care Physicians, will know not to charge at time of service
  - There may be instances where you will be required to pay at time of service, such as an emergency room visit. Once you receive the Cigna Explanation of Benefits, verify the amount you paid is correct
- **The claim process ideally works like this.**
  - You will go to your doctor/facility and not pay at time of service
  - Your doctor/facility will send the claim to Cigna
  - Cigna will process the claim and send a notice to your doctor/facility letting them know what to bill you. At the same time, they will also send you a notice (an Explanation of Benefits, or EOB) stating what you owe
  - When you receive the bill from the doctor/facility make sure it matches what is stated on your EOB. If it does, you can then pay the bill
    - If it does not match, the first place to start is to call the doctor/facility and tell them they billed you incorrectly. Explain to them what your EOB states and they can then re-process your bill

PRESCRIPTIONS - CLAIMS PROCESS FOR SERVICES SUBJECT TO THE DEDUCTIBLE

- Pharmacy claim systems are auto-adjudicated meaning that when you go to pick up your prescription, the pharmacy will automatically know how much your prescription costs and how much you owe.
- Payment for your prescription will be due at the time of pick up.

POCKET THE SAVINGS

Ten easy ways to lower your out-of-pocket health care expenses

1. Stay in network. You will save big when you use a doctor, hospital, or facility that's part of the Cigna network. Chances are, there is a network doctor or facility nearby.

2. Ask before you go. Your primary care doctor may be in your plan's network, but otherproviders they refer you to might be out-of-network. Make sure to ask if referrals are in your plan's network. If you do not, you may be surprised by a higher bill.

3. Know your plan – and save. If you use an out-of-network provider, your costs can add up quickly. That is because you are probably going to pay full price and not the discounted price an in-network doctor or facility would charge for covered services. Plus, the doctor or facility might charge more than what your plan will pay for out-of-network care. That means you will have to pay the difference.

4. Go with the Cigna Care Designation.
You may save even more when you choose a Cigna Care Designation doctor or a Centers of Excellence hospital. Look for these designations in the online directory:

- Cigna Care Designation - Doctors in 22 medical specialties, including primary care, who achieve top results based on Cigna cost-efficiency and quality measures.
- Centers of Excellence – Hospitals that show quality and cost-efficiency for certain procedures.

5. Get preventivecare. Checkups, immunizations, and screenings can help detect or prevent serious diseases and keep you in tip-top shape. Your primary care physician can help you coordinate tests and shots that are right for you, based on your age, gender, and family history.

6. Use an urgent care center. If your medical need is not serious or life threatening and you can't get an appointment with your doctor, you should consider an urgent care center instead of the emergency room (ER). An urgent care center provides quality care like an ER but can save you hundreds of dollars. Visit an urgent care center for thingslike:

- Minor cuts
- Burns and sprains
- Fever and flu symptoms
- Joint or lower back pain
- Urinary tract infections.

Average urgent care center cost:* $153
Average hospital ER cost: $1,757

Need to find a doctor, hospital, or other care facility? Use the online directory on **myCigna.com** or call the number on your Cigna ID card.

Together, all the way.℠

Cigna®

7. Go to a convenience care clinic.

Need to see your doctor but cannot get an appointment? Try going to a convenience care clinic. You will get quick access to quality, cost-effective medical care. You can find convenience care clinics in grocery stores, pharmacies, and other retail stores. A convenience care clinician can treat you for:

- Sinus infections
- Rashes
- Earaches
- Minor burns
- Other routine medical conditions.

Average convenience care clinic cost: $62
Average ER cost: $1,757

8. Stick with lower-cost labs.

If you use a national lab, such as Quest Diagnostics® or Laboratory Corporation of America® (LabCorp), you can save up to 75%.** Other labs may be part of the Cigna network, but you will see greater savings when you go to a national lab. And they have hundreds of locations nationwide.

Average Quest or LabCorp cost: $10.37
Average lab cost (other): $23.71
Average outpatient hospital lab cost: $53.99

9. Visit independent radiology centers.

If you need a CT scan or MRI, you could save hundreds of dollars by going to an independent radiology center. These centers can provide you with quality service like you'd get at a hospital, but usually at a lower price.

	CT	MRI
Average radiology center costs:	**$457**	**$706**
Average outpatient hospital costs:	**$1,376**	**$1,676**

10. Choose the right place for your colonoscopy, GI endoscopy or arthroscopy.

When you choose to have one of these procedures at an in-network freestanding outpatient surgery center, you could save hundreds of dollars. These facilities specialize in certain types of outpatient procedures. They offer quality care, just like a hospital. But at a lower cost to you.

Average outpatient surgery center: $1,100
Average hospital cost: $2,750

Visit **myCigna.com** to access the online directory and manage your health spending.

On the go and **need to know?** Use the myCigna Mobile App. Download it today from the App **Store**℠ or Google Play™.

Available on the App Store

ANDROID APP ON Google play

Cigna®

*Cost estimates are national 2020 averages of participating facilities; actual cost may vary by location, facility, and the type or level of services received.

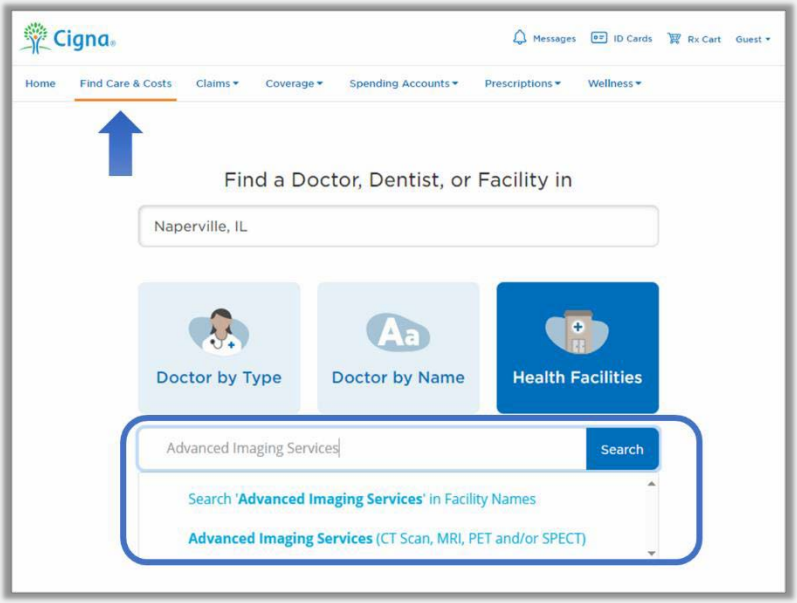
**Savings estimate is based on an internal Cigna national study of 2020 lab utilization data, costs and discounts. Savings will vary.

It’s Easy To Compare Costs

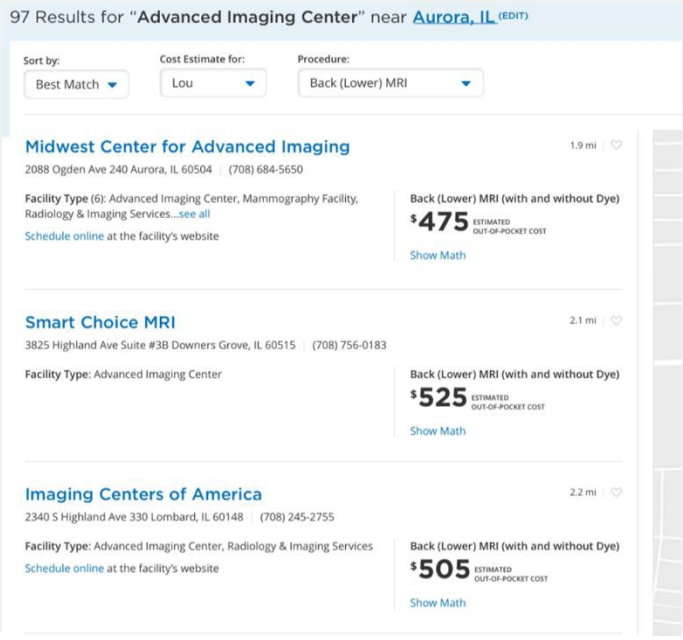
Medical

It’s easy to compare costs

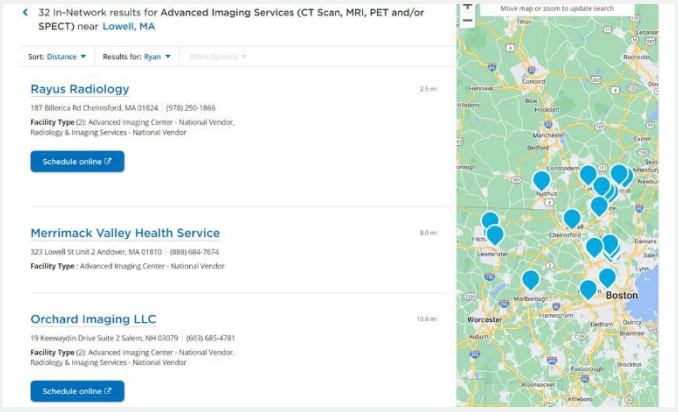
1. Log in to **myCigna.com** online or through the app.
2. Choose **Find Care & Costs** tab.
3. Search for providers, facilities, and services.



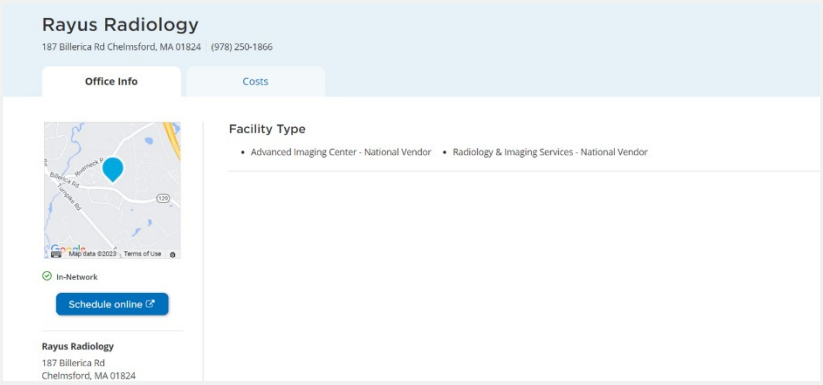
4. After searching for a provider or service, Cigna’s cost estimator tool will show you the estimated out-pocket-costs for that provider or service. This allows you to compare costs for different doctors, procedures, labs, and facilities near you.



5. After searching for a provider or service, Cigna's cost estimator tool will show you a list of providers or facilities in your search area. Click the provider or facility you would like to know more about.

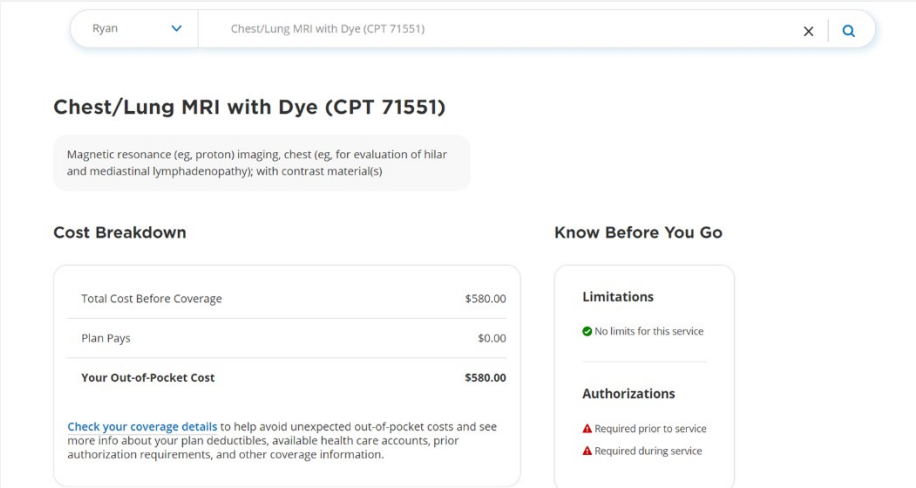


6. Click "Costs" Tab



7. Enter the procedure in the search bar and the cost breakdown will show.

*****_Please note that not all costs have been updated and may not show. Please contact provider or facility for further information._

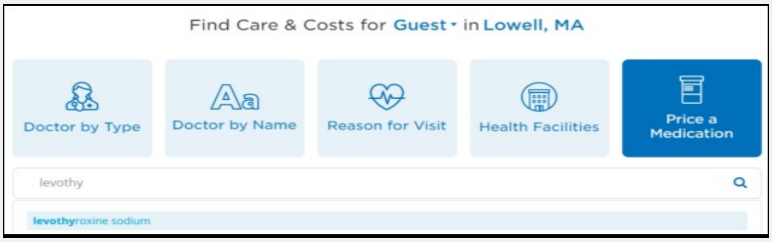


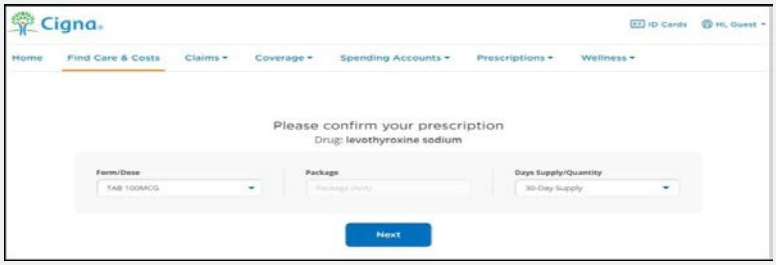
It’s Easy to Compare Costs

Prescriptions

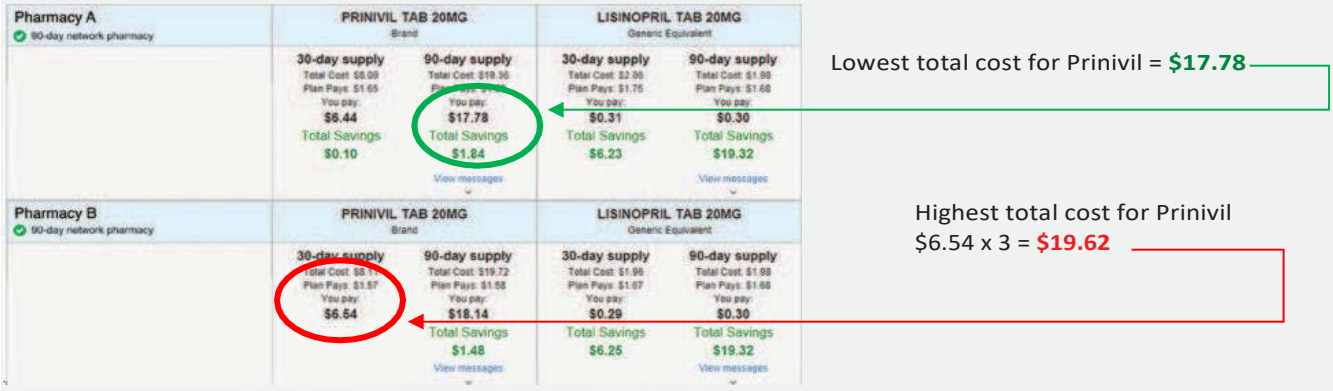
It’s easy to compare costs

1. Log in to **myCigna.com** online or through the app.
2. Choose **Prescriptions,** then **Price a Medication.**
3. Enter the medication name and dosage.





4. Select pharmacies near you to compare costs. In this example the total cost for a 90-day supply of Prinivil at Pharmacy A is the least costly option.



Lowest total cost for Prinivil = **$17.78**

Highest total cost for Prinivil
$6.54 x 3 = **$19.62**

If you have questions about your medication, please call the number on the back of your ID card. We’re here to help, anytime – 24/7.

*Please note that prices are not guaranteed, nor is the display of a price a guarantee of coverage. Your costs and coverage may vary at the time you fill your prescription at the pharmacy, and pricing at individual pharmacies may vary. Not all plans cover 90-day supplies. Coverage and pricing terms are subject to change. Your pharmacy may offer a special sale price on a specific medication which may be less than the price displayed here. Please consult your pharmacy.

**The downloading and use of the myCigna App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Search Cigna's Provider Network

Is your doctor or hospital in the Cigna network? Cigna's online directory makes it easy to find who (or what) you are looking for. You can search the network by following these 5 simple steps:

Step 1: Go to www.cigna.com, click on **FIND A DOCTOR** found at the top of the page

Step 2: Under "How Are You Covered?" click "Employer or School"

Step 3: Enter your address, city, or zip code. Search options are by doctor type, doctor name, or health facility

Step 4: Enter the remaining criteria and then click search for results

Step 5: Select "Continue" and follow the prompts

- If you are searching for a provider and are not yet a Cigna member, select "Open Access Plus, OA plus, Choice Fund OA Plus" as your plan type

Transition of Care

What is Transition of Care?

With Transition of Care, you may be able to continue to receive services for specified medical and behavioral conditions with health care professionals who are not in the Cigna network at in-network coverage levels. This care is for a defined period until the safe transfer of care to an in-network doctor or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your Cigna medical plan. You must apply no later than 30 days after the effective date of your coverage.

What is Continuity of Care?

With Continuity of Care, you may be able to receive services at in-network coverage levels for specified medical and behavioral conditions when your health care professional leaves the Cigna network. There must be solid clinical reasons preventing immediate transfer of care to another health care professional. This care is for a defined period. You must apply for Continuity of Care within 30 days of your health care professional's termination date. This is the date that he or she is leaving the Cigna network.

Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Pregnancy in the 2nd or 3rd trimester if you're a new enrollee or the date the health care professional leaves the network
- Pregnancy that is considered 'high-risk' if the mother is 35 years or older, or patient has/had: early delivery, gestational diabetes, pregnancy induced hypertension or multiple inpatient admissions during pregnancy
- Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction
- Recent major surgeries still in the follow-up period, that is generally 6 to 8 weeks
- Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions
- Behavioral health condition during active treatment

If you feel you may qualify for either of these programs you can submit a request to Cigna, in writing, using the Transition of Care/Continuity of Care request form found in PlanSource's Global Document tab. This form must be submitted at time of enrollment or when your health care professional leaves the Cigna network. After Cigna reviews and evaluates the information provided, they will send you a letter informing you whether your request was approved or denied. A denial will include information about how to appeal the determination.

MotivateMe by Cigna

The health of our employees matters! Early detection of illness and disease allows you to stay healthier, get more effective treatment and pay less for overall medical care. To help support you in leading a healthy lifestyle employees and spouses have the potential to earn up to $1,950 **combined** in incentives! The action items and incentive amounts are as follows:

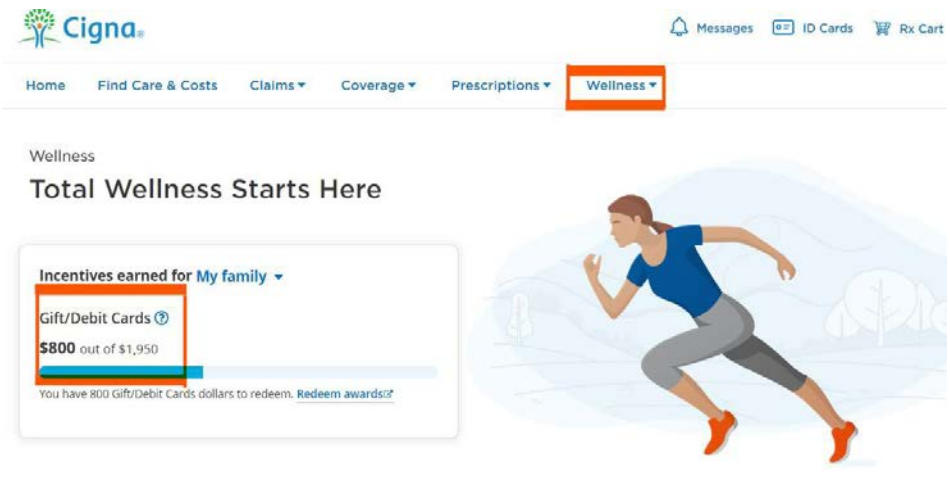
Type Goal	Employee	Spouse	Comment
Annual Physical	$200	$200	
Cancer Screening	$200	$200	
Center of Excellence	$500	$500	
Healthy Babies ($150/$75)	$150	-	Member can get either $150 (if they sign up in the first trimester) or $75 (if they sign up in the 2nd trimester). Member gets one or the other, not both.
Maximum You Can Get	$1,050	$900	
Combined Potential Reward Dollar Earnings	**$1,950**		In most situations, only 1 member (the employee or the spouse) will be pregnant. For illustrative purposes, the maximum amount you can earn under the Pregnancy program ($150) is listed under the employee.

Here's how it works!

1. Once action item is completed, your doctor will go through the normal process of submitting the claim to Cigna.
   - You have between January 1, 2025 – December 31, 2025 to complete your action item.
2. Cigna receives the claim, processes it, and credits you the incentive amount on your myCigna.com account.
   - If you are currently enrolled with Cigna and haven't already registered for a myCigna.com account, you may do so at any time.
3. Your incentive can be redeemed for a Visa card, or you can choose a gift card from hundreds of merchants such as L.L. Bean, Nordstrom, AMC Theatres, Panera Bread, Amazon and much more!

Note: Your incentive can take anywhere from 3 – 6 weeks from the date of your action item to appear on your myCigna.com account.

To redeem your incentive, go to your myCigna.com home page and select "Incentive Awards" under the Wellness header on your home page.



MSK Program: Pathwell Bone & Joint by Cigna

Musculoskeletal (MSK) conditions are on the rise and are unfortunately one of the top medical-spend categories. Cigna's Pathwell Bone & Joint program works to help employees with spine, hip, knee or shoulder pain by giving them access to designated providers who meet the quality and cost criteria. Employees in the program will also be supported by a Clinical Care Advocate, who will help them make the right decisions about their treatment path and avoid unnecessary surgeries.

For questions or support regarding the Program, call the Cigna Pathwell Bone & Joint Provider Team at (855) 678-0042.

Get Ahead of High Costs

Using predictive models, Cigna can help identify customers at risk for spine, knee, hip, or shoulder surgery up to one year in advance, and proactively reach out to encourage enrollment in the Pathwell Bone & Joint program to help arrange proper support.

Clinical Care Advocate

A Clinical Care Advocate will work 1:1 with employees via digital messaging and/or phone. Based on insights and assessment responses, they will customize the program to each employee's unique needs all while guiding, motivating, and encouraging their success.

Digital Guidance and Engagement

Cigna helps employees take greater control of their MSK pain with their guided digital experience. Powered by insights and evidence-based guidelines, the digital experience includes personalized activities, assessments, content, treatment guidance support, care navigation tools, and more.

The Right Care at the Right Time

When care is needed, Cigna helps connect employees with top-tier, in-network providers (in person or virtually) and helps to optimize available benefits. Employees also have access to programs that may support their medical, behavioral, or lifestyle needs throughout their MSK journey.

Surgery Benefit

If faced with surgery, a Benefit Specialist can help employees understand how to qualify for the zero or low-cost surgery benefit and travel benefit along with pre- and post- surgery support. Employees will have access to designated, in-network orthopedic surgeons and neurosurgeons that meet Cigna Healthcare affordability, quality, volume, and outcome selection criteria.

Health Savings Account (HSA)

If you enroll in Plans A or Plan B you might qualify for an HSA that allows you to set aside pre-tax dollars to cover certain out-of-pocket health care expenses not covered by the plan. Milton will also make employer contributions to your HSA.

- Tax-free employee and employer contributions
- Tax-free withdrawals for qualified health care expenses
  - Qualified health care expenses are any expense listed under IRS Publication 502 https://www.irs.gov/pub/irs-pdf/p502.pdf, such as medical/dental/vision expenses
- You decide how you want to use the money in your account to cover your out-of-pocket expenses. Do you use it to pay for your expenses as they occur, or do you save the money in your account and let it accumulate for future health care needs? Unlike a Health Care Flexible Spending Account (FSA), there is no "use it or lose it" rule. You remain in control of your account:
  - You decide how much to contribute – up to the IRS annual maximum limit
  - You choose where and how to spend the money in your HSA
  - Your HSA can be used for you, your spouse and any dependent you claim on your tax returns
  - You build tax-free savings to spend on eligible health care costs in the future even into retirement

Your HSA goes where you go - if you leave the company, your HSA is portable and is yours to keep.

Who is eligible for the HSA?
New hires are eligible to set up an HSA on the 1st of the month following benefits eligibility. Also, both new hires and existing employees must meet all of the following criteria as of January 1, 2025:
You are enrolled in Plan A or Plan B
You are not eligible or enrolled in Medicare or Tricare
You are not claimed as a dependent on someone else's tax returns
You are not covered under any other health insurance that is not considered an HSA qualified plan.
You or your spouse are not participating in a General-Purpose Health Care Flexible Spending Account (GPFSA), or do not have any balance in your GPFSA as of January 1, 2025*

**If you currently have a GPFSA we urge you to spend down your account before the end of the year. However, if you find that you are not able to do this* you will automatically have the balance remaining (up to $500) rolled over to the Limited Purpose Health Care FSA (LPFSA) which you can use for dental and vision expenses.

How Plan A and Plan B work with the Health Savings Account (HSA)

If you enroll in Plan A or Plan B and qualify for the HSA, PlanSource will provide you with the option to contribute to your HSA. Your HSA will be set up with HSA Bank, a Cigna partner. The employee and employer contributions and annual maximum for 2025 are as follows:

	Employee Contribution	ER Contribution -Plan A	ER Contribution – Plan B	Annual Maximum
Employee Only Coverage:	$3,300	$1,000	$750	$4,300
Employee, +1 or Family Coverage:	$6,550	$2,000	$1,500	$8,550
Additionally: If you are age 55 or older, you can make an additional 'catch-up" contribution of up to $1,000 per year				

Exciting News: The total annual employer contributions will be available to employees on the first payroll in January 2025. The HSA employer amount for New Hires will be prorated and accessible on their first payroll.

Health Savings Account (HSA)

Unlike an FSA, you are allowed to change your HSA contribution amount at any time throughout the year.

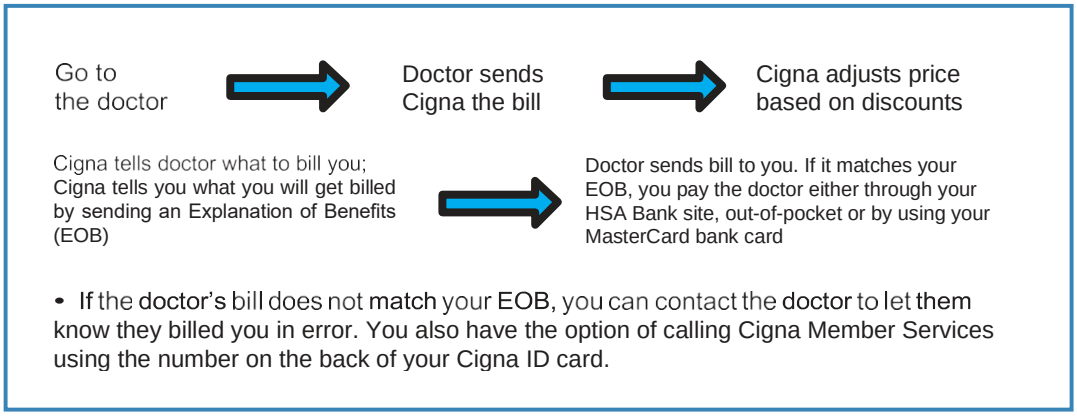
Using Your Health Savings Account (HSA)
First time HSA enrollees will receive a welcome packet and a bank debit card will be mailed to your home address. Important Reminder: Accounts cannot be opened without a physical address. Please be sure that your physical address (not a P.O. Box) is updated in UKG.

The debit card works just like a bank debit card meaning you can use it only up to your account's current balance. There are various ways you can pay for your qualified out-of-pocket expenses using your HSA. You can:

- Use your debit card*
- Register an online account with HSA Bank, log in and pay directly from the site
- Pay out-of-pocket and reimburse yourself through the HSA or
- Pay out-of-pocket and decide not to reimburse yourself so that your HSA account can continue to grow

**The HSA Bank debit card only supports purchases for qualified items at places that have the appropriate medical or pharmaceutical merchant code. If the card is denied yet is a qualified expense, you can pay with personal funds and reimburse yourself from your HSA.*

As a reminder, outside of pharmacies where you must pay at time of services, this is how your claims are processed under Plan A and Plan B:



ABOUT HSA BANK

HSA Bank, a division of Webster Bank, is a well-known, nationwide provider of HSA administration services. Here are some important things to know about your HSA with HSA Bank:

- When your account is created with HSA Bank you will automatically receive monthly electronic account balance statements. Should you wish to receive paper mail statements you must log in and actively elect this option. There is a fee of $1.85 per paper statement which is automatically withdrawn from your account
- Integrated, single sign-on and single view of both medical information as well as HSA account information is maintained throughout the online/customer experience via mycigna.com. Through here you can view claims, view your HSA balance and make payments to providers/facilities
- HSA Bank account holders have access to investment options. Offering two different investment options, self-direct brokerage or via mutual funds, subject to a $1,000 minimum balance in the HSA account
- Should you leave the company or inactivate your HSA, a monthly fee of $3.00 is automatically withdrawn from your HSA

Flexible Spending Accounts (FSA)

Those who elect medical Plan A or Plan B have the option of electing a Limited Purpose Flexible Spending Account (LPFSA). This pre-tax account is for dental and vision expenses only. Even though you can use your HSA for dental and vision expenses, you might prefer to put foreseeable dental and vision expenses into the FSA so that you can preserve your HSA dollars. The LPFSA works the same way our existing General Purpose Health Care FSA (GPFSA) works except that is limited to dental and vision expenses only.

You can set aside tax-free dollars each year to cover eligible out-of-pocket health care and daycare expenses. For the plan year, you can elect up to **$3,300** for either your General-Purpose Health Care Spending Account or your Limited Purpose Health Care Spending Account and you can set aside up to **$5,000** (**$2,500** if married filing separately) for eligible daycare expenses in the Dependent Care Spending Account. Each account is separate; you cannot use health care funds to pay for dependent care expenses or vice versa. You can elect to participate in both accounts.

How the Plans Work

- You elect a contribution amount to deduct from your pay on a pre-tax basis and put into the Flexible Spending Account
- You may not change your contribution amount during the plan year unless you have a Qualifying Life Event
- Expenses must be incurred between your enrollment date in the Flexible Spending Account and December 31, 2025
- You may submit claims for expenses incurred (your enrollment date – December 31, 2025) by March 31, 2026
- For 2025, up to $660 of unused Health Care FSA monies can be rolled over into the next year

It is important to plan your contribution amounts carefully. The Internal Revenue Service requires that you forfeit any money in excess of the $660 that is rolled over in your account for which you have not incurred eligible expenses by the end of the plan year.

General Purpose Health Care FSA (GPFSA)

Funds that you set aside in a GPFSA can be used to reimburse yourself for eligible out-of-pocket health care expenses not covered under the medical, prescription drug, dental or vision plans. Reimbursements can be made for most expenses that would qualify for a health care deduction on your income tax return.

Limited Purpose Health Care FSA (LPFSA)

Funds that you set aside in an LPFSA can be used to reimburse yourself for eligible out-of-pocket dental and vision expenses.

FSA Debit Card Process

If you are a first-time enrollee in the HealthCare FSA, PlanSource will send you an FSA debit card to your home. Many eligible transactions can be auto substantiated at the point of service. However, there are certain purchases that may be declined and require you to submit receipts to validate the expense. You will be reimbursed by PlanSource for these purchases once the expenses have been approved.

Eligible Health Care Expenses

- Deductibles, copayments, coinsurance
- Prescription drugs and medicines
- Over-the-counter medications that are medically necessary (Dr. prescription required)
- Hearing aids, batteries and exams
- Prosthetic, orthopedic, and orthotic devices
- Acupuncture, chiropractic, and physical therapy visits
- Vision care (exams, glasses, contacts, Lasik surgery)
- Dental care (including orthodontia)

Ineligible Health Care Expenses

- Over-the-counter medications not medically necessary
- Cosmetic expenses
- Massage therapy
- Health clubdues
- Weight loss programs
- Insurance premiums

Flexible Spending Accounts (FSA)

Dependent Care FSA

A Dependent Care Account can be used to pay for certain child/day care, or elder care expenses incurred during the plan year. Your dependent care expenses must be necessary in order for you and your spouse to work or actively look for work or attend school as a full-time student.

Eligible Dependent Care Expenses

- Childcare for a dependent age 13 or less, provided at a day care center or through a private provider
- Childcare for a dependent over age 13 if he/she is physically or mentally incapable of caring for him or herself
- Nanny services in the home associated with the care of a dependent
- Day camps associated with the care of a dependent
- Pre-school tuition that is day care related (price of tuition alone is not eligible)
- After-hours care that results from working odd hours or overtime

Ineligible Dependent Care Expenses

- Tuition cost for pre-school that is not associated with day care services, or for first grade and above
- Housekeeper/nanny services in the home that is not associated with care of a dependent
- Education related fees for classes or camps not associated with care of a dependent
- Entertainment related expenses
- Materials fee (i.e. books, clothing, food, etc.)
- After-hours care not associated with work

Dependent Care claims will be reimbursed only up to your account's current balance. If a dependent care expense exceeds the dependent care balance, you will be reimbursed the additional amount as contributions are made to your account through your payroll deductions.

Telemedicine

Cigna provides access to telehealth services through MDLIVE as part of your medical plan. Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. You can connect with a board-certified doctor via video chat or phone, without leaving your home or office.

Choose when: Day or night, weekdays, weekends, and holidays
Choose where: Home, work or on the go
Choose how: Phone or video chat

Say it is the middle of the night and your child is sick. Or you are at work and not feeling well. If you pre-register, you can speak with a doctor for help with:

› sore throat
› headache
› stomachache
› fever
› cold and flu
› allergies
› rash
› acne
› UTIs and more

The cost savings are clear.

Telehealth visits with MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, your telehealth services are only available for minor, non-life-threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

Choose with confidence.

MDLIVE uses quality national telehealth providers, so you can choose your care confidently. When you cannot get to your doctor, Cigna Telehealth Connection is here for you.

MDLIVE is only available for medical visits. For covered services related to mental health and substance abuse, you have access to the **Cigna Behavioral Health** network of providers.

› Go to Cignabehavioral.com to search for a video telehealth specialist

› Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

Signing up is easy!

- Set up and create an account with MDLIVE
- Complete a medical history using their "virtual clipboard"
- Download vendor apps to your smartphone/mobile device**
- Register today so you will be ready to use a telehealth service when and where you need it

	MDLive
Website	www.mdliveforcigna.com
Contact Number	888-726-3171
Telephonic Option	Yes
Video Chat Option	Yes
Prescription issuing available	Yes

MDLive services are charged based on plan benefits. The total cost can change from year to year and is also based on the plan you are enrolled in. Use the mycigna.com tool to see your cost share for MDLive services. Follow these steps once the mycigna.com tool is launched:

- Click **Talk to a Doctor**
- Click **Connect** in the **Medical** section
- Select the appropriate patient to view cost share for each MDLive service.

** Availability may vary by location and plan type and is subject to change. See vendor sites for details.
** The downloading and use of any mobile app is subject to the terms and conditions of the mobile app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Dental Insurance

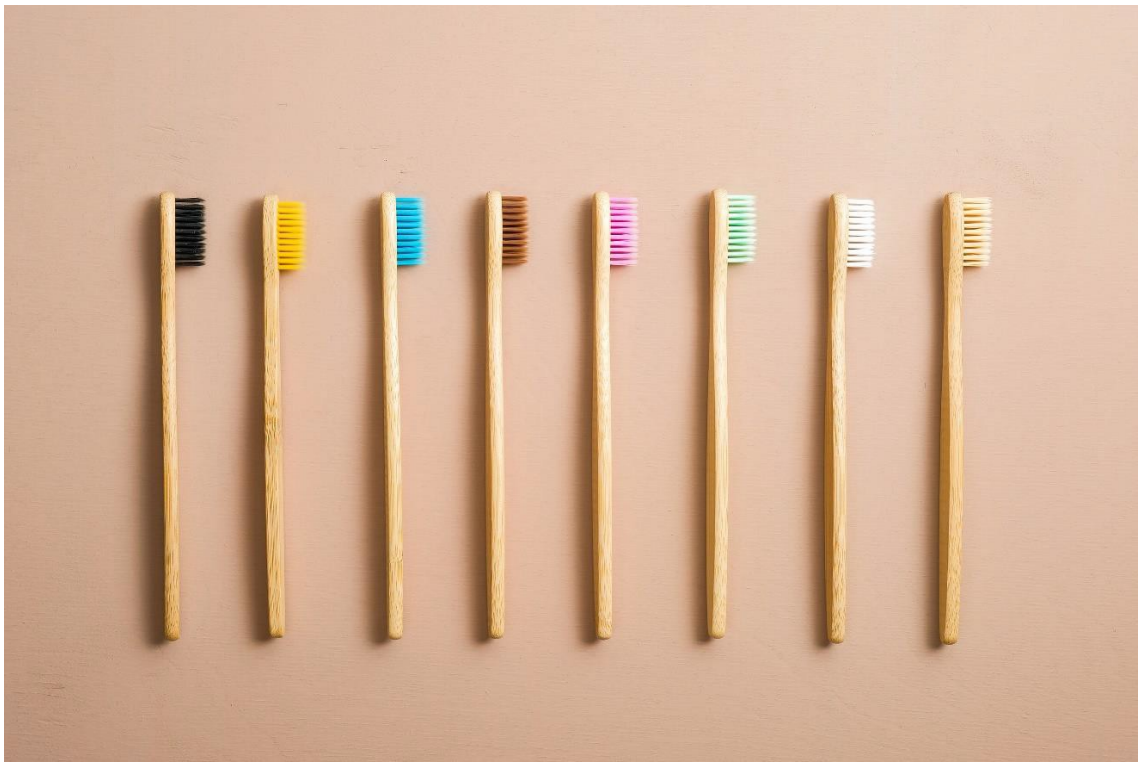
Delta Dental

The Delta Dental PPO Plus Premier plan provides access to two of Delta Dental's extensive national networks – Delta Dental PPO, with more than 283,000 dentist locations and Delta Dental Premier, the largest dental network in the country with more than 358,000 dentist locations. You will enjoy great benefits when you receive your dental care from a participating dentist in either the Delta Dental PPO or Delta Dental Premier networks.

- Both networks offer discounted fees and a no balance billing policy.
- You will receive good value from Delta Dental Premier network dentists who generally accept discounted fees but will be subject to the out-of-network co-insurance level shown in the Coverage Summary.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists and will receive the in-network co-insurance level shown in the Coverage Summary.

If you choose to receive services from a non-participating dentist, you will have higher out-of-pocket costs as the Delta Dental contract rates and the no balance billing policy do not apply.

Simply visit www.deltadentalma.com to find a participating dentist in your area.



DELTA DENTAL®

Delta Dental PPO℠ *Plus Premier*

Visit **deltadentalma.com** for detailed benefit information

Coverage Summary for Milton CAT Group #015734

Deductible: $50 per individual/$150 per family. Deductible waived for Diagnostic and Preventive categories.
Calendar Year Maximum: $1,500 per person.

Category / Procedure	Qualifications	PPO Network	Premier & Out of Network*
Diagnostic		100%	100%
Comprehensive Evaluation	Once every 60 months.		
Periodic Oral Exam	Twice every 12 months.		
Panoramic or Full Mouth X-rays	Once every 60 months.		
Bitewing X-rays	Twice every 12 months.		
Single Tooth X-rays	As needed.		
Preventive		100%	100%
Teeth Cleaning	Twice every 12 months.		
Fluoride Treatments	Twice every 12 months for members under age 19.		
Space Maintainers	Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth.		
Sealants	Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants also covered for members age 16 up to age 19 with a recent cavity and are at risk for decay.		
Restorative		80%	80%
Silver Fillings	Once every 24 months per surface per tooth.		
White Fillings	Once every 24 months per surface per tooth.		
Inlays	Once every 60 months per tooth, inlays are processed as a silver filling and the patient is responsible for the difference between the silver filling and the Delta Dental of MA negotiated fee for an inlay, where permitted by state law. In other states, the patient may be responsible for paying up to the provider's full submitted charge for an inlay.		
Protective Restorations	Once per tooth.		
Stainless Steel Crowns	Once every 24 months per tooth (on primary teeth only).		
Oral Surgery		80%	80%
Extractions	Once per tooth.		
General Anesthesia	General Anesthesia and IV sedation allowed with covered surgical impacted wisdom teeth only (up to one hour).		
Periodontics (on natural teeth only)		80%	80%
Periodontal Surgery	One surgical procedure per quadrant in 36 months.		
Scaling and Root Planing	Once in 24 months, per quadrant. No more than 2 quadrants per date of service.		
Periodontal Cleaning	4 times every 12 months following active periodontal treatment. Not to be combined with preventive cleaning.	100%	100%
Bone Grafts/GTR	No more than 2 teeth per quadrant per 36 months on natural teeth.		
Endodontics		80%	80%
Root Canal Treatment	Once per tooth.		
Root Canal Retreatment	Once per tooth after 24 months have elapsed from initial treatment		
Vital Pulpotomy	Limited to deciduous teeth.		
Prosthetic Maintenance		80%	80%
Bridge or Denture Repair	Once per bridge/denture per 12 months, after 24 months of initial insertion.		
Crown or Onlay Repair	Once per tooth per 12 months after 24 months of initial placement		
Rebase or Reline of Dentures	Once per denture within 36 months.		
Recement of Crowns & Onlays, Bridges	Once per crown, onlay or bridge.		
Emergency Dental Care		80%	80%
Palliative Treatment	Three occurrences in 12 months.		
Prosthodontics		50%	50%
Dentures	Once within 60 months (age 16 and older).		
Fixed Bridges	Once within 60 months (age 16 and older).		
Implants	Once per 60 months per Implant. (Pre-estimate recommended).		
Implant Abutments	Once per implant only when surgical implant is benefitted.		
Major Restorative		50%	50%
Crowns or Onlay	When teeth cannot be restored with regular fillings. Once within 60 months per tooth (age 12 and older).		
Cast Posts/Buildups	Once per tooth per 60 months only benefitted to retain a crown.		
Orthodontics: Covered at 50% of Maximum Plan Allowance charges up to age 19. $1,200 separate LIFETIME maximum. Orthodontic treatment must be administered/ supervised by a licensed dentist			

Additional Benefit Information

Deductible waived for periodontal cleanings.
This plan is eligible for Rollover Max. See the benefit guide for details.
Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds $300. This will help you estimate any out-of-pocket expenses you may incur and will confirm that the services are covered under your dental coverage.

*Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non- participating maximum plan allowance and the full fee charged by the dentist.

Delta Dental PPO *Plus Premier*

DELTA DENTAL®

Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental PPO *Plus Premier* subscriber, you have access to two of Delta Dental's extensive national networks—Delta Dental PPO, with more than 283,000 dentist locations and Delta Dental Premier, the largest dental network in the country with more than 358,000 dentist locations. Three out of four dentists nationwide participate in one or both of these networks.

You will enjoy great benefits when you receive your dental care from a participating dentist in either the Delta Dental PPO or Delta Dental Premier networks.

- Both networks offer discounted fees and a no balance billing policy.
- You will receive good value from Delta Dental Premier network dentists who generally accept discounted fees, but will be subject to the out-of-network co-insurance level shown on the front of this summary.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists and will receive the in-network co-insurance level shown on the front of this summary.

If you choose to receive services from a non-participating dentist, you will have higher out-of-pocket costs as the Delta Dental contract rates and the no balance billing policy do not apply.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at http://www.deltadentalma.com/members/discounts-on-covered-services/

Simply visit **www.deltadentalma.com** to find a participating dentist in your area.

Learn more at deltadentalma.com

Visit the member area of **www.deltadentalma.com** to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 1-800-872-0500.

You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at **www.deltadentalma.com**. In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:
Delta Dental of Massachusetts
1-800-872-0500
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

SP566 (6.20)

Vision Insurance

Vision benefits through EyeMed offer more than just an eye exam. You also receive benefits that help you save on your favorite eyewear or contacts, Lasik eye surgery, and more.

EyeMed has an extensive network of doctors along with facilities such as LensCrafters, Pearle Vision and Target. If you already have an eye doctor and you want to know if he or she is participating with EyeMed, you may call the doctor directly or contact EyeMed at (866) 800-5457. Be sure to refer to the "Insight" Network. To check providers online go to https://eyemed.com/en-us.

Below is a summary of benefits. A comprehensive summary can be found on the PlanSource benefits portal.

In addition to this, members enrolled in our Cigna medical plan have access to one eye exam each year. This exam is offered at no cost providing an in-network provider is used.

	In-Network Your Cost	Out-of-Network Reimbursement
Exams	$10	Up to $50 reimbursement
Retinal Imaging	Up to $39	Not Covered
Contact Lens Fit and Follow-Up Standard Premium	$40 10% off retail price	Not Covered Not Covered
Frame Any available frame at provider location	$0 copay; 20% off balance over $130	Up to $104 reimbursement
Standard Plastic Lenses **Lens Options** **Contact Lenses**	See EyeMed Summary of Benefits	See EyeMed Summary of Benefits
Frequencies of Benefit Exam & Lenses (or Contacts) Frames	(Plan allows member to receive either contacts and frame, or frames and lens services) Once every calendar year Once every other calendar year	
In-Network Discounts Available	40% off prescription sunglasses 20% off non-prescription sunglasses Hearing Care from Amplifon NetworkCare Lasik or PRK from U.S.	

Out of Network services – all out of network services are paid out of pocket by the member. Submitting a claim form with a copy of your receipt will allow EyeMed to reimburse you up to the maximum reimbursement amount.

Basic Life and AD&D Insurance

Milton provides company-paid Basic Life/Accidental Death & Dismemberment (AD&D) Insurance through The Standard to assist you and your family in the event of a loss.

	Salaried, Non-Union Hourly	MA/RI Machinists & Teamsters Unions	NH/VT Union, Scarborough, ME Union-Like	Brewer, ME Union
	All Benefits for full time employees begin on the 31st day of employment (30 day waiting period.)			
Benefits Summary				
Benefits Life Amount	1x annual salary up to $150,000 (minimum $50,000)	$50,000	$50,000	1x annual salary up to $50,000
Benefits AD&D Amount	1x annual salary up to $150,000 (minimum $50,000)	$20,000	$50,000	2x annual salary up to $100,000
Benefits Reduction Schedule	To 65% at age 67; To 50% at age 72	To 65% at age 67; To 50% at age 72	To 65% at age 67; To 50% at age 72	To 65% at age 67; To 50% at age 72
Accelerated Death Benefits	6 months; 50%	6 months; 50%	6 months; 50%	6 months; 50%
Conversion Privilege	Included	Included	Included	Included
Portability Privilege	Included	Included	Included	Included

Important Note: To ensure your assets are distributed according to your wishes, be sure to assign a beneficiary or living trust.

Voluntary Life and AD&D Insurance

You may purchase Voluntary Life and/or Accidental Death and Dismemberment Insurance for you and your eligible dependent through The Standard in the amounts shown below. Your cost of the Voluntary Life insurance is based on your age and the amount of coverage requested. Your spouse's cost of the Voluntary Life is based on their age and amount of coverage requested. The rates for employee and dependent coverage are outlined below. Payroll deductions are deducted on an after-tax basis.

Voluntary Life	
	Benefits Election Schedule
- Employee	Choice of $10,000 increments up to $800,000 (limited to 5 xs your annual salary)
- Spouse	Choice of $5,000 increments up to $250,000 (not to exceed 100% of employee amount)
- Child(ren)	$10,000 Children are defined as those live birth up to age 26
Guaranteed Issue Amount (GI) & Evidence of Insurability Rules (EOI)	
Guarantee Issue Amounts: Employee: $150,000 / Spouse: $30,000 Guarantee issue is the amount of coverage The Standard will guarantee you and/or your spouse. Any amounts exceeding the guarantee issue amount will require the employee and/or spouse to complete an evidence of insurability form which will then need to be approved by underwriting. Evidence of Insurability (EOI) is also needed if you are a late entrant and electing more than 1 or 2 increments of coverage. Late entrants are those who declined coverage when it was first offered.	
Enrollment / Election	
As mentioned above, you can elect voluntary life when you are first eligible or annually during each open enrollment. If you wish to avoid going through the evidence of insurability (EOI) process, you must stick to the guidelines as set forth by The Standard. To elect coverage with no EOI, see the guidelines below. Please refer to your Standard certificate of coverage for full details.	
- For new enrollees who are first-time eligible	Elect as many increments as desired but do not exceed the guarantee issue amount.
- New enrollees who are not first- time eligible (late entrant)	Elect 1 or 2 increments but do not exceed the guarantee issue amount.
- For existing enrollees who wish to increase coverage	Elect 1 or 2 increments but do not exceed the guarantee issue amount.
Voluntary AD&D (for Employees Only)	
	Benefits Election Schedule
Employee	Choice of $10,000 increments up to $800,000 (limited to 5 times your annual salary)

Important Election Reminders:

- You can increase your Life coverage by 1 or 2 increments ($10,000 or $20,000) with no proof of medical insurability providing your elected amount does not exceed the guarantee issue amount of $150,000.
- You can increase your Spouse coverage by 1 or 2 increments ($5,000 or $10,000) with no proof of medical insurability providing your elected amount does not exceed $30,000.
- Voluntary AD&D does not come with medical evidence insurability requirements so you can increase by as many increments as desired up to the maximum limit.

Important Notice:

- You must purchase coverage for yourself to purchase for your spouse and/or children.
- Milton CAT Group #166507

Disability Insurance

In the event you are unable to work as a result of an illness or injury, the company provides disability insurance through The Standard. The plans offer income protection and will replace a portion of your earnings while you are unable to work.

Short Term Disability (STD)

Benefits	The Standard					
Definition	**Salaried**	**Non-Union Hourly**	**ME Union**	**ME Union-Like and NH/VT Union**	**MA/RI Union**	**Milton Rents Union**
Waiting Period	Benefit eligibility for full-time employees begin on the 31st day of employment (30 day waiting period.)					
Benefits Percentage	66.67%	66.67%	60.00%	60.00%	66.67%	N/A
Benefits Maximum (Weekly)	$2,000	$1,250	$500	$400	$600	N/A
Benefits Start (Accident/Illness)	31 days/31 days	1 day/8 days	1 day/8 days	1 day/8 days	1 day/8 days	N/A
Benefits Duration	22 weeks	26 weeks	13 weeks	26 weeks	26 weeks	N/A
Premiums Paid By	Employer	Employer	Employer	Employer	Employer	N/A

Long Term Disability (LTD)

Benefits	The Standard				
Definition	**Salaried**	**Non-Union Hourly**	**ME Union**	**ME Union-Like and NH/VT Union**	**Milton Rents Union**
Waiting Period	Benefit eligibility for full-time employees begin on the 31st day of employment (30 day waiting period.)				
Benefits Percentage	60.00%	60.00%	60.00%	60.00%	N/A
Benefits Maximum (Monthly)	$10,000	$5,000	$2,000	$2,000	N/A
Pre-Existing Conditions	12 months	12 months	12 months	12 months	N/A
Elimination Period	180 days	180 days	90 days	180 days	N/A
Benefits Duration	Social Security Normal Retirement Age	Social Security Normal Retirement Age	Social Security Normal Retirement Age	Social Security Normal Retirement Age	N/A
Premiums Paid By	Employer	Employer	Employer	Employer	N/A

LTD Benefits received are reduced by other income received such as Workers Compensation and Social Security.

Voluntary Benefits

ACCIDENT INSURANCE PLAN

Voya Accident Insurance can help you be financially prepared in the event of an on-or-off-the job accidental injury. This money can help offset your out-of-pocket costs due to an accident.

- Accident insurance pays you Benefits for specific injuries and events resulting from a covered accident including, but not limited to, ambulance services, emergency treatment, MRIs/CT/CAT, EEG scans, therapy, fractures, dislocations, and more
- Includes an annual wellness benefits that pays an annual benefit if you complete your annual preventive care (medical, dental or vision visits)
- Benefits are paid directly to you on a per occurrence basis
- Spouse and Dependent Child(ren) coverage is also available
- Employees can choose between a Low Option or High Option

This plan is portable, so you may continue coverage if you leave the company.

CRITICAL ILLNESS INSURANCE PLAN

Voya Critical Illness Insurance pays you a lump-sum benefits if you are diagnosed with a covered disease or condition. You can use this money however you like.

- Coverage includes critical illnesses such as Heart Attack, Stroke, End Stage Renal (Kidney) Failure, Major Organ Failure, Invasive Cancer, Skin Cancer, and more
- Includes an annual wellness benefits that pays an annual benefit if you complete your annual preventive care (medical, dental or vision visit)
- Benefits are paid directly to you on a per occurrence basis
- Employees can choose between a Low Option or High Option
- Spouse and Dependent Child(ren) coverage is also available
- Rates are based on whether you're a tobacco user or non-tobacco user
- The rate issued to you at time of enrollment never changes, even as you age, providing you don't change plans in the future
- Benefits are limited to one payment per occurrence; however, the policy has a recurrence benefits where, under some circumstances, the benefits could pay out again

This plan is portable, so you may continue coverage if you leave the company.

Life Services Toolkit

Provided by The Standard for Term Life and Accidental Death and Dismemberment Insurance. The program provides assistance and resources to you, your family and your beneficiaries. Services include:

- Estate Guidance Will Preparation
- Financial Planning
- Funeral Arrangements
- Identity Theft Online Resources
- Beneficiary Support up to one year after a loss, six in-person sessions for grief counseling, or legal and financial information and unlimited phone counseling.

Visit www.standard.com/mytoolkit (username “assurance”) for information and tools.

Beneficiary support can be found by visiting www.standard.com/mytoolkit (username “support”) or call the assistance line at 1-800-378-5742.

Health Advocate Select

Fortunately, you do not have to take on the healthcare system by yourself. While you are out on a short-term disability claim, you can connect with a Personal Health Advocate who’ll help you navigate the complexities of the healthcare system. Simply take advantages of Health Advocacy Select, a service that is included with your group Short Term Disability insurance through The Standard. Some ways they can help you are:

- Assistance with understanding your medical benefits so you can take full advantage
- Make sense of your diagnosis and research treatment options
- Find and schedule appointments with the right doctors
- Manage your out-of-pocket expenses by finding alternative services and cost information
- Locate post pregnancy support in the event of a difficult delivery or when complications arise
- Resolve medical claims and billing issues
- Find resources for services that may not be covered through your employer’s health benefits program

Personal Health Advocates are available Monday – Friday, 8am – 11pm ET at 1-800-450-5543.

Emergency Travel Assistance

The Standard provides Travel Assistance through Assist America to employees and their household family members when traveling more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains
- Connection to medical care providers, interpreter services, local attorneys, and assistance in coordinating bail bond
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children
  if left unattended due to prolonged hospitalization
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded
- Evacuation arrangements in the event of a natural disaster, political unrest, and social instability

For assistance from the United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda, contact 1-800-872-1414. Contact 1-609-334-0807 from anywhere else. You can also text 1-609-334-0807 or email medservices@assistamerica.com.

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

Reference Number:
01-AA-STD-5201

Download on the App Store

GET IT ON Google Play

Make the Most of Your Future

Are you headed toward a comfortable retirement? Our company-sponsored retirement savings plan through Fidelity Investments can be your ticket to a brighter financial future – whether your destination's a long way off or just around the bend. Consider your 401k contributions as part of overall benefit package to provide you with long-term financial security.

Fidelity 401k Savings Plan

Your 401k savings plan is one of the best ways to save for your retirement and we encourage you to take advantage of that benefit.

Eligible Employees

Full time non-union employees and Scarborough union-like employees.

401k Match

The company offers a match of 100% of your first 3% of contributions and a match of 50% of contributions beyond 3%, up to a maximum annual employer match of $5,000.

Match Dates

Employer match dates are credited each payday and are fully vested immediately.

Changing Contribution Amounts

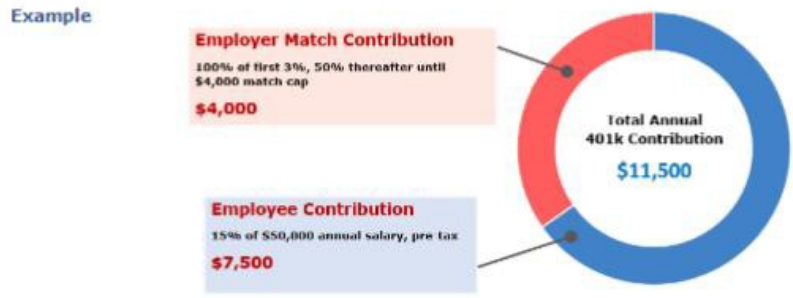
You can change your contributions anytime throughout the year at www.401k.com. Please note it can take up to two pay periods before the change goes into effect.

401k Contribution Limits

The 2025 contribution limits are $23,500 for those 49 and under, and those 50 and older can contribute an additional 7,500 or a total of $30,000 (typically called catch-up contributions).

How to Enroll

Log into www.401k.com, choose Get Started, and choose Enroll Now.



Focus on Wellness

Dana Farber Cancer Institute – Direct Connect

If you or your family are faced with a cancer diagnosis, the Direct Connect team can provide streamlined access and care coordination tailored to our individual situation. The Dana-Farber team will work closely with you and your loved ones to ensure you have what you need throughout your experience. The Dana-Farber Direct Connect program offers a wide range of holistic wellness resources to educate and support patients, families and caregivers. You can access Direct Connect by calling through DirectConnect@dfci.Harvard.edu or by calling 866-977-3262.

Omada for Cigna

Omada for Cigna is a digital lifestyle change program that combines the latest technology with ongoing support so you can make the changes that matter the most – whether that's around eating, activity, sleep, or stress. It's an approach shown to help you lose weight and reduce the risk of type 2 diabetes and heart disease. This program is available to eligible employees and their covered dependents. To see if you or your dependents are eligible, visit omadahealth.com/Miltoncat.

Effective 2/1: Encircle Rx Program by Cigna + Omada: Weight loss GLP1's now covered!

Encircle Rx is a weight management solution that offers GLP-1 weight-loss drug access with enhanced coverage criteria to control costs and optimize lifestyle changes. Did you know that just a 5% loss in weight can ***decrease*** the risk of chronic diseases related to obesity? Encircle Rx helps customers taking GLP-1 medications reach their healthy weight through guidance and support. Please see the next page for more on how GLP-1's will be approved, and for an example of how the solution works.

Employee Assistance Program (EAP)

Our employees and their families continue to be our most valuable resource. Now, more than ever, it is important to focus on our resilience and ensure that our employees and families have the resource they need to manage their overall well-being.

EmployeeConnect, is an Employee Assistance Program (EAP) program available throughout the year to assist you with your everyday needs, at no cost to you. It's all part of our commitment to supporting your well-being. Get help with work-life issues; marriage or family counseling, emotional or mental health assistance, substance use, stress, legal or financial services; and more.

You, your dependents (including children up to age 26) and all household members can connect 24/7 by phone, online, live chat, email, and text. There is even a mobile EAP app.

You can access the EAP program through www.healthadvocate.com/Standard3 or by calling 1-888-293-6948.

Preventative care

Good preventative care can help you stay healthy and detect any "silent" problems early, when they're most likely to be treatable. Most in-network preventative services are covered in full, so there's no excuse to skip them.

Have a routine physical exam each year. You'll build a better relationship with your doctor ad can reduce your risk for many serious health conditions.

Get regular dental cleanings. Studies show a link between regular dental cleanings and disease prevention – including lower risks of heart disease, diabetes and stroke.

See your eye doctor at least once every two years. If you have certain health risks, such as diabetes or high blood pressure, your doctor may recommend more frequent eye exams.

Don't have a Personal Doctor? You should. Here's why.

Better health. Getting the right health screenings each year can reduce your risk for many serious conditions. And remember, preventative care doesn't cost you anything and you can earn incentives.

A healthier wallet. A PCP can help you avoid costly trips to the ER. Your doctor will also help you decide when you really need to see a specialist and can help with coordinating care.

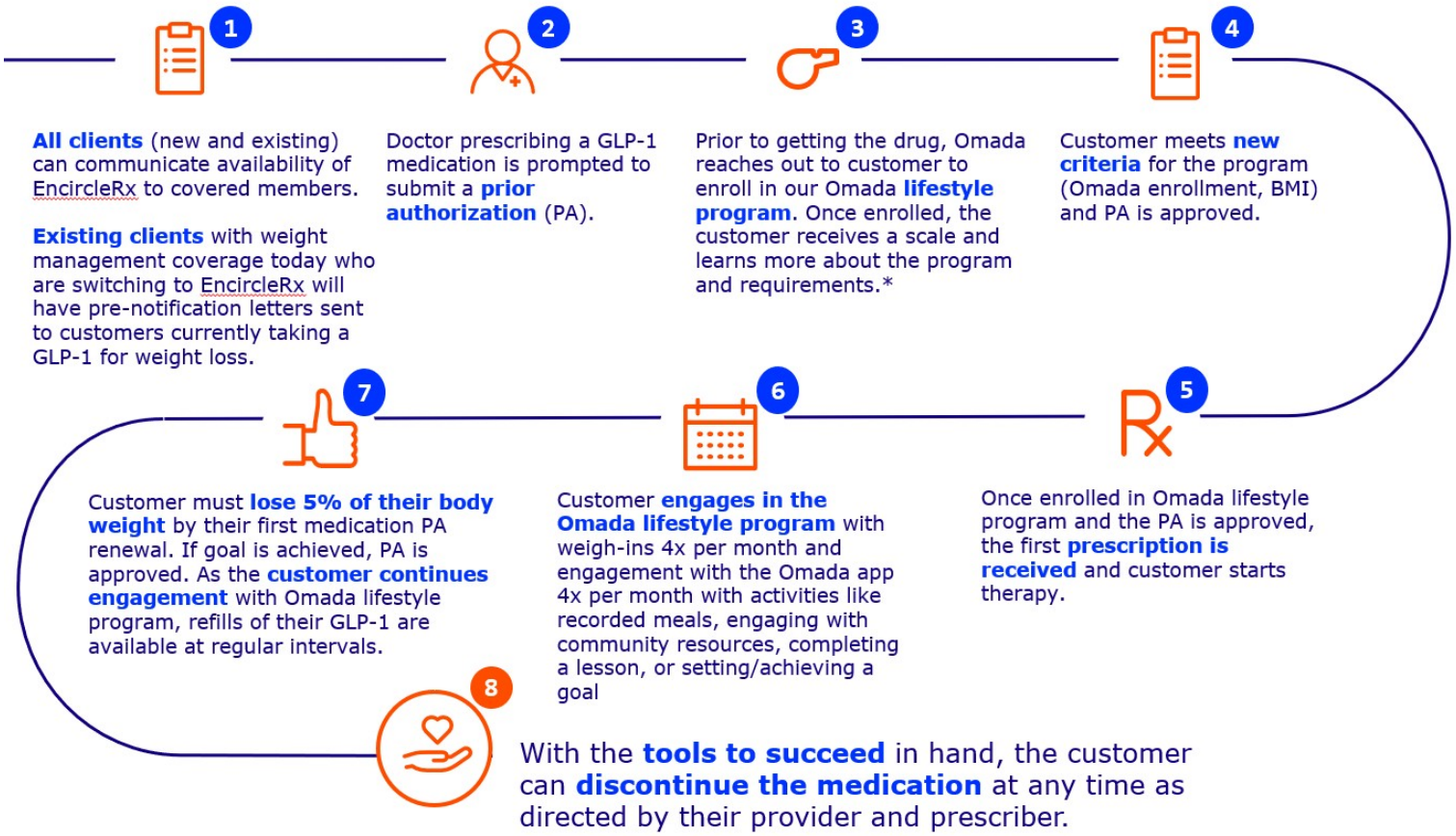
Peace of mind. Advise from someone you trust – it means a lot when you're healthy, but it's even more important when you're sick.

How Encircle Rx Works

Criteria for Encircle RX:

- Saxenda will be approved initially for 4 months
- Wegovy will be approved initially for 7 months
- Zepbound will be approved initially for 8 months

Members must demonstrate 5% body weight loss by the end of the initial authorization period in order to have the reauthorization approved. You only need to prove 5% body weight loss once, after the initial authorization period in order for the drug to be deemed successful.



Benefits Apps

On your mobile phone:

- Download apps from Google Play or the iTunes App Store

With the **Delta Dental App**, members receive quick and easy access to ID cards and are able to search and find a dental provider nearby. The easy-to-use Dental Care Cost Estimator tool provides estimated cost ranges for common dental care needs.

MyCigna with 1-touch fingerprint access. (Medical, Prescription, Flexible Spending Account and Health Spending Account (HSA)). Includes provider directory, coverage details, deductible expenses, account balances, claims information, and more.

PlanSource with touch ID. (Open Enrollment and benefit information). Look up coverages, dependents, effective dates, copays, your ID cards, and so much more.

My Benefits Accounts – WealthCare Mobile. (Flexible Spending Account). View your balances anytime, take a picture of a receipt and upload it to substantiate a purchase, and look at transaction history.

With MDLIVE for Cigna telehealth services, you can get the healthcare you need anytime, anywhere. Our nationwide network of U.S. board certified doctors or pediatricians are ready to assist you with non-urgent medical diagnosis via your MDLIVE for Cigna app 24 hours a day, 7 days a week, and even holidays.

EyeMed gives you access to your benefit information on-the-go. The app also gives you the ability to find savings for an exam, frames from top brands like Ray Ban, Michael Kors, Ralph Lauren, contacts and lenses, check your claims status, download your ID card and have direct access to EyeMed support.

Carrier Contact Information

Carrier	Phone	Website
Cigna **Medical**	Customer Service: 800-997-1654 Coverage and Claims: 800-CIGNA24	https://my.cigna.com/
Dana Farber Cancer Institute **Direct Connect**	866-977-3262	Email: DirectConnect@dfci.Harvard.edu
Delta Dental of Massachusetts **Dental**	800-872-0500	www.deltadentalma.com
EyeMed **Vision**	866-939-3633	www.eyemed.com
The Standard **Life and Disability Insurance**	888-937-4783	www.standard.com
PlanSource **Flexible Spending Accounts**	888-266-1732	https://plansource.wealthcareportal.com/page/home
Voya **Accident & Critical Illness**	800-955-7736	www.voya.com
The Standard **Life Beneficiary Services**	800-378-5742	www.standard.com/mytoolkit username = support
The Standard **Travel Assistance**	For assistance from the United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda, contact 1-800-872-1414. Contact 1-609-334-0807 from anywhere else. You can also text 1-609-334-0807	medservices@assistamerica.com
The Standard **Employee Assistance Program (EAP)**	888-293-6948	www.healthadvocate.com/Standard3
The Standard **Health Advocate Service**	844-450-5543	N/A
The Standard **Absence Management**	866-756-8116 (Group Policy # 166507)	www.standard.com/absence
PlanSource Helpline **Member Support**	877-549-8549 8am-8pm: Eastern M-F	www.PlanSource.com Email: contact.center@plansource.com
Human Resources	508-482-5740	Email: HR@miltoncat.com

Additional information regarding benefits plans can be found on the PlanSource online benefits portal.
Please contact Human Resources to complete any changes to your Benefits that are not related to your initial or annual enrollment.

Important Legal Notices Affecting Your Health Plan Coverage

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 page 9 for more details.

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE − FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Laurin Armendi
100 Quarry Drive
Milford, MA 01757
781-927-8032
laurin_armendi@miltoncat.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from Milton CAT About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Milton CAT 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. Milton CAT has determined that the prescription drug coverage offered by Cigna for the plan year 2025 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, the following options may apply:

- You may stay in the Cigna group health plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
  - During the Medicare prescription drug annual enrollment period, or
  - If you lose Cigna creditable coverage.
- You may stay in the Cigna group health plan and also enroll in a Medicare prescription drug plan. The Cigna group health plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Cigna group health plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Cigna group health plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 Milton CAT 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 or call Cigna at 800-244-6224.

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 Milton CAT changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (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:	01/01/2025
Name/Entity of Sender:	Southworth-Milton, Inc. d/b/a Milton CAT
Contact Position/Office:	Laurin Armendi
Address:	100 Quarry Drive, Milford MA 01757
Phone Number:	781-927-8032

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

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

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

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

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

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

ALABAMA – Medicaid
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 Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

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

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/fssa/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:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
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: https://www.mymaineconnection.gov/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: 1-800-977-6740
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: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 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: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

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

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: 1-800-356-1561
Medicaid 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: Children's Health Insurance Program (CHIP) (pa.gov) 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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services 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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
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 Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
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: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub.L.104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C.3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C.3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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 Employment-Based 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.[2]

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 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 Prog~~ram (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies 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 in that 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 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/getting-medicaid-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:

Name of Entity/Sender: Southworth-Milton, Inc. d/b/a Milton CAT
Contact--Position/Office: Laurin Armendi
Address: 100 Quarry Drive Milford, MA 01757
Phone Number: (781) 927-8032

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	4. Employer Identification Number (EIN)	
Southworth-Milton Inc. d/b/a Milton CAT	20258444	
5. Employer address	6. Employer phone number	
100 Quarry Drive	(781) 927-8032	
7. City	8. State	9. ZIP code
Milford	MA	01757
10. Who can we contact about employee health coverage at this job?		
Laurin Armendi		
11. Phone number (if different from above)	12. Email address	
	Laurin_armendi@miltoncat.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Regular full-time employee who is actively working a minimum of 30 hours per week and are not covered by a union-sponsored healthcare plan.

  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Legal Spouse, Dependent children to age 26.

  - [ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Summary of Benefits and Coverage (SBCs)

The Summary of Benefits and Coverage (SBC) document shows you how you and the plan would share the cost for covered health care services. Full copies of the SBC's can be found at Plansource.com

***Note*: This does not include any employee payroll contributions.**