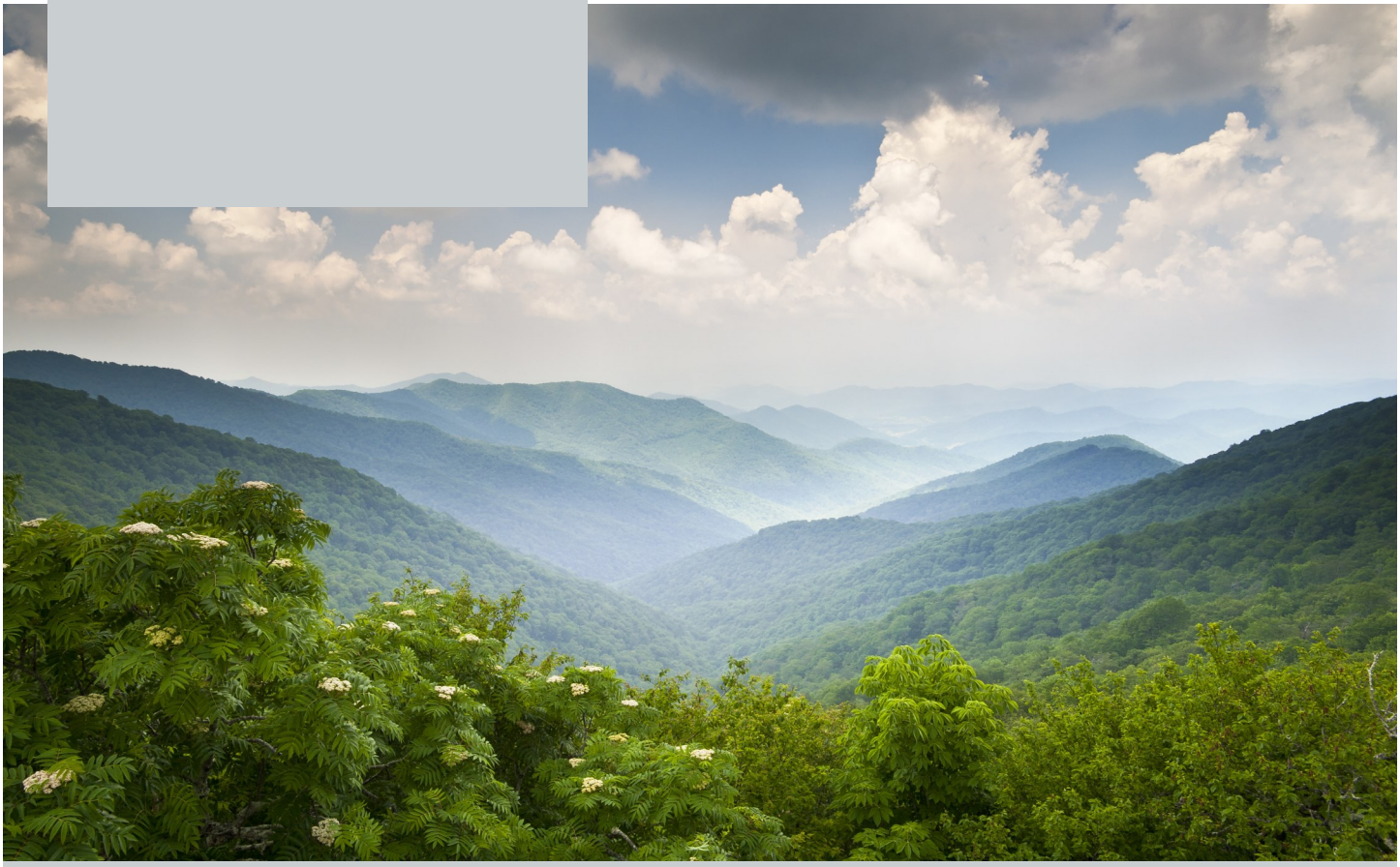
Benefits Enrollment Guide

2021—2022

Lincotek



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Enrollment Checklist

Information You Need to Know:

- ☐ You can enroll in benefits during your initial enrollment period as a newly eligible associate, during Annual Open Enrollment, or if you experience a Qualifying Life Event (QLE).
- ☐ The plan year is December 1, 2021— December 31, 2022
- ☐ **Please Note January 1, 2023 Change**: *The plan year will move to a January 1, 2023 effective date at the end of December 31, 2022. Your medical deductible and out of pocket maximum will run for those 13 months, not resetting until the new effective date of January 1, 2023.*
- ☐ Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your Employer and the change is permitted under the plan terms. Examples of these Qualifying Life Events (QLEs) are found on the next page.
- ☐ Before enrollment begins, take the time to educate yourself on all of the benefit options that are available to you. Review this Benefits Guide carefully as you consider your plan choices.
- ☐ If you are electing coverage for your eligible dependents, proof of dependent eligibility may be required.

Current Employees:

- ☐ Actively enroll between November 8 , 2021 and November 12, 2021.
- ☐ Verify your 2021-2022 benefits elections and deductions on the first paycheck you receive after your December 1 effective date to confirm everything is correct. If you see any errors, notify Human Resources immediately, otherwise corrections will not be honored.

New Hires:

- ☐ Be sure to make your elections **before your benefits effective date**. If you do not make elections, then you may not be able to enroll until the next open enrollment period.
- ☐ When you elect certain benefits, you may receive an ID card in the mail. Your ID card contains important information about you, your employer group and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.
- ☐ If you need to replace your ID card, or need an additional card, you can request another by contacting the carrier or by visiting the carrier's website online to print another copy.
- ☐ Verify your 2021-2022 benefits elections and deductions on the first paycheck you receive after your December 1 effective date to confirm everything is correct. If you see any errors, notify Human Resources immediately, otherwise corrections will not be honored.

If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices for your prescription drug coverage. See page 27 in the Required Annual Notices section for more details.

Eligibility & Enrollment

Lincotek is proud to offer a comprehensive program of benefits to service the diverse needs of our workforce, and we are committed to continually enhancing and expanding our offerings. The information in this document is meant to familiarize you with the benefits and programs currently in place. During the Annual Open Enrollment period, the benefits you elect will be effective December 1, 2021. For new hires, benefits are effective the first of the month following 30 days of continuous employment. Please remember that this guide is not intended to cover all provisions of all plans, but rather is a quick reference tool to help answer most of your basic questions. Please see each carrier's benefits Summary Plan Description or Certificate of Coverage for complete details of the benefits.

Am I Eligible?

Eligibility and required contributions for these benefits and programs depend on both your employee classification and whether you elect to extend coverage to your dependents.

Individuals eligible for coverage under the plans include:

- Your legal spouse
- Your dependent child(ren) up to age 26, regardless of full-time student status or marital status
- Your unmarried child(ren) of any age who, prior to age 26, has been declared incapable of self-support due to mental or physical disability

Once eligible, you will enroll in benefits using an online portal called Ultipro.

Qualifying Life Events (QLE)

Once you have made your benefit elections and your enrollment is closed, you cannot make changes until the next open enrollment period unless you experience a QLE such as:

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan
- Gain or loss of eligibility for CHIP or Medicare*

*You have 30 days from the date of the QLE to notify Human Resources and provide appropriate documentation to change your benefits. The exception to this rule is in the case of CHIP or Medicare benefits which allow a 60-day notification period.

Please note: Not every QLE permits a change in benefit plan elections. A change in election is permitted only when it is determined that the QLE affects eligibility for coverage of the employee, a spouse or a dependent under a benefit plan and in accordance with Section 125 regulations.

Plan	Eligibility	Benefits Effective Date
Medical & Prescription	Full-time, actively at work and scheduled to work 30+ hours per week	Benefits are effective the first day of the month following 30 days of employment
Dental		
Vision		
Flexible Spending Accounts (FSA)		
Healthcare Savings Account (HSA)		
Basic & Voluntary Life		
Long-Term Disability		
Voluntary Short-Term Disability		
Accident and Critical Illness		
EAP/Travel Assistance		

Medical Insurance– PPO Plan

Lincotek medical and prescription drug insurance is provided through Aetna. Below is a brief summary of the PPO Plan. In order to make the best use of your benefits and out-of-pocket expenses, we strongly encourage the use of in-network providers, Tier 1 drugs whenever possible, and Urgent Care facilities instead of Emergency room visits when appropriate.

Aetna PPO Plan — 1500 Plan		
Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Calendar Year Deductible Individual / Family	$1,500/$3,000	$3,000 / $6,000
Calendar Year Out-of-Pocket Maximum Individual / Family	$4,500 / $9,000 (includes deductible, coinsurance and copays)	$9,000 / $18,000 (includes deductible, coinsurance and copays)
Coinsurance	20%	40%
Preventive Care Services*	100% covered, no charge	30% after deductible
Primary Care Office Visit (in-person or virtual)	$25 copay	30% after deductible
Specialist Office Visit	$50 copay	30% after deductible
Urgent Care Facility	$50 copay	30% after deductible
Emergency Room	$350 copay	$350 copay
Inpatient Services	20% after deductible	40% after deductible
Outpatient Services	20% after deductible	40% after deductible
Prescription Drugs	**Retail (up to 30-day supply)**	**Mail Order (up to 90-day supply)**
- Tier 1 / Generic - Tier 2 / Preferred Brand Name - Tier 3 / Non-Preferred Brand Name - Tier 4 / Specialty	$15 copay $35 copay $85 copay 30% to a maximum of $250	20% of submitted cost; after network cost share 20% of submitted cost; after network cost share 20% of submitted cost; after network cost share 20% of submitted cost; after network cost share

*You can find a list of preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ When both preventive and diagnostic or therapeutic services occur at the same visit, members will pay a cost share for the diagnostic or therapeutic services. Additionally, when a preventive service turns into a diagnostic or therapeutic service in the same visit, the appropriate cost sharing will apply.

Medical Insurance– HDHP Plan

Lincotek medical and prescription drug insurance is provided through Aetna. Below is a brief summary of the High Deductible Health Plan (HDHP). If you elect this plan option, you may also participate and contribute to a Health Savings Account (HSA). However, you may ***not*** participate in a Health Care FSA plan, unless it is a Limited Purpose FSA. In order to make the best use of your benefits and out-of-pocket expenses, we strongly encourage the use of in-network providers, Tier 1 drugs whenever possible, and Urgent Care facilities instead of Emergency room visits when appropriate.

Aetna HDHP Plan — 2000 Plan		
Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Calendar Year Deductible Individual / Family	$2,000 / $4,000	$4,000 / $8,000
Calendar Year Out-of-Pocket Maximum Individual / Family	$4,000 / $8,000 (includes deductible, coinsurance and copays)	$8,000 / $16,000 (includes deductible, coinsurance and copays)
Coinsurance	100%	40%
Preventive Care Services *	100% covered, no charge	30% after deductible
Primary Care Office Visit (in-person or virtual)	10% after deductible	40% after deductible
Specialist Office Visit	10% after deductible	40% after deductible
Urgent Care Facility	10% after deductible	40% after deductible
Emergency Room	10% after deductible	10% after deductible
Inpatient Services	10% after deductible	40% after deductible
Outpatient Services	10% after deductible	40% after deductible
Prescription Drugs	**Retail (up to 30-day supply)**	**Mail Order (up to 90-day supply)**
- Tier 1 / Generic - Tier 2 / Preferred Brand Name - Tier 3 / Non-Preferred Brand Name - Tier 4 / Specialty	$15 copay after deductible $35 copay after deductible $85 copay after deductible 30% to a maximum of $250 after deductible	20% of submitted cost; after network cost share 20% of submitted cost; after network cost share 20% of submitted cost; after network cost share 20% of submitted cost; after network cost share

*You can find a list of preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ When both preventive and diagnostic or therapeutic services occur at the same visit, members will pay a cost share for the diagnostic or therapeutic services. Additionally, when a preventive service turns into a diagnostic or therapeutic service in the same visit, the appropriate cost sharing will apply.

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Aetna HDHP Plan — 5000 Plan		
Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Calendar Year Deductible Individual / Family	$5,000 / $10,000	$10,000 / $20,000
Calendar Year Out-of-Pocket Maximum Individual / Family	$5,000 / 10,000 (includes deductible, coinsurance and copays)	$10,000 / $20,000 (includes deductible, coinsurance and copays)
Coinsurance	100%	30%
Preventive Care Services *	100% covered, no charge	30% after deductible
Primary Care Office Visit (in-person or virtual)	100% after deductible	30% after deductible
Specialist Office Visit	100% after deductible	30% after deductible
Urgent Care Facility	100% after deductible	30% after deductible
Emergency Room	100% after deductible	100% after deductible
Inpatient Services	100% after deductible	30% after deductible
Outpatient Services	100% after deductible	30% after deductible
Prescription Drugs	**Retail (up to 30-day supply)**	**Mail Order (up to 90-day supply)**
- Tier 1 / Generic - Tier 2 / Preferred Brand Name - Tier 3 / Non-Preferred Brand Name - Tier 4 / Specialty	100% after deductible 100% after deductible 100% after deductible 100% after deductible	20% of submitted cost; after network cost share 20% of submitted cost; after network cost share 20% of submitted cost; after network cost share 20% of submitted cost; after network cost share

*You can find a list of preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ When both preventive and diagnostic or therapeutic services occur at the same visit, members will pay a cost share for the diagnostic or therapeutic services. Additionally, when a preventive service turns into a diagnostic or therapeutic service in the same visit, the appropriate cost sharing will apply.

When and Where to Get Health Care

Telehealth Virtual Visits

- Average wait time: 5 minutes
- Available 24/7/365
- Basic physician care from your PC, phone, laptop or tablet

Retail Health Clinics

- Average wait time: 15 minutes
- Available extended hours
- Basic care from a nurse practitioner

Primary Care Physician

- Scheduled visits
- Diagnose & treat a range of issues for the whole family
- Refer you to the right care when you need a specialist

Urgent Care Clinic

- Average wait time: 45 minutes
- Immediate quality care on a walk-in basis when your doctor is unavailable

Emergency Room

- Average wait time: 4 hours
- Available 24/7/365
- Emergency care when your life or health is threatened

Things to think about

- Non-emergency care delivered in the ER costs 5 times more than in a doctor's office or clinic
- Research studies indicate that between 8-27% of ER visits could have been treated in a less expensive care setting
- ER doctors do not typically have your full medical history, so they must order expensive tests to determine a diagnosis and course of treatment.
- Patients, when possible, should be treated by their primary care physician for non-emergency conditions in order to promote consistent, preventive and quality care.

Prescription Drug Plan Highlights

National Preferred Formulary Drug List

A preferred drug list helps keep healthcare costs down for everybody. It's a list of medicines that have been reviewed and approved for safety, effectiveness and cost by a panel of doctors and pharmacists. This list is continually reviewed and updated as new medicines become available.

Generic Drug Program

At Wal-Mart, Sam's Club, Target, and Walgreens you can get generics that are on their "**approved"** list for a lower cost than your normal drug copay. Some of them offer $4.00 per prescription, per month. This list is available on each of their respective websites (Walmart.com, Samsclub.com, Target.com, Walgreens.com) for further information.

Mail Order Program

The mail order program offers the convenience of obtaining home delivery of certain covered maintenance Prescription Drugs and Related Supplies through designated mail order Pharmacies. You can save money and take advantage of 24/7 access to a pharmacist. Order refills online, on the phone, or register for auto-refills. For more information contact Aetna at 888-Rx-Aetna.

Dispense as Written

When your doctor writes a prescription for you or a covered family member, unless the doctor specifically designates "DAW" (Dispense As Written), the pharmacist will dispense a generic medication, if one is available. Your doctor must write DAW on your prescription to avoid incurring a higher cost. Always talk to your doctor about what is right for you and your family.

Prior Authorization (PA)

The PA Program encourages safe and cost-effective medication use. The program applies to certain high-cost drugs that have the potential for misuse. Before medications in the PA Program can be covered under your benefit plan, your doctor will need to receive approval. If you are already taking or are prescribed a drug from the PA listing, your doctor must submit a request for consideration for coverage.

Step Therapy

Step Therapy helps you choose the most cost effective and appropriate medicine for certain medical conditions. The first step in the step therapy process, "first-line therapy," is usually a simple, inexpensive treatment that is known to be safe and effective for most people. First-line therapy is usually a generic drug in the same therapy class. If the first-line therapy does not work, the next step is to try second-line therapy.

Specialty Pharmacy

A specialty pharmacy provides medicine and therapy for patients with serious, chronic conditions like cancer, rheumatoid arthritis and hepatitis C. These medications normally have to be stored or handled in special ways. Your Specialty Pharmacy offers specialized teams of pharmacists, nurses and clinicians who are specially trained on your condition. This level of specialization gives you the most comprehensive and customized care available. Specialty medications ***must*** be filled through the specialty pharmacy.

Mobile Apps for Prescription Savings

There are free mobile apps for your iPhone, Android, or Windows phone. These apps will compare prescription drug costs in your area. You provide the drug name and quantity and it compares the costs at various pharmacies in your area. Rx Saver and Good Rx are just two available mobile apps.

Partnership for Prescription Assistance

As the cost of prescription drugs rise, Partnership for Prescription Assistance (PPA) is a free service that connects individuals with payment assistance programs for prescriptions and other medical supplies. PPA provides a single point of access to more than 475 patient assistance programs. For a full list of patient assistance programs visit **www.pparx.org/**.

Health Savings Account (HSA)

If you enroll in the **5,000** High Deductible Health Plan (HDHP), you should consider contributing to a Health Savings Account (HSA), administered by Aetna. With an HSA, you can gain more control over your health care expenses because contributions, interest and withdrawals for qualified health care expenses are all tax-advantaged. **This plan is not available for those enrolled in a PPO Plan.**

Why have an HSA?

- If you elect the **5,000** High Deductible Health Plan (HDHP) and select an HSA, the Company will contribute to your HSA annually
- Contributions are pre-tax
- Withdrawals to pay for eligible expenses are never taxed
- Accumulated interest earnings are tax-deferred, and if used to pay for eligible expenses, are not taxed upon withdrawal
- Use the money in the account to pay for eligible health care expenses throughout your life– including retirement, there is no time limit on spending your HSA funds
- The balance in your HSA account can be invested

Eligibility Requirements for Contributing to an HSA:

- Must be enrolled in a High Deductible Health Plan (HDHP)
- Must not be enrolled in Medicare
- Must not be covered by other medical insurance(s) which do not meet the definition of a HDHP such as a Health Care Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA), Tricare, VA benefits (including your spouse's)
- May not be claimed as a dependent on another individual's tax return

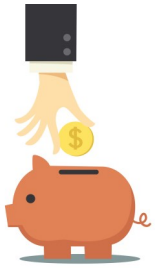
Health Savings Account (HSA)			
Coverage Level	**IRS 2022 Contribution Limits***	**EMPLOYER 2022 Contribution**	**Employee 2022 Maximum Contribution****
Employee Only	**$3,650**	**$500**	**$3,150**
Employee + Spouse	**$7,300**	**$1,000**	**$6,300**
Employee + Child(ren)	**$7,300**	**$1,000**	**$6,300**
Family Coverage	**$7,300**	**$1,000**	**$6,300**

*If you are married and your spouse is enrolled in an HDHP and has an HSA, the combined total of you and your spouse's HSA cannot exceed the federal maximum for family level coverage.

**If you are age 55 or older, you may make an additional pre-tax catch-up contribution of $1,000 per year.

All HSA participants will receive an HSA debit card from Aetna. Use your Debit Card for doctor's office visits, prescription drug copays, or any other valid medical, dental or vision expenses. Please retain all receipts to verify expenses, if required.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.



Flexible Spending Accounts (FSAs)

Lincotek continues to offer Health Care and Dependent Care Flexible Spending Accounts (FSAs), administered by our new carrier Flores. FSAs allow you to pay for eligible health care and dependent care expenses with pre-tax dollars which can increase your take-home pay. The Dependent Care FSA is offered to everyone, no matter what medical plan you may be covered under, through Lincotek or elsewhere.

There are three types of FSAs to choose from:

Health Care FSAs may be used to pay for eligible medical, prescription, dental and vision expenses not fully covered by your insurance plans for you and your tax eligible dependents. If you are enrolled in the HDHP Plan, you are not eligible to participate in the Health Care FSA.

Limited Purpose FSAs are available to those who are enrolled in a qualified High Deductible Health Plan (HDHP). Limited Purpose FSAs can only be used for eligible dental and vision expenses. When coordinated with an HSA, this account can further reduce your taxable income while allowing you to allocate your HSA funds to other purposes, including medical costs.

Dependent Care FSAs may be used to pay for eligible expenses related to the care and supervision of your child (to age 13) or adult dependent on your tax return. Eligible expenses include child or adult daycare, after school care, nursery school, nanny or babysitter. You must accumulate the funds in your Dependent Care FSA before you can be reimbursed.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.

2022 IRS Contribution Limits	Minimum	Maximum	Rollover
Health Care FSA	$100	$2,750	$550
Limited Purpose FSA	$100	$2,750	$550
Dependent Care FSA	$100	$5,000 (or $2,500 if married and filing separately)	N/A

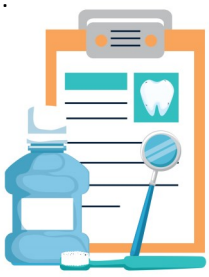
FSA Rollover: Flores allows participants to carry over up to $550 in unused money in the Health Care and/or Limited Purpose FSA at the end of the plan year to be used to reimburse expenses incurred in the next year. Any amount in excess of $550 will be forfeited, so plan accordingly.

Dental Insurance

Lincotek dental plan is administered by Lincoln. There You may continue to seek treatment from the dentist of your choice, but you will always realize your biggest savings by visiting in-network providers whenever possible. The chart below provides a summary of your dental benefits.

Dental Plans				
	Low Plan—Orthodontia Not Included		High Plan– Orthodontia Included	
Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Calendar Year Deductible Individual / Family	$50 / $150	$50 / $100	$50 / $150	$50 / $100
Calendar Year Maximum	$1,000	$1,000	$1,500	$1,500
Preventive Services (Covered services include oral exams, cleanings and x-rays)	Covered at 100%, not subject to deductible	Covered at 100%, not subject to deductible*	Covered at 100%, not subject to deductible	Covered at 100%, not subject to deductible*
Basic Services (fillings, root canals, endodontics, extractions)	20% after deductible	20% after deductible*	20% after deductible	20% after deductible*
Major Services (inlays, onlays, periodontics, bridgework, dentures)	50% after deductible	50% after deductible*	50% after deductible	50% after deductible*
Rollover Benefit	If total in-network claims per individual do not exceed $600, Lincoln will rollover $350 to the following year annual maximum. At least one eligible claim must be filed during the year. The maximum rollover amount is $1,000.	If total in-network claims per individual does not exceed $600, Lincoln will rollover $250 to the following year annual maximum. At least one eligible claim must be filed during the year. The maximum rollover amount is $1,000.	If total in-network claims per individual do not exceed $800, Lincoln will rollover $500 to the following year annual maximum. At least one eligible claim must be filed during the year. The maximum rollover amount is $1,250.	If total in-network claims per individual does not exceed $800, Lincoln will rollover $350 to the following year annual maximum. At least one eligible claim must be filed during the year. The maximum rollover amount is $1,250.
Orthodontia	Not Covered	Not Covered	50% with a lifetime maximum of $1,000	50% with a lifetime maximum of $1,000
Waiting Period	None	None	None	None

*Out of network claims will paid at 80% of Usual & Customary. Usual & Customary charges are based on prevailing cost of services with geographic areas for the insurance company.



Vision Insurance

Lincotek vision plan is administered by Lincoln, utilizing the Spectera network of providers. You may seek treatment from the provider of your choice, but you will realize your biggest savings by visiting in-network providers whenever possible. Please see the summary below for an outline of covered services.

Vision Plan		
Services	**In-Network (You Pay)**	**Out-of-Network* (You Pay)**
Eye Exam	$10 copay	Up to $40
Standard Lenses (instead of contacts) - Single - Bifocal - Trifocal - Lenticular	 $25 copay $25 copay $25 copay $25 copay	 Up to $40 Up to $60 Up to $80 Up to $80
Frames (instead of contacts)	$130 allowance, then 30% discount	Up to $45
Contact Lenses (instead of glasses) - Elective—select brand - Elective— non select brand - Medically Necessary**	 $25 copay Up to $125 allowance Covered in full	 Up to $125 Up to $125 allowance Up to $210
Frequency - Exam - Lenses - Contacts - Frames	Based on Date of Service 12 months 12 months 12 months 12 months	

*Out-of-network amounts are reimbursed to member.

** Contact lenses may be deemed medically necessary when vision cannot be corrected with glasses due to extreme vision problems, contact lenses will be deemed elective when vision can be corrected by glasses but contacts are worn.

Cost of Coverage

Aetna Medical– PPO Plan	Bi-Weekly Deduction
Employee Only	$59.81
Employee + Spouse	$301.68
Employee + Child(ren)	$240.44
Family	$466.70

Aetna Medical– HDHP 2000 Plan	Bi-Weekly Deduction
Employee Only	$20.04
Employee + Spouse	$202.20
Employee + Child(ren)	$161.15
Family	$324.55

Aetna Medical– HDHP 5000 Plan	Bi-Weekly Deduction
Employee Only	$0.00
Employee + Spouse	$118.31
Employee + Child(ren)	$94.29
Family	$203.36

Lincoln Dental Plans	Bi-Weekly Deduction Low Plan	Bi-Weekly Deduction High Plan
Employee Only	$5.23	$7.62
Employee + Spouse	$10.18	$15.07
Employee + Child(ren)	$12.83	$20.02
Family	$19.35	$29.88

Lincoln Vision Plan	Bi-Weekly Deduction
Employee Only	$2.45
Employee + Spouse	$4.62
Employee + Child(ren)	$5.43
Family	$7.64

Life and AD&D Insurance

Basic Life Insurance

Lincotek provides full-time employees with Basic Term Life and Accidental Death and Dismemberment (AD&D) Insurance administered through Lincoln. Please remember to review and update your beneficiary designation annually.

Benefit	Basic Life and AD&D Insurance
Employee Life	1x your base annual earnings minimum $50,000, up to a maximum of $300,000
Basic AD&D Amount	Matches Employee Life amount
Age Reduction Schedule	35% at age 65 additional 25% at age 70
Waiver of Premium	Yes, if disabled prior to age 60
Conversion	Included (must apply within 31 days of termination date)

Voluntary Life and AD&D Insurance

Lincotek is offering employees who would like to supplement their Basic Term Life and AD&D insurance benefits the opportunity to purchase additional coverage through Lincoln. You may elect Voluntary Life & AD&D for yourself, your spouse and your dependents in the amounts shown in the table below. Please note, you must elect Voluntary Life for yourself in order to enroll your spouse and/or eligible dependents. Dependent children are eligible for coverage through age 26.

Benefit	Voluntary Life and AD&D Insurance
Employee Life and Matching AD&D Amount	Increments of $10,000 up to the lesser of 5x annual salary or $500,000
Employee Guarantee Issue Amount	$200,000 For employees age 70 & over, maximum coverage is $50,000
Spouse Life	$5,000 increments up to the lesser 2.5 times the employee's annual salary or 50% of the employee's benefit amount up to $250,000
Spouse Guarantee Issue Amount	$30,000
Employee, Spouse & Child AD&D	**Employee**: Increments of $10,000 up to the lesser of 5x annual salary to $500,000 **Spouse**: Increments of $5,000 up to the lesser 2.5 times the employee's annual salary or 50% of the employee's benefit amount or $250,000 **Child**: 14 days—6 months $1,000; 6 mths to age 26, $10,000
Dependent Child Life	$0—1 day to 14 days $250—14 days to 6 months $2,000 increments to $10,000 max—age 19 or 26 if student
Age Reduction Schedule	65% at age 65 50% at age 70
Waiver of Premium	Yes, if disabled prior to age 60
Conversion and Portability Options	Included (must apply within 31 days of termination date)

Voluntary Life and AD&D Insurance	
Employee/ Spouse Age	**Monthly Premiums (per $1,000)**
<25	$0.053
25-29	$0.063
30-34	$0.085
35-39	$0.095
40-44	$0.106
45-49	$0.158
50-54	$0.243
55-59	$0.454
60-64	$0.698
65-69	$1.343
70-74	$2.177
75+	$2.177
AD&D Rate per $1,000	Employee—$0.020, Spouse & Child—$0.032
Child Life Rate per $1,000	$0.213

Voluntary Short-Term Disability

Voluntary Short-Term Disability

Disability benefits protect a portion of your income in the event of any injury, accident or illness that keeps you from working.

Employees have the option to purchase Voluntary Short-Term Disability (STD) Benefits through Lincoln. Benefits are provided in the event of becoming disabled for more than 8 days due to a non-work related illness, or on day one in the case of a non-work related accident or injury. The plan pays 60% of an eligible employees' pre-disability base weekly earnings, to a maximum of $2,500 per week for a qualified disability.

Benefit Detail	Voluntary Short-Term Disability
Elimination Period	8 days for accident or illness
Benefits Duration	13 weeks
Benefit Percentage	60% of weekly income
Maximum Benefit	$2,500 per week
Pre-Existing Conditions *	Pre-existing conditions may not be covered by this plan

**A pre-existing condition is a condition, regardless of cause, for which a medical device, diagnosis, care or treatment was recommended or received in the 12 months prior to your enrollment date. The plan will not pay benefits for any pre-existing conditions that result in disability during your first 12 consecutive months of coverage.*

Voluntary Short-Term Disability	
Employee Age	**Monthly Rate per $10 of weekly benefit**
< 29	0.499
30-34	0.499
35-39	0.499
40-44	0.521
45-49	0.535
50-54	0.544
55-59	0.558
60-64	0.605
65-69	0.626
70+	0.651

Voluntary Short-Term Disability

Sample Premium Calculation

Voluntary STD Rate $0.30
Yearly Salary $30,000
Weekly Income ($30,000 / 52 weeks) $576.92
Weekly Benefit Amount ($576.92 x **60%**) $346.15
Monthly Premium ($346.15 x $0.30 / $10 of benefit) $10.38
Weekly Premium ($10.38 x 12 months / 52 weeks) $2.40
OR Semi-Monthly Premium ($10.38 x 12 / 24 pay periods) $5.19

Long-Term Disability

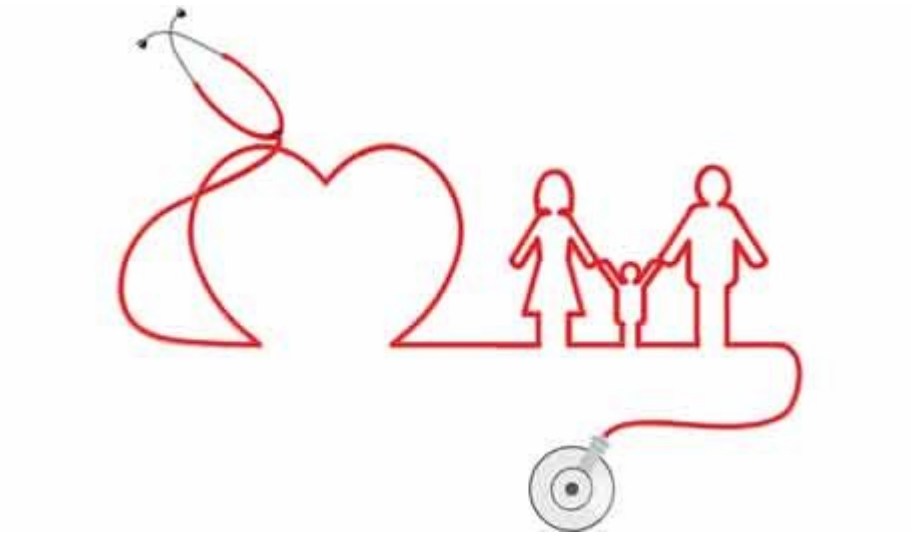
Long-Term Disability

Long-Term Disability (LTD) Benefits provide continued protection if you are still deemed disabled when STD benefits are exhausted, or for a specified period of time for a qualified disability if you did not elect STD coverage.

Lincotek provides all full-time eligible employees with Long-Term Disability Benefits administered through Lincoln. There is no cost to you for this valuable coverage. Benefits are provided on the 90th day of disability, payable up to Social Security Normal Retirement Age (SSNRA). Income loss is replaced at 60% of your base monthly earnings, to a maximum of either $6,000 or $10,000 per month for a qualified disability.

Benefit Detail	Long-Term Disability
Waiting Period	90 days
Benefits Duration	Benefits are paid to the later of either age 65 or Social Security Normal Retirement Age (SSNRA)
Benefit Percentage	60% of monthly income
Maximum Benefit	$6,000 Active Full-time employees earning less than $120K $10,000 Active Full-time employees earning $120K or more
Definition of Disability	Loss of duties and earnings
Pre-Existing Conditions	Pre-existing conditions may not be covered by this plan

**A pre-existing condition is a condition, regardless of cause, for which a medical device, diagnosis, care or treatment was recommended or received in the 3 months prior to your enrollment date. The plan will not pay benefits for any pre-existing conditions that result in disability during your first 12 consecutive months of coverage.*



Additional Benefits

Employee Assistance Program (EAP)

We all face difficulties in our life. During those times, having outside help can make the difference between solving a problem and continuing to struggle through periods of confusion, indecision and personal crisis. Lincotek is pleased to offer an Employee Assistance Program (EAP) administered by a new carrier this year Lincoln. Your EAP gives you confidential access to a licensed professional counselor who will provide short-term assistance with issues that are having an impact on your life and ability to focus on work. Some highlights of the EAP include:

- Unlimited confidential telephone access to EAP professionals 24/7
- Face-to-face sessions with a counselor may be available
- Legal assistance and financial services
- Access to an online library of educational articles and resources

Your Licensed Professional Counselor can help address:

- Anger, grief, loss, depression
- Job stress, burnout, work conflicts
- Marital relationships, family and parenting issues
- Addiction, eating disorders, mental illness
- And much more!

Website
GuidanceResources.com
Download the GuidanceNow mobile app
User Name: LFGSupport
Password: LFGSupport1

Phone
888-628-4824

Travel Assistance Program

Our Travel Assistance program through TravelConnect can provide assistance if an employee or eligible family member has an emergency while traveling. Assistance from a multi-lingual professional is just a toll-free phone call away. Services are available to employees and family members on any single trip up to 90 days in duration. Be sure to understand the plan coverage and limitations. This program is available at no cost to you and can help with:

- Arranging travel if you're injured and need emergency medical evacuation to a medical facility.
- Managing travel for a companion and/or your dependent children, including transportation expenses and accommodations of a qualified escort.
- Planning and paying for a safe evacuation because of a natural disaster, or a political or security threat.
- Arranging transportation of a deceased traveler.
- Securing emergency pet boarding and/or return and vehicle return.

mysearchlightportal.com
Enter Group ID #:LFGTravel123
Phone:
Call Collect from anywhere in the world:
+1-603-328-1955
Call toll free from U.S. or Canada:
866-525-1955

Voluntary Critical Illness

Lincotek provides eligible full-time employees with the opportunity to purchase Critical Illness Insurance through Lincoln. You pay the full cost of this coverage. Critical Illness insurance helps you cover the costs associated with being diagnosed with a specified condition. The table below outlines some of the conditions that are covered, as well as the benefit amount. The benefit is paid as a lump sum to you.

Benefit Category	Condition	Percentage of Payout
Heart/Circulatory	Heart Attack Heart Transplant Stroke	100%
Organ	Major Organ Transplant End Stage Renal Failure	100%
Cancer	Cancer (Invasive)	100%
	Carcinoma in Situ Benign Brain Tumor	25%

Benefit	Voluntary Critical Illness
Employee	$10,000, $15,000, $20,000
Spouse (under age 70)	$5,000, $7,500, $10,000 not exceed 50% of employee benefit
Dependent Child	Birth to 26 years- $2,500, $5,000, $10,000 not to exceed employee
Guarantee Issue Amount	Employee- $20,000 Spouse- $10,000 Child- $10,000

Monthly Rates	
Age	**Employee/Spouse Rate per $1,000 of Monthly Benefit**
< 24	$0.189
24-29	$0.264
30-34	$0.353
35-39	$0.514
40-44	$0.853
45-49	$1.417
50-54	$2.093
55-59	$2.883
60-64	$4.174
65-69	$5.973
70+	$5.973
Child(ren)	$0.344

Voluntary Accident

Lincotek provides eligible full-time employees with the opportunity to purchase Accident Insurance through Lincoln. You pay the full cost of this coverage. Accident Insurance helps you cover the costs associated with being in a covered accident. The table below highlights some of the accidents and conditions that are covered, as well as the benefit amount. This benefit is paid as a lump sum to you.

Initial Care and Emergency	
Emergency Room	$150 within 72 hours of accident
Major Diagnostic Exam	$150 within 60 days of accident
Initial Physician Office Visit	$75 within 60 days of accident
Ambulance	$225 ground/$1,125 air within 90 days of accident
Specified Injuries	
Concussion	$150 within 72 hours of accident
Severe Traumatic Brain Injury	$5,000 within 90 days of accident
Lacerations	$35 - $400 within 72 hours of accident
Burns	Up to $10,000 within 72 hours of accident
Dental Crown/ Dental Extraction	$150 / $75 within 7 days of accident
Hospital, Surgical and Diagnostic	
Admission	$1,000 within 180 day of accident
Daily Confinement	$200 per day within 180 days of accident (up to 365 days)

Lincoln Accident Insurance	Base Plan Monthly Rate	Sickness Hospital Benefits Monthly Rate Additional Cost
Employee Only	$9.99	$9.76
Employee + Spouse	$16.33	$23.03
Employee + Child(ren)	$17.51	$21.76
Family	$23.77	$33.09

Worksite Insurance Options

Lincotek offers employees the option of purchasing Accident, Critical and Optional Sickness Hospital Illness through Lincoln. Coverages are available for you, your spouse and/or dependent children.

With the Open Enrollment period for your 2021-2022 plan year benefits comes opportunities to enroll in Lincoln's additional insurance coverages as listed below.

- You may enroll in the new Critical Illness option, which includes cancer coverage during annual enrollment.
- You may enroll in the new Accident or Hospital Indemnity Insurance during annual enrollment.

Critical Illness

- Employee benefit options: $10,000, $15,000 or $20,000
- Spouse benefit options: $5,000, $7,500 or $10,000 not to exceed 50% of the employee benefit amount
- Child benefit options: $2,500, $5,000 or $10,000 not to exceed 50% of the employee benefit amount
- Guarantee issue: Employee $20,000 / Spouse $10,000 / Child - All Amounts
- Portable
- Examples of covered conditions: cancer, heart failure, end stage renal failure, major organ failure, brain tumor, and many more...

Accident Insurance

- 24 Hour Coverage
- Pays a set amount based on the injury and treatment received
- No medical questions or exams in order to be covered
- Coverage options: Employee, Employee & Spouse, Employee & Child(ren), or Family
- Portable

Optional Sickness Hospital Benefits

- Hospital Admission: $500 per insured per calendar year
- Hospital Confinement: $100 per day, up to 365 days maximum per calendar year
- ICU Confinement: $200 per day, up to 15 day maximum per calendar year
- Pre-existing limitation of 12 months prior / 12 months covered
- Coverage options: Employee, Employee & Spouse, Employee & Child(ren), or Family

Contact Information

Service	Vendor/Contact	Phone Number	Website/Email
Human Resources	**Stefano Paternuosto** **Colleen Dykins**	828-328-8726 828-578-9167	stefano.paternuosto@lincotek.com colleen.dykins@lincotek.com
Medical Plan or Prescription Drugs	**Aetna**	888-266-5519	www.myaetnawebsite.com
Health Savings Account (HSA)	**Aetna**	888-266-5519	www.myaetnawebsite.com
Flexible Spending Account (FSA)	**Flores**	800-532-3327	www.flores247.com
Dental	**Lincoln**	800-423-2765	www.lincoln4benefits.com
Vision	**Lincoln**	800-440-8453	www.lincoln4benefits.com
Life	**Lincoln**	800-423-2765	www.lincoln4benefits.com
Disability	**Lincoln**	800-423-2765	www.lincoln4benefits.com
Critical Illness & Accident	**Lincoln**	877-815-9256	www.lincoln4benefits.com

Find the nearest Retail Health Clinic locations at:

- **www.ccaclinics.org/membership/clinic-locations**
- **www.cvs.com/minuteclinic/clinic-locator**
- **www.walgreens.com/pharmacy/healthcare-clinic/locations**
- **www.riteaid.com/shop/info/pharmacy/services/rediclinic**

The information in this Enrollment Guide is presented for illustrative purposes and was taken from various summary plan descriptions and benefit information. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health

Terminology Tip Sheet

Patient Protection and Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Annual Limit: A cap on specific benefits your insurance plan will pay for services in a year while you're enrolled in a particular health insurance plan. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for that particular service for the rest of the year.

Out-of-Pocket Maximum: The most a Plan member must pay towards covered medical expenses in a benefit period for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the remainder of the benefit period.

Coinsurance: Your share (a percentage) of costs of a covered health care service you must pay after you have met your deductible.

Copayment: A fixed amount ($20, for example) you pay for a covered health care service.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest. Many plans pay for in-network preventive care before you meet your deductible or may pay the balance for a service, after you pay a copayment, prior to satisfying the deductible. Some of your dental options also have a deductible, generally for basic and major dental care services only.

Brand Formulary Drugs: The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Generic Drugs: These drugs are usually the most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non-formulary brand name drugs.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Non-Formulary Drugs: These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of-pocket cost to you.

Specialty Drugs: Prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions. Injectable drugs are an example of Specialty Drugs.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. These providers agree to accept pre-determined rates when servicing members, and will cost you the least out-of-pocket.

Qualifying Life Event: An occurrence that qualifies the subscriber to make an insurance coverage change, most often to pre-tax benefits, outside of Open Enrollment.

For a full glossary of terminology visit: https://www.healthcare.gov/glossary/

Required Annual Notices

Women's Health and Cancer Rights Act Enrollment Notice

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. The deductibles and coinsurance that apply can be found on pages 5-7 of this guide.

If you would like more information on WHCRA benefits, call your Plan Administrator Stefano Paternuosto, HR Manager at 828-328-8726.

Newborns' and Mothers' Health Protection Act Model Language

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).

Required Annual Notices– CHIP

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).**

State	Program	Website	Phone Number
Alabama	Medicaid	http://myalhipp.com/	1-855-692-5447
Alaska	Medicaid	The AK Health Insurance Premium Payment Program: http://myakhipp.com/ CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861
Arkansas	Medicaid	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
California	Medicaid	http://dhcs.ca.gov/hipp hipp@dhcs.ca.gov	916-445-8322
Colorado	Medicaid and CHiP	https://www.healthfirstcolorado.com/ https://www.colorado.gov/pacific/hcpf/child-health-plan-plus https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	1-800-221-3943 1-800-359-1991 / State Relay 711 1-855-692-6442
Florida	Medicaid	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia	Medicaid	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	678-564-1162 ext 2131
Indiana	Medicaid	http://www.in.gov/fssa/hip/ https://www.in.gov/medicaid/	1-877-438-4479 1-800-457-4584
Iowa	Medicaid and CHIP	https://dhs.iowa.gov/ime/members http://dhs.iowa.gov/Hawki https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas	Medicaid	https://www.kancare.ks.gov/	1-800-792-4884
Kentucky	Medicaid	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KIHIPP.PROGRAM@ky.gov https://kidshealth.ky.gov/Pages/index.aspx https://chfs.ky.gov	1-855-459-6328 1-877-524-4718
Louisiana	Medicaid	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488 (LaHIPP)
Maine	Medicaid	https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 TTY: Maine relay 711 1-800-977-6740

Required Annual Notices – CHIP pg 2

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, 2021. Contact your State for more information on eligibility –

State	Program	Website	Phone Number
Massachusetts	Medicaid and CHIP	https://www.mass.gov/info-details/masshealth-premium-assistance-pa	1-800-862-4840
Minnesota	Medicaid	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri	Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	Medicaid	http://www.ACCESSNebraska.ne.gov	Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
Nevada	Medicaid	https://dhcfp.nv.gov	1-800-992-0900
New Hampshire	Medicaid	https://www.dhhs.nh.gov/oii/hipp.htm	603-271-5218
New Jersey	Medicaid and CHIP	hhttp://www.state.nj.us/humanservices/dmahs/clients/medicaid/ http://www.njfamilycare.org/index.html	609-631-2392 1-800-701-0710
New York	Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	Medicaid	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota	Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma	Medicaid and CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon	Medicaid	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania	Medicaid	https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	1-800-692-7462
Rhode Island	Medicaid and CHIP	http://www.eohhs.ri.gov/	855-697-4347, or 401-462-0311
South Carolina	Medicaid	https://www.scdhhs.gov	1-888-549-0820
South Dakota	Medicaid	http://dss.sd.gov	1-888-828-0059
Texas	Medicaid	http://gethipptexas.com/	1-800-440-0493
Utah	Medicaid and CHIP	https://medicaid.utah.gov/ http://health.utah.gov/chip	1-877-543-7669
Vermont	Medicaid	http://www.greenmountaincare.org/	1-800-250-8427
Virginia	Medicaid CHIP	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp	1-800-432-5924
Washington	Medicaid	https://www.hca.wa.gov/	1-800-562-3022 ext. 15473
West Virginia	Medicaid	http://mywvhipp.com/	1-855-MyWVHIPP (1-855-699-8447)
Wisconsin	Medicaid CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming	Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

Required Annual Notices– Medicare Part D

Medicare Part D – Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lincotek 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. Lincotek has determined that the prescription drug coverage offered by the company is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Lincotek coverage will not will not be affected. Please see your current plan design(s) for a description of current coverage. Your current coverage pays for other medical expenses, in addition to prescription drugs. You will still be eligible to receive all of your current medical and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. However, your prescription benefits will not coordinate with the Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Lincotek coverage, be aware that you and any covered dependents will not be able to get this medical/prescription coverage back until the next annual open enrollment period for the following January effective date of coverage, and/or if a qualifying event or HIPAA special enrollment event occurs.

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

Required Annual Notices– Medicare Part D

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: November 1, 2021

Name of Entity/Sender: Lincotek

Contact: Position/Office: Stefano Paternuosto, HR Manager

Address: 1928 Main Ave SE, Hickory, NC 28602

Phone Number: 828-328-8726

Required Annual Notices– HIPAA SERs

HIPAA 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 towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you 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 after the marriage, birth, adoption, or placement for adoption.

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

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

To request special enrollment or obtain more information, contact Stefano Patermuosto, HR Manager at 828-328-8726.

Notes

Notes


Lincotek