ChemDesign

WE MAKE CHEMISTRY WORK

BENEFITS GUIDE

2024

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This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

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

Eligibility and Enrollment

Eligibility

Who is eligible?

ChemDesign Products, Inc. is proud to offer a comprehensive benefits package to eligible, full-time employees. The complete benefits package is briefly summarized in this booklet. Coverage for your medical, dental, health flexible spending account, ID Theft, Legal, and organ transplant benefits will start on the date of hire. Coverage for vision benefits will start on the first of the month following your date of hire. Coverage for your Basic Life and AD&D, Voluntary Life and AD&D, STD, LTD will start on the first of the month following your date of hire or if you are hired on the first business day of the month, your coverage will begin immediately.

You may enroll your eligible dependents for medical, dental, vision and voluntary life/AD&D coverage.

Eligible dependents include:

- Your legal spouse
- Your children up to age 26 (includes natural child, stepchild, legally adopted child, child placed for adoption, legal guardianship)
- Any dependent child who is incapable of self - support because of a physical disability as long as the child became incapacitated prior to reaching the limiting age of the plan

Enrollment and Changes

All employees must complete benefit enrollment/changes online through our benefit management system, Employee Navigator. One-on-one meetings will be held prior to open enrollment to discuss benefit changes and elections.

Any questions on enrollment are to be directed to the HR Department.

Once elected, your benefits will be effective for the entire benefit plan year (May 1 to April 30). You will have an opportunity to make changes to your benefit elections once a year during the annual enrollment period.

Outside of the annual enrollment period, you may only make changes to your benefit elections if you experience a qualified life event. Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified life event in order to make changes to your benefit elections during the plan year.

Qualified life events include:

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Change in child's dependent status
- Death of your spouse or dependent
- Change in residence due to an employment transfer for you or your spouse
- Significant change in your spouse's coverage

If you have a life event, you must make changes to your benefits within 30 days of the event. Documentation is required for all qualified life events. The change to your benefits must be consistent with the life event.

Upon separation of employment, medical, health flexible savings account, dental, vision and wellness benefits will end at the end of the month. All other health and welfare benefits end immediately.

Medical PPO Plan

Administered by UMR

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way - especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

PPO PLAN	In-Network	Out-of-Network
Embedded Calendar Year Deductible[1]		
Individual	$500	$1,000
Family	$1,000	$2,000
Embedded Calendar Year Out-of-Pocket Maximum[1]		
Individual	$3,600	$7,200
Family	$7,200	$14,400
Services (member pays)		
Preventive Care	0%	40% after deductible
Physician Visit	$35 copay per visit	40% after deductible
Specialist Physician Visit	$60 copay per visit	40% after deductible
Emergency Room	$150 copay per visit plus 20%	$150 copay per visit plus 20%
Urgent Care	$75 copay per visit plus 20%	40% after deductible
Hospital Inpatient Services	20% after deductible	40% after deductible
Hospital Outpatient Services	20% after deductible	40% after deductible
Retail Prescription Drugs[2]		
Tier 1	$20 / $40 / $60 copay	$20 / $40 / $60 copay
Tier 2	$40 / $80 / $120 copay	$40 / $80 / $120 copay
Tier 3	$60 / $120 / $180 copay	$60 / $120 / $180 copay
Specialty[3]	$0 copay or 30%	Not Covered
Mail Order Prescription Drugs		
Tier 1	$50 copay	Not Covered
Tier 2	$100 copay	Not Covered
Tier 3	$150 copay	Not Covered

[1] Embedded means that any combination of family members may help to meet the family OOP maximum and no one person is responsible for more than the individual OOP maximum.
[2] Prescription drug copays are stepped accordingly based on days supply obtained at retail.
[3] Specialty prescription drug copays can range from 0% to 30% under the PrudentRx Program that applies for these kinds of medications. Refer to the SPD for more details.

United Healthcare Choice Plus Network

Save money with generic drugs!

Ask your doctor if it's appropriate to use a generic drug rather than a brand name drug. Generic drugs are less expensive, contain the same active ingredients, and are identical in dose and form as a brand name drug.

Medical HDHP Plan

Administered by UMR

What is a HDHP (High Deductible Health Plan)?

A HDHP plan features lower premiums and higher out-of-pocket costs with deductibles before the plan begins covering costs. A HDHP plan is offered in conjunction with a Health Savings Account (HSA).

The plan includes 100% coverage with no deductible for certain preventive care services as specified by the Affordable Care Act when you see a network provider.

Additional preventive screenings and services may also be covered, depending on factors such as your age, gender and certain chronic conditions.

HDHP PLAN	In-Network	Out-of-Network
Aggregate Calendar Year Deductible[1]		
Individual	$1,600	$3,200
Family	$3,200	$6,400
Embedded Calendar Year Out-of-Pocket Maximum[2]		
Individual	$3,600	$7,200
Family	$7,200	$14,400
Services (member pays)		
Preventive Care	0%	40% after deductible
Office Visit	20% after deductible	40% after deductible
Emergency Room	20% after deductible	20% after deductible
Urgent Care	20% after deductible	40% after deductible
Hospital Inpatient Services	20% after deductible	40% after deductible
Hospital Outpatient Services	20% after deductible	40% after deductible
Retail Prescription Drugs[3]		
Tier 1	$20/$40/$60 copay after ded	$20/$40/$60 copay after ded
Tier 2	$40/$80/$120 copay after ded	$40/$80/$120 copay after ded
Tier 3	$60/$120/$180 copay after ded	$60/$120/$180 copay after ded
Specialty[4]	$0 copay or 30% after ded	Not Covered
Mail Order Prescription Drugs		
Tier 1	$50 copay after ded	Not Covered
Tier 2	$100 copay after ded	Not Covered
Tier 3	$150 copay after ded	Not Covered

[1] Aggregate means that the full family deductible amount must be met before the Plan begins to pay.
[2] Embedded means that any combination of family members may help to meet the family OOP maximum and no one person is responsible for more than the individual OOP maximum.
[3] Prescription drug copays are stepped accordingly based on days supply obtained at retail.
[4] Specialty prescription drug copays can range from 0% to 30% under the PrudentRx Program that applies for these kinds of medications. Refer to the SPD for more details.

United Healthcare Choice Plus Network

You pay out of pocket until you reach the deductible.

When you have an eligible expense, such as a doctor visit when you're sick, you will pay the full cost of your health expenses until you meet your deductible. You can choose to pay from your HSA or pay with cash or credit

Your plan covers cost of covered services.

Once the deductible is paid, your medical plan has 20% coinsurance. This means once you have met your deductible the plan begins to pay 80% and your out of pocket maximum has also been satisfied.

You are protected from major expenses.

An out-of-pocket maximum protects you from major expenses. The out-of-pocket maximum is the most you will have to pay in the plan year for covered health care. Your deductible, coinsurance, medical services and prescription drugs apply toward the out-of-pocket maximum.

About your Medical Coverage

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through ChemDesign.

You have two medical plan options:

- UMR PPO
- UMR HDHP

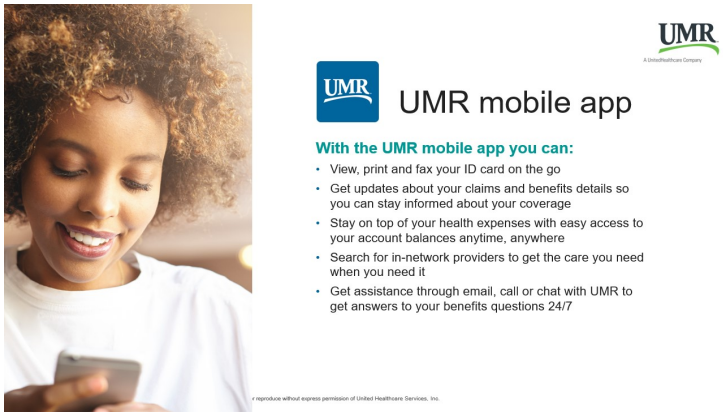
Preferred Provider Organization (PPO): A PPO Plan is a traditional plan that applies copays to certain services prior to your deductible being met. Your deductible will apply to major medical services, however copays may apply for prescription drugs and office visits without needing to first meet a deductible.

High Deductible Health Plan (HDHP): This plan requires that you meet the deductible prior to receiving coverage under this plan, except for certain preventive care services. This means, you will receive a discounted rate on your medical services, however you will be responsible for the total cost of this care until your deductible has been satisfied.

Find a Provider

Go to www.umr.com and click on “Find a provider”, which you can see in the picture to the right.

Then you will be able to find your Provider Network and View Providers.



Medical Key Terms

Annual Deductible: The amount you pay each calendar year for covered healthcare services before the plan begins to pay. For example: with a $500 deductible, you pay the first $500 of covered services (except preventive services or services covered under a copay), then the plan begins to pay.

Copayment: A fixed, flat dollar amount that you pay at the time of your medical care at an in-network provider.

Coinsurance: Once the annual deductible has been met, you will share in the cost of covered services with the plan. The plan will pay a higher percentage of the cost of care when you choose in -network providers.

Out-of-Pocket Maximum: The out-of-pocket maximum is the maximum dollar amount you would pay toward covered in-network medical costs in one plan year out of your own pocket. Once you reach this amount, the plan pays 100% of any additional coverage costs during the remainder of the plan year. Deductibles, coinsurance, office visits and prescription copays count toward the out-of-pocket maximum.

In-Network / Out-of-Network: When you review your medical benefits, you will see that there is a different level of coverage for services in-network and out-of-network. Out-of-network providers may also bill for additional costs outside of the insurance coverage if their billed rates exceed usual and customary amounts.

Care Search Rewards

Administered by UMR

Welcome to CareSearch Reward$

CareSearch Reward$ is a free program that rewards you for using cost-effective, high-quality physicians and facilities for you and your spouses' health care procedures. The program is simple: When you're ready to schedule an eligible procedure, visit umr.com and use the Health Cost Estimator Tool to find a qualifying physician or facility. Then make your appointment. Once you've had the procedure, you'll be rewarded. Using the CareSearch Reward$ program will lower the cost of your claim, and we'll pass that savings on to you.

Available to: Employees and spouses enrolled in ChemDesign's health care plan

Reward Type: Single-Use Prepaid Reward Card

How to find cost savings and be eligible for rewards

Step 1: Visit **umr.com.** Log in with the user name and password of the individual who will be receiving the service and treatment. If the individual is not a registered user, click on **Register.**

Step 2: Click on the **Health cost estimator** tile to access the tool.

Step 3: Click on the **Estimate your care button.**

Step 4: Confirm your zip code then click in the search bar to type in your procedure. Select **"Cost Estimates"** button from the "Find Care by Category" section. Select **"All"** button from the "What would you like a cost estimate for?" section. If you search for a procedure that requires a facility, your search will automatically populate a list of facilities. If your procedure requires an office visit, a physician list will populate. Select the appropriate Services and Treatment from the drop-down box.

Step 5: **If a physician list populates:** Select any **"2 blue hearts"** Premium Care Physician. **If a facility list populates:** Select a **"GREEN"** below average cost facility, clinic or hospital. If the search results do not show any "2 blue hearts" Premium Care Physicians or "Green" facilities, click on Refine Search to expand your location.

Earn cash back when you make good health care choices

The **CareSearch Reward$** program rewards you for choosing high-quality health care providers and lower-cost options. Simply choose a low-cost facility or provider using the Health cost estimator on **umr.com** before your appointment and you'll get dollars back after your procedure. It's that simple – there's nothing else to do to earn your reward.

Questions?

If you have questions, please call the toll-free member services number listed on the back of your UMR ID card or visit umr.com.

Telemedicine

Provided by Teladoc

Teladoc gives you access to U.S. board-certified doctors through convenience of phone, video or mobile app visits 24/7/365. It's an affordable alternative to costly urgent care and ER visits when you need care now.

General Medicine

Talk to a board-certified doctor or pediatrician 24/7 for non-emergency conditions.

- Prescription refills
- Sinus infections
- Allergies
- Stomach bug
- COVID-19 advice
- And more

Mental Health

Talk to a therapist or psychiatrist of your choice 7 days a week from anywhere.

- Stress and anxiety
- Depression
- Trauma
- Grief
- Burnout
- Medication management

Dermatology

Upload images and details of your skin issues in the Teladoc Health app. A dermatologist will review them and provide a treatment plan within 24 hours. Follow up via in-app messaging for 7 days after your results.

- Eczema
- Psoriasis
- Poision ivy
- Rashes
- Rosacea, And More

Chronic Condition Management

NEW

Chronic condition management services give eligible members access to connected health management devices, certified health coaches and mental health coaches. It's offered by Chemdesign at **no cost to you.**

- Diabetes Management
- Hypertension Management
- Diabetes Prevention

Already registered for Teladoc Health?	New to Teladoc Health?
• Simply log-in to your account via the Teladoc Health app or TeladocHealth.com • Select "Condition Management" to discover the support for your needs	• Download the Teladoc Health app or visit TeladocHealth.com and create your account • Once you complete registration, select "Condition Management" to find what benefit fits your needs

	PPO Plan Members	HDHP Plan Members[1]
General Medicine		
Per visit charge	$54	20% after deductible
Mental Health		
Therapist per visit charge	$95	20% after deductible
Psychiatrist first visit charge	$235	20% after deductible
Psychiatrist ongoing visits charge	$105	20% after deductible
Dermatology		
Per online review	$85	20% after deductible

Set up your account or log in to get started today

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Call 1-800-TELADOC (835-2362) | Download the app

Your care. Your way.

Access your Teladoc Health benefits anytime.

Scan the code to activate your benefits

Pharmacy Benefits

Administered by CVS Caremark

Prescription drug benefits are included with ChemDesign's medical plans and are administered by CVS/ Caremark. You can find out information about your prescription drug coverage through the CVS Caremark website at Caremark.com. By registering online and creating an account, you can stay updated on new ways to save.

Advanced Control Formulary

Visit CVS Caremark Advanced Control Formulary to see the current or next quarter's preferred drug list. Under Know What's Covered, click on the applicable list depending on the date you plan to purchase your medication.

- Generics will be reflected on the preferred medication list in *lower case italics*.
- Preferred brand name medications will be reflected on the preferred medication list in ALL CAPS.

Note: Non-preferred brand name medications will not appear on the preferred medication list. Contact Customer Care for more information about cost/coverage of non-preferred options or discuss with your provider if a generic or preferred brand is right for you.

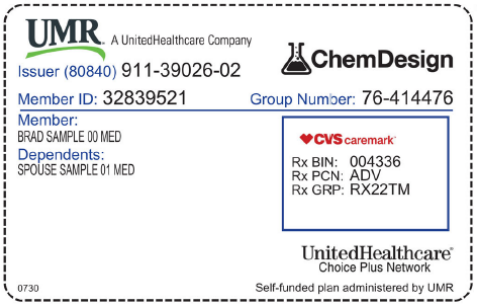
Preventive Drug Lists

All plans provide access to certain preventive drugs at 100% coverage based upon the Affordable Care Act (ACA) requirements. To see which medications are available based upon ACA preventive guidelines at 100% coverage, please visit 106-30561A Member No-Cost Preventive Services Drug List

Tips for Saving on Your Prescription Drugs

- Be sure the retail pharmacy you use is in your network.
- Know which medications are covered.
- Use the Check Drug Cost tool available at Caremark.com.
- Have 90-day supplies delivered by mail or purchase them at any CVS Pharmacy including those inside Target

Register at Caremark.com/StartNow to set up a personal account.



CVS Caremark

Mobile App & Delivery by Mail

The CVS Caremark **mobile app** gives you a secure, simple way to manage your prescription benefits and member information. Find a nearby pharmacy no matter where you are. Learn about your medication and get information you can trust day or night. Do all this – and much more – at your convenience.

- View drug costs and check for lower-cost alternatives / covered medications while you're at your doctor's office so you can jointly determine what medication is right for you
- Find network pharmacies
- Order maintenance medications via mail order, request refills, receive refill reminders and track order status
- Access your drug list, member ID cards and Rx history whenever you need them

Learn more at Caremark.com/OpenEnrollment or scan the code.

To scan the QR code:
Open the camera on your smart phone
Focus on the QR code
Tap the link that appears

The CVS Caremark **Rx Delivery by Mail** service offers an easy, safe & secure way to get the medications you take regularly.

90-day supplies typically cost less than 30-day supplies.

- *Convenience*: CVS Caremark Mail Service Pharmacy can deliver 90-day supplies of medications you take regularly to your door. You can also opt in to automatic refills too.
- *Savings*: Filling your Rx in 90-day supplies often comes with savings— plus, there's no additional costs for shipping.
- *Safety*: The secure, nondescript packaging protects your privacy.

Learn more at **Caremark.com/Rxdelivery** or scan the code.

To scan the QR code:
Open the camera on your smart phone
Focus on the QR code
Tap the link that appears

CVS Caremark

PrudentRx & Specialty Medications

CVS Caremark collaborates with **PrudentRx**— a program that may help you save money when you fill eligible specialty medications*

A prudent Rx trained member advocate will be able to assist you through a high-touch, proactive engagement process to facilitate enrollment and help you obtain non-need based manufacturer assistance where applicable.** Participating members will have a $0 out-of-pocket cost on eligible specialty medications.†

Your enrollment in the program will begin automatically, but additional steps may be needed.†† You may choose to opt-out at any time. ‡

PrudentRx can be reached at (800) 578-4403 to address any questions regarding the PrudentRx Copay Program.

*Due to limitations that exist within various external pharmacy systems, implementing the PrudentRx solution on high-deductible health plans (HDHPs) with health savings accounts (HSAs) will be limited to only those medications included on the client's specialty drug list and dispensed by CVS Specialty® and will not include limited distribution drugs.

**Not all specialty prescriptions offer manufacturer assistance. Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change. Copay assistance program may not be used with any Federal health care program.

†Participating members enrolled in an HDHP with HSA must fully satisfy their deductible before they are eligible for a final $0 out-of-pocket cost, unless the member has been prescribed a medication that qualifies as "preventive care" under the Internal Revenue Code, which is administered and enforced by the Internal Revenue Service.

††Some manufacturers require you to sign up to obtain copay assistance that they provide for their medications – in that case, you must call PrudentRx to participate in the copay assistance for that medication. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take.

‡If you choose to opt out of the program or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for 30 percent of the cost of your specialty medications.

CVS Specialty® provides personalized care to help make managing your condition a little easier.

What is a specialty pharmacy?

It's a pharmacy that provides specialized medications. This may include medications that help manage complex conditions (such as rheumatoid arthritis, multiple sclerosis and cancer) or those requiring injections or infusions.

A team of pharmacists and nurses specially trained in your condition

You can send a secure message to your CVS Specialty CareTeam any time you have a question about your health or medication. You can also get tips on how to take your medication correctly, help you manage side effects and stay on track.

A choice of pick up or delivery

Get the medication you need, when and where you need it. Have it delivered to any place nationwide or pick it up at any CVS Pharmacy® location.*

Learn more at Caremark.com/Specialty or scan the code.

To scan the QR code:
Open your camera
Scan the code
Tap the link

CVS Caremark Cost Saver

Administered by CVS Caremark

Lowering member costs

For many of us, prescription drugs are essential to managing our health, so affordability and accessibility are critical. Soaring prescription drug prices can put a financial strain on many Americans, and they often turn to drug discount cards or direct-to-consumer online pharmacies to save money. Historically neither of these integrated seamlessly with plan benefits, resulting in a poor member experience.

We make sure you can get low prescription prices. **Cost Saver complements your plan design by:**

- **Providing members with the best available prices** for many commonly prescribed, non-specialty generic drugs
- **Applying member out-of-pocket costs to deductibles** and out-of-pocket thresholds
- **Coordinating clinical support** and adherence programs using integrated data
- **Delivering a seamless member experience** that avoids wasted time shopping around for the best price

Working behind the scenes to deliver best pricing

With Cost Saver powered by GoodRx you can be confident that you are receiving the best possible price while preserving plan benefits. Best of all, members need only present their CVS Caremark ID card to get the lower price for their medications — no other action required.

Health Care Services

FREE and confidential health care services for our valued employees!

Primary Care

Bellin Health Employee Clinic—Marinette (2820 Roosevelt Road)

Full primary care (physicals, chronic disease management, and acute care.)

Providers at the clinic include a Physician Assistant, Nurse Practitioner, and a Medical Assistant.

This clinic is available to employees, spouses, and dependents.

Physical Therapy *(No Referral Necessary)*

ChemDesign (onsite - Wednesdays, 8:30-11:30am)

Confidential, customized treatment for acute injury, and muscle or joint discomfort from work or non-work related injuries or illnesses.

This clinic is available to employees only.

bellinhealth

Dental Low Plan

Administered by Delta Dental

Regular trips to the dentist are essential for good oral health. Dental insurance may help considerably with the costs. But a great smile often requires additional dental care, such as x-rays, sealants and emergency oral evaluation.

Basic Option with No Orthodontia Coverage	
Calendar Year Deductible	
Individual	$50
Family	$150
Individual Annual Maximum	
Per Calendar Year	$1,250
Preventive Services (member pays)	
Oral Exam	0%
X-Rays	0%
Cleanings	0%
Fluoride Treatments	0%
Space Maintainers	0%
Sealants	0%
Basic Services (member pays)	
Simple Extractions	20% after deductible
Fillings	20% after deductible
Major Services (member pays)	
Endodontics (Root Canal)	50% after deductible
Periodontics	50% after deductible
Surgical Extractions	50% after deductible
Crowns	50% after deductible
Inlays and Onlays	50% after deductible
Bridges and Dentures	50% after deductible
Implants	50% after deductible
Orthodontia	
	Not Covered

Enhanced Benefits Program

This program offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions, and suppressed immune systems) that can be positively affected by additional oral health care.

Dental Provider Networks

As a Delta Dental member, you have the flexibility to choose any dentist with your Delta Dental plan – PPO, Premier or non-network. Your out-of-pocket costs will vary depending on the dentist you choose.

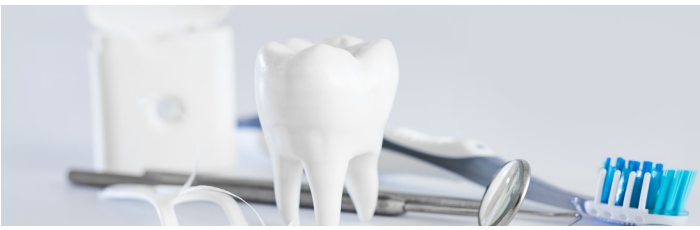
Dental High Plan

Administered by Delta Dental

Regular trips to the dentist are essential for good oral health. Dental insurance may help considerably with the costs. But a great smile often requires additional dental care, such as x-rays, sealants and emergency oral evaluation.

Buy-Up Option with Orthodontia Coverage	
Calendar Year Deductible	
Individual	$50
Family	$150
Individual Annual Maximum	
Per Calendar Year	$1,500
Preventive Services (member pays)	
Oral Exam	0%
X-Rays	0%
Cleanings	0%
Fluoride Treatments	0%
Space Maintainers	0%
Sealants	0%
Basic Services (member pays)	
Fillings	20% after deductible
Simple Extractions	20% after deductible
Surgical Extractions	20% after deductible
Endodontics (Root Canal)	20% after deductible
Periodontics	20% after deductible
Major Services (member pays)	
Crowns	50% after deductible
Inlays and Onlays	50% after deductible
Bridges and Dentures	50% after deductible
Implants	50% after deductible
Orthodontia	
Dependent children covered to age 19	Covered at 50% to $1,500 lifetime maximum

Helpful Tip: Minimize your out-of-pocket expense for dental care by asking your dentist for a pre-treatment estimate from Delta Dental before you agree to receive any prescribed major treatment.



Dental Provider Networks

As a Delta Dental of Wisconsin member, you have the flexibility to choose any dentist with your Delta Dental of Wisconsin plan – PPO, Premier or Non-Network. Your out-of-pocket costs will vary depending on the dentist you choose.

Vision Plan

Insured by Superior Vision

Even in today's economy, budgeting for regular eye exams is vital because early diagnosis and timely treatment of eye diseases - such as diabetic retinopathy, cataracts, and glaucoma - is made possible. Vision insurance can help defray the cost of those exams and treatment.

	In-Network	Out-of-Network Reimbursement
Annual Deductible	$0	$0
Benefits		
Exam	$10 copay	$34
Frames	$150 allowance	$74
Lenses		
Single Vision	$10 copay	$29
Bifocal	$10 copay	$43
Trifocal	$10 copay	$53
Contact Lenses		
Elective	$150 allowance	$100
Medically Necessary	Covered in full	$210
Fitting and Evaluation	$25 copay	Not Covered
Service Frequencies (from date of last service)		
Exams	Every 12 months	
Frames	Every 24 months	
Lenses	Every 12 months	
Contact Lenses	Every 12 months	

Flexible Spending Account

Administered by Diversified Benefit Services

FSAs allow you to use pre-tax dollars to pay for many health care expenses and dependent care expenses. The Health Care and Dependent Care FSA benefits are calendar year programs.

You decide how much you would like to set aside for health care expenses and/or dependent care expenses each year. That amount will be deducted from your paycheck on a pre-tax basis, so you save on income taxes and have more disposable income. That money is then credited to an individual "account" for you. You submit claims and are reimbursed from the account for your eligible expenses. **You must enroll for the entire year - the FSA plan year runs from January 1 through December 31.** Your election (payroll deduction amount) may not be changed during the year unless you have a qualifying life event or change in status.

Feature	Healthcare FSA	Limited FSA *(for individuals who contribute to an HSA)*	Dependent Care FSA
Maximum contribution per year	$3,200	$3,200	$5,000
Can be used for eligible…	Medical, dental and vision expenses for you and your dependents	Dental and vision expenses for you and your dependents	Daycare expenses for eligible dependents

Health Care FSA

You can use the Health Care FSA for eligible health care expenses incurred by you, your spouse or any of your eligible dependents for certain medical, dental and vision expenses.

Eligible expenses include (but are not limited to):

- Deductibles, copays and coinsurance; over the counter medications
- Glasses and contact lenses not covered by a vision discount plan; laser eye surgery; hearing aids; and other expenses allowed by the IRS.
- Procedures performed for cosmetic reasons DO NOT qualify.

Remember: If you do not use up the health FSA money you contributed during the current plan year, you will be allowed to carry forward up to **$640** to use during the new plan year.

In addition, there is a 90-day period at the end of the plan year to submit incurred expenses.

IMPORTANT NOTE: Employees enrolling in the High Deductible Health Plan and wish to set money aside in a healthcare FSA will need to elect the Limited FSA, per IRS guidelines.

Dependent Care FSA

You can use the Dependent Care FSA to pay for eligible daycare services. If you are married, you can use this account only if your spouse is employed or actively seeking work, is a full-time student for at least five months of the year, or is disabled.

You can pay daycare expenses for children under age 13, disabled children, disabled parents, a disabled spouse or relatives who qualify as dependents under the Internal Revenue Code. For your Dependent Care FSA contributions to be eligible for reimbursement, your provider must claim your payments as taxable income. Additional rules apply during leaves of absence for use.

Eligible daycare arrangements include (but are not limited to):

- Licensed nursery school and daycare centers for preschool children
- Day camps, after school care or in-home daycare for children under age 13
- Daycare centers for other qualifying dependents (elder care centers)
- Housekeepers, cooks or maids who provide dependent care in your home
- Individuals other than your dependents who provide daycare for your qualifying dependents, either inside or outside of your home

Life and AD&D Plans

Insured by UnitedHealthcare

Basic Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by the company. The company provides basic life insurance of 1x your salary up to $50,000 at no cost to you.

Basic Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. The company provides AD&D coverage of 1x your salary up to $50,000 at no cost to you. This coverage is in addition to your company-paid life insurance described above.

Company Paid Basic Life and AD&D	
Basic Life Benefit Amount	1x salary up to $50,000
Basic AD&D Amount	1x salary up to $50,000

Voluntary Life and AD&D Insurance

You may purchase life and AD&D insurance in addition to the company-provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage without answering medical questions if you enroll when during your time of hire.

Voluntary Life and AD&D			
	Employee	Spouse	Child(ren)
Benefit Increments	$10,000	$5,000	$2,000
Benefit Minimum	$10,000	$5,000	$2,000
Benefit Maximum	Lesser of $500,000 or 5x earnings	Lesser of 100% of the employee amount or $500,000	$10,000 for eligible children 6 months to 19 or 25, if full-time student. Eligible children 14 days to 6 months receive $1,000
Guaranteed Issue Amount	$150,000 or lesser of current amount	$25,000 or lesser of current amount	

Important Election Notes:

If you have never elected this benefit, you can choose up to the guaranteed issue amount without answering medical questions. If you wish to elect over the guaranteed issue amount, you will need to complete the Evidence of Insurability (EOI) process.

If you are currently enrolled in this benefit and wish to increase your coverage, you can elect up to the guaranteed issue amount without needing to answer medical questions. Any election over the guaranteed issue amount will require completion of the EOI process.

Life with Long Term Care

Insured by Trustmark

Universal Life

ChemDesign provides a Universal Life benefit. Universal Life Insurance helps to provide financial security even after loss. Whether you are married, a parent, or single and starting out, Universal Life helps take care of the people important to you if tragedy happens. You are able to choose a plan and benefit amount that provides the right protection for you.

Universal LifeEvents provides a **higher death benefit during your working years**, when your needs and responsibilities are the greatest. You can choose a plan and benefit amount that provides the **right protection for you.**

Long-Term Care

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents includes a **long-term care (LTC)** benefit that can help pay for these services at any age. This benefit **remains the same level** throughout your life, so the full amount is always available when you most need it.

You can collect 4% of your Universal Life death benefit per month for up to 25 months to help pay for qualified long-term care services, such as home health care or nursing home care. If you collect a benefit for LTC, your full death benefit is still available for your beneficiaries.

Disability Plans

Insured by UnitedHealthcare

Short-Term Disability

ChemDesign provides full-time employees with short-term disability income benefits, and pays the full cost of this coverage. Short-term disability (STD) insurance pays a percentage of your salary if you become temporarily disabled, which means that you are not able to work for a short period of time due to sickness or injury not related to your job. You are not eligible to receive short-term if you are receiving workers' compensation benefits.

Short-Term Disability	
Definition	All active full-time employees working 30 or more hours per week
Elimination Period	1 days for injury 8 days for sickness
Weekly Benefit	60%
Maximum Weekly Benefit	$2,500
Benefit Duration	13 weeks
Earnings Definition	Base salary, excluding commissions, overtime, bonuses and any other compensation

Long-Term Disability

ChemDesign provides full-time employees with long-term disability income benefits. Long-term disability (LTD) picks up where short-term disability leaves off. Once your short-term disability benefits expire, the long -term disability policy pays you a percentage of your salary. You are not eligible to receive long-term disability benefits if you are receiving workers' compensation benefits.

Long-Term Disability	
Eligible Employees	All active full-time employees working 30 or more hours per week
Definition	All Full-Time Employees
Elimination Period	90 days
Benefit Percentage	60%
Maximum Benefit	$10,000

Voluntary Accident Plan

Insured by UnitedHealthcare

How does it work?

Accident Insurance helps cover the added costs you may face following an injury. If you have a covered injury during the plan year and submit a claim, the Accident Protection Plan will pay you a cash benefit directly. Any payment you receive is in addition to the benefits your health plan gives you. Plus, you don't have to meet a deductible to receive the money—and you can use the money any way you want.

What's included?

Here's a short list of injuries and services that may qualify for a benefit payment:

- Ambulance services
- Emergency room and urgent care
- Doctor visits
- Hospital admissions and stays
- Medical appliances (e.g., crutches, wheelchair, walker)
- Rehabilitation
- Burns
- Concussions
- Fractures/dislocations
- Lacerations (cuts)
- Prescriptions
- Organized sports injuries
- Lodging, travel and child care

Accident Protection Wellness Benefit - Up to $100 per Year

Your Accident Plan includes a wellness benefit that helps pay for preventive care and other health screenings. Refer to the plan document for eligible tests and screenings.

Program Rules

1. Screenings must be completed during the calendar year.
2. A covered spouse can also earn a benefit.

Accident Insurance can pay you money for covered accidental injuries and their treatment.

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively at a U.S. location to receive coverage.

How much does it cost?		
Premium	Monthly	Weekly
You	$11.20	$2.58
You + Spouse	$17.89	$4.13
You + Children	$17.27	$3.99
Family	$28.20	$6.51

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/media/9486.
See Schedule of Benefits for a complete listing of what is covered.

Voluntary Accident Plan

Insured by UnitedHealthcare

Hernia Surgery	$300
Arthroscopic Surgery	$300
Non-Specific Surgery	
- General Anesthesia	$300
- Conscious Sedation	$150
Tendon / Ligament / Shoulder Cartilage / Rotator Cuff / Knee Cartilage Surgery	
- Surgery to repair one	$600
- Surgery to repair more than one	$1,200
- Exploratory without repair	$200
Blood/Plasma/Platelets	$400
Burns	
- 2nd Degree (at least 36% of body surface)	$750
- 3rd Degree (9 to 34 sq. inches)	$1,500
- 3rd Degree (35 or more sq. inches)	$12,000
	Skin Graft = 25% of burn benefit
Coma	$10,000
Concussion	$200
Lacerations	
- Greater Than 15 cm	$600
- 5 cm - 15 cm	$300
- Less Than 5 cm	$75
- Not Requiring Sutures	$45
Paralysis	
- Quadriplegia	$15,000
- Hemiplegia	$7,500
- Paraplegia	$7,500
Ruptured / Herniated Disc	$600
Emergency Dental Work	
- Crown(s)	$300
- Extraction(s)	$150
Medical Supplies / Over-the-counter(one time per plan year)	$20
Family Child Daycare (per day up to 30 days)	$45
Lodging (per day up to 30 days)	$225
Transportation (for special treatment more than 100 miles away, maximum of 3 trips per accident)	$300
Pain Management / Epidural (one time per covered accident)	$100
Fractures	Open Reduction / Closed Reduction
- Skull (Depressed, except bones of face or nose)	$6,000 / $3,000
- Sternum	$6,000 / $3,000
- Hip, Thigh (Femur)	$6,000 / $3,000
- Skull (Simple, except bones of face or nose)	$3,250 / $1,625
- Leg (from top of tibia to ankle joint)	$3,250 / $1,625
- Pelvis (Excluding Coccyx)	$3,250 / $1,625
- Vertebrae (body of)	$3,250 / $1,625
- Sacral / Sacrum	$1,200 / $600
- Face or Nose (except teeth)	$1,200 / $600
- Upper Arm (Elbow to Shoulder)	$1,200 / $600
- Upper Jaw (except Alveolar process)	$1,200 / $600
- Ankle	$1,200 / $600
- Foot (except Toes)	$1,200 / $600
- Forearm, Hand, Wrist (except Fingers)	$1,200 / $600
- Kneecap	$1,200 / $600
- Lower Jaw (except Alveolar process)	$1,200 / $600
- Shoulder Blade or Collarbone	$1,200 / $600
- Vertebral Process	$1,200 / $600
- Coccyx	$1,000 / $500
- Finger or Toe	$450 / $225
	Chip Fractures: 25% of amounts shown for Closed Reduction
Dislocations	Open Reduction / Closed Reduction
- Hip	$6,000 / $3,000
- Elbow	$1,350 / $675
- Ankle	$2,250 / $1,125
- Collar Bone (Sternoclavicular)	$1,350 / $675
- Foot (except toes)	$2,250 / $1,125
- Hand	$1,350 / $675
- Knee Cap (Patella)	$3,400 / $1,700
- Lower Jaw	$1,350 / $675
- Shoulder Blade	$1,350 / $675
- Wrist	$1,350 / $675
- Collerbone (Acromioclavicular separation)	$750 / $375
- Finger or Toe	$750 / $375
Organized Sporting Activity Injury	Increases amounts payable under Follow Up Care and Common Injuries sections by 25%
Additional Benefits	
Wellness Benefit Rider	$100, Employee and Insured Spouse

Voluntary Critical Illness Plan

Insured by UnitedHealthcare

How does it work?

The Critical Illness Protection Plan sends a lump-sum payment directly to you after diagnosis of a covered condition.

Enrolling in a Critical Illness Protection Plan helps give you and your family more financial security if you or a covered family member is diagnosed with a covered illness.

What's included?

The money is yours to use however you want, including paying for:

- Out-of-pocket health plan costs
- Mortgage or rent
- Groceries
- Prescriptions
- Treatment by a specialist
- Transportation to and from treatment

Covered Conditions

Base Conditions

- Benign brain tumor
- Cancer
- Chronic Renal Failure
- Coma
- Coronary Artery Disease
- Heart Attack
- Heart Failure
- Major Organ Failure
- Permanent Paralysis
- Ruptured aneurysm
- Stroke

Additional Conditions

- Advanced Alzheimer's
- Advanced multiple sclerosis
- Advanced Parkinson's
- Amyotrophic lateral sclerosis (ALS)
- Complete blindness
- Complete loss of hearing

Child-only conditions

- Cerebral Palsy
- Cleft lip/palate
- Cystic fibrosis
- Down syndrome
- Muscular dystrophy
- Spina bifida

Critical Illness Protection Wellness Benefit - Up to $100 per Year

Your Critical Illness Plan includes a wellness benefit that helps pay for preventive care and other health screenings. Refer to the plan document for eligible tests and screenings.

Program Rules

1. Screenings must be completed during the calendar year.
2. A covered spouse can also earn a benefit
3. The benefit will be paid for 1 test each calendar year, regardless of the test results. The benefit is paid in addition to any other payments you and/or your covered spouse receive under the policy.

Voluntary Critical Illness Plan

Insured by UnitedHealthcare

Maximum Benefit Amount	Option A	Option B	Option C
Employee	$10,000	$20,000	$30,000
Spouse	$10,000	$20,000	$30,000
Child(ren)	$5,000	$10,000	$15,000

Plan Provisions	
Reoccurrence Benefit**	Benefit payable for the same Covered Condition
Cancer Reoccurrence Benefit	Benefit payable for the same Cancer Condition category
Portability	Included

Covered Conditions	Percentage of Insured's Maximum Benefit Amount Payable
Cancer Conditions	
Invasive Cancer	100%
Non-invasive Cancer	25%
Skin Cancer	$250
Vascular Conditions	
Coronary Artery Disease Minor (Stent or Angioplasty)	25%
Coronary Artery Disease Major (Bypass Surgery)	50%
Heart Attack	100%
Ruptured Aneurysm	100%
Stroke	100%
Sudden Cardiac Arrest	100%
Organ Failure Conditions	
Bone Marrow Disease	100%
Chronic Renal Failure**	100%
Heart Failure**	100%
Major Organ Failure (Liver, Lung, Pancreas, Small Bowel)	100%
Functional Loss Conditions	
Coma	100%
Loss of Hearing**	100%
Loss of Sight**	100%
Loss of Speech**	100%
Paralysis	100%
Additional Conditions	
Addison's Disease**	25%
Benign Brain Tumor	100%
Crohn's Disease**	25%
Myasthenia Gravis**	25%
Severe Burns**	100%
Systemic Lupus Erythematosus**	25%
Systemic Sclerosis (Scleroderma)**	25%
Childhood Disease Conditions**	
Cerebral Palsy	100% of Dependent Child Benefit
Childhood Diabetes	100% of Dependent Child Benefit
Cleft Lip / Palate	100% of Dependent Child Benefit
Congenital Heart Disease	100% of Dependent Child Benefit
Cystic Fibrosis	100% of Dependent Child Benefit
Down Syndrome	100% of Dependent Child Benefit
Muscular Dystrophy	100% of Dependent Child Benefit
Sickle Cell Anemia	100% of Dependent Child Benefit
Spina Bifida	100% of Dependent Child Benefit

Voluntary Critical Illness Plan

Insured by UnitedHealthcare

Neurological Disease Conditions (diagnosis only)**	
Alzheimer's Disease	25%
Amyotrophic Lateral Sclerosis (ALS)	25%
Huntington's Disease	25%
Multiple Sclerosis	25%
Parkinson's Disease	25%

Advanced Neurological Disease Conditions (loss of ADLs)**	
Advanced Alzheimer's Disease	100%
Advanced Amyotrophic Lateral Sclerosis (ALS)	100%
Advanced Huntington's Disease	100%
Advanced Multiple Sclerosis	100%
Advanced Parkinson's Disease	100%

Additional Benefits	
Wellness Benefit	$100 Payable Once per calendar year per Insured

Wellness Benefit Covered Exams

Antibody or Serology testing
At-Home Screening tests for Colon Cancer
Biopsy
Blood Test for Cholesterol
Blood test for triglycerides
Biometric Screenings
Bone Density scans
Bone marrow testing
Breast ultrasound
Breast MRI
CA 15-3 (blood test for breast cancer)
CA 125 (blood test for ovarian cancer)
CEA (blood test for colon cancer)
Chest X-ray
Colonoscopy
Complete Blood Count
Doppler screening for carotids
Doppler screening for peripheral vascular disease
Doppler Screening for abdominal aorta
Echocardiogram
Electrocardiogram
Routine Dental Exam/Cleaning
Routine Comprehensive Eye Exam
Routine Comprehensive Hearing Exam
Routine Physicals
Well-Child Exams (up to age 18)
Genetic Testing
Immunizations
Endoscopy
Fasting blood glucose test
Fasting plasma glucose (FPG)
Flexible sigmoidoscopy
Hemoccult stool analysis
Hemoglobin A1C(HbA1c)
HPV Testing
Lipid Panel
Mammography
Monoclonal Antibody Therapy
Pap smear
PSA (blood test for prostate cancer)
Serum Protein Electrophoresis (blood test for myeloma)
Stress test on a bicycle or treadmill
Thin prep pap test
Thermography
Serum cholesterol test to determine level of HDL and LDL
Virtual Colonoscopy
Wellness Fair Screening
Whole Body Skin Cancer Screening

Benefit payable upon completion of a covered wellness exam or health screening test. per calendar year per Insured

Employee Assistance Program

Provided by BHS

Provided by BHS, your Employee Assistance Program (EAP) provides you and your household members with **free, confidential, 24/7 support** to help with personal or professional problems that may interfere with work or family responsibilities.

What Happens When you Call the EAP?

A Care Coordinator (master's level clinician) will confidently assess the problem, assist with any emergencies and connect you to the appropriate resources.

What can the EAP Provide Support For?

Relationships	Life Events
Boss/Co-worker	Birth/Death
Customers	Health/Illness
Friends	Marriage/Divorce
Spouse/kids	Promotion/Retirement

Risks	Challenges
Burnout/Anger	Daily responsibilities
Depression/Anxiety	Financial Legal

Work Life Services

- Child and elder care resources and referrals
- Free legal consultations and discounted services
- Financial counseling and resources

Call toll-free 1-800-327-2251

Email – Support@ BHSOnline.com

Connect2MyBenefits

We know that keeping track of your benefits can be difficult. That's why ChemDesign offers a portal that you and your family can access from your cell phone, your home computer—anywhere!

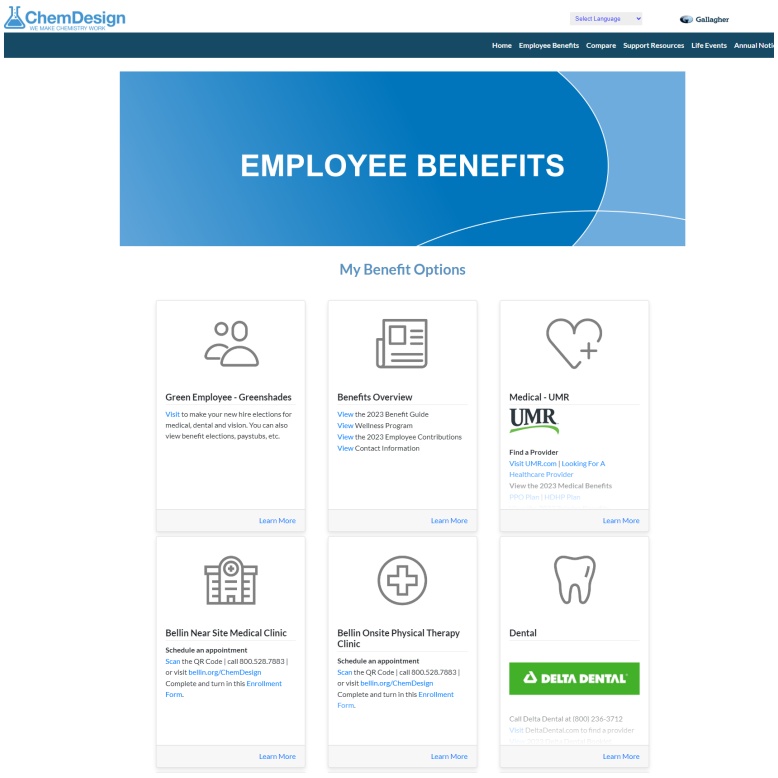
We encourage you to access the site today and bookmark it so you can revisit the site when you are looking for:

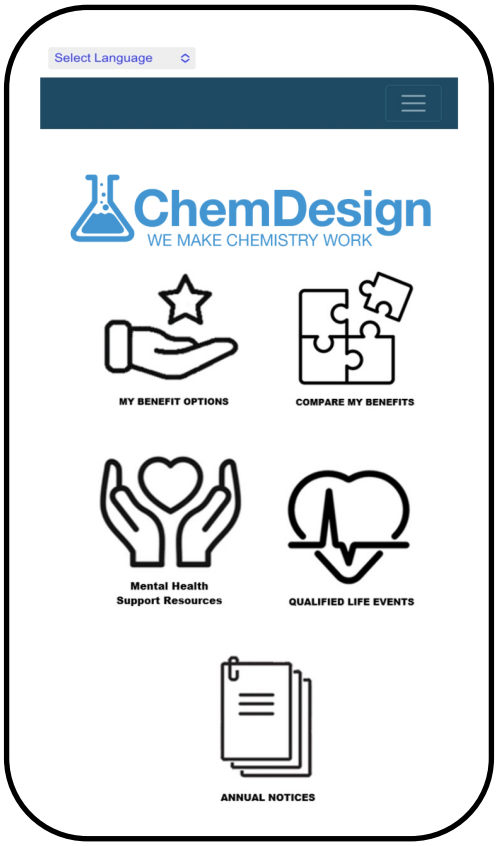
- Information on company-provided benefits—what coverage you have and how to use it
- Benefit forms
- Legislative updates
- Information for what to do when you experience a qualifying life event
- Company announcements

Scan the QR code or click the link below to access Connect2MyBenefits.

https://c2mb.ajg.com/chemdesign

The benefits platform can be accessed on your phone, computer or tablet!





Additional Benefits

ID Shield Services

Identity theft is unfortunately becoming more common and it's expensive and time-consuming to resolve on your own. ID Shield monitors all of your important information, provides identity specialist counseling to walk you through the process and address any questions while restoring your identity to pre-theft status. This benefit is 100% paid for by ChemDesign. You have the option to buy-up to family coverage.

Legal Shield Services

Employees also have the option of adding Legal Shield services for themselves and their family members at a low monthly cost. Unexpected legal questions arise every day and with LegalShield on your side, you'll have access to a quality law firm 24/7, for covered personal situations. From real estate to speeding tickets to Will preparation, and beyond, this benefit can help you with any personal legal matter-no matter how traumatic or how trivial it may seem. Because Legal Shield's dedicated law firms are prepaid, their sole focus is on serving you, rather than billing you.

401(k)

ChemDesign encourages all employees to save for retirement. We will match 50% up to 6% of employee contribution for a 3% maximum match. You can access your retirement account online at myretirement.americanfunds.com. Use the tools on this site to estimate your projected retirement income, adjust your contributions, rebalance your portfolio, and find educational resources and interactive planning tools to optimize your savings knowledge and investment potential.

Flexible Work Schedule and Vacation

Operators work a 12-hour rotating schedule, allowing for a wonderful work and life balance. The benefit of our unique rotating shift schedule is that operators work 14-days/ month with a scheduled 7-days off every 28-days.

In addition to that, paid time off packages up to 116-hours your first year. This includes two weeks paid vacation, along with 32-hours of paid personal holidays the first year.

Training

New operators go through a training process to ensure that they're ready to work on the chemical production floor. This comprehensive training includes vast topics on chemical processing with an emphasis on safety.

Employee Events and Activities

ChemDesign sponsors an active social committee with plans and events including:

- Annual Steak Fry
- Employee Luncheons
- Volleyball, Softball, Bowling, & Cycling Teams
- Annual Holiday Party

Wellness Program

Taking control of your health and wellbeing will reduce monthly premiums and ChemDesign is committed to helping you achieve your best health. That's why we offer a variety of wellness programs and activities designed to provide information and resources to help all of us make healthy living a way of life. It is our priority to offer affordable and quality health care coverage to all of our employees, but the increasing cost of providing health insurance coverage has made this task challenging. We strive to promote wellness so employees can stay healthy to not only live better lives, but also to keep health care costs low.

Preventive Care Exam

Getting face-to-face interaction with your doctor once per year is critical. Yearly checkups can ensure early detection should a small health issue arise. The cost of care for managing a small issue is less expensive than managing an escalated one. **There are medical premium discounts for completing the preventive care exam.**

Tobacco Cessation

While ChemDesign has discontinued the tobacco surcharge, we will continue to offer a free tobacco cessation program to employees and their family members who would like to participate. Please contact the HR Department for more information.

Fitness Reimbursement

Employees can be reimbursed up to a maximum of $800/ year for participating in qualified fitness activities including: health club memberships, fitness classes, diet programs (i.e. Weight Watchers, Noom) and entry fees for events (runs, walks, swims, cycling.) Please see HR Department to confirm that your fitness activity/event qualifies for reimbursement. You must show receipt/verification of participation and complete a company expense report for reimbursement. Reimbursement will be grossed up 20% and paid quarterly through payroll.

Voluntary Wellness Programs

Throughout the year, there may be voluntary wellness programs offered to address weight management, nutrition education, tobacco cessation and/or stress management.

If it is unreasonable for you to complete any wellness program or requirement to earn an incentive, please contact Human Resources.

Contribution Amounts

Medical

★ **Preventive Care Exam Incentive:**

Employees will earn a medical premium discount for completing a preventive care exam. Date of exam must occur between May 1, 2024 and March 31, 2025. Forms must be completed and returned by April 15, 2025.

Monthly Rates for the Medical PPO Plan			
	ChemDesign Pays	Without Preventive Care Exam Incentive	With Preventive Care Exam Incentive
Employee Only	**$841.04**	$168.21	$49.21
Employee + Spouse	**$2,018.50**	$403.70	$284.70
Employee + Child(ren)	**$1,597.98**	$319.60	$200.59
Family	**$2,607.23**	$521.45	$402.44

Weekly Rates for the Medical PPO Plan			
	ChemDesign Pays	You Pay Base Rate	All Wellness Activities
Employee Only	**$194.09**	$38.82	$11.36
Employee + Spouse	**$465.81**	$93.16	$65.70
Employee + Child(ren)	**$368.76**	$73.75	$46.29
Family	**$601.67**	$120.33	$92.87

Monthly Rates for the Medical HDHP Plan			
	ChemDesign Pays	Without Preventive Care Exam Incentive	With Preventive Care Exam Incentive
Employee Only	**$793.35**	$119.00	$0.00
Employee + Spouse	**$1,904.03**	$285.60	$166.60
Employee + Child(ren)	**$1,507.36**	$226.10	$107.10
Family	**$2,459.36**	$368.90	$249.90

Weekly Rates for the Medical HDHP Plan			
	ChemDesign Pays	You Pay Base Rate	All Wellness Activities
Employee Only	**$183.08**	$27.46	$0.00
Employee + Spouse	**$439.39**	$65.91	$38.45
Employee + Child(ren)	**$347.85**	$52.18	$24.72
Family	**$567.54**	$85.13	$57.67

Contribution Amounts

Dental and Vision

Monthly Rates for the Dental Low Plan		
	ChemDesign Pays	You Pay
Employee Only	**$29.04**	$7.84
Employee + Spouse	**$58.08**	$15.68
Employee + Child(ren)	**$61.37**	$16.57
Family	**$101.38**	$27.37

Weekly Rates for the Dental Low Plan		
	ChemDesign Pays	You Pay
Employee Only	**$6.70**	$1.81
Employee + Spouse	**$13.40**	$3.62
Employee + Child(ren)	**$14.16**	$3.82
Family	**$23.40**	$6.32

Monthly Rates for the Vision Plan	
	You Pay
Employee Only	$6.66
Employee + Spouse	$13.33
Employee + Child(ren)	$15.04
Family	$23.27

Weekly Rates for the Vision Plan	
	You Pay
Employee Only	$1.54
Employee + Spouse	$3.08
Employee + Child(ren)	$3.47
Family	$5.37

Monthly Rates for the Dental High Plan		
	ChemDesign Pays	You Pay
Employee Only	**$33.18**	$13.27
Employee + Spouse	**$66.36**	$26.54
Employee + Child(ren)	**$90.87**	$36.35
Family	**$167.90**	$67.16

Weekly Rates for the Dental High Plan		
	ChemDesign Pays	You Pay
Employee Only	**$7.66**	$3.06
Employee + Spouse	**$15.31**	$6.13
Employee + Child(ren)	**$20.97**	$8.39
Family	**$38.74**	$15.50

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below or your HR department.

	Carrier/ Administrator/ Vendor	Phone	Website/Email
Medical	UMR	(800) 826-9781	www.umr.com
Pharmacy	CVS Caremark	(866) 818-6911	www.caremark.com
Dental	Delta Dental	(800) 236-3712	www.deltadentalwi.com
Vision	Superior Vision	(800) 923-6766	www.superiorvision.com
Flexible Spending Account	Diversified Benefit Services	(800) 234-1229	www.dbsbenefits.com
Life, Disability, Accident, Critical Illness Plans	UHC	(800) 421-6204	www.uhc.com
Identity Theft Protection and Legal Plan	ID Shield	(888) 494-8519	www.idshield.com
Employee Assistance Program	BHS	(800) 327-2251	bhsonline.com
401(k)	Capital Group American Funds	(757) 670-4900	www.capitalgroup.com
401(k) Financial Counseling	Jeremy Bartels Financial Advisor	(715) 732-4408	Jeremy.Bartels@dwardjones.com

Important Notices

Newborns' and Mothers' Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: PPO PLAN (Individual: 20% coinsurance and $500 deductible; Family: 20% coinsurance and $1,000 deductible)
Plan 2: HDHP PLAN (Individual: 20% coinsurance and $1,600 deductible; Family: 20% coinsurance and $3,200 deductible)

If you would like more information on WHCRA benefits, please call your plan administrator at (715) 735 8272 or kgustafson@chemdesign.com.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

ChemDesign is committed to the privacy of your health information. The administrators of the ChemDesign Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure. The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Kaylyn Parker—HR Generalist/ Benefits Coordinator at (715) 735-8272 or kgustafson@chemdesign.com.

HIPAA Special Enrollment Rights

ChemDesign Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the ChemDesign Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Kaylyn Parker—HR Generalist/ Benefits Coordinator at (715) 735-8272 or kgustafson@chemdesign.com.

Important Notices

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Important Notices

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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Important Notices

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Important Notices

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIteShare Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/healthinsurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Important Notices

To see if any other states have added a premium assistance program since January 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)

Notice of Creditable Coverage

Important Notice from ChemDesign 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 ChemDesign 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. ChemDesign has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current ChemDesign coverage will not be affected. When this plan is not primary, the Plan will coordinate benefits with Medicare. If you do decide to join a Medicare drug plan and drop your current ChemDesign coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with ChemDesign and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ChemDesign 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).

Important Notices

Date:	**May 01, 2024**
Name of Entity/Sender:	**ChemDesign**
Contact—Position/Office:	**Kaylyn Parker—HR Generalist/Benefits Coordinator**
Office Address:	**2 Stanton Street** **Marinette, Wisconsin 54143-2543** **United States**
Phone Number:	**(715) 735-8272**

Important Notices

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it**. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Kaylyn Parker.

Important Notices

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

ChemDesign Products, Inc.
Kaylyn Parker—HR Generalist/Benefits Coordinator
2 Stanton Street
Marinette, WI 54143
(715) 735-8272
United States

[1]https://www.medicare.gov/basics/get-started-with-medicare/sign-up/

Important Notices

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [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 income for federal and state income tax purposes. Your payments for generally excluded from coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health 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.**

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

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

Important Notices

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 Kaylyn Parker.

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

3. Employer name ChemDesign		4. Employer Identification Number (EIN) 20-5669856
5. Employer address 2 Stanton St		6. Employer phone number (715) 735-8272
7. City Marinette	8. State Wisconsin	9. ZIP code 54143-2543
10. Who can we contact about employee health coverage at this job? Kaylyn Parker		
11. Phone number (if different from above)	12. Email address kgustafson@chemdesign.com	

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

• As your employer, we offer a health plan to: <<Check applicable box and insert plan information in that section.>>

- ☐ All employees. Eligible employees are:
- ☐ Some employees. Eligible employees are:

• With respect to dependents: <<Check applicable box and insert plan information in that section.>>

- ☐ We do offer coverage. Eligible dependents are:
- ☐ We do not offer coverage.

Important Notices

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. <<Check box if plan provides minimum value and coverage satisfies an affordability safe harbor.>>

☐ ** 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.

Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Important Notices

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the plan administrator.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting