



2025

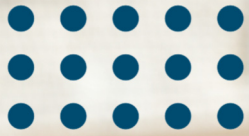
EMPLOYEE BENEFITS GUIDE

PS&S offers you and your eligible family members a comprehensive and valuable benefits program. This guide has been developed to assist you in learning about your benefit options and how to enroll.

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.



WELCOME TO PS&S!



Questions?

If you have questions about your benefits, please contact the Conner Strong & Buckelew Benefits Member Advocacy Center at [800.563.9929](tel:800.563.9929) (Monday through Friday, 8:30 am to 5 pm ET) or go to www.connerstrong.com/memberadvocacy and complete the fields.

Inside This Guide

Eligibility & Making Plan Changes	3
Medical & Prescription Benefits	4
Telemedicine	5
Health Savings Account (HSA)	6
Flexible Spending Account (FSA)	7
Dental Benefits	9
Vision Benefits	10
Employee Contributions	11
Life/AD&D and Disability	12
Voluntary Benefits	13
Company Benefits	16
Benefits Member Advocacy Center	18
BenePortal	19
Value-Added Services	20
Carrier Contacts	21
Legal Notices	22



ELIGIBILITY & MAKING PLAN CHANGES



Who is Eligible?

If you are a full-time employee at PS&S, you are eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 hours or more per week. New hires are eligible the 1st of the month following date of hire. Your dependents are eligible to participate in the PS&S benefit plans. Your eligible dependents include:

- A spouse to whom you are legally married
- A domestic partner
- A dependent child under age 26. Dependent children can include natural, adopted children, and stepchildren.
 - Coverage will terminate at the end of the month the dependent turns 26 but may be extended past the age of 26 for disabled dependents.

Making Changes During the Plan Year - Qualifying Life Events

Unless you experience a Qualifying Life Event, you cannot make changes to your benefits until the next Open Enrollment period. Qualifying Life Events include:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

You must notify People Operations within 30 days of experiencing a Qualifying Life Event.



MEDICAL BENEFITS

MERITAIN HEALTH (AN AETNA COMPANY)



PS&S offers the following medical plan options administered by Meritain Health (an Aetna Company). If you are enrolled in one of the medical plans you are automatically enrolled in the corresponding prescription plan. To locate a participating provider, visit <https://www.aetna.com/dsepublic/#/mymeritain>, in the “Enter Location Here” key in your zip code, city, and state. Next, key in or select “Aetna Choice POS II (Open Access)” and search for providers using the guided flow search or the search box.

MEDICAL BENEFITS	EPO HSA PLAN	EPO PLAN	POS PLAN	
	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Individual/Family	\$2,500/\$5,000	\$750/\$1,500	\$2,000/\$4,000	\$3,500/\$7,000
Calendar Year Out-of-Pocket Maximum Individual/Family	\$5,000/\$7,500	\$5,000/\$10,000	\$6,000/\$12,000	\$12,500/\$25,000
Preventive Care Services	Covered 100%	Covered 100%	Covered 100%	Plan pays 70%*
PCP Office Visit	Plan pays 90%*	\$30 copay	\$25 copay	Plan pays 70%*
Specialist Office Visit	Plan pays 90%*	\$60 copay	\$50 copay	Plan pays 70%*
Inpatient Hospital	Plan pays 90%*	Plan pays 90%*	Plan pays 80%*	Plan pays 70%*
Emergency Room	Plan pays 90%*	\$250 copay	\$250 copay	Plan pays 70%*
PRESCRIPTION DRUG BENEFITS				
Retail				
Generic	\$10 copay*	\$10 copay	\$10 copay	Plan pays 70%*
Brand	\$45 copay*	\$40 copay	\$40 copay	Plan pays 70%*
Non-Formulary	\$70 copay*	\$60 copay	\$60 copay	Plan pays 70%*
Mail Order				
Generic	\$20 copay*	\$20 copay	\$20 copay	Not Covered
Brand	\$90 copay*	\$80 copay	\$80 copay	Not Covered
Non-Formulary	\$140 copay*	\$120 copay	\$120 copay	Not Covered

* After deductible



Did You Know...

Preventive care services, such as routine physicals and immunizations for adults and children, are covered 100% in-network - no copays, deductibles, or coinsurance!



TELEMEDICINE

TELADOC

Talk to a Doctor 24/7 With Teladoc

Whether it's the weekend or you're traveling out of town, with Teladoc, plan members have access to medical care via phone or video consultation—anytime, anywhere.

What is Teladoc?

It is quality care when you need it most

Teladoc is a national network of U.S. board-certified doctors available 24/7/365 to diagnose, treat, and prescribe medication, if necessary, for many common medical issues. Using Teladoc is a convenient option when it's not possible to visit your doctor's office. Services are completely confidential.

Contact Teladoc for non-emergency medical conditions such as:

- Allergies
- Asthma
- Cold and flu symptoms
- Ear infections
- Pink eye
- Respiratory infections
- Sinus issues
- Urinary tract infections

Cost of Teladoc Services

The costs for Teladoc are dependent on the plan you are enrolled in. Please see below:

- **EPO HSA Plan:** 10% after deductible
- **EPO Plan:** \$15 copay
- **POS Plan:** \$10 copay



Contact Teladoc

To contact Teladoc, call **800.835.2362**, visit www.teladoc.com/aetna, or download the Teladoc mobile app to your device today.



HEALTH SAVINGS ACCOUNT (HSA)

FLORES

If you participate in the EPO HSA Plan, you may be eligible to participate in a Health Savings Account (HSA).

An HSA is a tax-exempt savings account that can be used for contributions, earnings and withdrawals for eligible expenses.



HSA Highlights

An HSA is portable, meaning that if you leave your employer, you can take your HSA funds with you. There is no “use it or lose it” provision with an HSA. If you don’t use the money in your account by the end of the year, it just stays there and collects interest on a tax-deferred basis.

An HSA includes a banking partner that offers you several investment options that suit your needs. An HSA does not require third party substantiation for transactions; however, you should keep records of these transactions in the event of an IRS audit.

HSA Eligibility

You may contribute to an HSA if you:

- Are covered under an HSA Qualified high deductible health plan (HDHP)
- Do not have disqualifying coverage such as other “first dollar” medical coverage etc.
- Are not entitled to (eligible and enrolled) Medicare
- Cannot be claimed as a dependent on someone else’s tax return

HSA Eligible Expenses Include:

- Medical and prescription drug deductibles, coinsurance and copayments
- Dental deductibles, coinsurance and copayments
- Orthodontia or other dental care
- Eye exams, contact lenses and glasses

HSA Contributions

The maximum amount that can be contributed to the HSA in a tax year is established by the IRS and is dependent on whether you have individual or family coverage in the EPO HSA plan. For 2025, the contribution limits are:

- \$4,300 for individual coverage
- \$8,550 for family coverage
- The annual catch-up contribute for age 55 and older is \$1,000



FLEXIBLE SPENDING ACCOUNT (FSA)

FLORES

IMPORTANT: FSA contributions need to be elected annually at Open Enrollment. Open Enrollment is your **once per year opportunity** to enroll or make changes to your benefits, unless you experience a Qualified Life Event.

What is a Flexible Spending Account?

With an FSA, you elect to have your annual contribution (up to the annual limit set by the IRS) deducted from your paycheck each pay period in equal installments throughout the year.

The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified medical, dependent care, and commuter expenses and services.

What are Commuter Benefits?

Commuter Benefits allow you to pay for eligible work-related transit and parking expenses through pre-tax payroll deductions from your paycheck.

For the 2025 plan year you may contribute:

- **TRANSIT:** up to \$325 per month for transportation (mass transit, train, subway, bus fares, ferry rides).
- **PARKING:** up to \$325 per month for parking expenses incurred at or near your work location or near a location from which you commute using mass transit.



How do I submit claims to Flores?

- **Via web:** You may scan your FSA or Commuter claim and upload it or complete your claim details online at www.flores247.com.
- **Via Flores mobile app:** Use your phone's camera to take a picture of your documentation and upload. Download Flores Mobile through the Apple store or Google play.

FLEXIBLE SPENDING ACCOUNT (FSA)

FLORES



Health Care FSA

You may contribute a maximum of \$3,300 per year. If you elect to contribute to an FSA account in 2025 and have funds remaining at the end of the year, a maximum of \$660 rolls over into 2026.

REALIZE THE SAVINGS!

You can set aside pretax money into an account to be reimbursed for eligible medical expenses. Savings will depend on your tax bracket. For example, if you are taxed at 25% and you enroll for \$3,300 you would save **\$825 in taxes.**

The Health Care FSA can reimburse you for eligible expenses you or your eligible dependents incur that are not paid by your existing health care plan. Eligible expenses include:

- Medical copays, coinsurance, and deductibles
- Routine wellness visits
- Prescription expenses
- Vision expenses such as eye exams, glasses, contacts, and LASIK
- Dental expenses and orthodontia payments

Dependent Care FSA

The Dependent Care FSA is a great way to pay for dependent care expenses for qualifying dependents (children under age 13 or a dependent of any age that lives in your household that is incapable of self care) with pre-tax dollars.

You may set aside a maximum of \$5,000 per year if you are married and filing a joint tax return or \$2,500 per year if you are married and filing separately. Eligible expenses include:

- Preschools (excludes tuition/kindergarten & educational expenses)
- Before and after school care
- Day camp (excludes overnight camp)

Limited Purpose FSA

If you are enrolling in the High Deductible Health Plan (HDHP) and elect the Health Savings Account (HSA)*, IRS rules prohibit you from participating in the Healthcare FSA. However, you may elect up to \$3,300 in a Limited Purpose FSA, which can be used for dental and vision expenses only. Eligible expenses include:

- **Vision expenses** such as eye exams, glasses, contacts, and LASIK
- **Dental expenses** such as cleanings and exams, non-cosmetic dental work, orthodontia

Have questions about your benefits?

The Conner Strong and Buckelew Benefits Member Advocacy Center (MAC) is here to help! Simply call **800.563.9929** (Monday – Friday, 8:30am to 5pm EST) or visit www.connerstrong.com/memberadvocacy.

DENTAL BENEFITS

UNUM



Eligible employees and their eligible family members may enroll in the Unum dental plan, which includes 100% coverage for preventive services such as routine dental exams, cleanings, and X-rays.

	LOW PPO PLAN	HIGH PPO PLAN
	IN-/OUT-OF-NETWORK	IN-/OUT-OF-NETWORK
Calendar Year Deductible Individual/Family	\$50/\$150	\$50/\$150
Calendar Year Maximum (per patient)	\$1,000	\$2,000
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year) Fluoride Treatment (once in a calendar year, children to age 19)	Plan pays 100%	Plan pays 100%
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	Plan pays 80%*	Plan pays 80%*
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	Plan pays 50%*	Plan pays 50%*
Orthodontia Benefits (children age 19 and below)	N/A	Plan pays 50%
Orthodontia Lifetime Maximum (per patient)	N/A	\$1,500

* After deductible

Did You Know...

Dental hygiene and health are directly linked to health in other areas of the body. Most people recognize the importance of maintaining good physical health, and having regular physical examinations, but we rarely extend the same consideration to our teeth. The truth is that good dental care is a crucial part of your overall physical health because other systems can be affected by your oral health. For example, taking proper care of your gums can help prevent heart disease.



VISION BENEFITS

UNUM



Take care of your vision and overall health while saving on your eye care and eyewear needs. Vision insurance can help you maintain your vision as well as detect various health problems. Health conditions such as diabetes and high blood pressure can be detected early through a comprehensive eye exam.

Eligible employees have the option of electing the voluntary vision plan through Unum. The plan provides coverage for a range of care including exams, frames, lenses, and contact lenses.

UNUM VISION PLAN

	IN-NETWORK	OUT-OF-NETWORK
Exams		
Routine	\$10 copay	Up to \$40
Contact Lens Fitting	\$40 copay	Not Covered
Lenses		
Single Vision	\$10 copay	Up to \$30
Bifocal	\$10 copay	Up to \$50
Trifocal	\$10 copay	Up to \$70
Lenticular	\$10 copay	Up to \$70
Frames	\$150 allowance	Up to \$105
Contact Lenses	\$150 allowance	Up to \$150
Frequency		
Exam		12 months
Lenses		12 months
Frames		12 months

EMPLOYEE CONTRIBUTIONS

MEDICAL, DENTAL & VISION BENEFITS



MEDICAL/PRESCRIPTION DRUG MONTHLY EMPLOYEE CONTRIBUTIONS

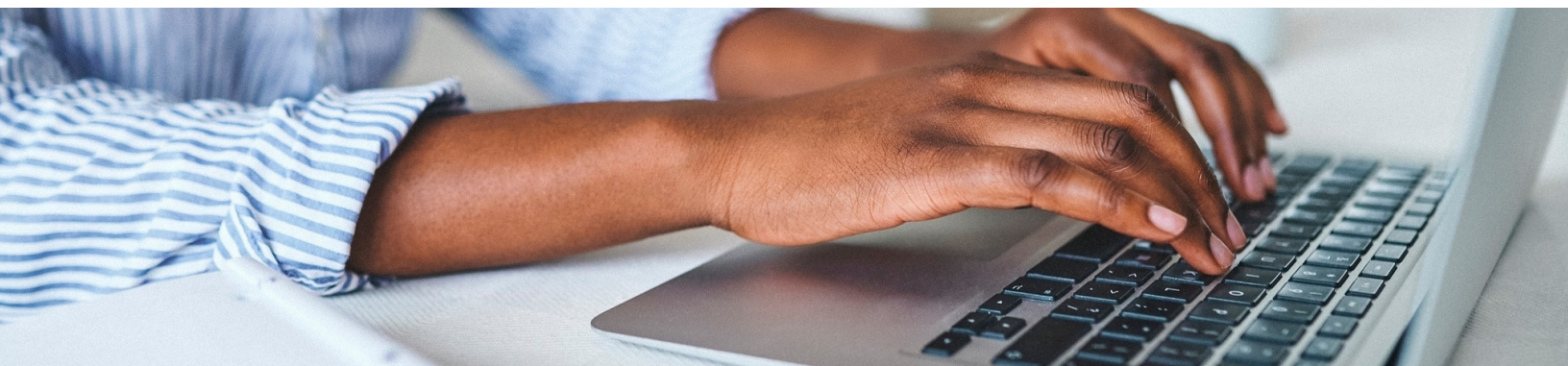
COVERAGE TIER	EPO HSA PLAN	EPO PLAN	POS PLAN
Employee Only	\$103.97	\$271.37	\$138.06
Employee & Spouse	\$463.64	\$798.07	\$525.15
Employee & Child(ren)	\$421.49	\$723.64	\$474.83
Family	\$670.17	\$1,150.73	\$756.12

DENTAL MONTHLY EMPLOYEE CONTRIBUTIONS

COVERAGE TIER	LOW PPO PLAN	HIGH PPO PLAN
Employee Only	\$9.06	\$13.70
Employee & Spouse	\$17.89	\$27.61
Employee & Child(ren)	\$22.86	\$26.95
Family	\$34.25	\$38.88

VISION MONTHLY EMPLOYEE CONTRIBUTIONS

COVERAGE TIER	VISION PLAN
Employee Only	\$2.62
Employee & Spouse	\$4.60
Employee & Child(ren)	\$4.60
Family	\$5.60



LIFE/AD&D AND DISABILITY

UNUM

Basic Life/AD&D

Life insurance can help provide for your loved ones if something were to happen to you. PS&S provides full-time employees with 1x annual earnings to a maximum of \$50,000 in group life and accidental death and dismemberment (AD&D) insurance. **PS&S pays for the full cost of this benefit.**

Short-Term Disability

Short-Term Disability (STD) is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work. **PS&S pays for the full cost of this benefit.**

After seven (7) calendar days of continuous disability, you may receive 60% of your average weekly wages to a maximum benefit of \$1,000 per week. This benefit can be paid for up to 26 weeks of continuous disability.

Long-Term Disability

Long-Term Disability (LTD) insurance protects workers in the event they become disabled for a prolonged period prior to retirement. **PS&S pays for the full cost of this benefit.**

LTD provides you with income continuation in the event your illness or injury lasts beyond 180 days. This helps to ensure you have a continued income if you are unable to work due to a covered sickness or injury. You may receive 60% of your pre-disability earnings to a maximum benefit of \$15,000 per month.



VOLUNTARY BENEFITS

UNUM



Voluntary Life Insurance

While PS&S offers basic life insurance, some employees may be interested in additional coverage based on their personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, **you are responsible for paying the full cost of coverage through payroll deductions.** You can purchase coverage for yourself, your spouse or your dependent child(ren) as outlined below:

Employee Coverage

- Increments of \$10,000
- Maximum coverage amount of 5x annual earnings or \$750,000 (whichever is less)
- Guaranteed issue amount of \$500,000

Spouse Coverage

- Increments of \$5,000
- Maximum coverage amount of \$100,000 or 100% of voluntary employee coverage (whichever is less)
- Guaranteed issue amount of \$25,000

Child Coverage

- Increments of \$2,000
- Maximum coverage amount of \$10,000

Please note: You must enroll in voluntary employee life insurance in order to purchase coverage for your spouse or dependent child(ren).

AGE BAND	FULL-TIME EMPLOYEES MONTHLY ATTAINED AGE COSTS (MONTHLY RATES PER \$1,000)	
	EMPLOYEE/SPOUSE	CHILD
15-24	\$0.050	\$0.367
25-29	\$0.060	
30-34	\$0.080	
35-39	\$0.091	
40-44	\$0.131	
45-49	\$0.215	
50-54	\$0.328	
55-59	\$0.478	
60-64	\$0.660	
65-69	\$1.270	
70-74	\$2.060	
75+	\$4.972	

Voluntary/Buy-Up Short-Term Disability (STD)

PS&S offers employees the option to purchase additional Short-Term Disability (STD) insurance, **you are responsible for paying the full cost of coverage through payroll deductions.** You can purchase coverage for yourself as outlined below:

- 75% of weekly earnings up to a maximum of \$1,154 per week
- Elimination period (accident/sickness) of 0/7 or 7/7
- Benefit duration of 3 or 6 months

Please note: the Voluntary/Buy Up STD plan will be offset by the STD plan provided to you by PS&S.



VOLUNTARY BENEFITS

UNUM



Accident Insurance

Accidents happen and they can affect more than just your physical health. With Accident Insurance, you get a benefit to help pay for costs associated with a covered accident or injury. You may utilize the payments as you best see fit.

Accident insurance covers:

- Initial & emergency care
- Hospitalization
- Fractures & dislocation
- Follow-up care

TIER	MONTHLY PREMIUMS
Employee	\$11.79
Employee + Spouse	\$20.85
Employee + Child(ren)	\$26.11
Employee + Family	\$35.17

Hospital Indemnity

A hospital stay can happen at any time, and it can be costly. Hospital Indemnity insurance helps you and your loved ones have additional financial protection.

With hospital indemnity insurance, a benefit is paid directly to the covered person, unless otherwise assigned, after a covered hospitalization resulting from a covered injury or illness.

Schedule of Benefits:

- Admission (1 day per year): \$1,000
- Daily stay (per day up to 365 days): \$45
- Short stay (1 day per year): \$250

TIER	MONTHLY PREMIUMS
Employee	\$8.96
Employee + Spouse	\$19.18
Employee + Child(ren)	\$12.44
Employee + Family	\$22.66

Critical Illness

We know that everyone has different needs when coping with a critical illness. With Critical Illness insurance, you get a benefit paid directly to the covered person, unless otherwise assigned, if they are diagnosed with a covered critical illness, such as:

- Cancer
- Heart attack
- Stroke
- Progressive disease

AGE	MONTHLY AGE ATTAINED COSTS EMPLOYEE, SPOUSE & CHILD(REN) COST	
	\$15,000 EMPLOYEE AND \$15,000 SPOUSE \$50 BE WELL BENEFIT	
<25	\$3.99	
25-29	\$4.74	
30-34	\$5.79	
35-39	\$6.99	
40-44	\$9.24	
45-49	\$12.54	
50-54	\$18.09	
55-59	\$24.84	
60-64	\$35.64	
65-69	\$52.14	
70-74	\$77.79	
75-79	\$108.84	
80-84	\$150.39	
85+	\$236.34	



VOLUNTARY BENEFITS

MetLife Pet Insurance

Many American households have at least one pet. In any given year, one in three of these beloved family members will need costly veterinary care, even if it's for routine exam visits and vaccinations. Should a pet become severely ill and need emergency care, costs can sometimes be more than pet owners can bear. With MetLife pet insurance, owners can focus on their pet's wellbeing without worrying about the cost for care.

A MetLife pet insurance policy provides you with the following coverage and key features:

- Covers all breeds and ages
- Optional wellness coverage
- Family plan (covers multiple pets)
- Healthy pet incentive

Pricing is customized to every pet and varies by species, age, breed, and zip code. Call [1.800.GET.MET8](tel:1800.GET.MET8) or visit www.metlife.com/getpetquote to get a quote today.

MetLife Legal

Legal issues occur throughout life, when employees are getting married, buying a home, becoming a caregiver or handling financial matters like debt or tax audits. Dealing with these matters can be costly and time consuming, taking employees away from work and impacting their overall well-being.

A MetLife legal insurance policy provides you with the following coverage and key features:

- Debt Collection Defense
- Home and Real Estate, Landlord/tenant assistance
- Estate planning
- Family and personal
- Civil lawsuits
- Eldercare issues

Cost per employee per month (covers spouses and dependents): **\$18.00**

Norton ID Theft Plans

With the ever-changing digital world and new cybercrimes constantly emerging, people should always have the right to feel safe and secure online. Employees can feel at ease knowing they have protection in place with Norton LifeLock Benefit Plans. As these threats evolve, it's important to stay one step ahead. Norton LifeLock Benefit plans are designed to help protect employees and ensure their well-being.

A Norton ID Theft insurance policy provides you with the following coverage and key features:

- Proprietary LifeLock Identity Alert System
- Financial protection: banking, credit, and investment accounts
- Lifestyle protection
- Social protection
- Preventative lock & freeze dashboard

BENEFIT ESSENTIAL	
Employee Only (18+)	\$7.99
Employee + Family	\$15.98
BENEFIT PREMIER	
Employee Only (18+)	\$11.49
Employee + Family	\$21.98
BENEFIT PREMIER PLUS	
Employee Only (18+)	\$14.49
Employee + Family	\$24.98



PS&S COMPANY BENEFITS

Paid Time Off (PTO)

This is time to be used without distinction between vacation, sickness, or personal time.

- Full-time employees receive full yearly PTO hours based on years of service that are front loaded each January 1st to use throughout the year.
- Regularly scheduled 32-hour employees are front loaded at a rate of 80% of a full-time employee. Please reference the Full Time Employee PTO Bank I Totals table in the Employee Handbook.
- Part-time employees accrue hours based on hours worked each month, at a rate according to the Part-Time Employee PTO Bank II Totals table in the Employee Handbook.
- Newly hired full-time and regularly scheduled 32-hour employees earn PTO time in the calendar year in which they start, on a pro-rated basis, at a rate equal to the total monthly equivalent in the PTO Bank I table, times the number of full months worked in their hire year.
- Employees may carry 40 hours over from the previous year as well.

The formal PTO policy can be found in the PS&S Employee Handbook.

Holidays

There are 8 official holidays observed by PS&S.

New Year's Day	Wednesday, January 1, 2025
Presidents' Day	Monday, February 17, 2025
Memorial Day	Monday, May 26, 2025
Independence Day	Friday, July 4, 2025
Labor Day	Monday, September 1, 2025
Thanksgiving	Thursday, November 27, 2025
Day After Thanksgiving	Friday, November 28, 2025
Christmas	Thursday, December 25, 2025

401(k) Plan

PS&S participates in a 401(k) Plan managed by Fidelity Investments. New employees are **automatically set up to have 6% deducted from their paycheck and invested into a default account.** The default account is a Fidelity Advisor Freedom Fund that most closely aligns with your projected retirement date based upon your birth year. You **MUST** register on the website to adjust the 6% (up or down) AND to change investment accounts.

The annual Company match is 50% up to a limit of 6% of your compensation deferral. The vesting schedule can be found on www.netbenefits.com.

In 2025 the annual maximum 401(k) contribution is \$23,500. The catch-up contribution limit is \$7,500. for employees aged 50-59 and \$11,250 for employees aged 60-63.

Employees are responsible for their own investment decisions. We strongly suggest employees take advantage of the investment educational materials available including seminars, enrollment packages, and online information at www.netbenefits.com.



PS&S COMPANY BENEFITS

PS&S Store Front

A new hire will receive a certificate to purchase attire, with the PS&S logo, from our PS&S Store Front. Thereafter, items may be purchased by employees at their expense. The PS&S Store Front link can be accessed from your Teams menu by choosing the Quick Links icon, find Store Front, click **"Go to Link"**.

Tuition Reimbursement

A tuition-reimbursement plan exists for eligible full-time employees pursuing work-related studies. New employees must be employed 6 months prior to applying for educational assistance. Prior approval by your supervisor is required. Reimbursement occurs after successful completion of a class - a grade of A or B is necessary (as is one year continued employment at PS&S upon completion of the course(s)). Reimbursement covers tuition, registration, and parking fees to a maximum of \$4,000 per semester and \$8,000 per calendar year. (Books, computers, etc., are not covered).

Employee Referral Reward Program

A referral reward of \$3,000 is available to full-time employees, referring candidates who are hired into full-time available positions. Referrals must be filed with People Operations at the time resumes are submitted and are paid out on a schedule.

- \$1,500 once the referred employee has completed 6 months of employment.
- \$1,500 once the referred employee has completed 1 year of employment.

(The referral reward is not available to Vice Presidents). Call People Operations for details.

Part-Time Employees:

Part-time, employees not working a regularly scheduled work week of 30 hours or more but who do average more than 20 hours per week over each quarter of the calendar year become eligible for holiday benefits. Holidays are prorated in proportion to the normal 40-hour work week. Part-time employees will accrue PTO according to the Part-Time Employee PTO Bank II Table, which can be found in the Employee Handbook.



BENEFITS MEMBER ADVOCACY CENTER (MAC)

CONNER STRONG & BUCKELEW

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits MAC can help guide the way!

The Benefits Member Advocacy Center (Benefits MAC), provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

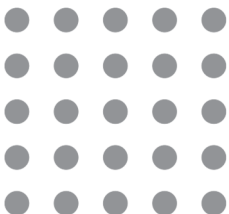
- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Rescue you from a benefits problem you've been working on
- Discover all that your benefit plans have to offer!

Member Advocates are available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

How to Contact Member Advocacy?

You may contact the Member Advocacy Team in any of the following ways:

- Via phone: [800.563.9929](tel:800.563.9929), Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Via the web: www.connerstrong.com/memberadvocacy
- Via email: cssteam@connerstrong.com
- Via fax: [856.685.2253](tel:856.685.2253)



BENEPORTAL

YOUR ONLINE BENEFITS RESOURCE

At PS&S, employees have access to a full-range of valuable employee benefit programs. With BenePortal, you and your dependents can review your current employee benefit plan options online, 24/7!

Use BenePortal to access benefit plan documents, insurance carrier contacts, forms, guides, links and other applicable benefit materials. BenePortal is mobile-optimized, making it easy to view your benefits on-the-go. Simply bookmark the site in your phone's browser or save it to your home screen for quick access.

BenePortal features include:

- Secure online access - with NO login required!
- Direct links to benefits enrollment sites
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!

Simply go to www.psandsbenefits.com to access your benefits information today!



VALUE-ADDED SERVICES

CONNER STRONG & BUCKELEW

Benefit Perks

This feature provides a broad array of services, discounts and special deals on consumer services, travel services, recreational services and much more. Simply access the site and register and you can begin using it now.

Learn more at: <https://connerstrong.corestream.com>

HUSK Marketplace

Achieving optimal health and wellness doesn't have to be complicated or expensive. Access exclusive best-in-class pricing with some of the biggest brands in fitness, nutrition, and wellness with HUSK Marketplace.

Learn more at:
<https://marketplace.huskwellness.com/connerstrong>

GoodRX

Compare drug prices at local and mail-order pharmacies and discover free coupons and savings tips.

Learn more at: <https://connerstrong.goodrx.com>

HealthyLearn

This resource covers over a thousand health and wellness topics in a simple, straight-forward manner. The HealthyLearn On-Demand Library features all the health information you need to be well and stay well.

Learn more at:
<https://healthylearn.com/connerstrong>



CARRIER CONTACTS

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

BENEFITS/RESOURCES	CONTACT	PHONE NUMBER	WEBSITE
Medical and Prescription	Meritain (an Aetna company)	800.925.2272	www.meritain.com
Health Savings Account (HSA)	Flores	800.532.3327	www.Flores247.com
Dental	Unum	866.679.3054	www.unumdentalcare.com
Vision	Unum	800.275.8686	www.EyeMedVisionCare.com/Unum
Life/AD&D, STD and LTD	Unum	800.275.8686	www.unum.com/register
Accident/Hospital/Critical Illness	Unum	800.275.8686	www.unum.com/register
Pet Insurance	MetLife	800.GET.MET8	www.metlife.com/getpetquote
Legal	MetLife	800.821.6400	https://members.legalplans.com
ID Theft	Norton	800.607.9174	www.nortonlifelock.com
Member Advocacy	Conner Strong & Buckelew	800.563.9929	www.connerstrong.com/memberadvocacy



LEGAL NOTICES

Availability of Summary Health Information

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

PS&S offers a series of health coverage options. You will receive a Summary of Benefits and Coverage (SBC) from Horizon. These documents summarize important information about all health coverage options in a standard format. Please contact People Operations if you have any questions.

Notice Regarding Special Enrollment

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

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 (CHIP).

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

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

To request special enrollment or obtain more information, contact Hayley Conklin, Deputy Executive Director & Interim Chief People Operations Officer at 973-849-1727.

Newborns' and Mothers' Notice

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

Women's Health and 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 benefits. If you have any questions, please speak with People Operations.

Mental Health Parity and Addiction Equality Act of 2008

This Act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

General Notice of COBRA Continuation Coverage Rights

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 the COBRA vendor.

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.

LEGAL NOTICES

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 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

People Operations
732-560-9700

Important Notice from PS&S 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 PS&S 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. PS&S has determined that the prescription drug coverage offered 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 PS&S coverage will be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage. (See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D).

If you do decide to join a Medicare drug plan and drop your current PS&S coverage, be aware that you and your dependents will be able to get this coverage back if there is a Life Event or at open enrollment.

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 PS&S 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 PS&S 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).

LEGAL NOTICES

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).

People Operations
732-560-9700

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

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

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

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

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

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

ALABAMA - Medicaid
Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS - Medicaid
Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID
Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-8442

FLORIDA - Medicaid
Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA - Medicaid
GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

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

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

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

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

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

MAINE - Medicaid
Enrollment Website: 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: 800-977-6740 TTY: Maine relay 711

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

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

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

MONTANA - Medicaid
Website: <http://dphs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HSHIPPProgram@mt.gov

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

NEVADA - Medicaid
Medicaid Website: <http://dhcfnv.gov>
Medicaid Phone: 1-800-992-0900

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

LEGAL NOTICES

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>

Phone: 1-800-692-7462

CHIP Website: <https://www.pa.gov/en/agencies/dhs/resources/chip.html>

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

Website: <https://medicaid.utah.gov/upp/>

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-562-3022

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <http://mywvhipp.com/> and <https://dhr.wv.gov/bms/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 800-251-1269

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

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565



INSURANCE MARKETPLACE NOTICE

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets our needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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 meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. 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. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to <https://www.healthcare.gov/marketplace/individual/>.

PART B: Information about Health Coverage Offered by Your Employer

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

3. Employer Name PS&S		4. Employer Identification Number 900590653	
5. Employer Address 3 Mountainview Road		6. Employer phone number 732-560-9700	
7. City Warren	8. State New Jersey	9. Zip Code 07059	
10. Who can we contact about employee health coverage that this job? People Operations			
11. Phone number (if different from above)		12. Email Address	

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



PS&S reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail.