2024/2025

Employee Benefits Overview

UNITED LABORATORIES

TABLE OF CONTENTS

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on page 27 for more details.

MAKE THE MOST OF YOUR BENEFITS

At United Laboratories, Inc. we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective:

August 1, 2024 - July 31, 2025

Who Can You Cover?

WHO IS ELIGIBLE?

In general, employees working 30 or more hours per week are eligible for the benefits outlined in this overview. In order to comply with the Affordable Care Act (ACA), United Laboratories, Inc. generally determines your eligibility for benefits based on using the Look-Back Measurement Method. Refer to the Look-Back Measurement Method section of this guide for additional information on how your eligibility is determined.

You can enroll the following family members in our medical, dental, vision, and voluntary life plans.

- Your spouse or civil union partner (the person who you are legally married to under state law, including a same-sex spouse.)
- Your children:
  - Under age 26 are eligible to enroll in medical, dental, vision, and voluntary life coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of United Laboratories, Inc. cannot also be covered as a dependent.
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage for new employees begins on the 1st of Month following 30 days for all benefits, except Short-Term Disability (STD). Short-Term Disability coverage starts on the 1st of the Month following 12 months of continuous full-time active work.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Notify Human Resources within 31 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Medical

BlueCross BlueShield of Illinois

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

	Blue Advantage HMO Plan
	In-Network* (Employees residing in Chicago metro area only)
Annual Deductible	$1,000 per individual $3,000 family limit
Coinsurance	You pay 20%; Plan 80%
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and all applicable copays including pharmacy)	Includes the Prescription Drug Out-of-Pocket Maximum $3,000 per individual $9,000 family limit
Office Visit	
Virtual Visits	Not Applicable
Primary Provider	$50 copay then plan pays 100%
Specialist	$70 copay then plan pays 100%
Preventive Services	Plan pays 100%
Lab and X-ray	Plan pays 100%
Inpatient Hospitalization	$200 copay per visit, then plan pays 80% after deductible
Outpatient Surgery	$150 copay per visit, then plan pays 80% after deductible
Urgent Care	$50 PCP or $70 Specialist copay (must be affiliated with member's chosen medical group or referral required)
Emergency Room	$250 copay per visit, then plan pays 80% after deductible (copay waived if admitted on an inpatient basis)
Vision**	Exam covered at 100% (1 exam every 12 months)

*Insured must pre-select a primary care physician (PCP). All care must be provided or coordinated by your PCP.
**Exam provided through EyeMed and discounts through EyeMed & Davis Vision for exams and hardware (LensCrafters, Pearle Vision, Sears Optical,Target Optical)

Medical HMO Video

Medical

BlueCross BlueShield of Illinois

	PPO Plan	
	In-Network	**Out-Of-Network***
Annual Deductible	$2,500 per individual $7,500 family limit	$5,000 per individual $15,000 family limit
Coinsurance	You pay 20%; Plan 80%	You pay 40%; Plan 60%
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and all applicable copays except pharmacy)	Separate from the Prescription Drug Out-of-Pocket Maximum	
	$5,500 per individual $10,200 family limit	$11,000 per individual $20,400 family limit
Office Visit		
Virtual Visits	$30 copay then plan pays 100%	Not Applicable
Primary Provider	$30 copay then plan pays 100%	Plan pays 60% after deductible
Specialist	$50 copay then plan pays 100%	Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Lab and X-ray	Complex imaging: Plan pays 80% after deductible; All other: $30 PCP or $50 specialist copay then plan pays 100%	Plan pays 60% after deductible
Inpatient Hospitalization	Plan pays 80% after deductible	$300 admission copay then plan pays 60% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	$150 copay then plan pays 100% (copay waived if admitted on an inpatient basis)	
Vision**	Not Covered	

*Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates.
**Discounts through EyeMed & Davis Vision for exams and hardware (LensCrafters, Pearle Vision, Sears Optical,Target Optical)

Medical PPO Video

Medical

BlueCross BlueShield of Illinois

	Blue Choice PPO Plan*		
	Blue Choice Network	**PPO Network**	**Out-Of-Network****
Annual Deductible	$500 per individual $1,500 family limit	$1,500 per individual $4,500 family limit	$3,000 per individual $9,000 family limit
Coinsurance	You pay 10%; Plan 90%	You pay 30%; Plan 70%	You pay 50%; Plan 50%
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and all applicable copays except pharmacy)	Separate from the Prescription Drug Out-of-Pocket Maximum $4,000 per individual $10,200 family limit	$5,600 per individual $10,200 family limit	$12,000 per individual $26,400 family limit
Office Visit			
Virtual Visits	$20 copay then plan pays 100%	$20 copay then plan pays 100%	Not Applicable
Primary Provider	$20 copay then plan pays 100%	$50 copay then plan pays 100%	Plan pays 50% after deductible
Specialist	$40 copay then plan pays 100%	$100 copay then plan pays 100%	Plan pays 50% after deductible
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 50% after deductible
Lab and X-ray	Complex imaging: plan pays 90% after deductible; All other: $20 PCP or $40 specialist copay then plan pays 100%	Complex imaging: plan pays 70% after deductible; All other: $50 PCP or $100 specialist copay then plan pays 100%	Plan pays 50% after deductible
Inpatient Hospitalization	$250 copay then 90% after deductible	$500 copay then 70% after deductible	$600 copay then 50% after deductible
Outpatient Surgery	$200 copay then 90% after deductible	$400 copay then 70% after deductible	$500 copay then 50% after deductible
Urgent Care	$75 copay then plan pays 100%		
Emergency Room	$400 copay then 90% after deductible (copay waived if admitted on an inpatient basis)		
Vision* **	Not Covered		

*Employees outside of Illinois use the PPO Network and receive the Blue Choice benefit level.
**Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates.
***Discounts through EyeMed & Davis Vision for exams and hardware (LensCrafters, Pearle Vision, Sears Optical,Target Optical)

Medical PPO Video

Medical

BlueCross BlueShield of Illinois

	100% HSA Plan	
	In-Network	**Out-Of-Network***
HSA Employer Contribution	United Laboratories will deposit on a quarterly basis $425.00 for single coverage ($1,700 annually) and $550.00 for family coverage ($2,200 annually) into your HSA account.	
Annual Deductible (the deductible can be offset by HSA funds)	$7,500 per individual $15,000 family limit	$15,000 per individual $30,000 family limit
Coinsurance	You pay 0%; Plan 100%	You pay 0%; Plan 100%
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and all applicable copays)	$7,500 per individual $15,000 family limit	$15,000 per individual $30,000 family limit
Office Visit		
Virtual Visits	Plan pays 100% after deductible	Not Applicable
Primary Provider	Plan pays 100% after deductible	Plan pays 100% after deductible
Specialist	Plan pays 100% after deductible	Plan pays 100% after deductible
Preventive Services	Plan pays 100%	Plan pays 100% after deductible
Lab and X-ray	Plan pays 100% after deductible	Plan pays 100% after deductible
Inpatient Hospitalization	Plan pays 100% after deductible	Plan pays 100% after deductible
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 100% after deductible
Urgent Care	Plan pays 100% after deductible	Plan pays 100% after deductible
Emergency Room	Plan pays 100% after deductible	
Vision**	Not Covered	

*Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates.
**Discounts through EyeMed & Davis Vision for exams and hardware (LensCrafters, Pearle Vision, Sears Optical,Target Optical)

Medical HSA Video

Medical

BlueCross BlueShield of Illinois

	80% HSA Plan	
	In-Network	**Out-Of-Network***
HSA Employer Contribution	United Laboratories will deposit on a quarterly basis $425.00 for single coverage ($1,700 annually) and $550.00 for family coverage ($2,200 annually) into your HSA account.	
Annual Deductible (the deductible can be offset by HSA funds)	$3,200 per individual $6,400 family limit	$6,400 per individual $12,800 family limit
Coinsurance	You pay 20%; Plan 80%	You pay 40%; Plan 60%
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and all applicable copays)	$6,200 per individual $12,400 family limit	$18,600 per individual $37,200 family limit
Office Visit		
Virtual Visits	Plan pays 80% after deductible	Not Applicable
Primary Provider	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist	Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Hospitalization	Plan pays 80% after deductible	$300 copay then 60% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 80% after deductible	
Vision**	Not Covered	

*Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates.
**Discounts through EyeMed & Davis Vision for exams and hardware (LensCrafters, Pearle Vision, Sears Optical,Target Optical)

Medical HSA Video

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

	Blue Advantage HMO Plan*
	In-Network
Annual Out-of-Pocket Limit	Prescriptions subject to Medical Out-of-Pocket Maximum
Pharmacy	
Preferred Generic	Plan pays 100%
Non-Preferred Generic	$10 copay then plan pays 100%
Preferred Brand	$50 copay then plan pays 100%
Non-Preferred Brand	$100 copay then plan pays 100%
Select Oral Contraceptives	$0 copay
Supply Limit	30 days
Mail Order	
Preferred Generic	Plan pays 100%
Non-Preferred Generic	$30 copay then plan pays 100%
Preferred Brand	$150 copay then plan pays 100%
Non-Preferred Brand	$300 copay then plan pays 100%
Preferred Specialty (30 day supply)	$150 copay
Non-Preferred Specialty (30 day supply)	$250 copay
Select Oral Contraceptives	$0 copay
Supply Limit	90 days

*If an insured selects a brand name drug when there is a generic equivalent available, the member will pay the applicable copay plus the cost difference between the selected drug and the generic equivalent.

Medical Prescription Drugs Video

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

	PPO Plan*	
	In-Network	**Out-Of-Network**
Annual Out-of-Pocket Limit	$1,000 per individual $3,000 per family	Not Applicable
Pharmacy	Preferred Network/Non-Preferred Network**	*Covered at 75% of the contracted pharmacy amount*
Generic	$10/$15 copay then plan pays 100%	$15 copay then plan pays 75%
Preferred Brand	$40/$50 copay then plan pays 100%	$50 copay then plan pays 75%
Non-Preferred Brand	$60/$70 copay then plan pays 100%	$70 copay then plan pays 75%
Select Oral Contraceptives	$0 copay	$0 copay
Supply Limit	30 days	30 days
Mail Order		
Generic	$20 copay then plan pays 100%	Not Applicable
Preferred Brand	$80 copay then plan pays 100%	
Non-Preferred Brand	$120 copay then plan pays 100%	
Specialty (30 day supply)	Covered at applicable copay	
Select Oral Contraceptives	$0 copay	
Supply Limit	90 days	

*If an insured selects a brand name drug when there is a generic equivalent available, the member will pay the applicable copay plus the cost difference between the selected drug and the generic equivalent.
**There are three levels of benefits. 1. Preferred Network Pharmacies – Walgreens, Walmart, Albertsons/Osco and Access Health/Independents 2. Non-Preferred Network Pharmacies – All other in-network pharmacies 3. Non-Network – Examples include CVS/Target and some independent pharmacies. All CVS pharmacies (including those located in Target stores) are excluded from the BCBSIL PPO pharmacy network. CVS pharmacies (including those located in Target stores) remain in the HMO pharmacy network.

Medical Prescription Drugs Video

Prescription Drugs

	Blue Choice PPO Plan*		
	Blue Choice Network	PPO Network	Out-of-Network
Annual Out-of-Pocket Limit	$1,000 per individual $3,000 per family		Not Applicable
Pharmacy	Preferred Network/Non-Preferred Network**		*Covered at 75% of the contracted pharmacy amount*
Preferred Generic	$0/$5 copay then plan pays 100%		$5 copay
Non-Preferred Generic	$10/$15 copay then plan pays 100%		$15 copay
Preferred Brand	$35/$45 copay then plan pays 100%		$45 copay
Non-Preferred Brand	$75/$85 copay then plan pays 100%		$85 copay
Select Oral Contraceptives	$0 copay		$0 copay
Supply Limit	30 days		30 days
Mail Order			
Preferred Generic	$0 copay		
Non-Preferred Generic	$20 copay then plan pays 100%		
Preferred Brand	$70 copay then plan pays 100%		
Non-Preferred Brand	$150 copay then plan pays 100%		Not Applicable
Specialty (30 day supply)	$150 copay then plan pays 100%		
Select Oral Contraceptives	$0 copay		
Supply Limit	90 days		

*If an insured selects a brand name drug when there is a generic equivalent available, the member will pay the applicable copay plus the cost difference between the selected drug and the generic equivalent.
**There are three levels of benefits. 1. Preferred Network Pharmacies – Walgreens, Walmart, Albertsons/Osco and Access Health/Independents 2. Non-Preferred Network Pharmacies – All other in-network pharmacies 3. Non-Network – Examples include CVS/Target and some independent pharmacies. All CVS pharmacies (including those located in Target stores) are excluded from the BCBSIL PPO pharmacy network. CVS pharmacies (including those located in Target stores) remain in the HMO pharmacy network.

Medical Prescription Drugs Video

Prescription Drugs

BlueCross BlueShield of Illinois

	100% HSA Plan*	
	In-Network	**Out-Of-Network**
Annual Out-of-Pocket Limit	Prescriptions subject to Medical Out-of-Pocket Maximum	
Pharmacy	Preferred Network/ Non-Preferred Network**	*Covered at 50% of the contracted pharmacy amount*
Preferred Generic	Plan pays 100% after deductible/ 100% after deductible	Plan pays 100% after deductible
Non-Preferred Generic	Plan pays 100% after deductible/ 100% after deductible	Plan pays 100% after deductible
Preferred Brand	Plan pays 100% after deductible/ 100% after deductible	Plan pays 100% after deductible
Non-Preferred Brand	Plan pays 100% after deductible/ 100% after deductible	Plan pays 100% after deductible
Select Oral Contraceptives	$0 copay	$0 copay
Supply Limit	30 days	30 days
Mail Order		
Preferred Generic	Plan pays 100% after deductible	
Non-Preferred Generic	Plan pays 100% after deductible	
Preferred Brand	Plan pays 100% after deductible	
Non-Preferred Brand	Plan pays 100% after deductible	
Preferred Specialty (30 day supply)	Plan pays 100% after deductible	Not Applicable
Non-Preferred Specialty (30 day supply)	Plan pays 100% after deductible	
Select Oral Contraceptives	$0 copay	
Supply Limit	90 days	

* For the HSA program, there is a preventive drug program which covers eligible prescriptions for certain preventive categories (i.e. high blood pressure, respiratory, high cholesterol, diabetic medications and supplies, etc.) prior to meeting your deductible.

**There are three levels of benefits. 1. Preferred Network Pharmacies – Walgreens, Walmart, Albertsons/Osco and Access Health/Independents 2. Non-Preferred Network Pharmacies – All other in-network pharmacies 3. Non-Network – Examples include CVS/Target and some independent pharmacies. All CVS pharmacies (including those located in Target stores) are excluded from the BCBSIL PPO pharmacy network. CVS pharmacies (including those located in Target stores) remain in the HMO pharmacy network.

Medical Prescription Drugs Video

Prescription Drugs

BlueCross BlueShield of Illinois

	80% HSA Plan*	
	In-Network	**Out-Of-Network**
Annual Out-of-Pocket Limit	Prescriptions subject to Medical Out-of-Pocket Maximum	
Pharmacy	Preferred Network/ Non-Preferred Network**	*Covered at 50% of the contracted pharmacy amount*
Preferred Generic	Plan pays 90% after deductible/ 80% after deductible	Plan pays 80% after deductible
Non-Preferred Generic	Plan pays 90% after deductible/ 80% after deductible	Plan pays 80% after deductible
Preferred Brand	Plan pays 80% after deductible/ 70% after deductible	Plan pays 70% after deductible
Non-Preferred Brand	Plan pays 70% after deductible/ 60% after deductible	Plan pays 60% after deductible
Select Oral Contraceptives	$0 copay	$0 copay
Supply Limit	30 days	30 days
Mail Order		
Preferred Generic	Plan pays 90% after deductible	
Non-Preferred Generic	Plan pays 90% after deductible	
Preferred Brand	Plan pays 80% after deductible	
Non-Preferred Brand	Plan pays 70% after deductible	
Preferred Specialty (30 day supply)	Plan pays 60% after deductible	Not Applicable
Non-Preferred Specialty (30 day supply)	Plan pays 50% after deductible	
Select Oral Contraceptives	$0 copay	
Supply Limit	90 days	

* For the HSA program, there is a preventive drug program which covers eligible prescriptions for certain preventive categories (i.e. high blood pressure, respiratory, high cholesterol, diabetic medications and supplies, etc.) prior to meeting your deductible.

**There are three levels of benefits. 1. Preferred Network Pharmacies – Walgreens, Walmart, Albertsons/Osco and Access Health/Independents 2. Non-Preferred Network Pharmacies – All other in-network pharmacies 3. Non-Network – Examples include CVS/Target and some independent pharmacies. All CVS pharmacies (including those located in Target stores) are excluded from the BCBSIL PPO pharmacy network. CVS pharmacies (including those located in Target stores) remain in the HMO pharmacy network.

Medical Prescription Drugs Video

Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

BlueCross BlueShield PPO/HSA Medical Plan Participants

- Call BlueCross BlueShield 24/7 NurseLine at 800-299-0274
- Find an urgent care center by visiting bcbsil.com/find-a-doctor-or-hospital
- Use BlueCross BlueShield MDLive Telehealth

BlueCross BlueShield HMO Medical Plan Participants

- Find an affiliated urgent care center by visiting Provider Finder® and selecting your network

Telehealth Virtual Visits Video

GET A VIDEO HOUSE CALL

BlueCross BlueShield PPO/HSA members can video chat with a doctor from the comfort of their own homes, without an appointment. MDLive Telehealth provides 24/7 access to U.S. board-certified physicians, for the fraction of the cost of an office visit. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. For more information, visit mdlive.com/bcbsil, download the mobile app, call 888-676-4204 or text BCBSIL to 635-483 (MDLive's online assistant Sophie will help activate your account).

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

GOING ABROAD?

When you travel overseas, you can rely on the BlueCard Program. This program offers access to an international network of participating doctors and hospitals for a broad range of medical care services. For non-emergency medical care outside the U.S, call BlueCard Access collect at 1.800.810.BLUE (2583).

Additional Program Benefits

BLUE ACCESS FOR MEMBERS

Go to www.bcbsil.com/member or download the BCBSIL Mobile App to register for access to check the status of your claims, sign up for mobile alerts about claim activity, print a temporary ID card, confirm who is covered, review your Explanation of Benefits (EOB) and more! You will need your medical ID card to register.

WELLBEING MANAGEMENT

Wellbeing Management provides personalized attention, support, online resources and health advocacy to help you optimize your health benefits. Take a health risk assessment, sign up for a fitness program, sign up for lifestyle management programs, etc. There are tutorials on more than 170 health topics available. Licensed behavioral health professionals can also help you access services and offer support with co-existing medical conditions and disorders such as anxiety or depression.

BLUE 365 DISCOUNTS

Log on to www.blue365deals.com/BCBSIL to access weekly deals such as health club memberships, athletic apparel, footwear, weight loss programs, vision products and services, dental solutions and more!

TOBACCO CESSATION

BlueCross BlueShield covers tobacco cessation counseling (including telephone, group and individual counseling) and screening for members who use tobacco products as well as two 90-day treatments for tobacco cessation medication per calendar year at no cost to you!

BLUECARD

Will you be traveling abroad? The BlueCard program is there for you if you are traveling across the country. BlueCard can help you access physicians, hospitals and health services across the nation. Call 800-810-BLUE (2583) for information on the nearest PPO doctors and hospitals.

Health Savings Account (HSA)

Do you want to save money on taxes? A Health Savings Account is a tax-advantaged, portable (you own it!) savings account that is offered if you enroll in our Benefit Resource, Inc. HSA Account.

You and United Laboratories, Inc. contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Any money that you don't spend grows year after year and can be used in the future, even after you retire. Benefit Resource, Inc. administers this account.

ACCOUNT CONTRIBUTIONS

	Company Contributes	You Can Contribute
Employee	United Laboratories will deposit on a quarterly basis $425.00 for single coverage ($1,700 annually) into your HSA account.	2024: $4,150 less employer contribution 2025: $4,300 less employer contribution
Employee + Family	United Laboratories will deposit on a quarterly basis $550.00 for family coverage ($2,200 annually) into your HSA account.	2024: $8,300 less employer contribution 2025: $8,550 less employer contribution
Catch Up Contributions	An additional $1,000 per year at age 55+	

USING YOUR MONEY

You can use your account to pay for qualified medical expenses that are not paid for by your high deductible health plan (HDHP). In general, your HSA can be used for these expenses:

- Medically necessary expenses that are not covered by your health plan including deductibles and coinsurance
- Dental care services
- Vision care services
- Prescription drugs
- Over-the-counter (OTC) medications
- Certain medical equipment

When possible, use your HSA debit card to pay for expenses. Make sure that you keep records of your receipts in case the IRS requests them.

ELIGIBILITY

You are not eligible to open or contribute to an HSA account if you are:

- Covered by a non-high deductible health plan
- Enrolled in a regular healthcare flexible spending account (you or your spouse count)
- Covered under Medicare, Medicaid or Tricare
- Someone else's tax dependent

Non-Qualified Expenses

If you use HSA funds for non-qualified expenses before age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only. Visit irs.gov/publications/p502 for details.

Medical HSA Video – http://meeting.videobenefitsguy.com/medhsa

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. And reimbursements from your FSA accounts are tax-free. You must re-enroll in this program each year. Benefit Resource, Inc. (BRI) administers this program.

IMPORTANT CONSIDERATIONS

- There's no "crossover" spending allowed between the healthcare and dependent care accounts.
- Expenses must be incurred between 08/01/24 and 07/31/25 and submitted no later than 9/29/25.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- You can keep (roll-over) up to $640 of unused money for use in the next plan year. Unused amounts above $640 will be lost, so it is very important that you plan carefully before making your election.
- FSA funds can be used for eligible expense incurred by you, your spouse, and your tax dependents only. Your spouse or tax dependent children do not have to be covered on the United Laboratories, Inc. health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts as proof that your expenses were eligible for IRS purposes.

TAX-FREE HEALTHCARE FSA

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $3,200 for the 2024 plan year. If you are enrolled in the HSA Plan, you can participate in our Limited Purpose Healthcare FSA which covers out-of-pocket vision and dental expenses ONLY.

TAX-FREE DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

Medical FSA Video

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

United Laboratories, Inc. provides you with a comprehensive coverage through Delta Dental of Illinois.

	PPO Plan		
	In-Network*	**Premier Network****	**Out-Of-Network*****
Calendar Year Deductible	$75 per individual		
Annual Plan Maximum	$1,500 per individual		
Diagnostic and Preventive	Plan pays 90% of reduced fee (deductible does not apply)	Plan pays 80% of Max. Plan Allowance after deductible	Plan pays 80% of Max. Plan Allowance after deductible
Basic Services	Plan pays 80% of reduced fee after deductible	Plan pays 70% of Max. Plan Allowance after deductible	Plan pays 70% of Max. Plan Allowance after deductible
Major Services	Plan pays 50% of reduced fee after deductible	Plan pays 50% of Max. Plan Allowance after deductible	Plan pays 50% of Max. Plan Allowance after deductible
Orthodontic Services			
Orthodontia	Plan pays 50% of reduced fee after deductible	Plan pays 50% of Max. Plan Allowance after deductible	Plan pays 50% of Max. Plan Allowance after deductible
Lifetime Maximum	$1,500 per individual		
Dependent Children	Covered to age 26		

* You will not be “balance billed" for charges exceeding Delta's allowed PPO fees
**You will not be "balance billed" for charges exceeding Delta's Maximum Plan Allowances (MPAs)
***You are responsible for charges exceeding MPAs

Dental Video

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through UnitedHealthcare.

	PPO Plan	
	In-Network	**Out-Of-Network**
Examination		
Benefit	$10 copay then plan pays 100%	Reimbursed up to $40
Frequency	1 x every 12 months from last date of service	
Materials	$25 copay then plan pays 100%	See schedule below
Eyeglass Lenses		
Single Vision Lens	Plan pays 100% of basic lens (materials copay applies)	Reimbursed up to $40
Bifocal Lens	Plan pays 100% of basic lens (materials copay applies)	Reimbursed up to $60
Trifocal Lens	Plan pays 100% of basic lens (materials copay applies)	Reimbursed up to $80
Frequency	1 x every 12 months from last date of service	
Frames		
Benefit	Reimbursed up to $130, plus a 30% discount on the overage at select providers (please check the provider finder to ensure the provider allows for discounts)	Reimbursed up to $45
Frequency	1 x every 24 months from last date of service	
Contacts (Elective)		
Benefit	Reimbursed up to $105	Reimbursed up to $105
Frequency	1 x every 12 months from last date of service in lieu of eyeglasses	

Vision Video

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company. Coverage is provided by Lincoln Financial. **Important note:** Employees must elect medical coverage to be eligible.

Basic Life Amount	$10,000
Basic AD&D Amount	$10,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

New Hires - Evidence of Insurability: If you select a coverage amount above $150,000 for employee and $20,000 for spouse for voluntary life, you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to determine if you are approved for the higher amount of coverage.

Existing Employees - Evidence of Insurability: During annual open enrollment, Employees and/or spouses who chose not to sign up at initial enrollment will not have the opportunity for the full guaranteed issue amount of $150,000 for employee and $20,000 for spouse coverage. They will have the opportunity to elect two increments only without evidence of insurability. Employees and spouses who enrolled for voluntary life coverage at initial eligibility, and who apply for additional voluntary life coverage during open enrollment and have not previously been withdrawn or declined, will be eligible for up to two increments ($20,000 employee or $10,000 spouse) of additional coverage without evidence of insurability up to the maximum coverage amount.

VOLUNTARY LIFE AND AD&D

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. Coverage is provided by Lincoln Financial.

Employee Voluntary Life Amount	Increments of $10,000 (minimum: $10,000) up to Lesser of 5 x covered annual earnings or $500,000
Employee Guarantee Issue Amount*	Lesser of 5 x covered annual earnings or $150,000
Spouse Voluntary Life Amount	Increments of $10,000 (minimum: $10,000) up to Lesser of 50% of employee amount or $250,000
Spouse Guarantee Issue Amount*	Lesser of 100% of employee's voluntary life amount up to $20,000
Child(ren) Voluntary Life Amount	**Age 15 days to 6 months:** $1,000 **Age 6 months to age 26:** $5,000 or $10,000
Voluntary AD&D	**Employee must elect voluntary life coverage in order to elect voluntary AD&D coverage. If elected, the voluntary AD&D amount will be the equivalent to the employee, spouse and child amount**

*If you elect coverage at your initial eligibility date

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

Coverage for new employees begins on the 1st of the Month following 12 months of continuous full-time active work for Short-Term Disability.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability (STD) coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. Benefits may be reduced by income from other income sources such as paid time off. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition. The cost of coverage is paid in full by the company. Coverage is provided by Lincoln Financial.

Weekly Benefit Amount	Plan pays 60% of covered weekly earnings
Maximum Weekly Benefit	$2,500
Benefits Begin After: Accident Sickness	14 days of disability
Maximum Payment Period*	13th week of disability

*Maximum payment period is based on the first day you are disabled, not when benefits begin.

Cost of Coverage

United Laboratories, Inc. pays for the full cost of coverage for employee only coverage for Basic Life/AD&D and STD coverage. You share in the cost of coverage for other plans and coverage levels.

Medical Blue Advantage HMO Plan	Your Weekly Cost
Employee Only	$67.63
Employee + Spouse	$152.30
Employee + Child(ren)	$111.85
Employee + Family	$189.98
Medical PPO Plan	**Your Weekly Cost**
Employee Only	$185.18
Employee + Spouse	$380.24
Employee + Child(ren)	$279.26
Employee + Family	$474.32
Medical Blue Choice PPO Plan	**Your Weekly Cost**
Employee Only	$81.60
Employee + Spouse	$167.56
Employee + Child(ren)	$123.06
Employee + Family	$209.02
Medical 100% HSA Plan	**Your Weekly Cost**
Employee Only	$54.08
Employee + Spouse	$111.05
Employee + Child(ren)	$81.56
Employee + Family	$138.52
Medical 80% HSA Plan	**Your Weekly Cost**
Employee Only	$63.90
Employee + Spouse	$131.22
Employee + Child(ren)	$96.37
Employee + Family	$163.68

Cost of Coverage

Dental PPO Plan	Your Weekly Cost
Employee Only	$3.69
Employee + Spouse	$7.38
Employee + Child(ren)	$7.38
Employee + Family	$8.86

Vision PPO Plan	Your Weekly Cost
Employee Only	$0.69
Employee + Spouse	$1.62
Employee + Child(ren)	$1.33
Employee + Family	$2.19

Voluntary Life	Your Monthly Cost Per $1,000 **Employee/Spouse** **(spouse's cost is based on spouse's age)**
Under Age 30	$0.09
Age 30-34	$0.09
Age 35-39	$0.12
Age 40-44	$0.20
Age 45-49	$0.29
Age 50-54	$0.49
Age 55-59	$0.85
Age 60-64	$1.34
Age 65-69	$2.09
Age 70-74	$3.35
Age 75 & over	$5.92

Voluntary Life	Your Monthly Cost Per $5,000/$10,000 **Child(ren)**
	$1.00/$2.00

Voluntary AD&D	Your Monthly Cost Per $1,000 **Employee/Spouse/Child(ren)**
	$0.05

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	BlueCross BlueShield of IL	HMO: (800) 892-2803 PPO & HSA: (800) 541-2768 Pharmacy: (800) 423-1973	www.bcbsil.com	B00110 (BAHMO) P17517 (PPO) 017438 (BCOPPO) PM4844 (100%HSA) PA2461 (80%HSA)
Dental	Delta Dental of IL	(800) 323-1743	www.deltadentalil.com	20208
Vision	United Healthcare	(800) 638-3120	www.myuhcvision.com	918548
Life/AD&D & Disability	Lincoln Financial	Life & Disability: (800) 423-2765	www.lincolnfinancial.com	Basic Life/AD&D: 000010283553 Voluntary Life: 00040000100029008 Voluntary AD&D: 000403008876 Short Term Disability: 000010283555 Long Term Disability: 000010283544
FSA and HSA	Benefit Resource, Inc.	(800) 473-9595	www.benefitresource.com	36-2535769

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if you understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Look-Back Measurement Method

You and your dependents are eligible for the medical plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. ACA full-time status can affect or determine medical benefits eligibility but is not a guarantee of benefits eligibility. United Laboratories, Inc. uses the Look-Back Measurement Method to determine whether an employee meets this eligibility threshold.

NEW EMPLOYEES

New employees hired to work full-time

If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group medical plan coverage as of the 1st of Month following 60 days.

New employees hired to work a variable hour or seasonal schedule

If you are hired into a part-time position, a position where your hours vary and United Laboratories, Inc. is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee.

Your 12-month IMP will begin on the first of the month following your date of hire or date of hire if hired on the first of any given month and will last for 12 months. If, during your IMP, you average 30 or more hours a week over that 12-month period, you will be full-time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends.

Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES

United Laboratories, Inc. uses the look-back measurement method to determine group medical health plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which United Laboratories, Inc. counts employee hours to determine which employees work full-time.

An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full-time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period.

If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

United Laboratories, Inc. uses the standard measurement period and associated stability period annual cycle set forth below.

Measurement Period: Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility	May 3 – May 2
Stability Period: Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period	August 1 – July 31

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are in this packet of open enrollment materials and include:

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- Patient Protection Notice
  Describes the right to designate a primary care provider.
- HIPAA Notice of Privacy Practices
  Describes how health information about you may be used and disclosed.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
  Describes availability of premium assistance for Medicaid eligible dependents.
- Health Insurance Marketplace Coverage Options
  Describes availability of insurance plans through the Marketplace.
- Illinois Consumer Coverage Disclosure Act

  The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

CURRENT PLAN DOCUMENTS

Important documents for our health plan are available upon request.

Important Notice from United Laboratories, Inc. 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 United Laboratories, Inc. 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. **United Laboratories, Inc. has determined that the prescription drug coverage offered by the United Laboratories, Inc. Group Insurance 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 United Laboratories, Inc. coverage will be affected.

The current prescription drug benefit offered through United Laboratories, Inc. Group Insurance Plans are as follows:

Retail Pharmacy HMO Plan: Preferred Generic - $0 copay; Non-Preferred Generic - $10 copay; Preferred Brand – $50 copay; Non-Preferred Brand - $100 copay.

Retail Pharmacy PPO Plan: Generic – $10/$15 copay; Preferred Brand – $40/$50 copay; Non-Preferred Brand - $60/$70 copay.

Retail Pharmacy Blue Choice PPO Plan: Preferred Generic - $0/$5 copay; Non-Preferred Generic – $10/$15 copay; Preferred Brand – $35/$45 copay; Non-Preferred Brand - $75/$85 copay.

Retail Pharmacy HSA 100% Plan paid after deductible is met: All drug classes covered at 100%

Retail Pharmacy HSA 80% Plan paid after deductible is met: Generic – 10%/20%; Preferred Brand – 20%/30%; Non-Preferred Brand – 30%/40%

Mail Order HMO Plan: Preferred Generic – $0 copay; Non-Preferred Generic - $30 copay; Preferred Brand – $150 copay; Non-Preferred Brand - $300 copay; Preferred Specialty - $150 copay; Non-Preferred Specialty -$250 copay.

Mail Order Pharmacy PPO Plan: Generic – $20 co-pay; Preferred Brand – $80 copay; Non-Preferred Brand - $120 co-pay. Specialty covered at applicable copay.

Mail Order Pharmacy Blue Choice PPO Plan: Preferred Generic - $0 copay; Non-Preferred Generic – $20 copay; Preferred Brand – $70 copay; Non-Preferred Brand - $150 copay; Specialty - $150 copay.

Mail Order Pharmacy HSA 100% Plan paid after deductible is met: All drug classes covered at 100%

Mail Order Pharmacy HSA 80% Plan paid after deductible is met: Generic – 10%; Preferred Brand – 20%; Non-preferred Brand – 30%; Preferred Specialty – 40%; Non-Preferred Specialty – 50%

If you do decide to join a Medicare drug plan and drop your current United Laboratories, Inc. coverage, be aware that you and your dependents will 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 United Laboratories, Inc. 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. 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 United Laboratories, Inc. changes. You also may request a copy of this notice at any time.

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

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 12, 2024
Name of Entity/Sender:	United Laboratories, Inc.
Contact:	Julie A. Remington, Director of Human Resources
Address:	320 37th Avenue, St. Charles, Illinois 60174
Phone Number:	(800) 323-2594 extension 7434

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Women's Health and Cancer Rights Act Notice

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

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

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

If you would like more information on WHCRA benefits, contact your Health Insurance issuer.

Newborns' and Mothers' Health Protection Act

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage 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). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

Patient Protection Notice

BlueCross BlueShield Blue Advantage HMO requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Blue Advantage HMO network and who is available to accept you or your family members. For a list of participating primary care providers visit BlueCross BlueShield's website at: www.bcbsil.com. From the home page, select "Provider Finder", select "Illinois" and for the network choose "Blue Advantage HMO". You may also contact Julie Remington, Director of Human Resources at extension 7434 in the Home Office.

For children, you may designate a pediatrician as the primary care provider.

If in addition to your primary care provider, you designate a health care professional who specializes in obstetrics or gynecology, you do not need prior authorization from BlueCross BlueShield or from a primary care provider in order to obtain access to obstetrical or gynecological care.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Notice of Special Enrollment Rights

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

If you are decline enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) 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' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the plan's General Contact.

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, 2023. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: 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://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

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)

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

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

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

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
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: 617-886-8102

MINNESOTA – Medicaid

Website: 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

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, 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 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.

Health Insurance Marketplace Coverage

For the Department of Labor's Employer Exchange/Marketplace Notices and Instructions, please click the link below:
http://www.datair.com/PDF/DOL Employer Exchange Notices.pdf

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 your 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 Julie Remington at (630) 377-0900 ext. 7434.

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.

[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.

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 United Laboratories, Inc.	4. Employer Identification Number (EIN) 36-2535769	
5. Employer address 320 37th Avenue	6. Employer phone number 630-377-0900	
7. City St. Charles	8. State IL	9. ZIP code 60174
10. Who can we contact about employee health coverage at this job? Julie Remington		
11. Phone number (if different from above) 630-377-0900 ext. 7434	12. Email address jremington@unitedlabsinc.com	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time employee of the employer. Full-time employee means a person who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse or civil union partner and dependent children until they reach age 26.

☐ We do not offer coverage.

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

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

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

Rev. 8/8/2024