

2024 TEAMMATE BENEFITS GUIDE

Active Day strives to offer you and your family a competitive and comprehensive benefits package. We encourage you to take the time to review this guide and educate yourself about the benefit options available to you.

The benefits in this guide are effective **June 1, 2024** through **May 31, 2025**.



Welcome

TO ACTIVE DAY!

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QUESTIONS?

If you have questions about your benefits, please contact Member Advocacy at **800.563.9929**, Monday through Friday 8:30 am to 5:00 pm. They can also be reached at **cssteam@connerstrong.com** or **www.connerstrong.com/memberadvocacy**.

Important Enrollment Information

Who is Eligible to Elect Benefits?

- **Medical Plan:** All teammates working 30 or more hours per week are eligible on the first of the month following 60 days of employment*.
- **Dental Plan:** All teammates working 32.5 hours or more per week are eligible on the first of the month following 60 days of employment.

Dependent Coverage

- **IBX Medical Plan:** until end of month in which they reach age 26
- **Dental Plan:** until end of month in which they reach age 26

** For employment classification below full time status, a 12-month look-back measurement period applies to determine eligibility*



Qualifying Life Events

Once you have made your elections, you will not be able to change them until the next Open Enrollment period unless you experience a qualified life event.

IRS §125 prohibits you from changing your enrollment during the Plan Year unless you experience a qualifying life event (QLE). Qualified status changes include: marriage, divorce, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in your spouse's benefits or employment status.



IMPORTANT!

If you do have a qualified life event, you must notify your manager within 30 days of experiencing a qualified status change.

Note: It is the teammate's responsibility to notify their manager at the time their dependent is no longer eligible under the above plans so that Active Day can issue a timely COBRA notification, and adjust their payroll deduction if necessary.

Enrollment Instructions

THEBENEFITSEXPERT (TBX)

Enrolling in Benefits

STEP 1: CREATE AN ACCOUNT

Register for an account on the MyTBX360 portal at my.tbx360.com/activeday, and follow the prompts to complete the process.

STEP 2: ENROLL INTO YOUR BENEFITS

Click the “My Benefits” link on the MyTBX360 portal to access TheBenefitseXpert enrollment site. You will be prompted to fill in your personal details to access your personalized account:

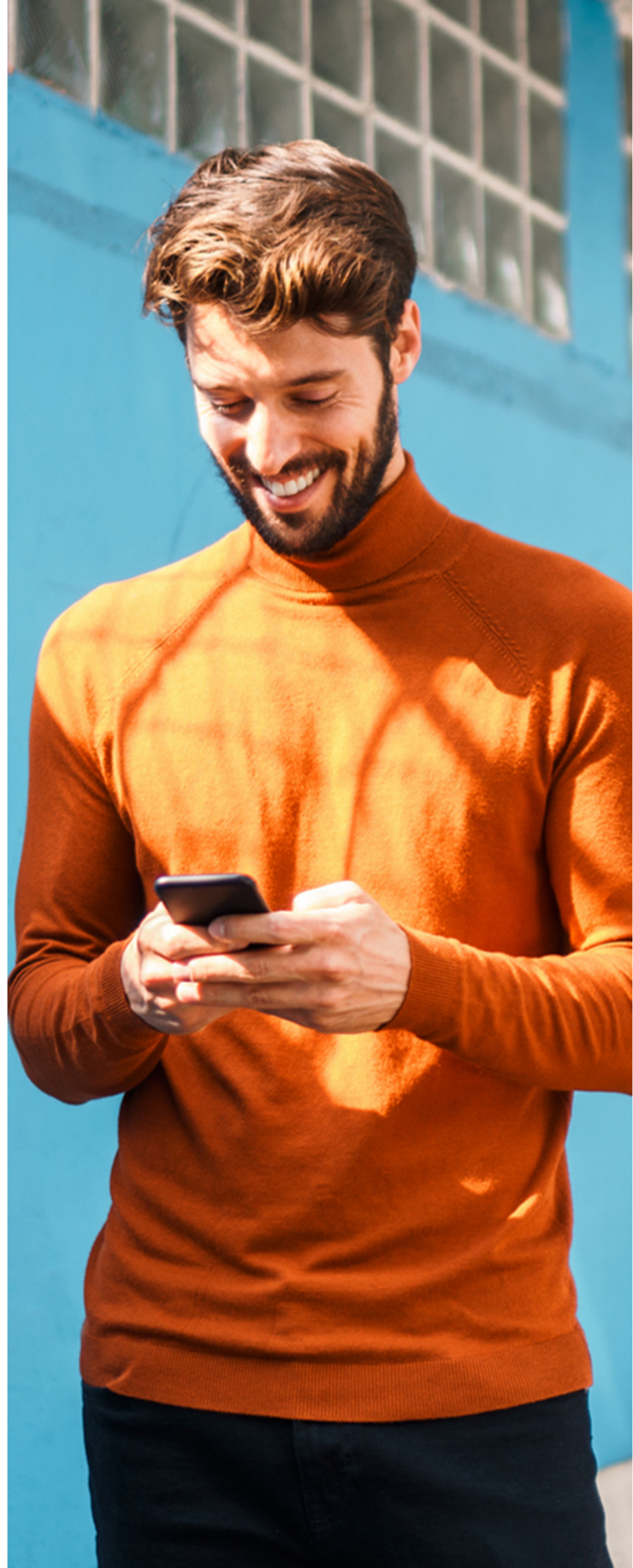
- **User ID**
Enter your Social Security Number or your employee ID. No dashes required.
- **Personal ID Number (PIN)**
Enter the last 4 digits of your Social Security Number and the last 2 digits of your birth year. No dashes required.

TIP:

Have the names, birthdates, and social security numbers of all eligible dependents you wish to enroll.

Questions?

For any assistance, you can call the TBX call center at **885.482.9669**.



Wellness Initiatives

Non-Tobacco User Affidavit

If you participate in the Active Day health plan with Independence Blue Cross you are eligible for the Payroll Deduction Reward with your enrollment. By signing this affidavit you are attesting that you have not used tobacco for 90 days prior to your effective date of coverage.

Active Day is proud to offer the Quit For Life®, Tobacco Cessation program to teammates who enroll in the Active Day health plan with Independence Blue Cross. There is no cost to you to participate in this program that provides coaching, nicotine replacement therapy and so much more. For more details on this program please visit the BenePortal site. You can also go to quitnow.net or call **1-866-QUIT-4-LIFE TTY 711** to get started.

Teammates who are currently tobacco users can qualify for the wellness discount by completing a smoking cessation program within 90 days of his/her medical coverage effective date.

Wellness Discount

Healthy living isn't always easy. It is important to keep it simple, set realistic goals, and remember that even small choices can add up to significant health benefits. Active Day is committed to helping teammates achieve their healthy lifestyle goals.

To promote our commitment to wellness, we offer a **\$25 bi-weekly discount on the medical plan contributions** by completing the following wellness activities. **This adds up to \$650 per year!**

Wellness Program

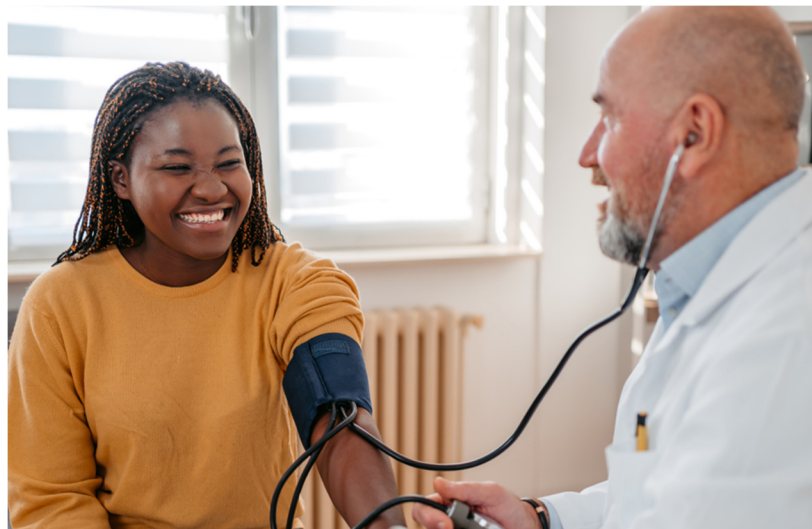
Active Day's wellness program requirements include the following wellness activities:

- Certifying that you are tobacco free
- Obtaining an annual physical and biometric screening
- Completing a health risk assessment through Virgin Pulse

If you enroll in medical benefits, please look out for additional details coming from Active Day when Virgin Pulse launches on June 1st!

To be eligible to continue to receive the wellness discount for the next plan year (June 1, 2025 - May 31, 2026) these items must be completed between June 1, 2024 and March 31, 2025.

The annual physical and screening are fully covered under preventive care with no cost sharing from the teammate. When you schedule your exam please be sure to schedule it as **"Annual Preventive Exam."**



wellnessworks

Additional Benefit Resources

GlobalFit Gym Discount Program

GlobalFit's Gym Network 360 provides exclusive savings to over 8,000 gyms and specialty studios across the country. Not a traditional gym goer? GlobalFit has you covered! Gym Network 360 provides various options for anyone looking to exercise wherever they choose and at their convenience. You will receive exclusive savings to virtual workout programs and an online library of fitness, wellness, and nutrition videos.

GlobalFit Virtual Nutrition

CHARGE Nutrition is an evidence based nutrition offering where members can meet 1-on-1 with a Registered Dietitian to establish personalized plans to establish their nutrition needs.

Learn more by calling **800.294.1500** or visit **globalfit.com/connerstrong**

GoodRx

This service offers an easy way to compare prices for all FDA-approved prescription drugs at virtually every pharmacy in America. You can find pharmacy coupons, manufacturer discounts, generics, comparable drug choices and savings tips all in one place. GoodRx can often beat the copay amount or help with drugs that are not covered by the plan.

For more information, visit **www.goodrx.com**



Member Advocacy

Member Advocacy is provided by our benefits consultant Conner Strong & Buckelew. It allows you to speak to a specially trained and experienced Member Advocate who can assist you with benefit claims issues, coverage questions, and enrollment inquiries.

Call the Conner Strong & Buckelew Member Advocacy hotline at **800.563.9929** or submit a request online at **www.connerstrong.com/memberadvocacy**.

Medical Plan Options

INDEPENDENCE BLUE CROSS

Below is a summary of the medical plans available to you, administered by Independence Blue Cross (IBX). If you need help finding an in-network provider, please visit www.ibx.com.

In-Network Benefits for New IBX Plan Options*

BENEFIT DESCRIPTION	IBX ENHANCED PPO	IBX CORE HDHP	IBX CATASTROPHIC HDHP
Deductible (Individual/Family)	\$1,500 / \$3,000	\$2,500 / \$5,000	\$6,750 / \$13,500
Coinsurance	80%	80%	100%
Out-of-Pocket Maximum (Individual/Family)	\$4,500 / \$9,000	\$6,350 / \$12,700	\$6,750 / \$13,500
Primary Care Physician Office Visit	\$10 copay	80% after deductible	100% after deductible
Specialist Office Visit	\$30 copay	80% after deductible	100% after deductible
Urgent Care Center	\$30 copay	80% after deductible	100% after deductible
Emergency Room (waived if admitted)	\$200 copay then 80%	80% after deductible	100% after deductible
Outpatient Surgery	80% after deductible	80% after deductible	100% after deductible
Inpatient Hospital Stay	80% after deductible	80% after deductible	100% after deductible
PRESCRIPTION DRUG BENEFITS			
RETAIL (30-DAY)			
Generic	\$10 copay	80% after deductible	100% after deductible
Preferred Brand	\$30 copay	80% after deductible	100% after deductible
Non-Preferred Brand	\$50 copay	80% after deductible	100% after deductible
MAIL ORDER (90-DAY)			
Generic	\$20 copay	80% after deductible	100% after deductible
Preferred Brand	\$60 copay	80% after deductible	100% after deductible
Non-Preferred Brand	\$100 copay	80% after deductible	100% after deductible

* For the out-of-network benefit design, please refer to the full plan summaries located on the TBX portal.



Medical Plan Options

INDEPENDENCE BLUE CROSS

The IBX medical plans give you the freedom to see any provider in or out-of-network without a referral. Members also receive in-network coverage across the country through BlueCard PPO® and around the world through BlueCard Worldwide®.

Plan features include:

- More than 750,000 physicians and 5,500 hospitals nationwide.
- Emergency care is covered anywhere anytime.
- Out-of-pocket max covers you for catastrophic expenses.
- Preventive care is covered 100% in-network and is not subject to the deductible (first dollar coverage).

Did You Know?

Here are some other great benefits provided to those who enroll in one of the Independence Blue Cross medical plans:

- You can receive up to \$150 of reimbursement towards Weight Watchers®, Weight Watchers® Online, or an approved weight management program at any network hospital.
- You can receive up to \$150 of reimbursement towards membership fees after 120 visits to an approved fitness center.
- You can receive up to \$150 of reimbursement towards an approved and completed tobacco cessation program.

To find out more about these great programs, please visit www.ibx.com.



Vision Plan Option

DAVIS VISION

When you enroll in the medical plan, you automatically have vision plan benefits administered through Davis Vision. Our vision plan gives you the freedom to see any provider in or out-of-network without a referral.

Davis Vision Plan

	IN-NETWORK	OUT-OF-NETWORK
Exam	\$0 Copay	Up to \$35 reimbursement to member*
Frames (two options)	Choose from participating provider's own frame collection and member receives allowance of \$65 ** Choose from the Davis Collection of Frames that is available at most participating providers and frames are covered in full	Eyeglasses are available to a \$100 reimbursement to the member*
Lenses & Spectacle Lenses	Covered at no extra cost and includes: all range of prescriptions, oversize lenses, glass or plastic lenses, single vision, bifocal, trifocal, or lenticular lenses	Spectacle lenses are available to a \$100 reimbursement to the member*
Additional Lens Options	Additional options covered at no cost include: glass grey #3 prescription sunglass lenses, tinting and polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters	
Contact Lenses (in lieu of eyeglasses)	Member receives allowance up to \$100**	Up to \$100 reimbursement to member*
Frequency	Once every two calendar years	N/A

* In lieu of participating provider benefit, member is responsible for balance

** Member is responsible for balance



Prescription Drug Plan

INDEPENDENCE BLUE CROSS

If you are enrolled in the medical plan, you are automatically enrolled in the prescription drug plan through Independence Blue Cross.

Note that the prescription drug benefit is subject to the HDHP deductible with the exception of certain preventive medications such as:

- Advair
- Actos
- Prozac
- Benicar
- Effexor XR
- Lipitor
- Diovan
- Wellbutrin
- Crestor

For a complete list of the medications, visit BenePortal at www.activedaybenefits.com.

You can fill prescriptions at participating retail pharmacies and receive up to a 30-day supply **OR** you can use the mail-order service and receive up to a 90-day supply. Certain limits and exclusions may apply.

Enhanced PPO Plan

If you are enrolled in the Enhanced PPO plan, and you fill your prescription at a **retail pharmacy** (30-day supply) you pay:

- \$10 generic
- \$30 preferred brand-name
- \$45 non-preferred brand-name

If you are enrolled in the Enhanced PPO plan, and you fill your prescription at a **mail-order prescription** (90-day supply) you pay:

- \$20 generic
- \$60 preferred brand-name
- \$100 non-preferred brand-name

Core/Catastrophic HDHP Plans

If you are in the Core HDHP or Catastrophic HDHP plan, and you fill a **retail pharmacy or mail-order prescription**, you will pay the full cost until the deductible is met. After the deductible is met, you will pay 20% of the cost of the prescription in the Core HDHP plan and 0% in the Catastrophic HDHP plan.

Using Mail-Order

It's easy to setup the mail-order service through FutureScripts. Most doctors use e-prescribing which transmits your prescription electronically.

Simply ask your doctor to send your prescription to FutureScripts. If you haven't yet established an online account with FutureScripts please visit www.futurescripts.com. You can provide a payment online and check the status of your 90-day prescription.



Health Savings Account

(HSA)

Active Day employees have the opportunity to contribute to a Health Savings Account via payroll deductions.

What is an HSA?

If you participate in one of the High Deductible Health Plans (HDHP), you can elect to participate in a Health Savings Account (HSA). An HSA is tax-exempt for contributions, earnings and withdrawals for eligible expenses (an expense which pays for care as described in Section 213 (d) of the Internal Revenue Code).

Some characteristics of an HSA:

- 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 verification for transactions, however you should keep records of these transactions in the event of an IRS audit.

IRS Limits

The maximum amount that can be contributed to an HSA in a tax year is established by the IRS and is dependent on whether you have single or family coverage in the HDHP plan. For 2024, the contribution limits are: \$4,150 for single coverage and \$8,300 for family coverage.



Using Your HSA

You make pre-tax contributions to your HSA. You decide how and when to use your HSA funds—choose to pay for your healthcare expenses or save them! The amount used from your HSA for services covered under your plan helps you meet your deductible.

A **deductible** is the amount you must pay for eligible health expenses before your health plan provides coverage. You can satisfy your deductible by using your HSA, your own money, or both. If you are receiving in-network services, you are still accessing the provider discounts.

Dependent Care FSA

FLORES

The Dependent Care FSA is a great way to pay for dependent care expenses for qualifying dependents 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:

- Before and after school care
- Babysitting and nanny expenses
- Daycare, nursery school, and preschool
- Summer Day Camp
- Adult Day Care Services

Ineligible Expenses:

- Overnight camps
- Tuition for kindergarten and above
- Educational expenses
- Fees not applied toward the care of the child

Important Rules Regarding Dependent Care FSA:

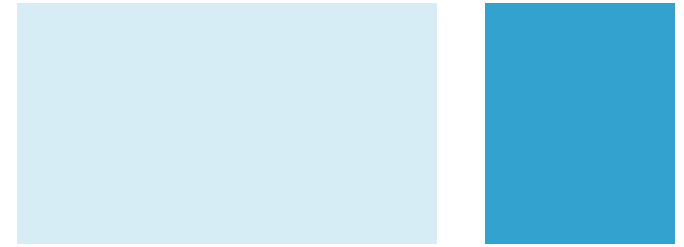
Dependent Care FSAs are use it or lose it, contributions cannot be returned in cash. If you don't use the funds within a specified time frame, then you lose those contributions.

Funds are reimbursed only. If enrolled in a Dependent Care FSA, you must pay for the eligible expenses out of pocket first, and then submit for reimbursement to the FSA vendor for reimbursement of the pre-taxed funds, put aside.

Filing a Claim is Easy:

- Incur an eligible expense and obtain an invoice or receipt from your dependent care provider.
- Download and fill out the Dependent Care claim form, available on the portal.
- Submit the invoice with a claim form via fax, mail, Mobile app, or upload at www.flores247.com.
- You will be paid via check or direct deposit. Claims are paid weekly.

For more information contact www.flores247.com or call **800-532-3327**



Dental Plan

CIGNA

A full benefit description can be found on the BenePortal site. Your Cigna PPO dental plan benefits run on a calendar year. Below is a summary of the dental plan available to you. **Please note: Cigna Dental does not issue enrollment cards.** Teammates can access dental coverage by calling Cigna Dental at **800.244.6224** or by visiting **www.mycigna.com**.

Cigna Dental Plan

BENEFITS*	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Calendar Year (January 1—December 31) (does not apply to preventive and diagnostic services)	None	\$50 per person/\$150 family
Annual Maximum	\$1,000 (combined in and out-of-network)	\$1,000 (combined in and out-of-network)
Preventive & Diagnostic Services Exams, Cleanings & Bitewing X-rays, Fluoride Treatment , Space Maintainers, Sealants	Plan pays 100%	Plan pays 100% of Cigna’s discounted in-network fees. Out-of-network provider can balance bill member for additional charges.
Basic Fillings, Simple Extractions, Endodontics (root canal), Periodontics, Oral Surgery	Plan pays 80%	Plan pays 80% of Cigna’s discounted in-network fees. Out-of-network provider can balance bill member for additional charges.
Crowns & Prosthodontics Crowns/Inlays/Onlays, Bridges and Dentures, Repairs	Plan pays 50%	Plan pays 50% of Cigna’s discounted in-network fees. Out-of-network provider can balance bill member for additional charges.
Orthodontia	Not covered	Not covered

* Frequency and/or age limitations may apply to some services. These limits are described in the plan’s summary booklet/certificate. Services for plastic, reconstructive, or cosmetic surgery, or other dental services or supplies which are primarily intended to improve, alter, or enhance appearance are considered cosmetic and are not covered under the plans.

Need help finding a provider?

Cigna has one of the largest national networks of dentists, and a provider can be located at **www.cigna.com**.

- Go to **www.cigna.com**, click on **FIND A DOCTOR/DENTIST** at the top of the screen. Then select the orange box that reads “If your insurance plan is offered through work.”
- Choose whether you’re looking for a dentist or a place to receive care.
- Enter the geographic location you want to search.
- Select one of the plans offered by your employer during open enrollment.
- Enter a name, specialty or other search word. Click **SEARCH** to see your results.



Employee Assistance Program

CAREBRIDGE

Make Emotional Wellbeing a Priority

REAL HELP, WHEN AND WHERE YOU
OR A LOVED ONE NEEDS IT

- **Confidential Mental Health Assistance:** Access to 24/7 guidance and counseling with licensed clinicians to assist with concerns such as stress, anxiety, depression, grief, substance abuse, and relationship conflicts. Support options include three in-person or telehealth referrals, text and chat.
- **Work-Life Solutions:** Experienced work-life specialists can provide qualified referrals and resources for everyday concerns including child and eldercare, education planning, legal, wellness support groups, transportation, relocation, and pet care.
- **Financial Wellness:** Improve your ability to feel good about your financial life now and in the future. Learn skills to assist with retirement planning, debt management, budgeting, establishing savings, and preparing for a crisis.
- **Stress Management:** Learn to eliminate the chronic negative effects of stress and enhance personal life satisfaction with actionable tools and coaching.
- **Digital Tools and Support:** Carebridge EAP App and myliferesource.com make it easy for you to access a wide array of mental health and life management resources including articles, trainings, calculators, self-care tips, mindfulness practices, discount shopping program, and more.



Contact Carebridge

Carebridge services are available 24/7 and are free and confidential.

Email: clientservice@carebridge.com

Website: myliferesource.com

Term Life Insurance

NEW YORK LIFE

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Underwritten and administered by **New York Life**, Active Day provides all active benefits-eligible employees with a basic Life/AD&D benefit.

This coverage is provided to you at no cost.

Supplemental Life Insurance

Underwritten and administered by **New York Life**, all benefits-eligible employees are eligible to participate in the Supplemental Employee, Spouse & Child Life Insurance Plans. **Since this plan is voluntary the employee is responsible for 100% of the premium.**

If you waive this coverage now and would like to purchase this coverage you will be required to complete a New York Life Enrollment & Statement of Health Form. Please note you are not guaranteed coverage until approved by New York Life, therefore no payroll deduction will be taken until approved.

Supplemental Life Calculation

(Election amount/1,000)*Rate = Monthly Premium

Example

If a 38-year-old employee elects \$50,000 in Voluntary Life Insurance, an amount of \$6.00 would be deducted on a **monthly** basis.

(Election amount of \$50,000 divided by \$1,000 = 50. Multiply 50 times the rate of \$.12 — and that equals \$6.00 as the **monthly** premium)

To calculate your **bi-weekly payroll deduction** — Take monthly premium, multiply by 12, then divide by 26.

Supplemental Employee Life

COVERAGE AMOUNT	GUARANTEED ISSUE AMOUNT (ONLY AVAILABLE TO NEW HIRES)
\$10,000 increments up to a maximum of \$500,000	\$150,000 up to age 64 \$10,000 for age 65+

Supplemental Spouse Life

COVERAGE AMOUNT	GUARANTEED ISSUE AMOUNT (ONLY AVAILABLE TO NEW HIRES)
50% of employee life insurance coverage up to a maximum of \$250,000	\$10,000

Supplemental Child Life

COVERAGE AMOUNT (AGE 14 DAYS TO 26 YEARS OLD)
10% of employee life insurance coverage up to a maximum of \$10,000 (coverage limits based on child(ren)'s age)

Monthly Supplemental Life Costs

EMPLOYEE & SPOUSE	
Age Band	Rate per \$1,000
<20	\$0.070
20-24	\$0.070
25-29	\$0.070
30-34	\$0.080
35-39	\$0.120
40-44	\$0.200
45-49	\$0.320
50-54	\$0.490
55-59	\$0.860
60-64	\$1.420
65+	\$2.280
CHILD RATE PER \$1,000	
\$0.170	

* Spouse rates based on employee's age

Short-Term Disability Insurance

NEW YORK LIFE

Underwritten and administered by **New York Life**, Active Day offers full-time employees the opportunity to elect Voluntary Short-Term Disability (STD) income benefits. Because this benefit is optional, the **employee is responsible for the cost**. In the event you become disabled from a non-work-related injury or sickness, disability income benefits provide a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

If you waive this coverage now and would like to purchase this coverage you will be required to complete a New York Life Enrollment & Statement of Health Form. Please note you are not guaranteed coverage until approved by New York Life, therefore no payroll deduction will be taken until approved.

SHORT TERM DISABILITY BENEFIT	
Benefits Begin	After 14 days of disability for injury/sickness
Benefits Payable	11 weeks
Percentage of income Replaced	60% of first \$1,667 of your pre-disability earnings
Weekly Maximum Benefit	\$1,000

MONTHLY SUPPLEMENTAL STD COSTS	
Age Band	Rate Per \$1,000
<20	\$0.692
20-24	\$0.692
25-29	\$0.784
30-34	\$0.637
35-39	\$0.526
40-44	\$0.480
45-49	\$0.461
50-54	\$0.535
55-59	\$0.692
60-64	\$0.840
65+	\$0.941

Supplemental STD Calculation

- Take annual salary and multiply by .60
- Take that total and divide by 52. This equals your weekly benefit amount.
- Take the weekly benefit amount and divide by 100.
- Then take that total and multiply by that monthly age banded rate.
This equals your **MONTHLY** premium.

Example

If a 38-year-old employee has an annual salary of \$25,000, an amount of \$7.58 would be deducted on a bi-weekly basis for Voluntary STD coverage. (Salary of \$25,000*.60 = \$15,000. Take \$15,000/52 = \$288.46; this is the weekly benefit amount. So \$288.46/100 = \$2.88 times the rate of \$5.70 = \$16.42 as the monthly premium.)

To calculate your **bi-weekly payroll deduction** — Take monthly premium, multiply by 12, then divide by 26. So \$16.42*12 = \$197.04/26 = \$7.57.

Voluntary Benefits

METLIFE & BANKERS WORKSITE

Whole Life Insurance

BANKERS WORKSITE

Whole Life Insurance provides guaranteed life insurance coverage and access to living benefits that can assist you or your family with large expenditures that can arise during critical medical events or in event of death. Additionally, a portion of premium paid accrues as a cash value that grows over time that can be used for loans, drawn for retirement, or to fund the policy premiums.

Benefits Enhancer Bundle

Critical Illness & Accident Insurance

METLIFE

Critical Illness & Accident Insurance cover accidental injuries and covered illnesses that include but are not limited to cancer, heart attack, stroke and paralysis. These two benefits have been bundled together to provide you the coverage to prepare for the unexpected.

Hospital Indemnity Insurance

METLIFE

Hospital Indemnity Insurance can supplement existing medical coverage and help provide financial support to pay for out-of-pocket expenses such as deductibles, copayments, and non-covered medical services in the event of a covered hospitalization. Benefits are paid regardless of what is covered by medical insurance and payments are made directly to you to spend as you choose.



Payroll contributions for these plans are specific to age and coverage level. Your costs can be determined by visiting my.tb360.com/activeday.



Pet Insurance

NATIONWIDE

Pet insurance is offered through Nationwide

Nationwide offers two plans for teammates to choose from: **My Pet Protection** and **My Pet Protection with Wellness500**.

My Pet Protection is a medical plan that offers an annual benefit of \$7,500 for eligible veterinary bills related to accidents, injuries and illnesses, including emergency clinics and specialists.

My Pet Protection with Wellness500 offers the same protection as our medical plan, but includes coverage for preventive care. With this plan, up to \$500 of the annual \$7,500 benefit can be used for wellness, including checkups, flea and heartworm preventives, vaccinations, spay and neuter and more.

Both plans are guaranteed issuance, have a \$250 annual deductible and include medical coverage with the choice of 50% or 70% reimbursement levels.



Apply for Pet Insurance

Signing up for Nationwide pet insurance is easy. Please visit

<https://benefits.petinsurance.com/activeday>
or call **877-738-7874**

*Please have your Paycom ID available and reference "Active Day" as your employer when applying.

	MY PET PROTECTION	MY PET PROTECTION WITH WELLNESS500
Accidents	✓	✓
Injuries	✓	✓
Illness	✓	✓
Hereditary and congenital conditions	✓	✓
Diagnostics and imaging	✓	✓
Procedures and surgeries	✓	✓
Wellness exams		✓
Vaccinations		✓
Flea prevention		✓
Spray or neuter		✓
And more	✓	✓

What makes My Pet Protection different?

My Pet Protection is available through workplace benefits programs and is guaranteed issuance. It also includes additional benefits like lost pet advertising, emergency boarding and more. It's no surprise that My Pet Protection is the most paw-pular coverage plan from America's #1 pet insurer.

Employee Payroll Contributions/Active Day Cost Share

Here are the per pay period costs/payroll deductions for each level of benefit that we offer.

Medical/Rx/Vision - Biweekly Wellness Rates

PLAN	LEVEL	TOTAL MONTHLY	ACTIVE DAY MONTHLY*	TEAMMATE PER PAY (26)
IBX Core PPO	Teammate	\$795.20	\$645.19	\$69.24
	Teammate + Spouse	\$1,829.77	\$1,087.55	\$342.56
	Teammate + Child(ren)	\$1,417.84	\$935.83	\$222.47
	Family	\$2,333.12	\$1,389.65	\$435.45
IBX Enhanced PPO	Teammate	\$900.56	\$651.58	\$114.91
	Teammate + Spouse	\$2,072.23	\$1,096.77	\$450.21
	Teammate + Child(ren)	\$1,605.71	\$945.20	\$304.85
	Family	\$2,642.29	\$1,402.61	\$572.16
IBX Catastrophic HDHP	Teammate	\$711.88	\$644.86	\$30.93
	Teammate + Spouse	\$1,638.05	\$1,073.42	\$260.60
	Teammate + Child(ren)	\$1,269.30	\$928.17	\$157.44
	Family	\$2,088.66	\$1,373.86	\$329.91

Medical/Rx/Vision - Biweekly Non-Wellness Rates

PLAN	LEVEL	TOTAL MONTHLY	ACTIVE DAY MONTHLY*	TEAMMATE PER PAY (26)
IBX Core PPO	Teammate	\$795.20	\$591.02	\$94.24
	Teammate + Spouse	\$1,829.77	\$1,033.38	\$367.56
	Teammate + Child(ren)	\$1,417.84	\$881.66	\$247.47
	Family	\$2,333.12	\$1,335.48	\$460.45
IBX Enhanced PPO	Teammate	\$900.56	\$597.41	\$139.92
	Teammate + Spouse	\$2,072.23	\$1,042.60	\$475.21
	Teammate + Child(ren)	\$1,605.71	\$891.03	\$329.85
	Family	\$2,642.29	\$1,348.44	\$597.16
IBX Catastrophic HDHP	Teammate	\$711.88	\$590.69	\$55.93
	Teammate + Spouse	\$1,638.05	\$1,019.25	\$285.60
	Teammate + Child(ren)	\$1,269.30	\$874.00	\$182.45
	Family	\$2,088.66	\$1,319.69	\$354.91

* Active Date Monthly contributions reflects contributions for Teammates completing wellness program requirements.

Cigna Dental DPPO Plan - Biweekly Rates

LEVEL	TOTAL MONTHLY	ACTIVE DAY MONTHLY	TEAMMATE PER PAY (26)
Teammate Only	\$24.60	\$0.00	\$11.35
Teammate + Spouse	\$49.49	\$0.00	\$22.84
Teammate + Child(ren)	\$51.26	\$0.00	\$23.66
Family	\$71.20	\$0.00	\$32.86

Note: For Supplemental Life and Short-Term Disability costs, see pages 16 and 17.

Legal Notices

Special Enrollment Notice

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 (including COBRA 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 or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility 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 (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' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

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 or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, 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. If you request a change

within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources.

Newborns' and Mothers' Health Protection Act 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 Notice

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

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
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): www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

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

Legal Notices

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: 678-561-1162 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
HIPPA Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPPA Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPPA Phone: 1-800-766-9012

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://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/la hipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: www.mymaineconnection.gob/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: 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: 1-573-751-2005

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: (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 HIPPA program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

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>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
Phone: 1-800-692-7462
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
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: <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: <https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://www.coverva.org/hipp/>
<https://www.coverva.org/en/famis-select>
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/>
<https://dhhr.wv.gov/bms/>
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPPA (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 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

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.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

A paper copy is available, free of charge, by emailing Christina Speck at cspeck@activedaycom.

Model General Notice of COBRA Continuation Coverage Rights

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 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; or
- 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 Christina Speck.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Legal Notices

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

Christina Speck, Director of Benefits
6 Neshaminy Interplex Suite 401 Trevose, PA 19053,
888-505-1088

Important Notice from Active Day 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 Active Day, 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:

- 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.
- Active Day, has determined that the prescription drug coverage offered by Independence Blue Cross 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 Active Day coverage will not be affected. [See pages 9 - 11 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 decide to join a Medicare drug plan and drop your current Active Day, medical and prescription coverage, be aware that you and your dependents will no longer be eligible to receive benefits under this plan.

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 Active Day, 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 Active Day, 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: April 2024

Name of Entity/Sender: Active Day

Contact--Position/Office: Human Resources/Benefits

Address: 6 Neshaminy Interplex Suite 401 Trevose, PA 19053

Phone Number: Christina Speck, 215.847.5797

Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law took effect in 2014, there was 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 began 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](https://www.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.

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.

3. Employer Name ADSC Holdings Inc d/b/a/ Active Day		4. Employer Identification Number 47-4866784	
5. Employer Address 6 Neshaminy Interplex Suite 401		6. Employer phone number 888-505-1088	
7. City Trevose	8. State PA		9. Zip Code 19053
10. Who can we contact about employee health coverage at this job? Christina Speck, Director of Benefits	11. Phone 888-505-1088		12. Email address cspeck@activeday.com



This material is intended to give you highlights of the Active Day Benefit Program, and is subject in all respects to the terms and conditions of those plans which may be modified or replaced from time to time at the discretion of the company and without notice. In the case of differences between these highlights and summaries or formal plans, the provisions of the Plan will govern. Nothing in this material should be construed as an employment contract or as a guarantee of employment, earnings or benefits.