













2025-26

EMPLOYEE BENEFITS GUIDE

WELCOME TO SIGMAPHARM!

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

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





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ELIGIBILITY & PLAN CHANGES

WHO IS ELIGIBLE?

If you're a full-time employee at Sigmapharm, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week.

In addition, employees who are eligible to participate in Sigmapharm's Benefit Program may also enroll their dependents in the medical, dental, voluntary vision, and life & AD&D programs. Dependents are defined as follows:

Medical, Dental and Vision

- Your legal spouse
- Children under the age of 26, regardless of student status
- Children over age 26, who are mentally or physically disabled and dependent upon you for support (proof of condition and dependence must be submitted)
- Children who are covered by a Qualified Medical Child Support Order

Supplemental Life and AD&D

- Your legal spouse
- Children under the age of 26, regardless of student status



MAKING PLAN CHANGES DURING THE YEAR – QUALIFYING LIFE EVENTS

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

Qualifying Life Events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan
- Becoming eligible for Medicare or Medicaid during the year
- Receiving a Qualified Medical Child Support Order (QMCSO)



NOTE: You must notify
Sigmapharm's Human Resources
Department within 31 days of experiencing
a Qualifying Life Event in order to make
changes. For additional information,
please contact Human Resources.

MEDICAL PLAN INDEPENDENCE BLUE CROSS

Our medical coverage is designed to provide you and your family with access to quality, affordable healthcare by covering a broad range of health care services and supplies including office visits, hospitalization, prescription coverage, and durable medical equipment.

Sigmapharm offers the following medical plan option, administered by Independence Blue Cross. This plan also includes prescription drug benefits. To locate participating providers, visit **www.ibx.com**.

PERSONAL CHOICE PPO PLAN

BENEFIT DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE 1 (Individual/Family)	\$0/\$0	\$10,000/\$20,000
COINSURANCE	0%	50%
OUT-OF-POCKET MAXIMUM ² (Individual/Family)	\$7,900/\$15,800	\$20,000/\$40,000
PRIMARY CARE PHYSICIAN (PCP) VISIT	\$40 copay	Plan pays 50% after deductible
SPECIALIST VISIT	\$70 copay	Plan pays 50% after deductible
PREVENTIVE CARE	Covered at 100%	Plan pays 50%, deductible does not apply
DIAGNOSTIC X-RAY/IMAGING (MRI, CT-SCAN) X-Ray Complex Imaging (CT/PET Scans, MRIs)	\$65 copay \$300 copay	Plan pays 50% after deductible
HOSPITAL SERVICES Inpatient ³ Outpatient Surgery/Facility	\$750/day; max of 5 copays per admission \$300 copay	Plan pays 50% after deductible
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES Inpatient ³ Outpatient	\$750/day; max of 5 copays per admission \$70 copay	Plan pays 50% after deductible
SPEECH THERAPY (20 visits per year) ⁴	\$70 copay	Plan pays 50% after deductible
PHYSICAL & OCCUPATIONAL THERAPY (30 visits per year) 5	\$70 copay	Plan pays 50% after deductible
URGENT CARE	\$75 copay	Plan pays 50% after deductible
EMERGENCY ROOM	\$300 copay (waived if admitted)	\$300 copay (waived if admitted)
MATERNITY HOSPITAL SERVICES ³	\$750/day; max of 5 copays per admission	Plan pays 50% after deductible
INPATIENT PROFESSIONAL SERVICES (Includes Maternity)	Covered at 100%	Plan pays 50% after deductible

Embedded deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits.

INCLUDED VISION BENEFITS

Your Personal Choice PPO plan also includes a vision benefit administered by Davis Vision. For more information, see page 11 of this guide.

² Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

⁴ Speech Therapy visit maximum is combined and includes in-network and out-of-network.

⁵ Physical and Occupational maximum visit limit is combined and includes in-network and out-of-network.

IBX MEMBER RESOURCES



GETTING MEDICAL CARE IS EASY!

With a Personal Choice PPO plan, care is always within reach. You have in and out-of-network coverage, and do not need to select a primary care physician (PCP) or obtain referrals for care.

BLUECARD PROGRAM

Take your healthcare benefits with you when you travel. With the BlueCard program, you have access to doctors and hospitals around the country.

Advantages

- In-network benefits coast-to-coast through BlueCard PPO providers
- Reduced out-of-pocket costs
- No claim forms or billing hassles

Access to Services

- Access providers in the BCBS Plan area where you receive services
- Claims are filed directly for you when you access a BlueCard PPO Provider

MEDICAL/RX CONTRIBUTIONS

MEDICAL/PRESCRIPTION PER PAY PAYROLL DEDUCTION		
EMPLOYEE	\$54.06	
EMPLOYEE + SPOUSE	\$152.78	
EMPLOYEE + CHILD(REN)	\$121.89	
EMPLOYEE + FAMILY	\$224.04	

REWARDS FOR HEALTHY LIVING

Get rewarded for wellness with the Achieve Well-Being rewards program! Employees can earn a \$300 gift card by completing the following:

- Annual check-up with your PCP
- Register for Teladoc Health at www.teladochealth.com
- Get digitally engaged by logging in at www.ibx.com and opting in to IBX Wire

To qualify for the gift card, employees will also need to complete any three (3) of the following:

- Get a preventive vaccine (e.g. flu, COVID-19, RSV)
- Complete an age- and gender-appropriate health screening
- Complete your Well-Being profile by logging in at www.ibx.com
- Complete a virtual or in-person nutrition counseling visit
- Visit a network dentist for an exam and/or cleaning

To get started with the Achieve Well-Being program, log in at **www.ibx.com**.

Online Tools and Resources

Our online tools make it easy and fun to reach your health goals!

- Complete the well-being profile and create an action plan
- Get reminders specific to your health goals, like getting fit, improving nutrition, sleeping better and managing stress
- Stay motivated with tokens and badges to celebrate your achievements
- Sync up fitness apps and devices to track your progress, create challenges and invite friends

PRESCRIPTION BENEFITS INDEPENDENCE BLUE CROSS



When you enroll in the medical plan, you automatically receive prescription drug coverage through Independence Blue Cross. Your prescription benefits include different pricing structures or "tiers" that enable you to control your out-of-pocket cost based on the medications your physician prescribes.

PRESCRIPTION BENEFITS

PERSONAL CHOICE PPO PLAN

RETAIL (UP TO A 30-DAY SUPPLY) 1	IN-NETWORK	OUT-OF-NETWORK
LOW-COST GENERIC DRUGS	\$3 copay	50% reimbursement after deductible
GENERIC DRUGS	\$10 copay	50% reimbursement after deductible
PREFERRED BRAND DRUGS	\$50 copay	50% reimbursement after deductible
NON-PREFERRED BRAND DRUGS	\$90 copay	50% reimbursement after deductible
SELF-ADMINISTERED SPECIALTY MEDICATIONS	Plan pays 50% up to \$500	Not Covered
MAIL-ORDER (UP TO A 90-DAY SUPPLY) ²		
LOW-COST GENERIC DRUGS	\$6 copay	
GENERIC DRUGS	\$20 copay	
PREFERRED BRAND DRUGS	\$100 copay	Not Covered
NON-PREFERRED BRAND DRUGS	\$180 copay	
SELF-ADMINISTERED SPECIALTY MEDICATIONS	Not Covered	

Maintenance medications may also be available for up to a 90-day supply at participating Act 207 Retail pharmacies for the same mail-order member cost-sharing as indicated above.

This program promotes the use of clinically-effective and cost-saving generic drugs. If you or a family member is currently taking a brand-name medication, and a generic is available, you will need to use the generic version or pay the cost difference between the two drugs, plus the applicable copay. For new prescriptions, if the prescribed medication is available in a generic form, you will automatically receive the generic.

PRESCRIPTION FORMULARY

Benefits will be provided for covered drugs and medicines appearing on the Drug Formulary. To check the formulary status of a drug or view a copy of the most recent formulary, log onto **www.ibx.com**.

Up to a 90-day supply of drugs to treat chronic conditions available at Rite Aid or mail-order for same cost share.

PRESCRIPTION RESOURCES

SAVE TIME AND MONEY WITH MAIL ORDER!

The benefits of using mail-order for your long-term prescription needs include:

- Free home delivery for medications you take regularly
- Minimizing trips to the pharmacy
- Managing prescription refills and bill pay online
- Staying on top of your medication routine with fewer trips to the doctor

To get started with home delivery, call the number on the back of your ID card or visit www.ibx.com to learn more.

IBX ONLINE TOOLS AND RESOURCES

By visiting www.ibx.com, you have access to a variety of tools and resources to help you manage your medications, including:

- Doctor and pharmacy finder
- Mail-order prescription management
- Prior authorization tracker
- Price-a-drug tool
- Discounts and savings
- Care cost estimator

DENTAL BENEFITS CIGNA

Good dental health is important to your overall well-being, and that is why Sigmapharm is pleased to offer this benefit at **no cost** to you and your family. Our dental benefit coverage is provided to you through Cigna.

With Cigna's dental plan, you'll have access to over 75,000 participating dentists nationwide when utilizing their DPPO Advantage Network. You can visit any licensed dentist without a referral. Typically, the contracted rates with network dentists are much lower than their regular fees, which can save you money by staying in-network. The plan provides coverage for preventive, basic, major, and orthodontia services.

CIGNA DENTAL PPO

	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE* (Individual/Family)	\$75/\$225	\$75/\$225
ANNUAL YEAR MAXIMUM* (Per patient)	\$1,250	\$1,250
PREVENTIVE & DIAGNOSTIC SERVICES Exams, Cleanings, X-rays	Covered at 100%	Covered at 100%
BASIC SERVICES Fillings, Extractions, Endodontics (root canal)	Plan pays 80% after deductible	Plan pays 80% after deductible
MAJOR SERVICES Crowns, Bridgework, Full and Partial Dentures	Plan pays 50% after deductible	Plan pays 50% after deductible
ORTHODONTIA BENEFITS (Adults and Dependent Children)	Plan pays 50% after deductible	Plan pays 50% after deductible
ORTHODONTIA LIFETIME MAXIMUM (Per patient)	\$1,500	\$1,500

^{*} Please note that the dental deductible and yearly maximum reset on a calendar year basis (January 1).

DENTAL ID CARDS

You will not be required to have an ID card to obtain services. Instead you can provide your dentist with your Social Security # and Group # (3346418) when accessing care. If you would still like to have a copy of your ID card, you can access and print one online by signing into your myCigna account at www.cigna.com.

FINDING A DENTAL PROVIDER

To find a participating Cigna Dentist, visit www.cigna.com and follow the prompts to "Find a Doctor, Dentist, or Facility". When selecting a plan, choose "Dental Plan" and then "DPPO/EPO > Total Cigna DPPO".

For questions concerning eligibility, benefits, or claims, visit www.cigna.com or call 800.244.6224.

VISION BENEFITS EYEMED



You have the option of electing the **voluntary** vision plan outlined below, administered by EyeMed. EyeMed is one of the nation's largest providers of vision care coverage with a network consisting of private practicing optometrists, ophthalmologists, opticians and optical retailers. These providers offer both eye exams and eyewear, making for a convenient, "one-stop" means of obtaining eye care.

EYEMED VISION CARE PLAN

	IN-NETWORK	OUT-OF-NETWORK
EXAM	\$10 copay	Up to \$40 reimbursement
FRAMES	\$130 allowance; 20% off balance over \$130	Up to \$91 reimbursement
LENSES Single Vision Lenses Bifocal Lenses Trifocal Lenses	\$25 copay	Up to \$30 reimbursement Up to \$50 reimbursement Up to \$70 reimbursement
CONTACT LENSES (In lieu of eyeglasses) Conventional Disposable Medically Necessary	\$130 allowance; 15% off balance over \$130 \$130 allowance Covered 100%	Up to \$130 reimbursement Up to \$130 reimbursement Up to \$210 reimbursement
FREQUENCY Vision Exam, Lenses, Frames	Every 12 months	Every 12 months

In addition to the benefits above, EyeMed members also receive the following discounts:

- **Second pair discount:** 40% off a complete second pair of prescription glasses*
- **Hearing care discount:** Save up to 64% off retail for hearing aids and materials**
- * These discounts are for in-network providers only. Benefits may not be combined with any discount, promotional offering, or other group benefit plans.
- ** Average member savings; prices differ based on hearing aid model purchased. Your actual savings may vary. Call Amplifon at 877.203.0675 for more information.

FINDING A VISION PROVIDER

To find a participating EyeMed vision provider near you, please call EyeMed at **866.939.3633** or log on to **www.eyemed.com**.



EYEMED VISION CONTRIBUTIONS

VISION PER PAY PAYROLL DEDUCTION		
EMPLOYEE	\$3.54	
EMPLOYEE + SPOUSE	\$6.73	
EMPLOYEE + CHILD(REN)	\$7.09	
EMPLOYEE + FAMILY	\$10.42	

ADDITIONAL VISION DISCOUNTS & SAVINGS



HEALTHY REWARDS VISION DISCOUNT PROGRAM

If you are enrolled in the dental plan offered

by Cigna, you have access to the Healthy Rewards Vision Discount Program. Cigna members can save on eyewear, eye exams, contact lenses, and more at participating providers. Participating national retailers include:

- LensCrafters
- Target Optical
- For Eyes
- Pearle Vision

For more information about Healthy Rewards and participating vendors, please visit **www.myCigna.com**.

ROUTINE VISION CARE SERVICES	CUSTOMER COST
ROUTINE VISION EXAM Including but not limited to eye health examination, dilation, refraction, and prescription for glasses	\$5 off routine exam
ROUTINE VISION CARE SERVICES Complete pair of glasses (frame/lenses/lens add-ons)	35% off retail cost
CONTACT LENSES AND PROFESSIONAL SERVICES Contact lens professional services (fitting and evaluation) Contact Lenses	\$10 off contact lens exam Check with your retail network eye care professional for any available offers on contact lenses. Receive 15% off retail costs of contacts at www.contactsdirect.com
NON-PRESCRIPTION SUNGLASSES	20% off retail cost

EYEMED LASIK & PRK BENEFIT

As an EyeMed Vision Care member, you are entitled to discounted LASIK and PRK procedures through the U.S. Laser Network. Please call **877.5LASER6** for further details.

CONTINUED EYEWEAR SAVINGS

After your initial benefits have been utilized, you are eligible to receive ongoing discounts on additional eyewear purchases at EyeMed provider locations.



VISION BENEFITS FOR THOSE ENROLLED IN THE IBX MEDICAL PLAN

In addition to the voluntary EyeMed plan, **if you elect to enroll in the IBX medical plan, you will automatically receive the vision benefits outlined below**, managed through the Davis Vision network. For more details, see the full plan summary on BenePortal. Take care of your vision and overall health while saving on your eye care and eyewear needs. Vision insurance can help you maintain your vision as well as detect various health problems. Health conditions such as diabetes and high blood pressure can be detected early through a comprehensive eye exam.

IBX/DAVIS VISION BENEFIT PROGRAM

	IN-NETWORK	OUT-OF-NETWORK
ROUTINE EYE EXAM ¹	\$10 copay	Up to \$40 reimbursement
At Davis Vision participating providers	\$10 copuy	op to \$40 telliborsement
LENSES 1		
Single Vision Lenses		Up to \$40 reimbursement
Bifocal Lenses	\$25 copay	Up to \$60 reimbursement
Trifocal Lenses		Up to \$80 reimbursement
Lenticular Lenses		Up to \$100 reimbursement
FRAMES		
Collection Fashion Frames	No charge	Not Covered
Collection Designer Frames	\$15	Not Covered
Collection Premier Frames	\$40	Not Covered
Non-Collection Frames	Up to \$100 Allowance (plus a 20% discount on overage) $^{\mathrm{2}}$	Up to \$50 reimbursement
Visionworks Frames Option	Up to \$150 Allowance (plus a 20% discount on overage) $^{\mathrm{2}}$	Not Covered
CONTACT LENSES (IN LIEU OF GLASSES)		
Non-Collection	Up to \$100 allowance ³	Up to \$80 reimbursement
Meically Necessary ⁴	No charge	Up to \$225 reimbursement
FREQUENCY		
Vision Exam	1 exam per year	
Lenses	1 pair per year	
Frames/Contact Lenses	1 pair every 24 months	

Combined in and out-of-network

⁴ Covered with prior approval



Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

Member is responsible for balance; additional discounts not applicable at Walmart, Costco or Sam's Club locations

FLEXIBLE SPENDING ACCOUNTS MYFLEXDOLLARS

Sigmapharm allows employees to redirect a portion of their pay, through pre-tax payroll deductions, into a Flexible Spending Account (FSA).

Your FSA benefits are administered by myFlexDollars, a Baker Tilly company and run on a calendar year basis. The money that goes into your FSA is deducted pre-tax from your pay.



"USE-IT-OR-LOSE-IT" RULE

If you do not use the money you contributed toward your Healthcare FSA by the end of the plan year, you will only be able to carry over a maximum of **\$660** into the following plan year.

Please note you **cannot** carry over remaining Dependent Care FSA dollars to the next plan year.

You have until March 31st to file a claim incurred before March 15th of the prior year.



HEALTHCARE FSA

The Healthcare FSA allows you to set aside pre-tax dollars via payroll deductions to pay for qualified healthcare expenses for you and your dependents. The annual maximum amount you may contribute is \$3,300 per calendar year.

The Healthcare FSA can be used for:

- Eligible medical procedures
- Prescriptions
- Doctor office copays
- LASIK eye surgery
- Non-cosmetic dental procedures
- Prescription contact lenses, glasses and sunglasses
- Hearing exams/aids

For a complete listing of eligible FSA expenses, review IRS publications 502 and 503, which can be found at **www.irs.gov**.

CARES Act and Qualifying Medical Expenses

Under the CARES Act, the definition of a qualifying medical expense now includes certain over-the-counter medications and products. Specifically, the act treats additional over-the-counter medications, along with menstrual care products, as qualified medical expenses that may be paid for using FSAs or other tax-advantaged accounts.

DEPENDENT CARE FSA

The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care expenses. The annual maximum amount you may contribute is **\$7,500** (or \$3,750 if married and filing separately) per calendar year.

The Dependent Care FSA can be used for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Expenses will qualify for reimbursement if they are the result of care for: your children, under the age of 13, for whom you are entitled to a personal exemption on your Federal income tax return; or your spouse / other dependents, including parents, who are physically or mentally incapable of self-care.

FLEXIBLE SPENDING ACCOUNTS MYFLEXDOLLARS

PREPAID BENEFITS CARD

Your Prepaid Benefits Card is an FSA debit card you can use towards any qualified healthcare expenses. The card pays your providers directly; you do not have to wait for reimbursement. You will receive two cards – one is a copy. Keep the second copy in a safe place.

FILING FSA EXPENSES AND ACCESSING YOUR FUNDS

- Expenses that have been processed through your benefits card will automatically be filed with myFlexDollars. Be sure to keep your receipts anyway.
- If you pay for an eligible service or product out-of-pocket, you can submit an itemized receipt/ bill online at www.myFlexDollars.com, or via the myFlexDollars app.
- You may submit an expense via fax to the Employee Benefits Center at: 866.406.0946. Phone Support is available at 800.307.0230.

ONLINE/MOBILE TOOLS TO HELP MANAGE YOUR ACCOUNT

·You can use www.myFlexDollars.com to:

- Check your account balance
- View the status of recently submitted expenses
- Submit expenses for reimbursement
- Upload receipts/supporting documentation
- Sign up for direct deposit
- Access plan information

You can use the myFlexDollars mobile app on your Apple or Android devices to:

- Check your account balance
- Submit expenses
- Upload receipts
- Receive alerts via text message



LIFE AND AD&D RELIANCE



Life and Accidental Death & Dismemberment (AD&D) insurance provides protection to those who depend on you financially, in the event of your death or an accident that results in death or serious injury.

BASIC LIFE AND AD&D

Sigmapharm provides Basic Life and Accidental Death & Dismemberment (AD&D) coverage to you at no cost.

Sigmapharm will automatically enroll you into these benefits assuming you meet the eligibility requirements.

As an eligible employee, Sigmapharm provides you with company paid basic life insurance in an amount that equals one times your base annual earnings up to a maximum of \$200,000. You are also provided with an equal amount of AD&D insurance. This benefit is reduced by 35% at age 65 and by 50% at age 70.



SUPPLEMENTAL LIFE AND AD&D

If you need additional protection beyond the Basic Life and AD&D insurance provided to you, you may purchase Supplemental Life and / or AD&D for yourself and your eligible dependents.

If you elect these coverages, you will be responsible for paying 100% of the cost and will have deductions taken from your paycheck in after-tax dollars. You will not be subject to imputed income and the benefit is tax-free.

Note: you may only elect coverage for your spouse or children if you have elected coverage for yourself.

SUPPLEMENTAL LIFE AND AD&D INSURANCE		
EMPLOYEE	Increments of \$10,000 up to 5 times salary or \$500,000, whichever is less	
SPOUSE (UNDER AGE 70) Increments of \$5,000, up to a maximum of \$100,000		
DEPENDENT CHILD(REN)	Choose between \$1,000, \$2,000, \$3,000, \$4,000, \$5,000 or \$10,000	
GUARANTEED ISSUE AMOUNTS*		
EMPLOYEE	\$100,000	
SPOUSE (UNDER AGE 70)	\$25,000	
DEPENDENT CHILD(REN)	\$10,000	

* If enrolling when initially eligible for benefits, you are automatically approved up to the guaranteed issue amount without being subject to Evidence of Insurability (EOI). Any employee or spouse amount elected over the guaranteed issue amount or outside the initial eligibility period is subject to EOI. The child amount is always guaranteed issue.

DISABILITY INSURANCE RELIANCE



SHORT-TERM DISABILITY

Short-Term Disability (STD) is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work. Sigmapharm provides this benefit to you at **no cost**.

After being totally disabled for 14 days, the STD benefit includes 60% of your pre-disability weekly earnings, subject to the plan's maximum weekly benefit of \$1,000, for up to 11 weeks (provided eligibility requirements are met).

For example, if your gross weekly income is \$500, your weekly STD benefit is \$300*.

This disability benefit also works with other sources of coverage to replace a certain percentage of your earnings. As a result, the disability payments you receive from our plan will be reduced by any benefits you are eligible to receive from social security, workers' compensation, retirement benefits or any other disability coverage to which you are entitled.

* Your weekly STD benefit will be reduced by applicable taxes including income and Social Security taxes

VOLUNTARY LONG-TERM DISABILITY

Long-Term Disability (LTD) is a cost-effective way to help protect your income when you are unable to work due to illness or injury. Accidents or illness can happen to anyone, and it can impact your ability to earn money. That's why financial experts recommend Long-Term Disability insurance as part of a sound financial plan.

This benefit is 100% employee paid.

The Long Term Disability benefit replaces a portion of your predisability monthly earnings, less other income you may receive from other sources during the same Disability (e.g., Social Security, Workers' Compensation, The benefit amount is 60% of your predisability monthly earnings, subject to the plan's maximum monthly benefit of \$6,000.

All active employees who work a minimum of 30 hours per week are eligible to participate in the Long-Term Disability benefit. For more information about coverage, visit www.sigmapharmbenefits.com.

* Your weekly LTD benefit will be reduced by applicable taxes including income and Social Security taxes

FILING A CLAIM RELIANCE



FOUR CONVENIENT WAYS TO FILE A CLAIM

Reliance Matrix makes it easy to start any benefit claim. Knowing what to do, and what to expect, will help you get prompt, appropriate service and improve your overall experience.

- Online 24/7 at www.reliancematrix.com
- Via phone: Speak to an intake specialist weekdays 9am - 9pm ET. toll free 855.775.2524.
- Email or Fax: You can also email your scanned claim form to ClaimsIntake@rsli.com or fax to 267.256.4262.
- Mobile: The Reliance Matrix is mobile responsive, simply visit the www.reliancematrix.com from your phones browser.

You will need a valid email address and some general information to get started. You will not need your policy number to submit a claim. Depending on which type of claim you are submitting, you should be ready to provide information such as: name, address, gender, date of birth, phone number, Social Security number, employer's name and address, your injury/condition and physician or medical provider information.

HAVE A QUESTION?

Many claims inquiries can be answered 24/7 online at **www.reliancematrix.com** (just click Customer Care) or through our telephonic Customer Care System at 800.351.7500. Representatives are available weekdays from 8am - 7pm ET.

HOW TO SUBMIT A CLAIM BY PHONE

To improve your claims experience, the below explains how to submit a claim for benefits by phone. Timely reporting of a claim is required for approval of benefits and it is easy to file a claim online 24/7/365. This is a fast, secure way to initiate a benefits claim for yourself or a family member.

STEP 1: Information you will need to report a claim to help expedite the process.

- Personal Information: Name, address, telephone number, and the last four digits of your Social Security number.
- Job Information: Job title, job description, workplace location and address, work schedule, Supervisor's name and telephone number, date of hire, and last day of work (if a disability claim).
- Illness/Injury Information: Nature of the illness, how, when, and, if applicable, where the injury occurred.
- Provider Information: Name, address, telephone number, and fax number for each treating healthcare provider.

STEP 2: To submit your claim, call the Customer Care team at **877.202.0055**, **prompt 1**. The Customer Care team will:

- Confirm your plan/benefit coverage
- Verify the reasons for your claim
- Request any additional information needed to make a decision
- Discuss the next steps in the decision process.

WORKSITE BENEFITS RELIANCE

ACCIDENT INSURANCE

With accident insurance from Reliance Standard, you can receive benefits to help with the expenses of a covered accident so you can focus on what really matters: healing.

You never know when you or someone you love could get hurt in an accident. Accidents can happen to anyone and come with costs, such as emergency room fees, doctor's bills, and lost income from missing work. Make sure you're protected!

CRITICAL ILLNESS INSURANCE

No matter where you are in life, you never know when you or a loved one could experience a critical illness, such as a heart attack or stroke. Medical advancements and early detection are helping many people survive critical illnesses. However, preventive tests and treatment can lead to increased medical expenses, and your health insurance may not cover these costs.

Reliance Standard Critical illness insurance helps supplement your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect costs related to a covered critical illness.

WANT MORE INFORMATION?

For more information and full coverage details on these benefits please visit

www.sigmapharmbenefits.com

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance helps covered employees and their families cope with the financial impacts of hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The money is paid directly to you, not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as coinsurance, copays, and deductibles.

CRITICAL ILLNESS		
DIGANOSIS (Included , but not limited to)	PERCENTAGE OF LUMP SUM RECEIVED	
ALZHEIMER'S	100%	
BENIGN BRAIN TUMOR	100%	
HEART ATTACK	100%	
PARALYSIS	100%	
PARKINSON'S	100%	
CORONARY DISEASE	25%	
HOSPITAL IND	EMTNITY	
INCLUDED BE	NEFITS	
HOSPITAL ADMISSION AMOOUNT	\$1,000	
HOSPITAL ADMISSION MAX PER YEAR	1	
HOSPITAL CONFINEMENT AMOUNT	\$200	
HOSPITAL CONFINEMENT (Days max per year)	31	
HOSPITAL CONFINEMENT ICU AMOUNT	\$200	
HOSPITAL CONFINEMENT ICU (Days max per year)	15	
ACCIDENT INS	URANCE	
BENEFITS (Included , bu	it not limited to)	
AMBULANE TRANSPORTATION	\$300 Ground / \$1,500 Air	
BLOOD/PLASMA/PLATELETS	\$300	
CHIROPRACTIC SERVICES	\$50 per session	
COMA	\$7,500	
CONCUSSION	\$150	
EMERGENCY TREATMENT	\$150	

TELEMEDICINE VIRTUAL CARE

TELADOC

Teladoc is a national network of U.S. board-certified doctors available 24/7/365 to diagnose, treat and prescribe medication when necessary for many common medical issues.

Meet with a physician from the comfort of your home—or anywhere else in the United States.
Teladoc gives you access to:

- Video visits with board-certified doctors on your smartphone, tablet, or computer
- Private and secure medical visits from any location within the United States

Using Telemedicine is a convenient option when it's not possible to visit your doctor's office for non-emergency medical conditions such as:

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

In addition to general medical care, Teladoc services are also available for dermatology and behavioral health care.

GETTING STARTED WITH TELADOC IS EASY!

Activate your Teladoc account and schedule an appointment in one of the following ways:

- Call 800.835.2362
- Visit www.teladochealth.com
- Download the Teladoc mobile app

VIRTUAL CARE

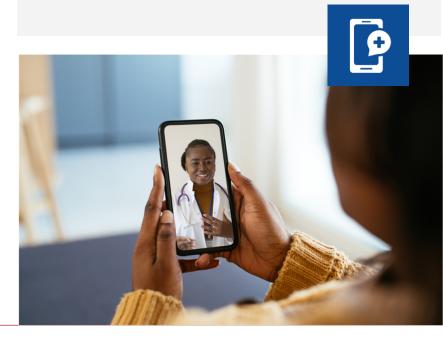
PCP and Specialists

Contact your in-network provider directly to set up a virtual care appointment. If the provider offers virtual care, the provider will give you instructions for setting up your appointment. The IBX Find a Doctor tool at **www.ibx.com** identifies if a provider offers virtual care services.

Behavioral Health Care Providers

To find a behavioral health provider, call the Mental Health/Substance Abuse number on the back of your member ID card or use the Find a Doctor tool on **www.ibx.com**. You may also use the following resources:

- Quartet: Use Quartet to connect with an innetwork mental health care provider who fits your needs and preferences. Visit quartethealth.com/ibx to get started.
- ATLAS: You also have access to ATLAS
 (Addiction Treatment Locator, Assessment, and Standards), an online tool by Shatterproof that connects you and your loved ones with trustworthy, in-network addiction treatment. For more information about the ATLAS tool, visit treatmentatlas.org.



ADDITIONAL BENEFITS

401(K) RETIREMENT PLAN

Sigmapharm realizes the importance of saving towards retirement and has established a 401(k) Plan to assist you. This plan allows you to use tax-deferred money to save for your retirement while earning interest and receiving free money through the employer match.

Eligibility

As a full-time employee you are initially eligible to enroll in the 401(k) Plan effective the 1st of the month following date of hire. Thereafter, you may enroll effective the 1st of any calendar month.

Employer Match

An employer matching contribution may be made on your behalf at the discretion of Sigmapharm.

Sigmapharm currently matches up to 3% of your pay.

Vesting

Your contributions to the 401(k) Plan are immediately 100% vested. Any employer matching contribution is also 100% vested immediately.



PAID TIME OFF (PTO)

Sigmapharm provides each eligible employee with paid Vacation Time and Personal Emergency Time. Please see the table below for details on how time is earned or accrued.

TYPE OF PTO	AMOUNT OF TIME
VACATION TIME First Year Years 2-4 Years 5-9 Years 10+	3.33 hours / month of employment (40 hrs max) 10 days (80 hours) of paid vacation 15 days (120 hours) of paid vacation 20 days (160 hours) of paid vacation
PERSONAL EMERGENCY First Year Years 2+	Earn 4 days (32 hours) Earn 4 days (32 hours)

PAID MATERNITY LEAVE

Sigmapharm provides two full weeks pay for an employee due to the birth of the employee's own child. These two weeks cover salary for the elimination period under the company-paid STD.

BABY BLUEPRINTS PROGRAM

Independence Blue Cross

The Baby BluePrints program supports expectant mothers and promotes a healthy pregnancy throughout each trimester. To get started, call **800.598.BABY**. Upon calling, a Health Coach will ask you a series of questions to complete the enrollment process.

Once enrolled, you will receive a welcome letter that includes a childhood immunization schedule, information on how to access educational materials on our secure member website, **www.ibx.com**, and the phone number for questions and support during pregnancy. In addition, high-risk members eligible for condition management will be given the name and contact information for a Health Coach.

GETTING THE MOST OUT OF YOUR BENEFITS



ALWAYS CONSIDER YOUR IN-NETWORK OPTIONS FIRST

You will typically pay less for covered services when providers, facilities and labs are in-network with your medical plan. Innetwork providers agree to discounted fees. You are responsible only for any copay or deductible that is included in your plan design. The amount you are required to pay out-of-pocket for out-of-network services may be significant.

Balance billing occurs when providers bill a patient for the difference between the amount they charge and the amount that the patient's insurance pays. The amount that insurers pay providers is almost always less than the providers' "retail price." Some providers will bill the patient for the difference, or balance; this is called balance billing.



IN-PATIENT VS. OBSERVATION Knowing the Difference Is Important

The difference between inpatient and observation status is important because benefits and provider payments are based on this status. Patients admitted under observation status are considered outpatients, even though they may stay in the hospital and receive treatment in a hospital bed.

Hospital admission status may affect coverage for services such as skilled nursing. Some health plans, including Medicare, require a three-day hospital inpatient stay minimum before covering the cost of rehabilitative care in a skilled nursing care center. However, observation stays regardless of length, do not count towards the requirement.

A new law requires hospitals to give Medicare patients notice of an observation status within 36 hours. This status determines how the hospital bills your health plan. Even if you are NOT under Medicare, when you or your family member arrives at the hospital, you can ask questions like:

- Is the patient's status inpatient or observation?
- How long will the hospital stay be?
- Will there be a need for specialized skilled or rehab care after discharged?

Asking these questions throughout the hospital stay is important because hospitals can change the status from one day to the next. You can ask to have the status changed, but it is important to do so while still in the hospital. If necessary, you can request the hospital's patient advocate for assistance.

URGENT CARE VS. EMERGENCY ROOM

Urgent Care centers can be the perfect option for those that need medical attention for conditions that are not life threatening. You may opt out of an ER visit and instead visit Urgent Cares for the following:

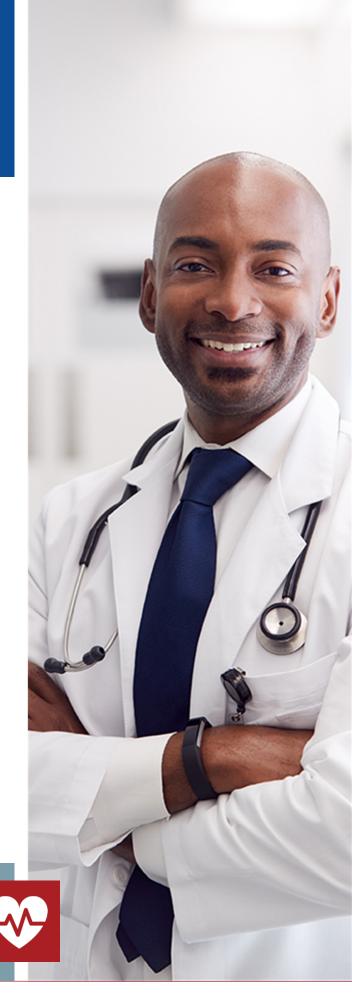
- Minor fractures
- Back pain
- Minor headaches
- Nausea, vomiting, diarrhea
- Blood work
- Ear or sinus pain
- Cough or sore throat
- Lab services

- Animal bites
- Stitches
- Sprains and strains
- Mild asthma
- Allergies
- Minor allergic reactions
- Cold or flu symptoms

Emergency rooms will treat these problems also, but typically minor conditions such as these are not prioritized and those suffering from them can experience lengthy wait times. 90 percent of urgent care patients wait 30 minutes or less to see a provider, and 84 percent are in and out within an hour.

Urgent care centers are typically more affordable than an ER visit, and there are convenient locations situated in places like shopping centers and commercial plazas.

Urgent Care is in-network with most major insurance providers, Medicare, Medicaid, worker's compensation and motor vehicle insurance.



VALUE-ADDED SERVICES CONNER STRONG & BUCKELEW



BENEFITPERKS REWARDS PROGRAM

CSB Benefit Perks is a discount and rewards program provided by Conner Strong & Buckelew (CSB) that is available to all employees at no additional cost.

The program allows employees to receive discounts and cash back for hand-selected shopping online at major retailers.

Use the Benefit Perks website to browse through categories such as: Automotive, Beauty, Computer & Electronics, Gifts & Flowers, Health & Wellness and much more! Employees can also print coupons to present at local retailers and merchants for in-person savings, including movie theatres and other services.

Start saving today by registering online at **connerstrong.corestream.com**.



BENEFITS MEMBER ADVOCACY CENTER

Do you need help resolving a benefits issue? The Benefits Member Advocacy Center (Benefits MAC), provided by Conner Strong & Buckelew, allows you to speak to a specially trained Member Advocate who can help you get the most out of your benefits.

You can contact the Benefits MAC for assistance if:

- You believe your claim was not paid properly
- You need clarification on information from the insurance company
- You have a question regarding a medical bill
- You are unclear on how your benefits work
- You need information about adding or removing a dependent
- You need help resolving a benefits problem you've been working on

You can contact the Benefits MAC in any of the following ways:

- Via phone: 800.563.9929, M-F 8:30 am to 5:00 pm
- Via the web:www.connerstrong.com/memberadvocacy
- Via e-mail: cssteam@connerstrong.com

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

VALUE-ADDED SERVICES CONNER STRONG & BUCKELEW

HUSK

Save money and achieve your fitness goals! Choose from over 10,000 gyms including national chains, regional chains, and local gyms.

Save with Husk Lowest Price Guarantee

- Enrolling is easy! Husk handles all inquiries, enrollments, etc.
 No paperwork, no payroll deductions, and no hassle!
- Start by moving! Once you enroll, you can start by noon the next day!

For more information, visit

https://marketplace.huskwellness.com/connerstrong

GOODRX

This services 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 https://connerstrong.goodrx.com

HEALTHYLEARN

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

For more information, visit

www.healthylearn.com/connerstrong



BENEPORTAL ONLINE BENEFITS RESOURCE

YOUR BENEFITS INFORMATION — ALL IN ONCE PLACE!

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

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

BenePortal features include:

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

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



BENEFITS CONTACTS & RESOURCES



BENEFITS / RESOURCES	PROVIDER NAME	PHONE NUMBER	WEBSITE
MEDICAL/PRESCRIPTION BENEFITS	Independence Blue Cross (IBX)	800.275.2583	www.ibx.com
DENTAL	Cigna	800.244.6224	www.cigna.com
VISION BENEFITS	EyeMed	866.939.3633	www.eyemed.com
LIFE AND AD&D, SHORT-TERM AND LONG-TERM DISABILITY BENEFITS	Reliance	800.351.7500	www.reliancestandard.com
FLEXIBLE SPENDING ACCOUNTS, COBRA	Baker Tilly Vantagen (MyFlexDollars)	855.869.3539	www.myFlexDollars.com
TELEMEDICINE	Teladoc	800.835.2362	www.teladochealth.com
BENEFITS MEMBER ADVOCACY TEAM	Conner Strong & Buckelew	800.563.9929	www.connerstrong.com/memberadvocacy



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.

Sigmapharm offers a series of health coverage options. You should receive a Summary of Benefits and Coverage (SBC) during Open Enrollment. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions or did not receive your SBC.

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 31 days 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 31 days 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 medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, 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

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 March 17, 2025. Contact your State for more information on eligibility —

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

for an employer-sponsored plan.

ALASKA - Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/ Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: https://health.alaska.gov/dpa/

Pages/default.aspx

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

CALIFORNIA – Medicaid Health Insurance Premium Payment (HIPP) Program

Website: http://dhcs.ca.gov/hipp

Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO — Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711

CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711

Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/

HIBI Customer Service: 1-855-692-6442

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

Health Insurance Premium Payment Program

All other Medicaid

Website: https://www.in.gov/medicaid/

http://www.in.gov/fssa/dfr/

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA - Medicaid and CHIP (Hawki)

Medicaid Website:

https://hhs.iowa.gov/programs/welcome-iowa-

medicaid

Medicaid Phone: 1-800-338-8366

Hawki Website:

https://hhs.iowa.gov/programs/welcome-iowa-

medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563

HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp

HIPP Phone: 1-888-346-9562

KANSAS - Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY - Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

https://chfs.ky.gov/agencies/dms/member/Pages/

kihipp.aspx

Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov/

agencies/dms

LOUISIANA - Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/

ahinn

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618

-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://

www.mymaineconnection.gov/benefits/s/?

language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711

Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA - Medicaid

Website:

https://mn.gov/dhs/health-care-coverage/

Phone: 1-800-657-3672

MISSOURI - Medicaid

Website: http://www.dss.mo.gov/mhd/participants/

pages/hipp.htm Phone: 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

 ${\sf NEVADA-Medicaid}$

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. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/ humanservices/dmahs/clients/medicaid/

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html

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

NEW YORK - Medicaid

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

medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

NORTH DAKOTA - Medicaid

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

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON - Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/

index.aspx

Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-

program-hipp.html Phone: 1-800-692-7462

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

program

Phone: 1-800-440-0493

UTAH - Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

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

Email: upp@utah.gov Phone: 1-888-222-2542

Adult Expansion Website: https://medicaid.utah.gov/

expansion/

Utah Medicaid Buyout Program Website: https://

medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VERMONT- Medicaid

Website: https://dvha.vermont.gov/members/

medicaid/hipp-program Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select and https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP Phone: 1-800-432-5924

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 March 17, 2025, 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

Continuation Coverage Rights Under COBRA Introduction

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you

may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA

Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period 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

Human Resources 215-352-6655 3375 Progress Dr, Bensalem, PA 19020.

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Sigmapharm group health plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

- your past, present or future physical or mental health or condition;
- 2) the provision of health care to you; or
- the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Human Resources.

Effective Date

This Notice is effective October 1, 2024.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information:
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For **Payment.** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stoploss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. If the Plan uses or discloses protected health information for underwriting purposes, including determining eligibility for benefits or premium, the Plan will not use or disclose protected health information that is genetic information for such purposes, as prohibited by the Genetic Information Nondiscrimination Act of 2008 (GINA) and any regulations thereunder

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We

may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the

appropriate foreign military authority. Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official—

in response to a court order, subpoena, warrant, summons or similar process;

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral

Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also

release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures of Your Medical Information Require Your Authorization

Written Authorization: Your medical information will not be used or disclosed for any purpose not mentioned above in the "How We May Use and Disclose Your Protected Health Information" section except as permitted by law or as authorized by you. This includes disclosures to personal representatives and spouses and other family members as described below. In the event that the Plan needs to use or disclose medical information about you for a reason other than what is listed in this notice or required by law, we will request your permission to use your

medical information and the medical information will only be used as specified in your authorization. You may complete an Authorization form if you want the Plan to disclose medical information about you to someone else.

Any authorization you provide will be limited to the specific information identified by you and you will be required to specify the intended use or disclosure and name then person or organization that is permitted to use or receive the information specified in the authorization form. You have the right to revoke a previous authorization. Requests to revoke an authorization must be in writing. The Plan will honor your request of revocation for the prospective period of time after the Plan has received your request. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

In addition, the Plan will not sell your medical information or use it for marketing purposes (that are not considered as part of treatment or healthcare operations) without a signed authorization from you. Also, if applicably, the Plan will not disclose psychotherapy notes without a signed authorization from you.

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
- 2) treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information maintained in any form (paper or electronic) that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to Human Resources. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Human Resources.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to Human Resources. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures

To request this list or accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the

list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to Human Resources. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Human Resources. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information. You will receive a notification to your last know address within 60 days of the discovery. The notification will include:

- specific information about the breach including a brief description of what happened
- a description of the types of unsecured medical information involved in the breach
- any steps you should take to protect yourself from potential harm resulting from the breach
- a brief description of the investigation the Plan is performing to mitigate the harm to you and protect you from future breaches
- a contact information where you may direct additional questions or get more information

about the breach.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you may obtain a paper copy of this notice by contacting Human Resources

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Important Notice from Sigmapharm 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 Sigmapharm 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.
- 2. Sigmapharm has determined that the prescription drug coverage offered by the Insert Name of 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.

PRESCRIPTION BENEFITS	PERSONAL CHOICE PPO	
RETAIL (UP TO A 30-DAY SUPPLY)	IN-NETWORK*	
Low-Cost Generic Drugs	\$3 copay	
Generic Drugs	\$10 copay	
Preferred Brand Drugs	\$50 copay	
Non-Preferred Brand Drugs	\$90 copay	
Specialty Medications	Plan pays 50% up to \$500	
MAIL-ORDER (UP TO A 90-DAY SUPPLY)	IN-NETWORK	
Low-Cost Generic Drugs	\$6 copay	
Generic Drugs	\$20 copay	
Preferred Brand Drugs	\$100 copay	
Non-Preferred Brand Drugs	\$180 copay	

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 Sigmapharm coverage will not be affected. If you elect Part D coverage, the plan will coordinate with Part D.

*Drugs are covered out-of-network at a 50% reimbursement after deductible, with the exception of specially medications

If you do decide to join a Medicare drug plan and drop your current Sigmapharm 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 Sigmapharm 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...

- 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).

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 Sigmapharm 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
 - 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

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: 2024

Name of Entity/Sender: Sigmapharm Laboratories

Contact--Position/Office: Adrienne Stewart
Director. HR

Address: 3375 Progress Drive, Bensalem, PA 19020 Phone Number: 215-352-6655 ext. 271



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