Employee Benefits Guide 2025

Effective January 1, 2025– December 31, 2025

Table of Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 39 for more details.

Eligibility

Who is Eligible?

- An active full-time employee working 30 or more hours per week

Your dependents are eligible if they are:

- Your legal spouse
- Your child(ren)* up to age 26
- Your disabled child(ren) age 26 and older if they are disabled and legally dependent on you

* Includes natural, step, legally adopted/or a child placed for adoption, or a child under your legal guardianship.

Making Benefit Changes During the Plan Year

The benefit elections you make during your initial enrollment period will be in effect through the end of the plan year. If you have a "qualifying life event," you may make changes to certain benefits if you apply for the change and provide supporting documentation to Human Resources within 30 days of the event. Proof of life events is subject to approval. Please reach out to your employer for specific documentation to be submitted for a qualified life event during the benefit year. Changes are effective prospectively unless the event is for birth, adoption, or placement for adoption.

Qualified Life Event		
Change in Marital Status	**Change in Dependents**	**Change in Employment**
• Marriage • Divorce • Death of your spouse	• Birth, adoption or placement for adoption of an eligible child (Retroactive to the date of the event) • Death of your covered dependent • Gain or loss of Medicare or Medicaid during the year	• Change in you or your spouse's work status that affects benefits eligibility. • Your spouse's Open Enrollment differs from yours • Relocation if the move impacts eligibility for the plan

Your Coverage

When Does Coverage Begin?

Benefits for new hires, unless explained otherwise, will become effective following 30 days from date of hire.

If you do not enroll during your eligibility period, you may enroll at the next open enrollment period.

Termination of Coverage

If you or a covered dependent no longer meet the eligibility requirements or if your employment
ceases, your benefits will end.

You are responsible for informing Human Resources within 30 days if any of your dependents become ineligible for benefits.

Benefits can be cancelled due to:

- Open Enrollment
- Termination (voluntary or involuntary)
- Retirement
- Qualified Life Event

Enrollment

When Can I Enroll in Benefits?

You can enroll for benefits:

- Within 30 days of first becoming eligible for benefits
- During the annual Open Enrollment period
- During the plan year, if you experience a Qualifying Life Event

How Do I Enroll?

To enroll (or make changes) to your benefits, register/log onto employeenavigator.com.

Please note that all Weaber employees will need to create a new Employee Navigator account for the January 1, 2025 plan year. You may not reuse your previous Employee Navigator username when registering for a new account.

For new user registration, you will need:

- Your legal First & Last name
- Last 4 of your SSN
- Birth Date

Create your username & password and save for future reference. Again, you may not re-register for Employee Navigator using your old username. You must create a new username when registering for the January 1, 2025 plan year.

Annual Open Enrollment

This is a once-a-year opportunity to review your benefit plan elections and make adjustments that meet the needs of you and your family. Changes will go into effect January 1st.

How a Health Plan Works

A Note About Health Care Reform

If you choose to purchase individual coverage through the Marketplace, you should know that because Weaber, Inc.'s medical insurance meets specific ACA requirements, you may not be eligible to receive a federal subsidy.

Additional information is available at www.healthcare.gov.

Preventive care

Like physical exams, flu shots and screenings – is covered 100% when you use in-network providers.

Deductible Amount

The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.

Out of Pocket Maximums

The most you will pay each year for eligible network services including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the plan year.

Copays

A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.

Coinsurance

Once you've met your deductible, you and the plan share the cost of care, called coinsurance. For example, you pay 20% for services and the plan will pay 80% of the cost until you have reached your out-of-pocket maximum.

Medical Overview

We offer a Performance Blue PPO medical plan through Capital Blue Cross with the following features:

- Deductibles and out-of-pocket maximums accumulate January 1, 2025 – December 31, 2025.
- Includes prescription drug coverage through **MagellanRx**.
- You have the option to receive care from three network levels: Performance Plus (preferred) Network, Performance Select or Out-of-Network providers. **Higher benefits are paid when using Performance Plus network**. See more information on pages 8-9.
- Preventative care is covered at 100% when using an in-network provider.
- Please refer to the Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC) as well as the carrier contracts for information regarding specific benefit levels, exclusions and limitations for all policies.

Medical Provider Finder

To search for in-network medical providers:

Log onto capbluecross.com.

Network: Performance PPO

Access care from your home through Telehealth Services.
Log onto virtualcarecbc.com.

Download the Mobile App Today!

Download on the App Store

GET IT ON Google Play

Performance PPO
Know Where to Go!

Powered by quality, driven by choice

When it comes to your healthcare, employees often need to choose between a high-quality offering and keeping costs low – trying to find a balance between can be challenging. Capital Blue Cross has introduced a plan that provides both quality care and low costs while preserving choice for employees—Performance PPO. Using clinical data to identify high-performing providers, Performance PPO places those doctors and hospitals in a select lower-cost tier. In addition to lower costs, employees have the freedom to choose to get their care from several renowned health systems throughout Central Pennsylvania and the Lehigh Valley.

Performance Plus

Lowest costs from high-performing providers

These high-performing providers can be found throughout our region and offer a wide range of specialty care. You enjoy a lower out-of-pocket cost when you seek care from these health systems:

- **WellSpan**
- **St. Luke's**
- **Lancaster General Health**
- **Penn State Health**
- Access to the largest healthcare network in the U.S., with a network that includes 96% of the nation's hospitals and 95% of its doctors*

Performance Select

Low costs (not as low as Performance Plus) from high-performing providers

Delivering peace of mind with access to more doctors and hospitals—locally and nationally

There's power in choice, and having more control over where you can get in-network care adds value to your health plan.

- Convenient access to local care from providers you know and trust
- No referrals, freedom to choose any provider
- Preventive services from in-network providers are covered at 100%

High-quality, low-cost care near home

Performance PPO reflects an industry-wide shift toward better outcomes and value through collaboration with providers. It gives you more control of their overall health with a distinct network design that keeps cost efficiency top of mind.

*According to the Blue Cross Blue Shield Association.

Data-driven healthcare

What does high quality mean? Providers are considered high quality when they provide:

- Patient-centric care that reduces waste and prevents harm.
- Evidence-based medicine to effectively treat patients.
- Health management to prevent illness and better manage chronic conditions.
- Improved outcomes for patients such as fewer sick visits and lower readmission rates, to deliver better employee health.

Our Performance PPO reflects an industry-wide shift toward better outcomes and value through collaboration with providers. It gives employees more control of their overall health.

Across the board savings

All of this equates to lower costs to employees and employers in both money and time away from work. When employees are healthier, everyone is happier.

Employees also have access to the Capital Blue Cross VirtualCare app, to receive medical and behavioral healthcare without leaving their home.

More than health insurance

We deliver more than health benefits—we provide choices that empower you to use, experience, and manage your health plan in ways that best meet your needs.

Capital Blue Cross App

See your ID card, manage your benefits, and find providers all from your mobile devices.

Healthy Blue Rewards

Take the small steps to better health and earn gift cards for completing healthy activities.

MyCare Finder

Access MyCare Finder's user-friendly tools to easily find providers and make informed decisions about where to get care.

Blue365®

Enjoy exclusive discounts on gym memberships, nutrition plans, fitness apparel, and much more.

CapitalBlueCross.com

Medical

Benefits are shown as a summary of your medical plan benefits offered to you. For details and limitations, please refer to your summary of benefits for specific requirements regarding pre-authorizations, coverage limits, and out-of-network costs.

Capital Blue Cross Performance PPO 1500	Member Responsibilities		
You Pay In-Network	Preferred Network **(Performance Plus)** (Individual / Family)	In-Network **(Performance Select)** (Individual / Family)	**Out-of-Network (Individual / Family)**
Deductible	$1,500 / $3,000	$3,000 / $6,000	$7,500 / $15,000
Coinsurance	20% *	20% *	20% *
Coinsurance Out-of-Pocket Max.	$2,500 / $5,000	$5,000 / $10,000	$10,000 / $20,000
Out-of-Pocket Maximums	$7,500 / $15,000		$0 / $0
Coinsurance/Copays			
Preventive Care	0%	0%	40% *
Primary Care	$25 copay	$35 copay	40% *
Telemedicine	$10 copay	$10 copay	N/A
Specialist Care	$50 copay	$60 copay	40% *
Urgent Care	$50 copay	$75 copay	40% *
Emergency Room Care	$200 copay	$200 copay	$200 copay
Outpatient Surgery	20%*	20%*	40% *
Inpatient Hospitalization	20%*	20%*	40% *

*** After Deductible**

Preventive Care

- Your medical plan provides 100% coverage (no cost to you) for mandated routine health screenings.
- Routine visit will only be covered under preventive care when using an in-network provider.
- Full list: healthcare.gov/what-are-my-preventive-care-benefits/.

Magellan Rx Pharmacy	
Pharmacy Retail RX (only 30-day supply shown) through Magellan	
Generic (Tier 1)	$10 copay
Preferred Brand (Tier 2)	$40 copay
Non-Preferred Brand (Tier 3)	$70 copay
Specialty (Tier 4)	25% coinsurance ($150 minimum / $300 maximum per prescription)

Prescription Drugs

Get the Most from Your Prescription Coverage.

When you enroll in a medical plan, you receive comprehensive prescription drug coverage through MagellanRx. For a list of approved drugs, log onto www.magellanrx.com.

Formulary: Net Results

- If you take a maintenance medication, you can save money by enrolling in mail order RX. Mail Order copays for a 90-day supply are only **twice** the Retail copay amount.
- Not all medications can be filled via mail order.
- Specialty medications must be filled at the approved MagellanRx Pharmacy through Payer Matrix.
- Ask your doctor if it is appropriate to use a generic drug rather than a brand name. Some medications require programs to control cost of prescription drug expense.
- Compare Pharmacies for the best price.
- Prescription Management may apply; such as prior authorization, step therapy, and quantity limits.

Formulary lookup tool

To find drugs that are covered by your plan, we offer an easy-to-use formulary drug lookup tool. The drugs in our formulary have been approved by the Food and Drug Administration (FDA) as safe and effective. They were selected by our team of expert health care professionals.

Click or scan this QR code to access the formulary lookup tool.

Questions?

Visit **magellanrx.com** or call **866.545.9428**. Support is available to members, pharmacies and prescribers 24 hours a day, 7 days a week. **Magellan Rx Mobile App** is also available.

Prescriptions filled at a non-network pharmacy are not covered.

Mail Order Pharmacy
Magellan Rx Pharmacy

How to fill your first prescription with our pharmacy

If you already have a 90-day prescription:

Mail your 90-day prescription and home delivery order form with payment information to Magellan Rx Pharmacy, P.O. Box 620968, Orlando, FL 32862.

Home delivery order forms are available at magellanrx.com/member/forms

If you need a new prescription:

First, ask your doctor to write two prescriptions:

1. **30-day supply to fill right away at your local pharmacy**
2. **90-day supply with refills to start your home delivery service**

Next, ask your doctor to ***e-prescribe*** to Magellan Rx Pharmacy, LLC (Mail-ORL) or ***fax*** your prescription to 888-282-1349.

How to get refills

ONLINE PORTAL
Submit your refill orders and pay **online** through your secure member portal.

PHONE
Call us at **800-424-8274 (TTY 711)** with your prescription number and payment information.

MAIL
Complete the refill section on the home delivery order form and **mail** it to Magellan Rx Pharmacy, P.O. Box 620968, Orlando, FL 32862.

Direct Care

Premium Services at Discounted Cost

Weaber has contracted with OSS Health. If you, or your loved one, is in need of medical services or treatment, this program is available for you to receive quality health care at discounted costs. Below are examples of available procedures that are included in this program.

OVERVIEW

If care is needed, the employee contacts OSS and speaks with a Patient Navigator using the contact information provided on your card to schedule your initial appointment.

The Patient Navigator oversees all aspects of your care. This streamlines the paperwork process and shortens wait times for treatment.

SERVICES INCLUDE

- Inpatient Services
  - Spine and joint surgery
- Outpatient Services
  - Orthopedic repair surgery
  - Arthroscopic procedures
  - Fracture repair
- Pain Management Injections
- Radiology Testing
  - MRI/MRA
  - CT scans

PROGRAM INCLUDES

- Office visits
- Medical Equipment / Instrumentation
- Facility & Physician Fees
- Surgery
- Anesthesiology Services
- Pain Management
- Imaging
- Rehabilitation / Physical Therapy
- Home Health Care *(if prescribed)*

For more information:

717-848-4800 extension 4424

gsematoske@osshealth.com

Flexible Spending Accounts (FSA)

You can use available pre-tax funds set aside for eligible expenses for any IRS claimed taxable dependent, regardless if they are covered under your plan.

You have immediate access to the entire balance of your elected amount on the 1st day of the plan year

You cannot change the amount you are contributing during the year unless you have a qualified life event. Plan year runs 01/2025 - 12/2025.

IRS Contribution Limit 2025	Healthcare FSA	Dependent Care FSA
	$3,300/annually (allows $660 rollover)	$5,000/annually ($2,500 if married and filing separately)

Healthcare FSA

- Use for medical, dental and vision expenses
- You have the option to roll over up to $660 of unused FSA dollars to the following plan year
  - These roll over funds will not count against your future FSA election / contribution limit
  - Any unused balances in excess of $660 at the end of the plan year will be forfeited

**Not available to HSA plan participants.*

Dependent Care FSA

- Use to pay for costs of dependent care for:
  - Children under age 13
  - Older dependents , including children, spouses and parents who are physically or mentally unable to care for themselves that live with you more than ½ of the year
  - Interest that accrues
- Eligible expenses include daycare, before-school and after-school care, babysitters and elder daycare
- Kindergarten or higher education does not qualify.

Register your online account through Health Equity. Please refer to your FSA plan documents regarding filing claims, debit cards, and grace periods.

To view eligible purchases with your FSA account, please visit healthequity.com.

Dental (PPO)

Dental insurance is offered through **Delta Dental**. Your choice of dentists can determine the cost savings you receive. You will pay less for in-network services. For out-of-network providers, **Delta Dental** will pay claims based on reasonable and customary (R&C) charges. You are responsible for paying the balance of the bill.

Please refer to plan summary for out-of-network benefits, subject to balance billing, and limitations.

Delta Dental	Base Plan		Buy-Up Plan	
Plan Design	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
2025 Year Annual Max	Up to $1,000/per person		Up to $2,000/per person	
Calendar Year Deductible	None / None		$50 / $150	
Benefit	**Plan Pays**	**Plan Pays**	**Plan Pays**	**Plan Pays**
Preventive Services	100%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services	0%	0%	50%	50%
Orthodontia	Not Covered	Not Covered	Not Covered	Not Covered

Vision

Routine eye exams are important for maintaining good vision and can also provide early warning of other health conditions. The vision plan through Capital Blue Cross provides coverage for exams, glasses and contact lenses, as shown below.
In-network coverage is provided when you use Capital Blue Cross providers.

Refer to plan summary for more details on vision benefits, allowances and limitations. Additional discounts for lens options and additional services are available at in-network providers only.

Here is what you'll pay in-network and out-of-network:

CBC 12/0 Optimal	You Pay	Plan Allowance / Reimbursement
Based on Calendar Year	In-Network	Out-of-Network
Eye Exam *Once every 12 months*	$0 copay	Allowance up to $32
Lenses **Single, Lined Bifocal, Lined Trifocal, Lenticular** *Once every 12 months*	0%	Up to $25 (single), $36 (bifocal), $46 (trifocal), $72 (lenticular)
Frame *Once every 12 months*	Allowance up to $200; plus 30% off retail balance	Allowance up to $60
Contacts *Instead of glasses,* *Once every 12 months*	Allowance up to $115; plus 25% off retail balance	Allowance up to $75

Life Insurance

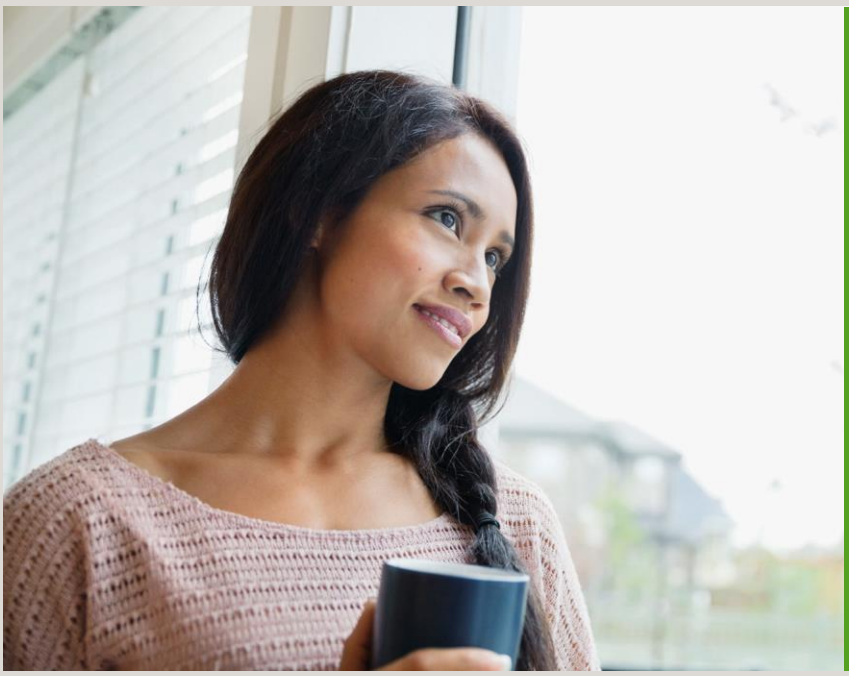
Basic Life/AD&D

A Basic Life insurance policy is provided to you at no cost through **The Hartford.** You are automatically enrolled in this benefit. This coverage includes an Accidental Death and Dismemberment (AD&D) provision, at the same coverage amount, in the event of accidental death and other conditions. Please refer to the benefit summary for details.

According to federal law, only the first $50,000 of employer-paid life insurance is not taxable. Premium paid by Weaber, Inc. for coverage levels over $50,000 will be taxable to you and will be included on your year-end W-2 statement.

What is Life Insurance?

- A lump sum payment distributed to beneficiaries upon death of the insured or insureds.
- Reassurance that your loved ones would be financially secure if you passed away unexpectedly. Average funeral cost is $10,000.



Reminder! Update your Beneficiaries!

Plan for your expected and unexpected life changes by ensuring you and your family are protected. Update your beneficiaries now and keep them current each year.

Voluntary Life Insurance

Voluntary Life and AD&D

As a new hire, you can purchase Voluntary Life insurance through **The Hartford** for you, your legal spouse and dependent children without providing medical information up to certain guarantee issue (GI) amounts (see chart). Please refer to the benefit summary for details.

Voluntary Life and AD&D	
Employee	Increments of $10,000 to lesser of 5x times your salary or $500,000 Guarantee Issue*: $100,000
Spouse	Increments of $5,000 to lesser of $150,000 or 50% of Employee's Voluntary Life Inaurance amount Guarantee Issue*: $25,000
Child (up to age 26)	Flat Amount: $10,0000 Guarantee Issue*: $10,000

*Medical review (often referred to as evidence of insurability or EOI) is completed via the enrollment site. *Guarantee issue is the amount of coverage you or your dependents can elect up to without medical questions. Guarantee issue is only available to newly benefit eligible employees.*

Reminder! Update your Beneficiaries!

Plan for your expected and unexpected life changes by ensuring you and your family are protected. Update your beneficiaries now and keep them current each year.

Short Term Disability

Short-Term Disability insurance is provided to you at no cost, therefore your benefit while out on Disability, will be taxable. You are automatically enrolled in these benefits through **The Hartford.**

Short-Term Disability

Short-Term Disability (STD) benefits are payable when you are unable to work due to an injury or illness unrelated to work.

When do the benefits start?
15th day of accident or illness

Benefit duration is reduced by the initial disability waiting period (before benefits begin).

How much would the benefit pay?
The lesser of $5,000 or 60% of basic weekly earnings

Are there any pre-existing exclusions?
N/A

How long will the benefit pay?
Up to 24 weeks

STD benefits integrate with state mandated disability plans. Maternity claims fall under this policy.

NEW! Voluntary Long-Term Disability

Voluntary Long-Term Disability is available for Weaber employees interested in additional financial protection in the case of a disability. **Please note** that while this benefit is being offered during Open Enrollment, at least 10% of the Weaber population that is eligible for benefits must participate in order for the benefit to become effective January 1, 2025. If minimum participation is not met, anyone who elects this coverage will not be enrolled and will not have payroll deductions taken. This coverage is administered through the Hartford.

Long-Term Disability

Long-Term Disability (LTD) benefits are payable when you are unable to work due to an injury or illness unrelated to work.

When do the benefits start?

181st day of accident or illness

Benefit duration is reduced by the initial disability waiting period (before benefits begin).

How much would the benefit pay?

60% of monthly earnings to a maximum of $6,000

Is there a minimum benefit amount I can elect?

The greater of $100 or 10% of basic weekly earnings

Are there any pre-existing exclusions?

N/A

How long will the benefit pay?

Up to Social Security Normal Retirement Age. For those over age 65 at the time of disability, the benefit period is based on an age schedule.

Voluntary Accident Insurance

No one plans to have an accident, but it can happen at any time. To support you in the case of an accident, Weaber, Inc offers the opportunity to enroll in an additional voluntary benefit plan through Allstate. This plan does not replace medical insurance and does not replace your medical coverage, but rather pays cash directly to you in addition to any benefits you receive from your health plan.

Accident Insurance

Accident insurance pays a cash benefit when you or your covered family members suffer injuries sustained in an accident. Covered injuries include fractures, burns, concussions, tears, lacerations, broken teeth and eye injuries. Additional benefits may be paid, including ambulance, emergency care, testing and therapy.

BENEFIT AMOUNTS

Benefits are paid once per accident unless otherwise noted here or in the Important Information About Coverage.

BASE ACCIDENT BENEFITS		PLAN 1
Accidental Death	Employee	$40,000
	Spouse	$20,000
	Children	$10,000
Common Carrier Accidental Death (fare-paying passenger)	Employee	$200,000
	Spouse	$100,000
	Children	$50,000
Dismemberment[1]	Employee	$40,000
	Spouse	$20,000
	Children	$10,000
Dislocation or Fracture[1]	Employee	$4,000
	Spouse	$2,000
	Children	$1,000
Hospital Confinement (Pays once/year)		$1,000
Daily Hospital Confinement (Pays daily)		$200
Intensive Care (Pays daily)		$400
Ambulance	Ground	$200
	Air	$600
Accident Physician's Treatment		$100
X-Ray		$200
Emergency Room Services		$200

[1]Up to amount shown; actual amount paid depends on injury and is based on Schedule of Benefits and Factors in your certificate of coverage.

BENEFIT ENHANCEMENTS		PLAN 1
Lacerations (Pays once/year)		$100
Burns (other than sunburns)	< 15% body su	$200
	> 15% or more	$1,000
Skin Graft (% of Burns Benefit)		50%
Brain Injury Diagnosis (Pays once)		$300
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI)		$100
Paralysis (Pays once)	Paraplegia	$15,000
	Quadriplegia	$30,000
Coma with Respiratory Assistance (Pays once)		$20,000
Open Abdominal or Thoracic Surgery		$2,000
Tendon, Ligament, Rotator Cuff	Surgery	$1,000
or Knee Cartilage Surgery	Exploratory	$300
Ruptured Spinal Disc Surgery		$1,000
Eye Surgery		$200
General Anesthesia		$200
Blood and Plasma		$600
Appliance		$250
Medical Supplies		$10
Medicine		$10
Prosthesis	1 device	$1,000
	2 or more devic	$2,000
Physical Therapy (Pays daily; max. 6 days/accident)		$60
Rehabilitation Unit (Pays daily)		$200
Non-Local Transportation		$800
Family Member Lodging		$200
Post-Accident Transportation (Pays once/year)		$400
Accident Follow-Up Treatment		$100
ADDITIONAL RIDER BENEFIT		**PLAN 1**
Outpatient Physician's Benefit		$100

Voluntary Pet Insurance

Total Pet Plan

The Total Pet Plan from Pet Benefit Solutions provides everyday savings on veterinary care and pet products, as well as access to other pet care services and discounts.

The Total Pet Plan allows all animals to be covered. Weaber employees may enroll in this plan throughout the plan year.

DISCOUNTS ON PRODUCTS AND RX

PETplus

- Receive member-only pricing (up to 40% off) on prescription medications, preventatives, food, toys, treats & more
- Shipping is always free and same-day pickup is available for human-grade medications
- Covers dogs & cats
- Covers pre-existing conditions

24/7 PET TELEHEALTH

AskVet

- Access real-time vet support, even when your vet's office is closed
- Chat a US-based veterinarian 24/7
- Unlimited support on your pet's health, wellness, behavior and more
- Covers dogs & cats

DISCOUNTS ON VETERINARY CARE

Pet Assure

- Save 25% on all in-house medical services at any network vet
- Instant savings; no claim forms or waiting for reimbursements
- Covers all pets
- Covers pre-existing conditions
- Visit www.petbenefits.com/search to locate a network vet

LOST PET RECOVERY SERVICE

PetTag

- Durable tag can be scanned from any smart phone to access your contact information
- Instantly update contact information online, even after your pet goes missing
- Covers any pet wearing a collar!

401(k) Retirement Savings Plan

Our 401(k) Retirement Savings Plan allows employees to save for retirement through convenient payroll deductions. Employees who are at least 18 years of age become eligible to participate in the Plan upon their date of hire. The Plan, administered by JP Morgan Chase, is designed with the following features:

- Weaber, Inc. will match $0.25 on the dollar up to the first 4% of earnings.
- Employer contributions are 20% vested after 2 years of service, increasing 20% per year until being fully vested after 6 years of service.

IRS Elective Deferral Limit	2024	2025
Maximum Deferral Limit	$23,000	$23,500
Catch Up Contributions (Ages 50+)	$7,500	$7,500

You Choose When to Pay Taxes

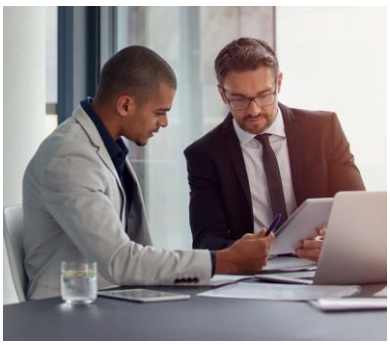
Making contributions to the 401(k) plan offers tax benefits. The type of contributions you make—pre-tax, Roth (after-tax) or a combination of the two—will determine when you pay taxes on your contributions. You can:

Pay taxes later. If you make pre-tax contributions to the 401(k) Plan, you will lower your taxes today.

The money you contribute, and any earnings will not be subject to income taxes until you withdraw it, likely in retirement.

Pay taxes now. If you make Roth contributions to the 401(k) Plan, you will pay income taxes on the contributions today.

You can withdraw your contributions and any earnings tax-free once you have had the account for at least five years and have reached age 59½.



Cost of Coverage

Contributions are made from each paycheck toward the benefits below. These are automatically deducted from your gross pay before Federal Income and Social Security taxes are calculated. Since contributions are deducted before your pay is taxed, your taxes will be based on a lower gross pay, and you end up paying lower taxes on the same salary.

Medical Contributions Per Pay (Weekly)

Capital Blue Cross / MagellanRx	Performance PPO 1500
Employee Only	$41.17
Employee + Spouse	$105.57
Employee + Child	$63.34
Employee + Children	$90.79
Employee + Family	$123.52

$20 per pay surcharge applies for Tobacco Users * See Notice Regarding Reasonable Alternative on p.27

Dental Contributions Per Pay (Weekly)

Delta Dental	Base Plan	Buy Up Plan
Employee Only	$0	$3.00
Employee + One Dependent	$0	$5.00
Employee + Family	$0	$7.00

Vision Contributions Per Pay (Weekly)

Capital Blue Cross	
Employee Only	$0
Employee + Spouse	$0
Employee + Child(ren)	$0
Employee + Family	$0

Cost of Coverage (Continued)

Contributions are made from each paycheck toward the benefits below. These are automatically deducted from your gross pay before Federal Income and Social Security taxes are calculated. Since contributions are deducted before your pay is taxed, your taxes will be based on a lower gross pay, and you end up paying lower taxes on the same salary.

Accident Contributions Per Pay (Weekly)

Allstate		Annual Wellness
Employee Only	$3.18	$200/year
Employee + Spouse	$4.57	$400/year
Employee + Child(ren)	$6.46	$400/year
Employee + Family	$8.07	$400/year

Pet Insurance Contributions Per Pay (Weekly)

Pet Benefit Solutions	
One Pet	$2.71
Two or More Pets	$4.27

Graham Company Concierge Line

Navigating your benefit selections can be a complicated process. Graham Company's Concierge Line is here to help!

Contact Graham for support with:

- Eligibility Questions
- Claims Issues
- Prior Authorizations
- ID Cards
- Understanding Coverage

You may reach the Graham Concierge Line via phone or email:

1-888-842-1488

Graham-Benefits@MarshMMA.com

The Concierge Line is staffed Monday through Friday from 9:00 AM – 5:00 PM EST.

Contact Information

Benefit	Partner	Website	Contact
Medical Group #00532008	Capital Blue Cross	capbluecross.com	800.962.2242
Pharmacy (Mail Order)	MagellanRx	Magellanrx.com	800.545.9428
Specialty Pharmacy	Payer Matrix	payermatrix.com	877.305.6202
Dental Group #18709	Delta Dental	deltadentalins.com	800.932.0783
Vision Group #00532008	Capital Blue Cross	capbluecross.com	800.962.2242
Flexible Spending Accounts	Health Equity	healthequity.com	877.924.3967
Basic and Voluntary Life and AD&D	The Hartford	thehartford.com	888.563.1124
Disability	The Hartford	thehartford.com	888.277.2767
Accident	Allstate	Allstate.com	717.715.5120
Pet Insurance	Pet Benefit Solutions	petbenefits.com	888.913.7387
401(k)	JP Morgan Chase	Jpmorganchase.com	800.935.9935
Employee Benefits Broker	Graham Company	Grahamco.com	1-888-842-1488 Graham-Benefits@MarshMMA.com
Human Resources	Weaber, Inc.	-	717.867.2212

*** Notice Regarding a Reasonable Alternative**

You may qualify for an alternative standard and pay the lower premium by participating in a tobacco cessation program such as the one available at no cost through Cigna Tobacco Cessation Program.

An exception to the tobacco user's premium may apply for a tobacco user who has been diagnosed with an uncontrolled health factor and whose physician advises against stopping the use of tobacco.

YOUR PLAN RIGHTS

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about you prescription drug coverage. Please see page 12 for details.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by **Weaber, Inc. Inc**

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that is not considered affordable and doesn't meet certain minimum value standards. The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a new kind of tax credit that lowers your costs.

Does Weaber, Inc. Inc Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1, 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by **Weaber, Inc. Inc** then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after - tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit.

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

Open enrollment for health insurance coverage through the Marketplace generally begins November 1 for coverage starting as early as January the following year. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period when you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. You may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a temporary Marketplace Special Enrollment Period for certain individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. If you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What About Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in Weaber, Inc's group plan, you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in the employer's health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your HR representative. Additionally, the Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Weaber, Inc. Inc

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

If you are not eligible for health insurance coverage through you and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Employer Name: Weaber, Inc.
Employer Identification Number (EIN): 32-0362825501
Employer Address: 1231 Mt Wilson Rd, Lebanon, PA 17042
Employer Phone Number: (717) 867-2212
Who Can We Contact About Employee Health Coverage at this Job? Matthew Drye, Human Resources Manager at 717) 926-8811

1. Indexed annually; see this link for 2024.
2. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

YOUR PLAN RIGHTS

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

1. As your employer, we offer a health plan to:

   Employees regularly working 30 or more hours per week.

2. With respect to dependents:

   We do offer coverage. Eligible dependents are: Legal spouses, children up to age 26*, and children of any age who are mentally or physically disabled and depend on you for support.

   * Includes natural, step, legally adopted/or a child placed for adoption, or a child under your legal guardianship.

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

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

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

WOMEN'S RIGHTS AND CANCER ACT NOTICE

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and treatment of physical complications of mastectomy.

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.
Contact Capital Blue Cross at 800.962.2242 for more information.

NEWBORNS AND MOTHER'S HEALTH PROTECTION ACT

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2009

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA):

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets.

NOTICE OF PATIENT PROTECTIONS:

Weaber, Inc. Inc generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select primary care provider, and for a list of participating primary care providers, contact Capital Blue Cross at 800.962.2242.

For children, you may designate a pediatrician as the primary care provider for the Weaber, Inc. Inc Capital Blue Cross medical plan.

You do not need prior authorization from Weaber, Inc. or from any other person(including a primary care provider) in order to obtain access to obstetrical or gynecological care from health care professional in our network who specializes in obstetrics and gynecology. The health care professional, however, may be required to comply with certain procedure, including obtaining prior authorization for certain services, following a pre-approved treatment plan , or procedures for making referrals. For a listing of participating healthcare professionals who specialize in obstetrics or gynecology, contact Capital Blue Cross at 800.962.2242

NOTICE REGARDING SPECIAL ENROLLMENT

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.
Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.
Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact:

NAME Matthew Drye
ADDRESS 1231 Mt Wilson Rd
CITY, STATE Lebanon, PA 17042
TELEPHONE (717) 926-8811

HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

PRIVACY OBLIGATIONS OF THE PLAN

The Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following are the different ways the Plan may use and disclose your PHI:

- **For Treatment.** The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise emergency room physicians about the types of prescription drugs you currently take.
- **For Payment.** The plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- **To the Plan Sponsor.** The Plan may disclose your PHI to designated personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to designated HR personnel so that they can carry out related administrative functions. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other employee or department and (2) will not be used for any employment related actions and decisions or in connection with any other sponsored employee benefit plan.
- **To a Business Associate.** Certain services are provided to the Plan by third party administrators known as "business associates." For example, we may forward information about your health care treatment to our broker to assist with the claim processing. In doing so, we will disclose your PHI to the broker so he/she can perform their claim payment function. However, we will require its business associates to appropriately safeguard your health information.
- **Health-Related Benefits and Services.** The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- **Personal Representative Involved in Your Care.** The Plan may also advise a family member or close friend about your condition, your location (for example that you are in the hospital) or death.
- **As Required by Law.** The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

SPECIAL USE AND DISCLOSURE SITUATIONS

The Plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes.** The Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful process.
- **Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official (for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime).
- **Workers' Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

The plan is required to obtain plan participants' authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, to sell PHI, or to use or disclose PHI for any purpose not described in the notice. The Plan Administrator must obtain this authorization from the plan participant in writing. The plan participant my revoke this authorization anytime in writing by contacting the Plan Administrator at the address below:

1231 Mt Wilson Rd
Lebanon, PA 17042

HIPAA PRIVACY NOTICE (CONTINUED)

PROHIBITED USE OF PHI

The plan is prohibited from using PHI that is genetic information for underwriting purposes

YOUR RIGHTS REGARDING YOUR PHI

Your rights regarding PHI the Plan maintains about you are as follows:

- **Right to Inspect and Copy.** You have the right to inspect and copy PHI maintained by the Plan. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not included psychotherapy notes. To inspect and copy PHI maintained by the Plan, **you must submit your request in writing** to the Plan Administrator. The Plan may charge a fee for the cost of copying, mailing, or other costs associated with your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- **Right to Request Restrictions.** You have the right to request a restriction on the health information the Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan disclosed about you to someone who is involved in your care, like a family member or friend. (For example, you could ask that the Plan not use or disclose information about a surgery you had.) To request restrictions, **you must make your request in writing** to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. **Note:** The Plan is not required to agree to your request.

- **Right to be Notified of a Breach.** You have the right to receive notice if there has been a breach of your unsecured protected health information.

- **Right to Amendments to Your PHI.** If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be submitted in writing to the person listed below.

- **Right to an Accounting of Disclosures.** You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures. Your request to for an accounting must be submitted in writing to the person listed below.

- **Right to Request Confidential Communications.** You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

If you wish to make any of the above-listed requests, you may write to the Plan Administrator at the address listed below in the Contact Information section.

Changes to this Notice: The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice on the Intranet.

Complaints: If you believe your privacy rights under this policy have been violated, you may file a written complaint with Human Resources at the address listed below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission occurred.

HIPAA PRIVACY NOTICE (CONTINUED)

Other Uses and Disclosures of Health Information: Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization, however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information:

If you have any questions about this notice, please contact:

MATTHEW DRYE
HUMAN RESOURCES MANAGER
(717) 926-8811

Notice Effective Date: 11.1.2024

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

You are receiving 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 generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

Read this notice carefully to help understand your COBRA rights. Keep in mind that 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete 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 does not 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 known as 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 may be required to pay for COBRA continuation coverage.

EMPLOYEE If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events happens:

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

SPOUSE If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

DEPENDENT CHILDREN Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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."

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUED)

RETIREE COVERAGE

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA 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;
- COMMENCEMENT OF A PROCEEDING IN BANKRUPTCY WITH RESPECT TO THE COMPANY;] OR
- The employee's becoming entitled to Medicare benefits (under Part A, Part B or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: **Capital Blue Cross at 800.962.2242** The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives timely 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. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage. COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of **36 months.**
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of **18 months.** There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

DISABILITY EXTENSION

If you or anyone in your family covered under the Plan is determined by the Social Security Administration 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 total 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 continuation coverage. The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUED)

SECOND QUALIFYING EVENT EXTENSION

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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or 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.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid 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.**

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 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.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2.Weaber, Inc. Inc has determined that the prescription drug coverage offered by Weaber, Inc. Inc 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 15 to December 7. 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 Weaber, Inc. Inc coverage will not be affected. Upon enrollment in a Medicare drug plan, you may continue the Weaber, Inc. Inc coverage, and the coverage will coordinate with Part D coverage according to the Medicare Secondary Payer Law. Please contact us for more information about what happens to your coverage if you decide to enroll in a Medicare Part D program.

If you do decide to join a Medicare drug plan and drop your current employer-sponsored coverage, you and your dependents will be able to get this coverage back at a future date, though you may need to wait until Weaber, Inc.'s next open enrollment period to resume coverage under the group plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

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

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Capital Blue Cross through Weaber, Inc. Inc changes. You also may request a copy of this notice at any time. For more information about his notice or your current prescription drug coverage, please contact Matthew Drye the Human Resources Manager at 610.350.4492

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

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

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

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

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

NOTES

NOTES

1(888) 842-1488
www.grahamco.com
Graham-Benefits@MarshMMA.com