2025

Employee Benefits Guide

BENEFITING A BETTER YOU

BOX™
PACKAGING PARTNERS

CONTENTS

MEDICARE PART D NOTICE

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

GETTING STARTED 2

WHO'S ELIGIBLE FOR BENEFITS? 3

CHANGING YOUR BENEFITS 4

ENROLLING FOR BENEFITS 5

MYBENEFITS.LIFE 6

MEDICAL, DENTAL & VISION 7

WHICH PLAN IS RIGHT FOR YOU? 8

FIND A PROVIDER 9

MYCIGNA APP 10

HSA OPEN ACCESS PLUS MEDICAL PLAN 11

HEALTH SAVINGS ACCOUNT (HSA) 12

PPO OPEN ACCESS PLUS MEDICAL PLAN 13

HMO MEDICAL PLAN 14

DENTAL 18

VISION 19

LIFE & DISABILITY 20

BASIC LIFE & AD&D, SHORT-TERM DISABILITY (STD)

VOLUNTARY PLANS 22

VOLUNTARY LIFE AND AD&D, LONG-TERM DISABILITY (LTD), ACCIDENT INSURANCE, CRITICAL ILLNESS INSURANCE, ID THEFT, PET INSURANCE

WELLBEING & BALANCE 26

LIFEBALANCE PROGRAM, EMPLOYEE ASSISTANCE PROGRAM (EAP), NO COST CIGNA MEMBER WELLNESS RESOURCES

IMPORTANT PLAN INFORMATION 30

BENEFIT COSTS, PLAN CONTACTS, ANNUAL NOTICES

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are an active full-time employee working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.

Eligible dependents

- Legally married spouse or domestic partner
- Natural, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

Who is not eligible?

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

- Parents, grandparents, and siblings.
- Employees who work less than 30 hours per week, temporary employees not on BOX Partners' payroll, contract employees, or employees residing outside the United States.

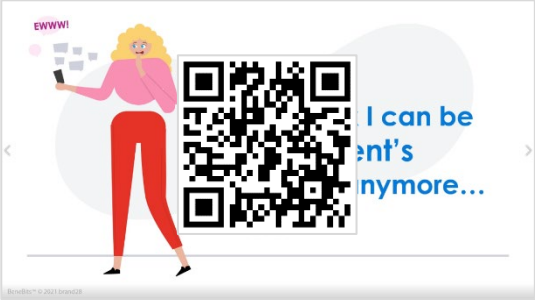
When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the 1st of the month following 30 days of employment.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

CHANGING YOUR BENEFITS

Click to play video



LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 31 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

ENROLLING FOR BENEFITS

Enrollment Instructions

You will utilize Paycom, your benefits administration system, to enroll for benefits. Below you will find step-by-step instructions on how to enroll. You can access Paycom by clicking **HERE** or by scanning the QR code below.

Step 1:

From the Notifications Center, tap the current year's Benefits Enrollment. Review the instructions and tap "Start Enrollment."

Step 2:

Review your information. Tap "Edit" to change anything or "Next" to continue.

Step 3:

Complete the Pre-Enrollment Questions and tap "Save and Next." You can also edit existing dependent and beneficiary information on this screen, as well as add a dependent or beneficiary.

Step 4:

Choose to enroll in or decline a plan by checking the appropriate option. If necessary, choose which dependents to add. When finished, tap "Enroll." Continue for each benefit plan.

Step 5:

When finished, review your enrollment and tap "Finalize." Then, tap "Sign and Submit" in the pop-up window. To view your current benefits at any time, navigate to Benefits > Current Benefits.

THE EASY WAY TO GET BENEFITS INFO

Click to play video

GET MYBENEFITS.LIFE®

On the web:

Boxpartners.mybenefits.life

On your smartphone

Download from the App Store or Google Play.

Login With Employer Key

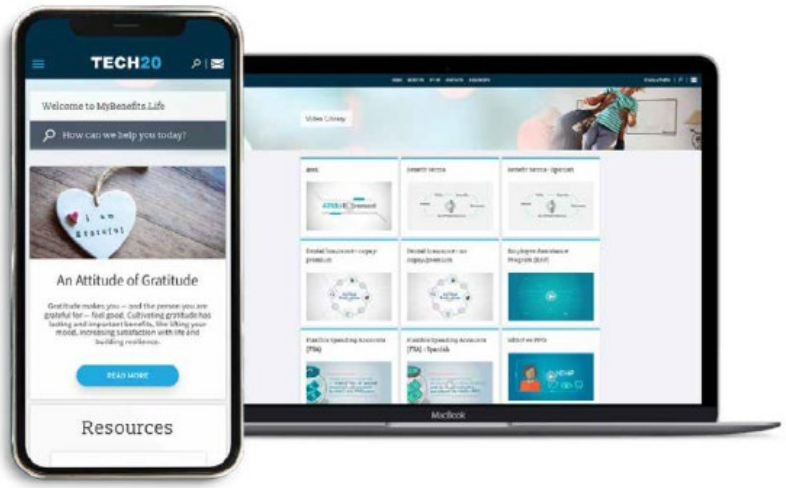
BOX

MyBenefits.Life® gives you all your benefits information in one place

You can bank online, book a vacation online, and read the news online. Why should your benefits information be any different? MyBenefits.Life® is both a website and a mobile app that gives you access to the benefits information you need, when you need it.

Here's what you'll find on MyBenefits.Life®

Benefits	See benefit details and costs—for all plans you're eligible for, such as healthcare, disability, life insurance, and more
Search	Can't find it? Just search the site
Articles & Video Library	Have 2 minutes? Increase your benefits IQ with short explainer articles and videos
Financial Wellness	Want to understand your finances better? Learn how in the Digital Financial Wellness Center, powered by Prudential
Glossary	HDHP? EOB? Coinsurance? Get the definitions in plain English
Inbox	Get messages from your HR team
Enroll	Time to enroll? Get the link here
Documents	Important benefit plan notices ("the fine print")
Contacts	Find HR, benefits, and carrier contacts
Get Help	Need help? Reach helpful resources



MEDICAL

OUR PLANS

HSA Open Access Plus Medical Plan

PPO Open Access Plus Medical Plan

HMO Medical Plan (IL Only)

Click to play video

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

WHICH PLAN IS RIGHT FOR YOU?

Through Cigna, you will be offered (3) medical plans. Take a moment to review the features, benefits and disadvantages each plan provides.

Consider the HSA Open Access Plus Medical Plan if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You want tax-free savings on your healthcare costs
- You want to build a savings account for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings.
- Note: BOX Partners funds a portion of the HSA.

Disadvantages: The main disadvantage to this plan is the higher deductible you have to meet. The high deductible is placed on this plan because of the fact that when enrolled in this plan, you enroll in the Health Savings Account (HSA) that helps offset the high costs.

Consider the PPO (Preferred Provider Organization) Open Access Plus Medical Plan if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers.

Disadvantages: The main disadvantage to a PPO is that the cost tends to be higher for the member/ employee. In addition, out-of-pocket costs are also typically higher due to deductibles and the cost sharing that is involved in a PPO plan.

Consider the HMO (Health Maintenance Organization) Medical Plan if:

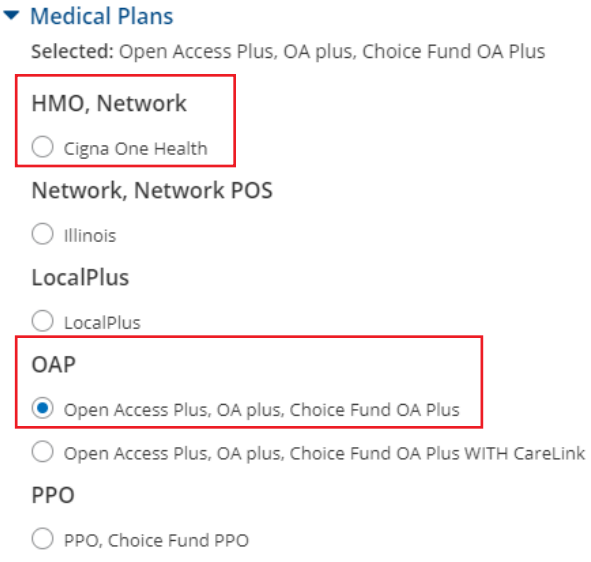
- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don’t see any doctors that are out-of-network.

Disadvantages: The main disadvantage to an HMO is that options for service providers are limited to network care providers only. In addition, if you enroll in this plan, you are required to select a PCP (primary care physician), in which referrals are required to see a specialist.

The HMO Plan is only available in Illinois.

FIND A PROVIDER

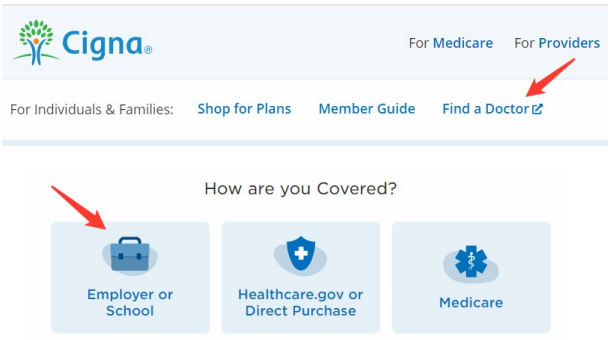
NOTE: You can search for doctors as a "guest" without logging in and/or before your Cigna coverage is active. Below is a screenshot of the networks you should choose for the HMO plan and the Open Access Plus HSA/PPO plans:



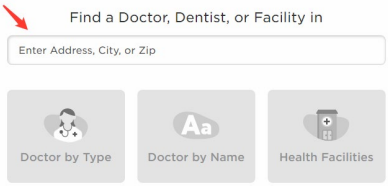
Whether you enroll in the HMO, the PPO Open Access Plus, or the HSA Open Access Plus, you can maximize your benefits by utilizing in-network providers. Please note that the HSA & PPO Open Access Plus Medical Plans both utilize the Cigna Open Access Plus (OAP) Network of Providers.

How to Find a Provider

Step 1: Go to **cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."



Step 2: Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to search your results.



Step 3: Answer any clarifying questions, and then verify where you live, as that will determine the networks available. You will be prompted to log in.

Step 4: Optional: Select one of the plans offered by BOX Partners during open enrollment.

MYCIGNA® APP

Get to know the full value of myCigna.

There are so many ways to help manage your health. Now it's easier than ever to manage your health and make the most of your health plan on the myCigna® website and app. From programs that help improve your health to tools that help manage your health spending, there's so much you can do.

With myCigna, you can now:

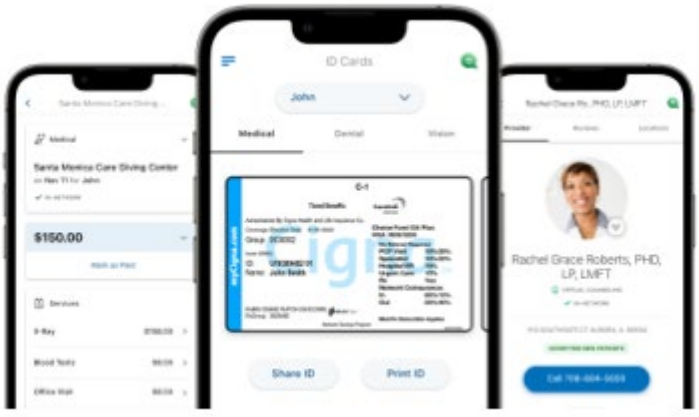
- Find in-network doctors, hospitals and medical services
- See cost estimates for medical procedures
- Compare quality of care information, including patient reviews from Cigna customers
- Manage and track claims
- Track expenses and pay bills online
- View, print and send ID cards
- Use the click-to-chat feature to connect with a live Cigna rep
- View your HSA balance and transactions (if enrolled in the HSA Open Access Plus Medical Plan)

Register now.

1. Enter your first name, last name, date of birth and zip code. Click Next.
2. Confirm your identity with one of the options listed. Enter the requested information.
3. Create a username and password.

Need help with registration or login? Call 800.853.2713.

Download on the App Store GET IT ON Google Play



MEDICAL- HSA Open Access Plus Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	In-Network (Open Access Plus)	Out-of-Network
Annual Deductible	$2,000 individual $3,300 family member $4,000 family	$4,000 individual $4,000 family member $8,000 family
Annual Out-of-Pocket Maximum	$4,000 individual $4,000 family member $8,000 family	$6,000 individual $6,000 family member $12,000 family
Office Visit	Plan pays 80%*	Plan pays 60%*
Specialist	Plan pays 80%*	Plan pays 60%*
Preventive Care	No Charge (deductible waived)	Plan pays 60%*
Chiropractic	Plan pays 80%* 20 days max	Plan pays 60%* 20 days max
Acupuncture Care	Plan pays 80%* 20 days max	Plan pays 60%* 20 days max
Lab and X-ray	Plan pays 80%*	Plan pays 60%*
Urgent Care	Plan pays 80%*	Plan pays 60%*
Emergency Room	$150 + 20%* (copay waived if admitted)	$150 + 20%* (copay waived if admitted)
Hospitalization	Inpatient: Plan pays 80%* Outpatient: Plan pays 80%*	Inpatient: Member pays $300/ visit + 40%* Outpatient: Plan pays 60%*
Durable Medical Equipment	Plan pays 80%*	Plan pays 60%*
PRESCRIPTION DRUGS		
Out-of-Pocket Maximum	Combined with Medical	
Deductible	Combined with Medical	
Retail	**30 day supply**	
Generic	$10 copay*	Plan pays 50%*
Preferred	$40 copay*	Plan pays 50%*
Non-Preferred Brand	$60 copay*	Plan pays 50%*
Mail Order	**90 day supply**	
Generic	$20 copay*	Plan pays 50%*
Preferred Brand	$80 copay*	Plan pays 50%*
Non-Preferred Brand	$120 copay*	Plan pays 50%*

*Coinsurance and/or copay listed is subject to the plan deductible.

HSA Open Access Plus
HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the HSA Open Access Plus Medical Plan
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.

See how much you could save on taxes with an easy **HSA calculator.**

SAMPLE HSA CARD

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How the HSA Open Access Plus Medical Plan works

- Your HSA account is set up automatically after you enroll in the HSA Open Access Plus Medical plan.
- You can contribute up to the limits set by the IRS.

  Individual: $4,300 per year
  Family: $8,550 per year
  Are you over the age of 55? You can contribute an additional $1,000 per year, in what is commonly called a "catch-up" contribution.
- To help you get started BOX Partners will make an annual total contribution of $750 for individual or $1,500 for family enrollment which will be deposited throughout the year in amounts of $28.84 per pay period for individual or $57.69 per pay period for family enrollment.
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items. For a complete list of eligible expenses, you can visit **Cigna.com/expenses.**

Four reasons to love an HSA

1. **Tax-free*.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses. Refer to your state's tax legislation.
2. **No "use it or lose it."** Your balance accumulates year after year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

**Employer HSA contributions are considered income and are taxed accordingly in the states of California and New Jersey.*

MEDICAL- PPO Open Access Plus Plan

Under this PPO Plan, you have the freedom to see any provider, regardless of whether they are in or out of the PPO network. Unlike an HMO, you do not require the election of a primary care physician, meaning you do not require a referral from a PCP to see a specialty doctor.

	In-Network	Out-of-Network
Annual Deductible	$2,000 individual $4,000 family	$4,000 individual $8,000 family
Annual Out-of-Pocket Maximum	$4,000 individual $8,000 family	$6,000 individual $12,000 family
Office Visit	$30/ visit (deductible waived)	Plan pays 60%*
Specialist	$30/ visit (deductible waived)	Plan pays 60%*
Preventive Care	No Charge (deductible waived)	Plan pays 60%*
Chiropractic	$30/ visit (deductible waived) 20 days max	Plan pays 60%* 20 days max
Acupuncture Care	$30/ visit (deductible waived) 20 days max	Plan pays 60%* 20 days max
Lab and X-ray	Plan pays 80%*	Plan pays 60%*
Urgent Care	Plan pays 80%*	Plan pays 80%*
Emergency Room	$150/ visit + 20%* (copay waived if admitted)	$150/ visit + 20%* (copay waived if admitted)
Hospitalization	Inpatient: Plan pays 80%* Outpatient: Plan pays 80%*	Inpatient: Member pays $300/ visit + 40%* Outpatient: Plan pays 60%*
Durable Medical Equipment	Plan pays 80%*	Plan pays 60%*
PRESCRIPTION DRUGS		
Rx Copay Out-of-Pocket Maximum	$1,000 individual/ $3,000 family	
Deductible	Not applicable	
Retail	**30 day supply**	
Generic	$10 copay	Plan pays 50%
Preferred	$40 copay	Plan pays 50%
Non-Preferred Brand	$60 copay	Plan pays 50%
Mail Order	**90 day supply**	
Generic	$20 copay	Plan pays 50%
Preferred Brand	$80 copay	Plan pays 50%
Non-Preferred Brand	$120 copay	Plan pays 50%

*Coinsurance and/or copay listed is subject to the plan deductible.

MEDICAL- HMO Plan (Available in IL only)

Under the HMO Medical Plan, you pay a small fee (copay), usually paid at the time of the appointment, for most office visits and medical services. You pay no deductibles or coinsurance. If you elect this plan, you are required to select a Primary Care Physician (PCP). Your PCP provides general medical care such as annual check-ups and authorizes referrals to other doctors, specialists and facilities your PCP not does provide.

	In-Network
Annual Deductible	None
Annual Out-of-Pocket Maximum	$2,000 individual $4,000 family
Office Visit	$20/ visit
Specialist	$40/ visit
Preventive Care	No Charge
Chiropractic	$20 copay 20 days max
Acupuncture Care	$20 copay 20 days max
Lab and X-ray	No Charge
Urgent Care	$40 copay
Emergency Room	$250/ visit (copay waived if admitted)
Hospitalization	Inpatient: $200/ visit Outpatient: $100/ visit
Durable Medical Equipment	No Charge
PRESCRIPTION DRUGS	
Out-of-Pocket Maximum	Combined with Medical
Deductible	Not applicable
Retail	**30 day supply**
Generic	$10 copay
Preferred Brand	$50 copay
Non-Preferred Brand	$90 copay
Mail Order	**90 day supply**
Generic	$30 copay
Preferred Brand	$150 copay
Non-Preferred Brand	$270 copay

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	• Cold, flu, allergies • Headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7	**$$$$$**

PREVENTIVE CARE SCREENING BENEFITS

TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Preferred Brand
$$$	Non-Preferred Brand

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website, call the customer service number on your ID card or click this LINK.

DENTAL

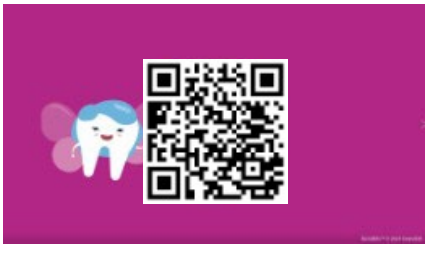
Why sign up for dental coverage? It's important to go to the dentist regularly. Brushing and flossing are great, but exams catch dental issues early before they become more serious, expensive and difficult to treat.

The Cigna Dental PPO Plan provides you the ability to visit any dentists in the Cigna PPO network. Once you enroll in the Cigna Dental PPO Plan, you can use myCigna.com to choose dentists and create, download and print a personal directly. You can verify plan details such as coverage, print a dental ID card, get the forms you need, estimate your dental costs before your next visit and much more! Visit myCigna.com today to get started.

	Cigna Dental PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible (waived for preventive) Individual Family	 $50 $150	 $50 $150
Annual Plan Maximum	$2,000	
Diagnostic & Preventive	No Charge	
Basic Services[1] Fillings Root Canals Periodontics	 Plan pays 80%* Plan pays 80%* Plan pays 80%*	 Plan pays 80%* Plan pays 80%* Plan pays 80%*
Major Services	Plan pays 50%*	Plan pays 50%*
Orthodontia Services	Not Covered	

[1]Anesthesia, Repair & Maintenance of Dentures and Surgical Extractions are covered as Basic Services.
*Coinsurance listed is subject to the plan deductible.

Click to play video



VISION

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

The Cigna Vision Plan provides participants with access to a large network of vision care providers. To locate a network provider, please visit myCigna.com. Your Cigna Vision utilizes the EyeMed network.

	Cigna Vision Plan	
	In-Network	**Out-of-Network**
Examination Benefit Frequency	 $10 copay 1 x every 12 months	 Plan pays up to $60 1 x every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 $25 copay $25 copay $25 copay 1 x every 12 months	 Plan pays up to $40 Plan pays up to $65 Plan pays up to $75 1 x every 12 months
Frames Benefits Frequency	 $130 allowance 1 x every 24 months	 Plan pays up to $78 1 x every 24 months
Contact Lenses (elective)* Benefit Frequency	 $130 allowance 1 x every 12 months	 Plan pays up to $115 1 x every 12 months

* Contact lenses are in lieu of eyeglass lenses and frames benefit

Click to play video

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record —receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

COMPANY-PROVIDED BENEFITS

Basic Life and AD&D Insurance

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. This benefit is administered through New York Life.

New York Life Basic Life and AD&D Insurance	
Basic Life Amount	1x your annual salary, up to $50,000 Minimum Amount: $10,000
Basic AD&D Amount	1x your annual salary, up to $50,000 Minimum Amount: $10,000
Guarantee Issue Amount	$50,000

Short-Term Disability (STD)

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. Your STD benefits are administered by New York Life.

New York Life Short-Term Disability (STD) Plan	
Weekly Benefit Amount	$500
Benefits begin	14 days after accident or sickness
Maximum Payment Period	13 weeks

VOLUNTARY LIFE AND AD&D INSURANCE

Protecting those you leave behind

Voluntary Life and AD&D Insurance allows you to purchase additional insurance to protect your family's financial security. BOX Partners is excited to offer this benefit with the new addition of AD&D. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself. This benefit is administered through New York Life Insurance.

New York Life Voluntary Life and AD&D Insurance	
Employee	Up to $500,000, not to exceed 5x your annual salary
Guaranteed Issue	$100,000
Spouse	Up to $250,000, not to exceed 50% of employee amount
Guaranteed Issue	$25,000
Child(ren)	
Birth to 6 months	$1,000
6 months to 26 years	Up to $10,000 (increments of $1,000)

You automatically receive AD&D coverage in the same amount as your approved voluntary life election.

Guaranteed Issue: If you purchase life insurance coverage above a certain limit (the “guaranteed issue” amount) or after your initial eligibility period, you will need to submit Evidence of Insurability (EOI) with additional information about your health in order for New York Life to approve the requested amount of coverage. There is a Guarantee Issue (GI) amount of $100,000 for employees and $25,000 for spouses. Evidence of Insurability (EOI) is required for amounts over the Guarantee Issue up to the maximum.

VOLUNTARY LONG-TERM DISABILITY INSURANCE (LTD)

THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

Coverage is available for you to purchase for yourself and is administered through New York Life Insurance.

New York Life Long-Term Disability (LTD) Plan	
Maximum Monthly Benefit	60% of your income up to $5,000
Elimination Period	90 days or until the end of the STD maximum benefit period

VOLUNTARY HEALTH-RELATED PLANS

THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident Insurance from Cigna helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a fixed cash, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

You may be eligible for a $50 wellness benefit if you receive a covered wellness screening . Examples include (but are not limited to) certain blood tests, general health exams, mammography, routine dental, vision, and gynecological exams. This also includes COVID-19 immunization, tests, and screenings.

Below you will find your bi-weekly rates for both the Low Plan and the High Plan.

	Low Plan	High Plan
Employee Only	$4.27	$6.69
Employee + Spouse	$7.06	$11.17
Employee + Child(ren)	$8.06	$12.88
Employee + Family	$10.86	$17.36

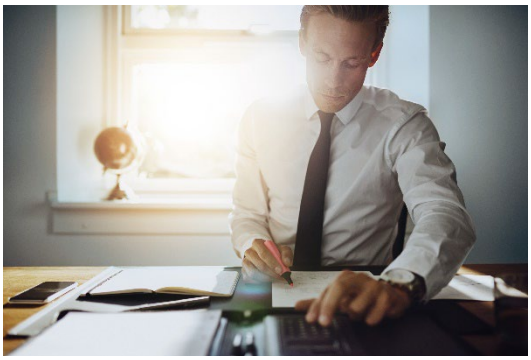
Critical Illness Insurance

Critical illness insurance from Cigna can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

You may be eligible for a $50 wellness benefit if you receive a covered wellness screening . Examples include (but are not limited to) certain blood tests, general health exams, mammography, routine dental, vision, and gynecological exams. This also includes COVID-19 immunization, tests, and screenings.

You can find your rates for this plan in the Other Voluntary Benefit Costs section.

VOLUNTARY BENEFITS



PLAN CONTACT INFORMATION

Refer to your Plan Contacts or visit your MyBenefits.Life site to view contact information for these plans.

Identity Theft Protection

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve.

For an affordable monthly premium, identity theft protection from All State helps protect your personal information through proactive monitoring, identity restoration, and resolution. You can enroll in this program during open enrollment.

Identity Theft Protection (bi-weekly rate)	
Employee Only	$4.13
Employee + Family	$7.82

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account.

Most plans offer coverage for costs associated with both accidents and illnesses—even medications. Pets Best provides coverage for this program for dogs and cats only. You can enroll in this program at any time during the year through our custom enrollment link: **www.petsbest.com/BOXPARTNERS**

Please note that pet insurance policies are effective the day AFTER application.

WELLBEING & BALANCE

PLANS TO HELP YOU SAVE

- LifeBalance
- Employee Assistance Program (EAP)
- Cigna Member Wellness Resources

Click to play video

Is it time for a "wellness" checkup?

Ignoring your financial health and overall emotional health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future.

LifeBalance will provide you with exclusive employee discount programs to help save on a variety of purchases, activities, entertainment, etc.

Your Employee Assistance Program (EAP) will allow you to work on your mental and emotional well-being to ensure you are not only physically, but mentally healthy for a fulfilling life.

Lastly, as a Cigna member you have access to a wide variety of member wellness resources, ranging from digital program to discount programs, and much more!

LIFEBALANCE PROGRAM

"LifeBalance connects me with events, locations, services, and adventures that I would have otherwise been unaware of"

-Olivia Ramos, LifeBalance member

Health. Happiness. Savings.

LifeBalance specializes in offering savings where you work, live, and play. The program's discount network is constantly growing with new local and regional savings options, making it easy to provide meaningful employee discounts. They offer employee savings and benefits at more than 20,000 recreational, cultural, well-being, and travel related businesses. LifeBalance's unrivaled focus ensures that meaningful savings are available in your community.

Make your LifeBalance with savings on:

- **Fitness** – Health club memberships, yoga, cycling, running, and more
- **Travel** – Lodging, car rentals, cruises, vacation packages, and tours
- **Attractions** – Admission to theme parks, water parks, zoos, and museums
- **Spa & Relaxation** – Massages, meditation, gardening, and more
- **Movie Tickets** – Tickets to theaters nationwide
- **Performing Arts Tickets** – Plays, musicals, family shows, symphonies, and more.
- **Sports** – Sporting event tickets, sports camps, gear, and classes
- **Eating Well** – Weight management, meal delivery, supplements, and more

Create an account today.

1. Visit **boxpartners.lifebalanceprogram.com** on any device.
2. Enter your preferred email address, then click "Let's Get Started."
3. Enter your first and last name, and your zip code. If prompted, select your city from a drop-down menu of locations.
4. Enter a password for your account, set your preferences using the checkboxes, and click "Submit."

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone

866.248.4096

Website

Liveandworkwell.com
Company access code: BOX

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern.

Your Employee Assistance (EAP) and WorkLife Services are available to you at no cost as part of your benefits with BOX Partners. This includes 24/7 access to your EAP over the phone and online. You can call to speak with master's-level employee assistance specialists who provide consultation, risk screening advocacy, referrals and educational materials. Their website is available in English and Spanish.

You have access to 5 free face-to-face counseling sessions.

Through your Optum EAP, you also have access to Talkspace, an alternative to face-to-face counseling sessions, where you can obtain online therapy with a licensed therapist. You can start therapy within hours of choosing your EAP provider, message your EAP provider whenever and choose real-time face-to-face video visits by appointment, when needed.

ADULT & ELDERCARE SUPPORT

- Grief/loss
- Retirement planning
- Adult daycare programs
- Financial and legal issues
- In-home/ nurse care options

CHILD AND FAMILY SUPPORT

- Childcare options
- Adoption resources
- Day/ summer camps
- Emergency/ sick-child care
- Parent/ family support groups

CHRONIC ILLNESS AND CONDITION SUPPORT

- Respite services
- Caregiving services
- Assistive technology
- Affordable housing resources
- Meal and transportation resources

CONVENIENCE SERVICES

- Pet services
- Traveling needs (business and leisure)
- Car and home repair maintenance
- Shopping, dining and recreation recommendations

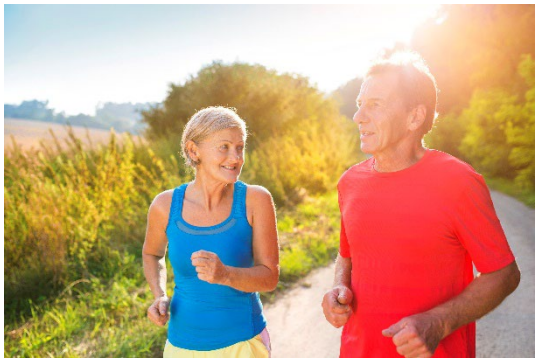
EDUCATIONAL RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

NO COST CIGNA MEMBER WELLNESS RESOURCES



Through Cigna, you now have access to a variety of wellness resources, at no cost to you. While not all may be included here, you can contact Human Resources for a complete listing of all Cigna Member Wellness Resources.

Digital Programs

OMADA – This is a digital lifestyle program aimed at individuals who may be at risk of developing diabetes. The program helps you lose weight, gain energy and reduce the risk of heart disease and type 2 diabetes. You will work with a health coach, have online peer support, can access interactive online lessons, and you will receive a digital scale.

You must meet clinical inclusion criteria to participate. To see if you qualify for this program, take this short assessment.

RECOVERYONE – With RecoveryOne, you can schedule a virtual appointment with a Physical Therapist who will customize a recovery plan to assist with the rehabilitation of muscular injuries. The app also includes weekly check-ins with a certified health coach and videos to guide you through their exercises.

Create an account and get started HERE.

Financial Programs

IDENTITYFORCE – Identity theft monitoring and white glove restoration service is available to all Cigna members and their dependents (up to age 26).

Get started HERE or contact at 833.580.2523.

Discount Programs

HEALTHY REWARDS – You can get discounts on a variety of wellness equipment and services.

LOG IN to myCigna.com > Wellness > click on each of the wellness topics to learn what discounts are available

ACTIVE & FIT – You can get access to over 11,000+ fitness centers with the flexibility to change any time along with over 2,500 on-demand workout videos.

LOG IN to myCigna.com > Wellness > Exercise > Gym Memberships

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit contributions for the 2025 plan year
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

YOUR BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes. **The following contribution amounts are bi-weekly (26 pay periods in the calendar year).**

MEDICAL

	HSA Open Access Plus Plan	PPO Open Access Plus Plan	HMO Plan
Employee Only	$41.48	$75.11	$69.24
Employee + Spouse/DP	$413.03	$559.28	$524.87
Employee + Child(ren)	$370.97	$502.35	$505.22
Employee + Family	$597.49	$808.46	$813.08

DENTAL

Dental PPO Plan	Cost
Employee Only	$17.79
Employee + Spouse/DP	$34.98
Employee + Child(ren)	$31.22
Employee + Family	$48.41

VISION

Vision Plan	Cost
Employee Only	$2.52
Employee + Spouse/DP	$5.04
Employee + Child(ren)	$5.70
Employee + Family	$8.81

Domestic Partner Coverage, Taxes and Imputed Income

Unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income (or imputed income) on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you.

VOLUNTARY LIFE AND AD&D INSURANCE COSTS

If you elect voluntary coverage, your premium is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck.

VOLUNTARY LIFE AND AD&D INSURANCE – MONTHLY RATE PER $1,000 OF COVERAGE		
AGE	**EMPLOYEE**	**SPOUSE**
<20-24	$0.108	$0.108
25-29	$0.089	$0.089
30-34	$0.102	$0.102
35-39	$0.118	$0.118
40-44	$0.157	$0.157
45-49	$0.253	$0.253
50-54	$0.406	$0.406
55-59	$0.620	$0.620
60-64	$1.192	$1.192
65-69	$1.300	$1.300
70-74	$4.382	**Spouse Coverage ends at 70**
70+	$4.382	

Rates are based on employee and spouse age on your effective date (for new hires) and then January 1 of each year thereafter.

CALCULATE YOUR PER PAY PERIOD LIFE INSURANCE COST

1. Desired Coverage ($1,000 Increments)

You:	Spouse:

2. Divide Step 1 by 1,000 =

You:	Spouse:

3. Multiply Step 2 by Rate from Table =

You:	Spouse:

4. Multiply Step 4 by 12 (months) and divide by 26 (pay periods) =

You:	Spouse:

5. Add You + Spouse from Step 4:

TOTAL COST PER PAYCHECK:

OTHER VOLUNTARY BENEFITS COSTS

CRITICAL ILLNESS MONTHLY RATE			
AGE	**$10,000**	**$20,000**	**$30,000**
Under 25	$6.82	$12.56	$18.30
25-29	$7.29	$13.50	$19.71
30-34	$8.62	$16.16	$23.70
35-39	$11.00	$20.92	$30.84
40-44	$14.61	$28.14	$41.67
45-49	$19.45	$37.82	$56.19
50-54	$25.91	$50.74	$75.57
55-59	$32.28	$63.48	$94.68
60-64	$38.45	$75.82	$113.19
65-69	$47.10	$93.12	$139.14
70-74	$62.49	$123.90	$185.31
75+	$84.43	$167.78	$251.13

LONG-TERM DISABILITY (LTD) MONTHLY RATE PER $100 OF MONTHLY COVERED PAYROLL Your monthly covered payroll is your monthly benefit divided by 60%. Example: If your monthly benefit is $2,000, your covered payroll would be $3,333 (2,000/0.60).	
AGE	**COST**
Under 25	$0.107
25-29	$0.138
30-34	$0.263
35-39	$0.411
40-44	$0.614
45-49	$0.827
50-54	$1.146
55-59	$1.215
60-64	$1.282
65-69	$1.333
70+	$1.366

PLAN CONTACTS

Provider	Plan	Phone Number	Website
Medical and Rx			
Cigna	Medical HMO HSA Open Access Plus PPO Open Access Plus	800.244.6224	www.myCigna.com
Dental			
Cigna	Dental PPO	800.244.6224	www.myCigna.com
Vision			
Cigna	Vision Plan	877.478.7557	www.myCigna.com
Life and AD&D			
New York Life	Basic Life and AD&D Voluntary Life	800.362.4462	www.newyorklife.com
Additional Benefits			
Cigna	Accident & Critical Illness	800.754.3207	SuppHealthClaims.com
All State	ID Theft	800.789.2720	https://myaip.com/signin
LifeBalance	Discount Program		Boxpartners.lifebalanceprogram.com
Optum	Employee Assistance Program (EAP)	866.248.4096	Liveandworkwell.com Access Code: BOX
Pet Insurance	Pets Best	888.984.8700	www.petsbest.com/BOXPARTNERS Discount Code: BOXPARTNERS

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Note: Beginning January 1, 2022 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

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

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

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

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on your benefits administration system, Paycom.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Illinois Consumer Coverage Disclosure Act:** A list of Essential Health Benefits that are and are not covered by your employer-provided group health insurance coverage.

COBRA CONTINUATION COVERAGE

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

BOX™

PACKAGING PARTNERS