2025

Benefits Enrollment Guide

FOR BENEFITS EFFECTIVE JANUARY 1, 2025

Raycap

Raycap Employees

We are excited to introduce your updated Benefits Guide, which includes important information about the new health insurance options available to you as well as the benefits you've come to enjoy. At Raycap, we believe in supporting our employees in every way possible, and that includes providing comprehensive benefits to help safeguard your health, well-being, and future. With our switch to a new Benefits Consultant, we are pleased to provide health insurance options with access to the Cigna health insurance network to improve the employee experience.

We understand having access to quality insurance is crucial, and we're committed to ensuring you have the resources and support you need to make informed decisions about your benefits. Whether you're selecting coverage for yourself, your family, your pet, or preparing for future needs, we want to make sure you feel confident and cared for.

Your contributions are truly valued at Raycap and we want to make sure you have everything you need to thrive—at work and beyond. Please take some time to review the Guide, and if you have any questions or need assistance, don't hesitate to reach out to your local onsite HR department.

Thank you for being such an important part of our team. We're committed to supporting you in the best way possible.

The Raycap Management Team

Disclaimer: This Guide is intended to acquaint employees with a summary of Raycap's benefits plans along with the additional benefits voluntarily provided by Raycap. It is not a contract and should not be construed as establishing any contractual obligation. Raycap reserves the right to revise, supplement, or rescind any benefits outlined in this Guide. Plans may have certain limitations, and details are provided in policy documents which will prevail in the event of any discrepancy.

Table of Contents

Please take the time to review this Enrollment Guide carefully. It contains important information about your benefits and the deductions you will authorize to be taken from your pay.

By reviewing this information in advance, you will also have the opportunity to decide whether or not to include your dependents in these important benefits.

Enrollment Information

Enrollment for Current Employees

During the Annual Enrollment period, you may add, drop or make changes to your group benefits. **Your choices will become effective January 1st**. Human Resources will contact you prior to this period to provide enrollment information.

During this Open Enrollment period, we recommend you review your current benefits to make decisions for the upcoming plan year.

Reviewing Changes:

Changes made during the Annual Open Enrollment period are effective January 1st of each plan year (except for policies and/or amounts requiring the approval of underwriters)

As of January 1, you should verify changes have been processed by checking the status of your enrollment on the ADP Self Service portal by visiting **Myself > Benefits > Enrollments** and confirming deductions are correct on your pay statements.

You may reach out to Human Resources if you need any assistance.

Qualifying Life Events (Status Changes)

There are two opportunities when an employee may enroll in Raycap's insurance policies:

1. During the Annual Open Enrollment period
2. As a newly eligible employee

Special Enrollment Circumstances

There are, however, special circumstances that will create a 'Qualifying Life Event' which allows you and/or your dependents to join company benefits on the first of the month following the date the event occurred.

Examples of Qualifying Life Events include, but are not limited to: involuntary loss of other group coverage, marriage, divorce, court order, birth, and adoption. Please be aware that you must notify HR of this status change within 60 days of the event occurring and provide any documentation for the substantiation of that event.

Important Note

See Human Resources for Changes

You may change your demographic information or beneficiary designations at any time throughout the year.

Demographic changes include:

- Address update
- Contact number update
- Name update (requires proof of a current Social Security care)

New Hire Enrollment

Enrollment Preparation

Enrollment Timeline

You must complete your enrollment **within 5 days** from the Benefits Effective Date cited in the chart below. Should you resign, retire, or no longer be employed by Raycap, your medical, vision and dental benefits will end on the last day of the month.

How to Enroll

Raycap uses ADP's Employee Self Service portal (**workforcenow.adp.com**) for direct enrollment in the benefits listed. Members of Human Resources are available to assist you in navigating the ADP portal and providing direct access to the site.

Benefits Member Advocacy Center (Benefits MAC)

Through our Benefit Consultants, Conner Strong & Buckelew, you will have access to the Benefits Member Advocacy Team who can assist in answering benefit questions you may have to help determine your benefit enrollments. Please see page 15 for more details.

Information You Will Need:

Please have the following information ready when enrolling:

- Your name, date of birth, and Social Security Number.
- The name(s), date(s) of birth, and Social Security Number(s) of your dependent children up to age 26. Dependent children include your natural children, adopted children, stepchildren, and children for whom you have legal guardianship (if applicable).
- The name, date of birth, and Social Security Number of your spouse (if applicable).
- Your current address will ensure your ID cards and other important benefits information will be sent to the correct address.
- The full name and relationship of your beneficiary; (your beneficiary must be at least 18 years of age, or you will be required to name a guardian for them).

New Hire Enrollment	
Benefits Eligibility	Employees working 30 hours or more per week.
Benefits Effective Date	The 1st of the month following completion of 30 days of employment. This effective date applies only to the benefits listed. It does not apply to the Raycap Retirement Plan, a 401(k).
Benefits Cost to Employee	Premium costs are listed in this Guide or may be found by visiting ADP's Employee Self Service portal: **Myself > Benefits > Enrollments**.
Dependent Coverage	Available through Raycap's group plans and are paid by the employee through tax-exempt payroll deductions.

Key Contacts

Benefits Consultants, Carrier Portals, and other Websites

Over 95% of your questions may be resolved through Raycap's Benefits Consultant, insurance carrier portals, and other websites. The portals provide easy access to your plans and claim information, including information about your enrolled dependents. It's simple for you to log into each of the sites. Registering on interactive portals provides access to valuable tools for obtaining answers to most of your questions.

Coverage	Carrier/Contact	Phone Number	Website/Email
Benefits Member Advocacy (Benefits MAC)	Conner Strong & Buckelew (CSB)	800.563.9929	www.connerstrong.com/memberadvocacy
New! **Medical/Billing Navigation**	Marpai Health	855.389.7330	www.marpaihealth.com
Prescription Drug	Liviniti	800.710.9341	www.liviniti.com
Dental	Guardian	800.541.7846	guardiananytime.com
Vision	Guardian	877.814.8970	guardiananytime.com
Basic and Voluntary Life and AD&D, Disability	Guardian	888.482.7342	guardiananytime.com
Health Savings Account	Bank of America	800.718.6710	myhealth.bankofamerica.com
New! **Healthcare FSA and Dependent Care FSA**	Flores	800.532.3327	flores247.com
Specialty Medications	ScriptSourcing	410.902.9811	www.scriptsourcing.com
Mail Order Medications	Liviniti	800.710.9341	liviniti.heathdyne.com
Virtual Care	Recuro Health	855.673.2876	recurohealth.com
Pet Insurance	Nationwide	877.738.7874	my.petinsurance.com
PTO and 401(k)	ADP	866.695.7526	workforce.adp.com

Benefits MAC & BenePortal

Additional Benefits Resources

Benefits Member Advocacy Center (MAC)

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits MAC can help guide the way!

The Benefits Member Advocacy Center ("Benefits MAC'), provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits.

Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provide or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Guide you through the enrollment process or how you can add or delete coverage for a dependent
- Rescue you from a benefits problem you've been working on
- Discover all that your benefits have to offer!

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

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

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

¿Habla Español?

Spanish-speaking representatives are available to assist.

BenePortal

Your benefits information — all in one place!

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

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

BenePortal features include:

- Secure online access – with NO login required!
- Direct links to ADP Workforce Now
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!

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

New! Medical Benefits

Your Plan Options

Effective January 1, 2025, Marpai Health in conjunction with PermaFair will be the new administrator of Raycap's medical coverage. Liviniti will remain the administrator for prescription drug coverage. Members will continue to have one ID card for medical and pharmacy for all plans.

MARPAI

PERMA FAIR

Value Plan (PermaFair)

This plan offers the lowest individual/family deductible ($500/$1,000) along with a set copay structure for prescription and provider services. This plan is the least expensive in terms of bi-weekly contributions.

Cigna High Deductible Health Plan (HDHP)

A high deductible plan offering Raycap's contribution of $80 over 26 pay statements ($2,080 annually) is credited to an HSA account to offset services subject to the high deductible.

The 2025 deductible for the HDHP plan will be $3,300 for an individual and $6,600 for a family. With this plan, the deductible is equal to your out-of-pocket maximum. Once you meet your deductible, the insurance pays 100% of your bills for the remainder of the year.

This plan has multiple tax advantages; you can also contribute your own funds through payroll deductions to a Health Savings Account (HSA), thereby paying for your health expenses tax- free. Complete information about HSAs is provided beginning on page 17.

About HSA Contributions

If you elect to contribute to your HSA, your contributions are free from federal, state, and other payroll taxes.

- In 2025, the maximum amount that can be contributed to an HSA is $4,300 for an individual or $8,550 for a family. After Raycap's contribution of $2,080, your annual contribution may only be $2,220 for an individual or $6,470 for a family.
- If you are 55 or older at the end of the year, you may contribute an additional $1,000 in Catch-Up contribution.

Cigna PPO Plan

This plan offers in and out-of-network benefits. Individual/Family in-network deductible is $1500/$3000. This plan offers set copays for prescription and provider services. The out-of-pocket maximum is $3,500 for individuals and $7,000 for a family. Out-of-network cost share is reflected on page 9.

Medical Benefits

Administered by Marpai Health/PermaFair

If you enroll in one of the medical plans, you are automatically enrolled in prescription drug coverage. **See page 10 for details.**

	Value Plan (PermaFair)	Cigna HDHP		Cigna PPO	
Coverage	**In-Network Only**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Employer HSA Funding	N/A	$2,080		N/A	
Annual Deductible	$500 Individual / $1,000 Family	$3,300 Individual / $6,600 Family	$6,000 Individual / $12,000 Family	$1,500 Individual / $3,000 Family	$5,000 Individual / $10,000 Family
Annual Out-of- Pocket Maximum	$2,500 Individual / $5,000 Family	$3,300 Individual / $6,600 Family	$12,000 Individual / $24,000 Family	$3,500 Individual / $7,000 Family	$10,000 Individual / $20,000 Family
Coinsurance	You pay 30%	Covered 100%	You pay 50%*	You pay 30%	You pay 50%
Preventive Care	Covered 100%, no deductible	Covered 100%, no deductible	You pay 50%*	Covered 100%, no deductible	You pay 50%*
Office Visit	PCP: $20 copay / Specialist: $40 copay	Covered 100%*	You pay 50%*	PCP: $20 copay Specialist: $40 copay	You pay 50%*
Mental Health/ Substance Abuse Office Visits	$20 copay	Covered 100%*	You pay 50%*	$20 copay	You pay 50%*
Complex Imaging	You pay 30%*	Covered 100%*	You pay 50%*	You pay 30%*	You pay 50%*
Routine Radiology	You pay 30%*; 100% at Quest/Labcorp	Covered 100%*	You pay 50%*	You pay 30%*	You pay 50%*
Outpatient Surgery	You pay 30%*	Covered 100%*	You pay 50%*	You pay 30%*	You pay 50%*
Inpatient Hospital Services	You pay 30%*	Covered 100%*	You pay 50%*	You pay 30%*	You pay 50%*
Emergency Room	$250 copay	Covered 100%*		$250 copay	
Urgent Care	$40 copay	Covered 100%*	You pay 50%*	$40 copay	
Rehabilitation Services	$40 copay	Covered 100%*	You pay 50%*	$40 copay	
Durable Medical Equipment (DME)	You pay 30%*	Covered 100%*	You pay 50%*	You pay 30%*	You pay 50%*
Chiropractic Care**	$40 copay	Covered 100%*	You pay 50%*	$40 copay	

* *After deductible*
** *20 visits per calendar year*

Please note that all plans have embedded deductibles which means that individual family members don't have to meet the full family deductible to begin receiving after-deductible benefits. Instead, their benefits kick in as soon as they meet their individual deductible.

Prescription Benefits

Managing your Prescription Drug Costs

If you enroll in one of the medical plans, you are automatically enrolled in the corresponding prescription drug coverage below.

	Value Plan (PermaFair)	Cigna HDHP	Cigna PPO
Retail Pharmacy (Up to a 30-day supply)			
Generic	$10 copay	Covered 100% after deductible	$10 copay
Brand	$35 copay	Covered 100% after deductible	$35 copay
Non-Formulary	$60 copay	Covered 100% after deductible	$60 copay
Mail-Order Pharmacy (Up to a 90-day supply)			
Generic	$20 copay	Covered 100% after deductible	$20 copay
Brand	$70 copay	Covered 100% after deductible	$70 copay
Non-Formulary	$120 copay	Covered 100% after deductible	$120 copay

About Liviniti

Liviniti is a streamlined, fully transparent, and pass-through pharmacy benefit manager dedicated to self-insured employers. You must use a Liviniti network pharmacy. Most drugstores, such as Walgreens, Rite-Aid and CVS as well as retails stores such as Walmart, Target and some grocery chains accept Liviniti. Improving drug affordability and access is key to Raycap's focus on employee well-being.

- Call: **800.710.9341**
- Visit: **liviniti.com**

Liviniti Mail-Order Pharmacy

Liviniti streamlines prescription delivery, saving time and cutting costs by sending medications to your doorstep or designated address for chronic and long-term therapy.

Use Liviniti for any prescribed drug covered by your plan, and easily transfer prescriptions from your current pharmacy for convenient refills.

- Call: **855.772.9384**
- Visit: **liviniti.heathdyne.com**

ScriptSourcing - Specialty Medications

$0 RX Copay Program. Name-brand maintenance and specialty medications. ScriptSourcing is a leading pharmaceutical company that focuses on improving global access to medications. They use advanced technology and partnerships to make sure people get the medicines they need, when they need them, and at a fair price.

- Call: **410.902.8811**
- Visit: **scriptsourcing.com/med-finder**

Dental Benefits

Administered by Guardian

Dental Benefits are available to you and your eligible dependents to cover routine care such as exams, x-rays, cleanings, fillings, and periodontal care.

Orthodontia is an included benefit under your Guardian policy. Under this dental plan, you may seek services from an In-Network (Dental Guard Preferred Network) or Out of Network provider. However, seeking care from an In-Network provider will reduce your out-of-pocket expenses.

For a full description of covered services, log onto **GuardianAnyTime.com** for additional information.

To search for in-network dentists please visit **www.guardianlife.com**. You can also search for dentists on the go through Guardian's mobile app, which can be downloaded from the App Store or Google Play.

	Guardian Dental Plan	
Coverage	**In-Network**	**Out-of-Network**
Deductible	$25 Individual / $75 Family	
Annual Maximum	$1,250	$1,250
Class I Benefits Diagnostic Services Preventive Services Radiograph	Plan pays 100%, no deductible	Plan pays 100%, no deductible
Class II Benefits Oral Surgery Services Endodontic Services Periodontic Services Minor Restorative Services	Plan pays 100% after deductible	Plan pays 80% after deductible
Class III Benefits Major Restorative Services Prosthodontic Services	Plan pays 60% after deductible	Plan pays 50% after deductible
Class IV Benefits Orthodontic Services (Child/Adult)	Plan pays 50% up to a lifetime maximum of $3,000	

New Hire Non-Enrollment

If you do not enroll at your hire date and wish to do so later, you are considered a late enrollee. For all late enrollees, there is a 6-month waiting period for covered Basic Services, 12 months for Major Services, and 24 months for Orthodontic Services.

Annual Maximum Rollover

Please note that a person may be eligible for a rollover of a portion of his or her unused Annual Maximum for Group I, II, and III Non-Orthodontic services. To qualify for this benefit a covered person must submit one claim within the plan year that is in excess of any deductible, but not exceeding the below Rollover Threshold.

- Rollover Threshold: $600
- Rollover Amount (In-Network providers): $450
- Rollover Amount (Out-of-Network providers): $300
- Rollover Account Limit: $1,250

Vision Benefits

Administered by Guardian

Vision coverage is offered through Guardian. To maximize your vision benefits, please visit a Vision Service Plan (VSP) Choice Network Preferred Provider; however, you may visit a vision care provider out of the VSP Choice Network and submit your claim for reimbursement at the levels defined below.

Customer Service can help you find a vision care provider or tell you whether yours is in the network. Call VSP at **877.814.8970** or visit **vsp.com**.

Additional Benefits Include:

- Laser VisionCare Program offers discounts for laser surgery, including PRK, LASIK, and Custom LASIK.
- "Low Vision" is vision loss sufficient to prevent reading and to perform daily activities. With pre-approval from VSP, Low Vision supplemental testing is covered every two years, and VSP will pay 75% of the cost for approved Low Vision aids, to a maximum of $1,000 (less any amount) paid for supplemental testing) per member every two years.

	Guardian Vision Plan	
Coverage	**VSP Choice Network Provider**	**Non-VSP Choice Network Provider**
Well Vision Exam	$10 copay	Up to $39 reimbursement
Lenses		
Single Vision	$25 copay	Up to $23 reimbursement
Lined Bifocal	$25 copay	Up to $37 reimbursement
Lined Trifocal	$25 copay	Up to $49 reimbursement
Frames	$130 allowance	Up to $46 reimbursement
Contact Lenses		
Elective	$130 allowance	Up to $100 reimbursement
Medically Necessary*	$0 copay	Up to $210 reimbursement
Service Frequencies		
Single Vision	Once per calendar year	
Lined Bifocal	Once per calendar year	
Lined Trifocal	Once per calendar year	

** Requires Prior Authorization*

About your Guardian Benefits

Tools and Resources

It's easy to use your Guardian benefits

Innovative tools that make it easy and convenient to use your benefits anytime, anywhere.

Guardian is committed to making it as easy as possible for you to use and understand your benefits, with customer service you can depend on.

Find a provider online

- Go to **guardianlife.com**
- Simply click on **Find a Dentist** or **Find a Vision Provider** at the top of the webpage
- Follow the easy steps to search for care

View/Print your ID card at Guardian Anytime

- No need for an ID card to use your Guardian benefits. Simply provide your Group ID number to your doctor's office at the first visit.
- However, if you'd like to print out a copy of your ID card, visit the **Forms and Materials** section of **guardianlife.com/login** – *it's fast and easy*

Access to an array of tools

- Guardian Anytime includes easy-to-use tools to help understand the value of your benefits. This includes educational articles and dental cost estimator tools.
- Additional vision tools can be found by clicking the vision button within the **View My Plan Benefits and Coverage** page.

Real-time assistance

- Speak to a Guardian representative about your benefits and claims for help using **guardianlife.com**.

Medical, Dental, and Vision Benefit Rates

Employee Contributions Per Payroll

Raycap continues to provide cost-effective, value-added insurance to employees ensuring a choice of medical plans. Marpai and PermaFair administer the 2025 Raycap medical plans. The company has set pricing using a dual option of Cigna plans and Indexed-Based Pricing (See Glossary of Terms page 30) to ensure choice in medical plans. Marpai and PermaFair administers the 2025 Raycap plans.

Medical/Prescription Drug Benefits (Per-Payroll Cost)			
Tier	**Value Plan (PermaFair)**	**Cigna HDHP**	**Cigna PPO**
Employee Only	$10.30	$51.50	$63.86
Employee/Spouse	$115.36	$144.20	$161.71
Employee/Child(ren)	$92.70	$104.03	$121.54
Family	$161.71	$190.55	$230.72

Dental (Per Payroll Cost)	
Tier	**Guardian Dental Plan**
Employee Only	$0.00
Employee/Spouse	$18.00
Employee/Child	$15.00
Employee/Child(ren)	$27.00
Family	$41.00

Vision (Per Payroll Cost)	
Tier	**Guardian Vision Plan**
Employee Only	$0.00
Employee/Spouse	$4.00
Employee/Child	$3.00
Employee/Child(ren)	$4.00
Family	$7.00

Medical Claims Assistance

Frequently Asked Questions

Raycap's team of professionals is available to assist our employees with complex claims. In using our Benefits Consultant, the Conner Strong & Buckelew Benefits Member Advocacy Center, we aim to deliver a result that is fair to both the healthcare provider and the patient.

What should I do if I receive a bill from a provider that is above what Marpai/ PermaFair determines to be "reasonable and allowed?"

When you receive a bill from your provider, call or log on to your Marpai account to compare your bill from the provider to the Explanation of Benefits (EOB) listed charges and patient responsibility.

If there is a discrepancy, ***DO NOT PAY THE BILL***. Immediately contact Raycap's Benefits Consultant, Conner Strong & Buckelew (**see contact info on this page**).

Will I be harassed by bill collectors?

Generally, no. Based on the Federal Fair Credit Reporting Act, if there are amounts unpaid and presently under dispute by the provider, neither the provider nor another entity acting on the provider's behalf may take action to collect the disputed amount from the patient during the process.

That said, there may be aggressive organizations not abiding by federal laws. These organizations should be referred to your Benefits Consultant who will have Marpai contact the organization on your behalf.

Will my credit be affected?

No. The Federal Fair Credit Reporting Act mandates neither the provider nor their agent may threaten the patient's credit rating or report them as delinquent while the claim is in dispute.

Will I need to provide any information to the Benefits Consultant?

Yes. Your name, the provider name, and dates of service. You may need to confirm your employer group information and submit a copy of the bill and any provider correspondence you've received. Based on the information provided, and the nature of the claim, the Benefits Consultant will contact the provider to discuss charges on your behalf. We'll also provide a claim number you can reference when speaking with other professionals on your behalf.

Will the provider know a Benefits Consultant or a Healthcare Navigator is involved in my case?

Yes, the Benefits Consultant will work in conjunction with Marpai. The provider will be contacted via a telephone call and in writing, informing them the Healthcare Navigator will be the liaison between the provider and your TPA, and all communications with you should cease immediately.

Will I know the status of the dispute?

Yes, your Benefits Consultant will work with you throughout the process. You will be updated periodically and notified by your Benefits Consultant when the dispute is finalized.

Who do I contact with questions?

Conner Strong & Buckelew, Benefits Member Advocacy Team:

- Call: **800.563.9929**
- Visit: **www.connerstrong/memberadvocacy**

Virtual Health

Recuro Health

Discover a tailored virtual care solution

Now you can talk to a doctor 24 hours a day, 365 days a year. If you have access to a phone, you have access to care.

This does not replace your own primary care physician — it simply expands the hours during which you can reach a physician. You might use it in the middle of the night, when you're out of town, or when you've run out of an essential prescription.

Our physician network includes U.S.-based and licensed primary- care doctors, pediatricians, and board-certified specialists. They average 10-years of experience and are supported by bilingual patient-care specialists with expertise in diagnosing and treating your symptoms via telephone.

Create your Account Today!

- Call: **855.6RECURO**
- Visit: **recurohealth.com**

Request a consult

By phone, web, or mobile app.

Talk to a doctor

Your doctor diagnoses and provides treatment.

Get better

If medically necessary, your doctor will issue a prescription.

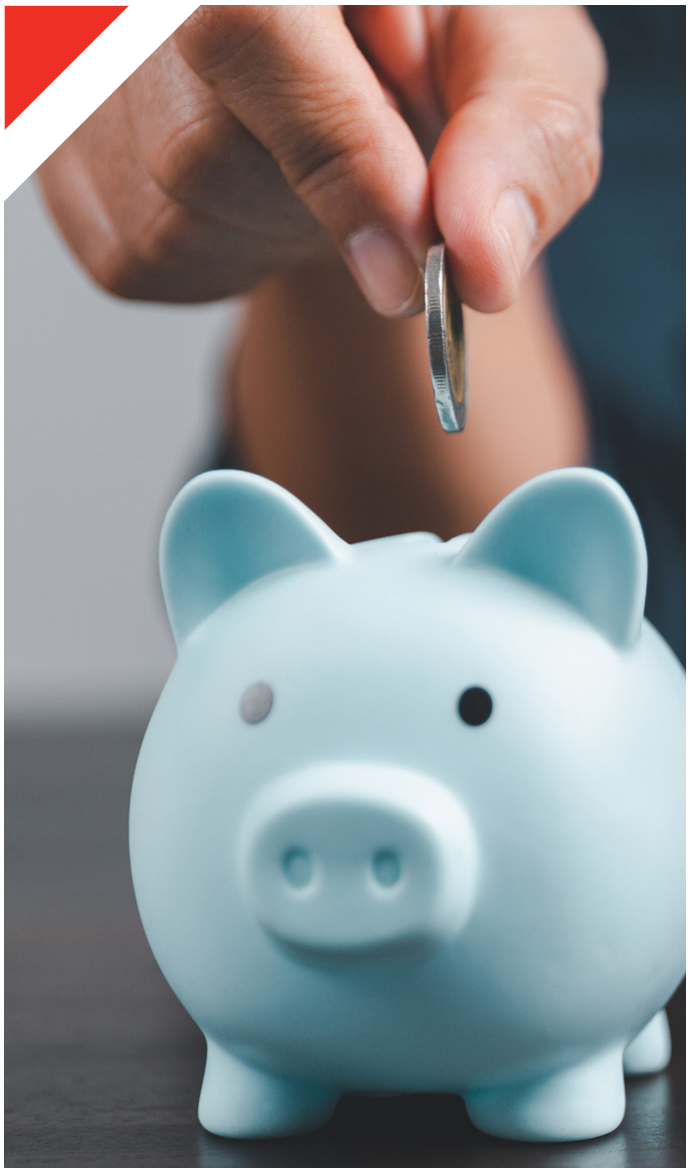
Health Savings Account (HSA)

Bank of America (BofA)

Bank of America (BofA) is the Administrator of the HSA plans and provides individual HSA accounts for those employees choosing the HDHP Medical Plan. Once enrolled, go to the member website at **myhealth.bankofamerica.com** for step-by-step instructions. You may also manage your account by downloading the "MYHealth BofA" mobile app from the App Store.

Health Savings Account Defined

A Health Savings Account is a company-sponsored, individually-owned, tax-preferred savings account funded by the company and the employee to offset eligible medical expenses and deductibles or to supplement retirement savings. This feature is only available to any employee enrolled in HDHP. A significant component of the HDHP is a cash deposit into a separate account in your name.



How It Works

Company Funding:

Raycap contributes a bi-weekly amount to your account. Company contributions are tax-free or tax-deferred, depending on how the money is eventually spent. For plan year 2025, biweekly amount for each of the 26 pay statements is $80 ($2,080 annually).

Individual Funding:

If you elect to contribute to your own HSA through payroll deduction, your contributions are free from federal, state, and other payroll taxes. The employee maximum contribution allowed for plan year 2025 is:

- Individual: **$2,220**
- Family: **$6,470***
- Catch Up Contribution: **$1,000****

* *Family is defined as employee plus one or more dependents.*

** *Starting at age 55*

Individuals who are enrolled in Medicare or the Flexible Spending Account (FSA) may not contribute to an HSA and will not receive an employer HSA contribution.

Important: For tax purposes, the information above assumes a full year of employment with an HDHP contribution of $2,080. For those employees with less than a full year of service, the individual IRS contribution maximum is $4,300, family $8,550, less any biweekly amounts credited to you in 2025.

Health Savings Account (HSA)

Bank of America (BofA)

Using the Account Balances

The accumulated balances in your account may be used for any IRS-qualified medical and dental expenses such as health plan deductibles and other out-of-pocket medical and dental costs, lab tests, optical (including LASIK surgery), and more.

See IRS Publication 502 (**irs.gov/pub/irs-pdf/p502.pdf**) for a full list of these expenses.

Distributions

Tax-free distributions are:

- Qualified out-of-pocket medical expenses (medical, dental, and vision).
- Expenses for COBRA coverage.
- Qualified Long Term Care coverage, limited to age- based IRS restrictions.
- Health plan costs while you are receiving unemployment compensation.

HSA Advantages

- **Investment Opportunities –** Your HSA can be invested pre-tax, similar to a 401(k) and grow tax- free or tax-deferred, depending on how the money is eventually spent.
- **Portability –** You own your account; if you leave Raycap, your funds go with you. If you join a company with an HSA bank, you will be able to roll over your funds into a new HSA. All contributions to the Raycap HSA will cease when you terminate.
- **Long Term Savings –** Because your funds can roll over from year to year, the funds in your account will grow. HSAs are also referred to as "the Medical IRA."
- **Retirement Bonus –** At age 65, you may take penalty- free distributions from your HSA for any reason. To be both tax-free and penalty-free, the distribution must be for a qualified medical expense. Withdrawal for any other purpose is subject to ordinary income taxes.
- **Catch-Up Contribution –** If you're age 55 or older, you may make annual catch-up contributions of $1,000.

Benefits Debit Card

A convenient feature of your HSA is a Debit Card with approved providers for easy access to your account. The card allows you to pay for eligible expenses and services at the point of service by automatically deducting the amount from your HSA.

Flexible Spending Accounts (FSA)

Flores

Employees may enroll in:

- A **Health Care Account** for health care reimbursement
- A **Dependent Care Account** for childcare or eldercare reimbursement. A Dependent Care Account is used to pay for eligible dependent care expenses such as childcare for children under age 13. It also covers anyone you claim as a dependent on your federal tax return who is physically or mentally incapable of self-care.

FSA Enrollment

During open enrollment, if you want an FSA, you must enroll and make a new Health and/or Dependent Care FSA election for the calendar year.

How FSAs Save You Money

FSAs allow you to set aside before-tax dollars to cover qualified expenses you would customarily pay out-of- pocket with after-tax dollars. You pay no federal, state, or Social Security taxes on the money you place in your FSA. With a bit of planning, you can increase your net pay.

Note: Any expense reimbursed through your FSA cannot be claimed as a deduction or credit on your federal or state tax return.

See IRS Publication 502 (**irs.gov/pub/irs-pdf/p502.pdf**) for a list of qualified expenses.

How FSAs Work

You will need to estimate what your out-of-pocket health care and childcare/eldercare expenses will be for the year. Based on this estimate, you will then specify the amount of dollars to contribute to your FSA for the year through payroll deduction.

Contribution maximums for calendar year 2025 will increase to $3,300 for your Health Care FSA and up to $5,000 for your Dependent Care FSA if married and filing jointly, and $2,500 if married and filing separately. Once you begin depositing funds in your FSA, you can start getting reimbursed for eligible expenses.

You can be reimbursed up to the full amount of your annual Health Care Account contribution, regardless of the amount you have deposited in your account. For your Dependent Care Account, you can be reimbursed up to the amount you have deposited.

Prior Year Balances and Carry Overs

You will have until March 15 of the 2025 Plan Year to submit claims for reimbursement of 2024 eligible expenses. Up to $640 of your Health Care account balance may be carried forward to the following year and used to fund eligible expenses. This carryover amount will not affect your ability to contribute the maximum in the subsequent Plan Year.

Flex (Debit Card)

A convenient feature of your FSA is a debit card for easy access to your account. The Take Care® card allows you to pay for eligible expenses and services at the point of service by automatically deducting the amount from your FSA.

Savings and Spending Accounts Frequently Asked Questions (FAQ)

What is the advantage of an HSA over an FSA?

Any unused account balance in an HSA rolls over and accumulates yearly, unlike the FSA that has an annual "use it or lose it" rule. In addition, HSA accounts have an earning component with either earned interest or market gains; this allows your balance to grow tax-free.

May I change my HSA contribution or make additional contributions during the plan year?

Yes, the Plan allows you to make additional contributions or change your contributions on a quarterly basis as long as they do not exceed the IRS maximum allowable. Contact Human Resources to authorize your changes.

What if I do not use all the money in my FSA by the end of the year?

The Plan starts on January 1st of each year and ends on December 31st. According to IRS guidelines, any unused funds will be lost. Raycap provides a grace period, which allows you until March 31st of the following year to file your claims. After that date, claims will no longer be accepted for the previous Plan year.

What happens to my Saving and Spending Accounts if I terminate?

If you still have a balance in your FSA Health Care Account, you may elect, through COBRA, to continue to access those monies for expenses incurred after your termination date through the end of the Plan year as long as you continue to make COBRA payments. If you do not enroll in COBRA, these monies will be forfeited to Raycap.

Your HSA is your personal account. You may port this account to another employer who has a similar benefit or use the balance to pay for your eligible medical expenses.

Reminder: Healthcare Account

Regardless of Plan year, a prescription from a physician is the only acceptable form of documentation for reimbursement for OTC drugs and medicines, or as regulated by your state law. Insulin, medical devices (crutches, blood sugar monitors, etc.), and items such as bandages, contact lens solution, denture bond, etc., remain eligible and do not require a prescription.

Disability and Life Insurance

Guardian

Guardian Life Insurance is a market leader in both group and individual disability insurance. Insurance is another valuable part of your compensation package protecting your income and assets if you become ill or injured and can't work. Raycap offers Short-Term and Long-Term Disability for employees only and life insurance for employees and their dependents.

Short-Term Disability

Short Term Disability (STD) is a benefit paid to replace a portion of your income for a short period of time. To receive STD payments, you must satisfy the following requirements:

- You must be deemed medically unable to work by Raycap STD Plan (through Guardian).
- You must satisfy an elimination period, a period during which you are unable to work due to injury or illness. The waiting period is 0-days for an injury and 7-days for an illness.

You must use your accrued Paid Time Off (PTO) before the elimination period will begin.

Short-Term Disability Benefit	
Benefit Amount*	60% of weekly earnings
Maximum Weekly Benefit	$3,000
Benefit Begins	0 days for injury (benefits begin immediately); 7 days for sickness (benefits begin on the 8th day)
Benefit Duration	13 weeks

* *New Jersey State rate is 85% of average weekly wage to a maximum rate of $1,081 per week.*

Long-Term Disability

Long Term Disability (LTD) is a benefit paid to replace a portion of your income for a longer period of time.

Long-Term Disability Benefit	
Benefit Amount	60% of monthly earnings
Maximum Monthly Benefit	$15,000
Benefit Begins	90 consecutive days of any one period of disability (benefits begin on the 91st day)

Age when Disabled	Maximum Benefit Payable
Prior to Age 65	To Social Security Retirement Age
Age 65 through 85	To age 70, but not less than one year
Age 69 and over	1 year

Basic Life and AD&D Insurance

Raycap provides all full-time employees with Basic Life and Accidental Death and Dismemberment coverage.

Your disability and life insurance coverage will end on the day you terminate employment or retire. You do have the option to port your coverage upon cessation of employment.

Life insurance coverage amount will decrease at age 70. Additional information may be found on the Guardian website at **GuardianAnyTime.com**.

Basic Life and AD&D Benefit Amount	
Employee	100% of W-2 earnings up to $250,000
Spouse	$5,000
Child	$2,000

Employee Assistance Program (EAP)

Work-Life Matters

In addition to the health benefits, including behavioral health, offered through Recuro Health (page 16), all Raycap employees have access to EAP benefits administered by WorkLifeMatters.

The EAP offers support, guidance, and resources to help you resolve personal and financial issues and meet life's challenges. This service is provided at no additional cost to you.

To access the EAP, please call **800.386.7055** or visit **worklife.uprisehealth.com**. The EAP is always ready to assist you.

Guardian EAP can help you or a family member:

- Locate childcare and eldercare services and obtain matches to the appropriate provider based on your or your family's preferences or criteria. The consultant will be able to confirm space availability.
- Speak with financial experts by phone regarding issues such as budgeting, controlling debt, teaching children to manage money, investing for college, and preparing for retirement.
- Work through complex, sensitive issues such as personal or work relationships, mental health conditions or substance abuse.
- Obtain a referral to a local attorney for a free, 30-minute in-person or telephonic legal consultation.
- Work on problem-solving skills
- Have a confidential sounding board and an objective point of view.

Online Services

You also have unlimited website access enabling you to:

- Read booklets, life articles and guides
- View videos and online seminars and listen to podcasts.
- Subscribe to email newsletters.
- Find information on parenting, retirement, finances, education and more.
- Use health management online calculators and other tools to help with topics such as losing weight or starting an exercise program.
- Access links to other informative websites.
- Use school, camp, eldercare and childcare locators.
- Use financial calculators, retirement planners, worksheets and more.

Confidential Advice

Your calls and all counseling services are completely confidential. Information will be released only with your permission or as required by law.

The EAP service is not an insurance product.

The program is available **24 hours a day, every day, to you and members of your household**. You'll receive up to three face-to-face counseling sessions per issue and unlimited telephonic consultations.

Get started today!

1. Visit: **worklife.uprisehealth.com**
2. Enter **matters** as the login ID and the password **wlm70101** when prompted.

Note: *It is a violation of our company's contract to share this information with individuals who are not eligible for this service.*

Voluntary Insurance

Guardian

Voluntary Term Life Insurance

If you wish to increase the protection you presently provide your dependents through life insurance coverage; you may consider the Voluntary Term Life program.

All full-time employees (including spouses and children) are eligible for Voluntary Life Insurance at group rates.

- Coverage is available for employees in $10,000 increments to a maximum of $500,000, for spouses in increments of $5,000 to a maximum of $250,000. The child(ren) benefit is $10,000.
- Coverage amounts in excess of the Guaranteed Issue will require Evidence of Insurability (EOI) and approval by the underwriter. The Guaranteed Issue amounts for employees are $150,000 age 65 and below, $50,000 for ages 65-69 and $10,000 for age 70 and above.

  The Guaranteed Issue amounts for spouses are $30,000 for age 65 and below, $10,000 for ages 65-69, and $0 for age 70 and above. All dependent child(ren) amounts are guaranteed.

  – Employees who decline coverage at initial employment or who wish to increase their coverage amounts after initial eligibility must submit EOI.

- Coverage will be effective the first day of the month following completion of 30 days of employment and after payroll deduction of applicable premium.

Benefit Reductions: Your insurance, if in place prior to age 70, will reduce to 65% of coverage at age 70 and to 50% at age 75.

Note: Contact Human Resources for any changes to Voluntary Term Life.

Accident and Critical Illness Plans

The Accident and Critical Illness Plans offer greater financial security while offering discounted group premiums and efficient administration. Premiums are paid on a pre-tax basis through payroll deductions authorized by you. Contact Guardian for a complete schedule of benefits.

Off Job Accident Coverage

- Pays lump sum benefits directly to employee for all accidental injuries.
- Pays towards surgeries related to any accident, hospital visits, x-rays, ambulance rides, and follow-up visits.
- Helps to cover employees' out-of-pocket and deductible expenses from their major medical insurance.
- Increased benefit coverage for covered children injured while playing organized sport.
- Portable.
- Guaranteed Issue – No medical questions.

Critical Illness with Cancer Coverage

- Protects against the extremely high cost of a critical illness diagnosis.
- Provides lump sum benefits between $5,000 and $30,000 for treatment of a variety of critical illnesses – including Cancer, Heart Attack, Stroke, Kidney Failure, Organ Transplant, and more.
- Employee and Spouse coverage available.
- Children automatically receive 25% of employee-elected benefit free of charge.
- Portable.
- Please note this plan includes a $75 Wellness Incentive benefit. Any enrolled individual will be eligible for this incentive each plan year as long as a Wellness test or procedure is performed during that year. Wellness tests and procedures include but are not limited to:
  - Breast Ultrasound,
  - Chest X-Ray
  - Colonoscopy
  - Blood Glucose Test (Fasting)
  - Cholesterol Test

Voluntary Pet Insurance

Nationwide

How to Enroll

- Visit **petsnationwide.com** and enter Raycap, **OR**
- Call **877.738.7874** and mention the Raycap name

Raycap has partnered with Nationwide to provide you and your family with an additional level of coverage for all members of your family, and that includes those members of your family with four paws. My Pet Protection® from Nationwide® is a reimbursement indemnity plan for dogs and cats. The plan will reimburse for a portion of eligible veterinary expenses related to accidents, injuries, and illnesses. As a Raycap employee, you're eligible for preferred pricing and additional discounts for multiple pets.

Summary of Benefits:

- Visit any vet, anywhere
- Choose from 70% and 50% reimbursement of vet's invoice
- Low $250 annual deductible
- Pet Rx Express for prescription medications
- Easy online claim submission
- 24/7 VetHelpline access for policyholders
- Pay Premiums through payroll deductions

Premium is based on:

- Species of pet
- Employee state of residence
- Reimbursement level selected: 50% or 70%

24/7 Veterinary Help (Pet Telemedicine)

Veterinary professionals are available 24/7 through vethelpline, a service provided exclusively for Nationwide pet insurance members. You can get live help with any pet health concern, including identifying urgent care needs.

Exclusions

No pet insurer covers pre-existing conditions. A pre- existing condition is any illness or injury the pet had before coverage started. Not all pre-existing conditions are excluded permanently; if you have medical records from a veterinarian showing that the pet's condition has been cured for at least six months, you can request a review. Review forms and instructions on how to request a review can be found at **petinsurance.com/forms**.

Member Care

Our Member Care department is available Monday - Friday 5:00 a.m. to 7:00 p.m. and Saturday 7:00 a.m. to 3:30 p.m. (PST) to assist with policy questions and concerns.

Managing Your Account

Once you are enrolled, and you may enroll anytime during the year, your account may be managed through the online portal to update contact and payment information, submit claims, check claims status, and access exclusive member extras.

Once logged in, members can also download forms and more. If you submit a claim, you may choose to have reimbursements deposited directly into your bank account. For cancellations, you must call Nationwide directly at **800.540.2016**.

Coverage Highlights	My Pet Protection
Annual Deductible	$250
Reimbursement	50% or 70%
Maximum Annual Benefit	$7,500
Pre-Existing Conditions	Not Included
Accidents and Illnesses	Included
Hereditary and Congenital	Included
Cancer	Included
Dental Disease	Included
Hospitalization or Treatment	Included
Behavioral Treatments	Included
Rx Therapeutic Supplements	Included
24/7 vethelpline ($150)	Included
Advertising and Reward	Included
Emergency Boarding	Included
Loss Due to Theft	Included
Mortality Benefit	Included

Discounts	My Pet Protection
Multi-pet (2-3 pets)	5%
Multi-pet (4+ pets)	10%

Paid Leave

Paid Time Off (PTO)

Company policy allows employees to accrue time off for each hour paid, capped at 40-hours per week. Accruals are calculated on paid hours up to 2080 hours per year, excluding overtime.

Hourly accrual percentages and maximums are found in the PTO Accrual Table below. Accrual activity is documented on your bi-weekly Pay Statement. PTO is paid at the base rate of pay at the time personal leave is used.

PTO Accrual				
Years of Service	**Accrual Rate per Hour**	**Accrual Rate per Pay Period**	**Annual PTO Accrual**	**Accrual Maximum Hours**
1st year (0 – 12 mos)	0.04615	3.69231	12 days (96 hours)	96
2 – 3 years (13 – 36 mos)	0.05769	4.61538	15 days (120 hours)	120
4 – 5 years (37 – 60 mos)	0.06923	5.53846	18 days (144 hours)	150
6 – 9 years (61 – 180 mos)	0.08077	6.46154	21 days (168 hours)	200
10+ years (109+ mos)	0.09231	7.38462	24 days (192 hours)	250

* *Employees moving to the next "Years of Service" level start accruing at a higher Accrual Rate per Hour on the first day of the pay period following the employee's anniversary date. No accrual continues after the Accrual Maximum is reached.*

Paid Time Off (PTO)

Raycap

PTO Maximum Accrual

In order to maintain a healthy work/life balance, you are expected to take PTO during the year in which it is accrued. If you do not choose to take your full allocation for a legitimate business or personal reason that year, you may Accrue or "Bank" PTO up to the Maximum Accrual allowed based on the PTO Accrual Table.

No PTO hours will accrue beyond the Maximum Accrual. Suppose you reach your Maximum Accrual at any time during the year. In that case, your hourly accrual will be discontinued until you use PTO or take advantage of the Company's Cash Out Option allowing your balance to fall below Maximum Accrual. You will receive notification from the Payroll Department prior to reaching your Maximum Accrual. Once your balance falls below the Maximum, your accruals will resume.

PTO Cash Out Option

As an additional benefit and to support funding for personal needs such as vacations, emergencies, etc., employees with an accrued PTO amount of 80-hours or greater have an option to sell up to a maximum of 40-hours, **ONCE PER CALENDAR YEAR**.

The Cash Out will be paid through payroll direct deposit. Final approval must be obtained from the Heads of Human Resources as well as Finance at least one week before the payout request date. If you choose to take less than 40-hours, the remainder will not be available within the current year.

Effect of Taking the Cash Out Option

Since you are essentially selling your PTO, you will be receiving monies that are considered additional income and will be taxed accordingly. There will be no deductions from the Cash Out for voluntary benefits authorized by you. However, your contributions to your 401(k) as well as the Company's contributions will be deposited into your account.

The PTO Cash Out Option Request form is available on the ADP Employee Self Service portal: **Resources > Company Information > Forms Library**.

Holidays

All regular full-time employees are eligible for eight (8) hours of holiday pay at their standard pay rates. Regular part-time employees are eligible for holiday pay calculated on the number of work hours normally scheduled for the day when there is no holiday. Raycap may amend dates around holidays falling on weekdays to provide uninterrupted time off.

Raycap recognizes 10 official holidays each year:

- New Year's Day
- Presidents' Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Day before Christmas
- Christmas Day
- 10th Holiday to be assigned by the Company based on calendar year

New Parent Leave

Raycap offers five (5) days of paid parental leave to all employees to support the birth or adoption of a child. For departmental planning purposes, employees should keep their department head, and Human Resources informed as to anticipated dates of arrival.

Bereavement Leave

An employee may be granted up to three (3) consecutive paid days off from regularly scheduled work to make arrangements for or to attend the funeral of an immediate family member. Immediate family members are defined as spouse, child, parent, brother, sister, grandparent, grandchild, and step or in-law as applicable.

Leave must be taken at the time of the bereavement and not deferred unless there are special circumstances. This should be discussed with Human Resources.

Tuition Assistance

Raycap

Tuition Reimbursement

Raycap offers regular full-time employees the opportunity to increase their knowledge, skills, and career potential through this program. Employees with six months of service prior to the beginning of classes are eligible. Tuition is reimbursed at either 100% or 50%, depending on the courses. Raycap favors continuing education and will apply a liberal view in determining the benefit to the Company for purposes of approving course work.

To be reimbursed at 100%, expenses must be for: Job-related courses, general business and marketing courses, or courses leading to an associate's or bachelor's degree with a major related to Raycap's business.

- Courses in graduate or professional programs related to your current job assignment.
- Non-job-related courses may be approved if required for a job-related degree program.

Courses leading to an undergraduate or graduate degree which are non-job related at Raycap are eligible for reimbursement at 50%.

Courses must be taken at an accredited college or university and must be relevant to your current job or to a future job in Raycap. Courses must be taken on your own time and should not interfere with regular work schedules. Employees who are in scholarship programs or receiving special grants or federal aid are not included in this program.

A signed approval must be obtained from your department head before enrolling in a course, and final approval is granted at the discretion of Human Resources

Reimbursement Terms

Reimbursement is based on obtaining a passing grade of "C" or better in the course. Any grade of "pass" in a course graded on a pass/fail basis is eligible for reimbursement. A grade of "fail" is not eligible. Reimbursement applies to tuition and registration fees only. The maximum reimbursement you may receive in a twelve-month period is $7,500. You will be required to repay the reimbursement if you should leave Raycap within 12 months of receiving a reimbursement.

Processing Reimbursements

To receive reimbursement, submit an original bursar's receipt indicating payment for the course, as well as an original passing grade report. Certain tuition reimbursements may be treated as ordinary income and will be subject to federal, state, and local taxes.

Tuition Restitution

Tuition Assistance expenses must be refunded when you leave Raycap, for whatever reason, within 12 months of receiving Tuition Assistance reimbursement. However, the Company will forgive 8% of the reimbursement for each month you remain during the 12-month period.

Continuing Education Units (CEU) or Continuing Education Credits (CEC)

Raycap will reimburse the cost of CEUs or CECs required to retain a professional license or certification, provided these are job-related.

Important Note

The Tuition Assistance Request form is available on the ADP Employee Self Service portal: **Resources > Company Information > Forms Library**

Retirement Plan

ADP Retirement Services

401(k) Plan

The 401(k) is a tax-qualified, defined retirement benefit that affords the opportunity to build tax-deferred savings for the future by investing before-tax or after-tax dollars in a choice of mutual funds, including a money market fund maintained and administered by ADP Retirement Services. The maximum investment contribution is set annually by the IRS.

Eligibility

Regular full-time and regular part-time employees who are 18 years of age or older. After satisfying six (6) months of service (1000 hours for part-time), employees are qualified for inclusion in the Plan and will be automatically enrolled in the next full calendar quarter.

Plan Funds

Prior to your eligibility date, an enrollment kit will be forwarded to your home address by ADP so you may decide on the many saving options available to you. Information on funds' performance will be available through ADP-trained Investment Advisors.

Contributions

Once enrolled and an account established, you will receive a 3% Company contribution to your account each payday. This amount is calculated on your eligible bi- weekly earnings, including overtime. You may also elect to contribute to the Plan by authorizing a direct contribution from your salary. You may change the dollar amounts or the percentages of your contribution at any time by logging in to ADP Investments: **mykplan.com**.

Traditional vs. Roth Contributions

You may defer a portion of your salary into a Traditional account or a Roth account. Traditional dollars are pre-tax dollars subject to taxation upon retirement when you take a distribution from your account. A Roth account uses after- tax dollars. Because you have already been taxed on these dollars, your retirement distribution is tax free.

Plan Costs

Raycap assumes the total cost of the administration of the 401(k) Plan while you remain in the Plan. You will receive the full investment value of the contributions to the funds you choose.

Loans

No loans are allowed under the Plan.

Retirement Plan

ADP Retirement Services

Rollover Contributions

Even before you join the Retirement Plan, you are allowed to make a rollover contribution, directing a benefit payment received from a previous employer to the Raycap Plan.

By rolling over your benefit, you keep deferring taxes on it. You also avoid the federal government's 10% penalty tax. A rollover contribution may be made at any time after your employment as a salaried employee but no later than 60 days after you receive a payment from a prior employer.

To qualify, the amount you receive must be from a Qualified Defined Contribution Plan, and only tax-deferred money can be rolled over.

Withdrawals

Financial hardship withdrawals may be taken if you meet the federal government's definition of a financial hardship. If you do, you can only withdraw your own before-tax and Roth contributions. In general, financial hardship withdrawals are:

- Purchase of your primary residence
- Bankruptcy
- Eviction from, or foreclosure on, your primary residence
- Unreimbursed medical or funeral expenses for you or a member of your immediate family
- College tuition for a dependent.

Tax Impact on Withdrawals

There are tax and penalty consequences resulting from a withdrawal, and you will be suspended from making deferral contributions to the Plan for six (6) months after you receive the distribution. ADP is required by the IRS to withhold 20% of the taxable amount you withdraw. If you are younger than age 59½, you will owe the IRS an additional 10% penalty on the amount withdrawn unless the money is used to pay certain unreimbursed medical expenses or is paid to you because of your total and permanent disability.

Additional Services

Edelman Financial Engines is your employer-sponsored retirement investment advisor. ADP Retirement Services has made the services of Edelman Financial Engines available to assist participants with a balance in the company 401(k).

ADP recognizes many participants could use help with decisions in their 401(k) and are not always confident about being financially educated. This Online Advice is available at no cost to you.

You will find more information on all services offered in "Your Guide to Edelman Financial Engines" provided on the ADP Self Service portal: **Resources> Company Information>Tools/ References**. To speak with an advisor Call: **844.861.0028** Monday- Friday 9:00 am to 9:00 pm ET.

More Info

Raycap, Inc. 401(k) Plan Summary Plan Description is available on the ADP Employee Self Service portal: **Resources > Company Information > Tools/References.**

Glossary of Terms

Understanding your Benefits

AD&D (Accidental Death & Dismemberment)

A plan that provides benefits in the event of accidental death or dismemberment (generally, an accident resulting in death, loss of part of the body, or loss of the use of part of the body).

Allowed Amount

The maximum amount of the billed charge payable for covered services. Also, see "Reasonable & Customary."

Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover, this amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90.

Beneficiary

A person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit under the plan.

Co-payment or Copay

A set amount you pay out-of-pocket for a particular service. The plan pays the balance.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan.

Deductible

The out-of-pocket amount you must pay each plan year before the plan pays for eligible benefits.

EOB

The Explanation of Benefits (EOB) is a document that is generated when healthcare is used. It details the cost sharing between the health plan and the patient. It is not a bill.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Generic

Your prescription drug copay depends on the class or group of your prescribed medication. A generic drug generally has the lowest copay level. A generic drug is no longer produced only under a brand name. Once a drug's patent expires, many companies begin to manufacture "generic" versions of a previously brand-name-only drug. Generic medicines are identical to brand-name drugs in chemical makeup ("active ingredients"), usage, strength, and dosage. They are regulated and approved by the FDA just as brand-name drugs are; however; they are much less expensive.

Guaranteed Issue

The right to purchase insurance without a physical examination; the present and past physical condition of the applicant is not considered.

HIPAA

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules.

HIPAA Authorization

Under HIPAA, a document authorizing the use or disclosure of an individual's Protected Health Information by a Covered Entity for any purpose described in the document and meets specific requirements.

Glossary of Terms

Understanding your Benefits

Negotiated Rates

The costs for health care services negotiated between the insurance carrier and in-network healthcare providers. Negotiated rates are typically less than Reasonable and Allowed.

Non-Preferred Brand

Your prescription drug copay depends on the class or group of your prescribed medication. A non-preferred brand-name drug generally has the highest copay level because it is not on the plan's list of preferred drugs. Find out how different drugs are classified by your plan by visiting the plan's website.

Out of Pocket Expenses

Copays, deductibles, and other expenses not covered by the health plan.

Preferred Provider Network (PPO)

A health insurance plan that provides coverage through a network of selected medical providers. PPOs are also known as managed care plans.

Qualifying Event

Certain life events which may allow you to make allowable changes to your benefits. Qualifying Events include: marriage, divorce, domestic partner changes, death, birth, adoption or placement for adoption, and significant change in employment.

Reasonable & Customary

Refers to the amount insurance providers use to determine payments on services, usually the amount paid on out- of-network services. Determined using historical data collected by the claims administrator for providers' charges within specific geographic areas and independent claims research. Updated periodically to ensure current data and payment.

Legal Notices

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. Please contact Human Resources if you did not receive your SBC.

Special Enrollment Notice

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Raycap Human Resources at 973.777.8899.

Health Insurance Portability and Accountability Act

In April 2003, the final regulations that place restrictions on how personally identifiable health information may be used and disclosed by certain organizations became effective. These regulations (the Privacy Rules) implement the privacy requirements contained within the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA Privacy Rules establish a uniform, minimum level of privacy protections for all health information. In summary, the HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed;
- Require that individuals be told how their health information will be used and disclosed;
- Provide individuals with a right to access, amend or copy their medical records;
- Give individuals a right to receive an accounting of disclosures, to request special restrictions, and to receive confidential communications; and
- Impose fines where the requirements contained within the regulations are not met.

Raycap is HIPAA compliant. For more information refer to your HIPAA Privacy Notice or contact the Human Resources Department.

Women's Health and Cancer Rights Act Notice

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

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

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

If you would like more information on WHCRA benefits, contact Raycap Human Resources at 973.777.8899.

Coordination of Benefits

Your plan includes a Coordination of Benefits (COB) provision. COB is intended to ensure that all the payments for a given service, made by all health plans that may cover you or your dependents, do not exceed the amount the doctor or facility actually charged.

Michelle's Law

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued if written certification from a treating physician is received until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

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.

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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
Website: http://myalhipp.com/
Phone: 1-855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP 855.692.7447)

CALIFORNIA - MEDICAID
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916.445.8322
Fax: 916.440.5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800.221.3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800.359.1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855.692.6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877.357.3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678.564.1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678.564.1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid Website: https://www.in.gov/medicaid/
http://www.in.gov/fss/dfr/
Family and Social Services Administration
Phone: 1-800.403.0864
Member Services Phone: 1-800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800.338.8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800.257.8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888.346.9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800.792.4884
HIPP Phone: 1-800.967.4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877.524.4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888.342.6207 (Medicaid hotline) or 1-855.618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: www.mymaineconnection.gob/benefits/s/?language=en_US
Phone: 1-800.442.6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.977.6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800.862.4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800.657.3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800.694.3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.495.1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800.992.0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603.271.5218
Toll free number for the HIPP program: 1-800.852.3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800.356.1561
CHIP Premium Assistance Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800.701.0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800.541.2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888.365.3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800.699.9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800.692.7462
CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855.697.4347, or 401.462.0311 (Direct RIte Share Line)

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SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888.549.0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888.828.0059

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800.440.0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888.222.2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800.562.3022

VIRGINIA – Medicaid and CHIP
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
Phone: 1-800.432.5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800.562.3022

WEST VIRGINIA – Medicaid and CHIP
Website: http://mywvhipp.com/ and https://dhhr.wv.gov/bms/
Medicaid Phone: 304.558.1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855.699.8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800.362.3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 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

Family, Medical and Uniformed Services/ Leaves of Absence

The Family and Medical Leave Act (FMLA) entitles eligible employees to take up to 12 workweeks of unpaid, job-protected leave in a 12 month period for specified family and medical reasons, or for any "qualifying exigency" arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. The FMLA also allows eligible employees to take up to 26 workweeks of job-protected leave in a "single 12-month period" to care for a covered service member with a serious injury or illness.

Additionally, you may be entitled to certain rights and benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA provides that returning service members are reemployed in the job that they would have attained had they not been absent for military service, with the same seniority, status and pay, as well as other rights and benefits determined by seniority.

USERRA also requires that a person reemployed under its provisions be given credit for any months he or she would have been employed but for the military service in determining eligibility for FMLA leave. A person reemployed following military service is eligible for credit for the period of military service towards the months-of-employment and hours worked FMLA eligibility requirements.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than those applicable to medical/surgical benefits.

MHPAEA applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. The MHPAEA does not require that a plan provider medical/surgical and mental health or substance abuse disorder benefits; however, if a plan providers MH/SUD benefits, it must comply with the MHPAEA's parity provisions.

National Medical Support Notice

Federal Law requires that group health plans provide medical care coverage of a dependent child pursuant to a Nation Medical Support Notice (NMSN). State child support enforcement agencies are required to use an NMSN when enforcing the health care coverage provisions of medical child support orders.

We are required by federal law to comply with this regulation, including ensuring that the notice received is a qualified NMSN. We must also notify you when an MNSN is received, and any additional requirements you may have to comply with the notice.

Note: the regulation also provides that an employee can be involuntarily enrolled when necessary for the child to have coverage.

Please contact Human Resources with any questions about the Federal regulation.

Newborns' and Mothers' Health Protection Act Notice

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

Genetic Information Nondiscrimination Act (GINA) Notice

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.

Grace's Law Hearing Aid Coverage

This law requires coverage for medically necessary expenses incurred in the purchase of a hearing aid for a covered person age 15 or younger.

The coverage must be provided for the purchase of a hearing aid for each ear, when that is medically necessary and prescribed or recommended by a licensed physician or audiologist.

Benefits during every 24-months period may be limited to $1,000 per hearing aid for each hearing-impaired ear. If a hearing aid that is selected is priced higher than the benefit available under this law, the purchaser is responsible for the difference.

The physician and patient would discuss the means by which the patient would receive this care. These services are subject to any applicable copayments, deductibles, and coinsurance in your plan. The law also includes the standard NJ requirement that

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benefits are to be provided to the same extent as for any other condition under the contract.

Model General Notice of COBRA Continuation Coverage Rights

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare

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Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Marpai Health Medical Plans; Raycap Human Resources, 973.777.8899

Important Notice from Raycap, Inc. About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Raycap, Inc. has determined that the prescription drug coverage offered by the Raycap Employee Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Raycap, Inc. coverage will be affected. The Raycap Employee Benefits Plan does not allow for dual coverage. If you choose to enroll in Medicare Part D, your prescription drug coverage under Raycap's plan will end for you and your covered dependents.

If you do decide to join a Medicare drug plan and drop your current Raycap, Inc. coverage, be aware that you and your dependents will be able to re-enroll in the plan at a later time. Please carefully review your options before making a decision to ensure that your choice aligns with your needs and the needs of your dependents.

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 Raycap, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. 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 Raycap, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

- For more information about Medicare prescription drug coverage: Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

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

Date:	10/14/2024
Name of Entity/Sender:	Raycap, Inc.
Contact--Position/Office:	Sammy Smithley, VP, Finance & Accounting
Address:	806 S Clearwater Loop, Post Falls, ID 83854
Phone Number:	208.777.1166

Insurance Marketplace Notice

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 ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based 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 through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally 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. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for 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. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, 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 an employment-based health plan (such as an employer-sponsored health 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 an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based 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 Human Resources.

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 Your Employer

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

1 *Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.*

2 *An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.*

3. Employer name Raycap, Inc.		4. Employer Identification Number (EIN) 203942471
5. Employer address 806 S Clearwater Loop		6. Employer phone number
7. City Post Falls	8. State ID	9. ZIP code 83854
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) 973.777.8899	12. Email address gganley@raycap.com	

Notes

Notes

Raycap

Raycap Inc. | **info@raycap.com**

Please note this Guide is a general summary of your benefits. For more specific details, you may refer to each carrier's Benefit Summaries, which are online and available through Human Resources. Every effort has been made to ensure this Guide accurately represents benefits. However, if there is any discrepancy between the terms in this Guide and the terms in the Plan document, the Plan document will prevail.