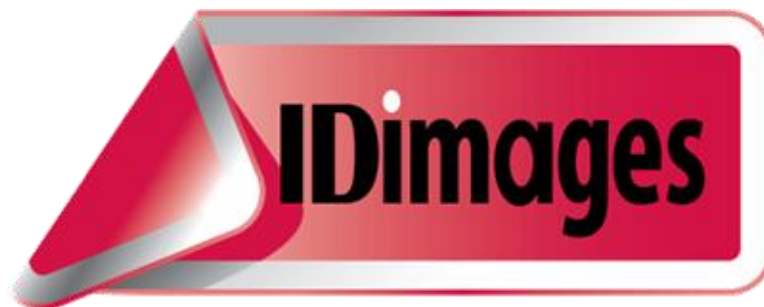




Delivering Label Solutions

BENEFITS GUIDE

2023 - 2024



Welcome to Your Benefits!

At I.D. Images, you are a vital part of our success as a company, and the work you do makes a difference. We are pleased to offer you a robust benefits program that focuses on overall wellness in all areas of life.

Our benefits program has valuable tools and resources for your physical and financial health as well as the support you need to handle your day-to-day responsibilities. Because everyone's needs are different, we give you options, so you can choose the plans you need at a price you can afford.

Take a look at the benefits described in this guide to make the most of your benefits package. If you have any questions, reach out to Human Resources or to the individual carriers.

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Please refer to plan documents for details, including important coverage exclusions and limitations. If there are any discrepancies between this benefits summary and plan documents, the plan documents will govern.

Eligibility and Enrollment

Employee and Dependent Eligibility

You are eligible to enroll in benefits if you are a regular, full-time employee working a minimum of 30 hours per week.

If you are a new hire, you have 30 days from your date of hire to enroll in benefits. Benefits begin on the first of the month following 60 days.

You can also enroll the following eligible dependents:

- Your legal spouse or qualified domestic partner.
- Your biological and/or adopted children and stepchildren up to the end of the month in which they turn age 26 (Your spouse's/domestic partner's biological and/or adopted children are eligible if they meet the age and dependent criteria.)

Coverage may be extended to a child named in a Qualified Medical Child Support Order or to a physically or mentally disabled child if the disability occurs before the child reaches age 26.

Qualifying Events

A qualifying event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some qualifying events include:

- Marriage, legal separation or divorce,
- Qualified Domestic Partnership,
- Birth, adoption or custody change of an eligible dependent,
- Beginning or ending of spouse's employment,
- A change in employment (for either you or your spouse) from part-time to full-time or full-time to part-time, or
- Moving to individual coverage under the Exchange.

If such a change occurs, you must make the changes to your benefits within 30 days of the Qualifying Event date.

Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the Qualifying Event may result in your having to wait until the next open enrollment period to make your change; this includes the enrollment of a newborn child. Please contact Human Resources to make these changes.

Open Enrollment

Open enrollment is your annual opportunity to:

- Review and make changes to your benefits
- Add or drop covered dependents

After open enrollment ends, you will have to wait until the following year's open enrollment to make any changes, unless you have a qualifying event

Passive Enrollment

We are conducting a passive open enrollment, which means that employees will be automatically re-enrolled in their current selection for the upcoming year. In order to make changes, you must make new selections during the open enrollment process

How to Enroll

Using your employee credentials, log into the Paycom app or www.paycomdfw.net
Click the link for 2023 Benefit Enrollment.



Medical Benefits

We value your and your family's health and well-being. That's why we offer comprehensive medical coverage to provide all the benefits and resources you need to support your health throughout the year.

To better evaluate the coverage and features available to you, please review the following brief summary of benefits.

Your Medical Options

You have a choice of the following plan options:

- **Basic Aetna Open Access Managed Choice** - POS \$6,500
- **Enhanced Aetna PPO Open Access Managed Choice** - POS \$1,500
- **Aetna High Deductible Health Plan (H.S.A compatible) Open Access Managed Choice** - POS \$3,750

Aetna

Phone: 833-639-1634

Website: www.Aetna.com

Selecting a Plan That's Right for You

Choosing the right medical plan takes careful consideration. Before making your decision, be sure to look closely at these factors:

- **Choice:** Some plans offer greater provider and facility networks than others. If you prefer to seek services both in and out of the network, choose a plan that offers higher levels of coverage and gives you the flexibility to select your provider.
- **Coverage:** Whether routine, surgical, prescription or another type of coverage, determine if the plan covers the services and medical treatments you value most.
- **Cost:** Each plan contains a variety of cost components. Consider the amount of your payroll deduction, as well as other plan expenses such as deductibles, copayments or coinsurance.

How to Find a Network Provider

Finding an in-network provider near you is easy. Visit www.aetna.com or call 833-639-1634.

You can also download the Aetna mobile app for on-the-go access via Google Play or Apple Store.

Medical Benefits *continued*

Prescription Drugs

Your medical plan includes coverage for prescription medication. Using in-network pharmacies will ensure you receive the highest level of benefits. Be sure to bring your ID card when filling a prescription. Keep in mind that there are certain preventive medications that are covered in full. Visit your prescription drug carrier’s website for a list of covered medications.

If you use daily medication for a chronic condition, such as diabetes, high blood pressure, or high cholesterol, use the mail order program to save time and money. You will receive a 90-day supply of your medication at your home address or at your nearest in-network pharmacy.

Preventive Care

Getting regular checkups and exams can help you stay healthy and catch issues early before they become big problems. Your medical plan provides coverage for preventive care services and immunizations – at no cost to you. As long as you see a doctor or use a pharmacy or lab in the plan’s network, you won’t have to pay anything for preventive services and immunizations. Talk to your doctor about which screenings and immunizations are right for you.

Do You Know Where to Go?

Knowing where to go if you get sick or hurt can save you time and money and help you get the best medical care. Unless you have a true emergency, the emergency room (ER) shouldn’t be your first stop. Your medical plans give you a variety of options for you to receive excellent care anytime of the day or night.

				
Virtual Care	Retail Health Clinic	Primary Care Physician	Urgent Care	Emergency Room
Average Cost				
\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$
When Services are usually available				
24/7/365 via video or phone	Weekday, sometimes weekends	Weekdays	Usually open every day and during the evening, including holidays	24/7/365
When you should go				
• Minor health conditions, such as headaches, nausea, cold and flu symptoms • Sinus pain • Earache	• Minor health conditions, such as headaches, nausea, cold and flu symptoms • Sinus pain • Earache • Shots • Minor burns	• Minor health conditions, such as headaches, nausea, cold and flu symptoms • Sinus pain • Mild asthma • Back pain	• Minor health conditions, such as headaches, nausea, cold and flu symptoms • Sinus pain • Animal bites • Sprains and strains • Stitches • X-rays	• Emergency care, such as life-threatening allergic reactions, severe asthma, chest pain, major injury, loss of consciousness, vomiting blood

Basic

Aetna Open Access Managed Choice - \$6,500

With the Basic Aetna Plan, you have the flexibility to choose any provider. You do not have to select a primary care physician (PCP) to oversee your care or give referrals. Keep in mind that benefits are highest when using an in-network provider.

Aetna OAMC		
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$6,500	\$15,000
Family	\$13,500	\$30,000
Calendar Year Out-of-Pocket Maximum (includes Deductible)		
Individual	\$7,900	\$25,000
Family	\$15,800	\$50,000
You Pay		
Services		
Preventive Care	Covered 100%	50%; after deductible
Primary Care Physician	\$40 copay	50%; after deductible
Specialist	\$75 copay	50%; after deductible
Urgent Care	\$75 copay	50%; after deductible
Emergency Room	\$350 copay; after deductible	\$350 copay; after deductible
Prescription Drug Coverage		
Retail Rx (up to 30-day supply)		
Generic	\$10 copay	Covered 100%; after applicable in-network cost share
Brand Name	\$50 copay	Covered 100%; after applicable in-network cost share
Non-Formulary	\$90 copay	Covered 100%; after applicable in-network cost share
Specialty Drugs	Preferred 30% maximum \$250; Non-Preferred 40% maximum \$400	Covered 100%; after applicable in-network cost share
Mail Order Rx (90-day supply)		
Generic	\$25 copay	Not applicable
Formulary	\$125 copay	
Non-Formulary	\$225 copay	

Enhanced

Aetna PPO Open Access Managed Choice - \$1,500

With the Enhanced Aetna PPO Plan, you have the flexibility to choose any provider. You do not have to select a primary care physician (PCP) to oversee your care or give referrals. Keep in mind that benefits are highest when using an in-network provider.

Aetna OAM PPO		
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$1,500	\$6,000
Family	\$3,000	\$12,000
Calendar Year Out-of-Pocket Maximum (includes Deductible)		
Individual	\$5,000	\$20,000
Family	\$10,000	\$40,000
You Pay		
Services		
Preventive Care	Covered 100%	50%; after deductible
Primary Care Physician	\$35 copay	50%; after deductible
Specialist	\$50 copay	50%; after deductible
Urgent Care	\$50 copay	50%; after deductible
Emergency Room	\$250 copay; copay waived if admitted	\$250 copay; copay waived if admitted
Prescription Drug Coverage		
Retail Rx (up to 30-day supply)		
Generic	\$10 copay	Covered 50% of submitted cost; after applicable in-network cost share
Brand Name	\$50 copay	Covered 50% of submitted cost; after applicable in-network cost share
Non-Formulary	\$90 copay	Covered 50% of submitted cost; after applicable in-network cost share
Specialty Drugs	Preferred 30% maximum \$250; Non-Preferred 40% maximum \$400	Covered 50% of submitted cost; after applicable in-network cost share
Mail Order Rx (90-day supply)		
Generic	\$25 copay	Not applicable
Formulary	\$125 copay	
Non-Formulary	\$225 copay	

High Deductible Health Plan with HSA

Aetna HDHP Open Access Managed Choice POS - \$3,750

With the High Deductible Health Plan (HDHP), you have the flexibility to choose any provider. You do not have to select a primary care physician (PCP) to oversee your care or give referrals. With Aetna HDHP you have the opportunity to enroll in a Health Savings Account, a tax-advantaged savings account with funds you can use toward qualified medical eligible cost. Details on HSA on the following page. Keep in mind that benefits are highest when using an in-network provider.

HDHP Aetna OAM POS		
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$3,750	\$9,000
Family	\$7,500	\$18,000
Calendar Year Out-of-Pocket Maximum (includes Deductible)		
Individual	\$6,450	\$25,000
Family	\$12,900	\$50,000
You Pay		
Services		
Preventive Care	Covered 100%	30%; after deductible
Primary Care Physician	10%; after deductible	30%; after deductible
Specialist	10%; after deductible	30%; after deductible
Urgent Care	10%; after deductible	30%; after deductible
Emergency Room	10%; after deductible	Same as in-network
Prescription Drug Coverage		
Retail Rx (up to 30-day supply)		
Generic	\$10 copay	Covered 50% of submitted cost; after applicable in-network cost share
Brand Name	\$50 copay	Covered 50% of submitted cost; after applicable in-network cost share
Non-Formulary	\$90 copay	Covered 50% of submitted cost; after applicable in-network cost share
Specialty Drugs	Preferred 30% maximum \$250; Non-Preferred 40% maximum \$400	Covered 50% of submitted cost; after applicable in-network cost share
Mail Order Rx (90-day supply)		
Generic	\$25 copay	Not applicable
Formulary	\$125 copay	
Non-Formulary	\$225 copay	

Health Savings Account (HSA)

What is a Health Savings Account?

A Health Savings Account (HSA) is an individually-owned savings account that allows you to set aside pretax dollars to pay for qualified health expenses, including your deductible.

Are you Eligible?

- You are eligible to open an HSA if:
- You are enrolled in the High Deductible Health Plan
- You are not covered by a non HDHP health plan, or a spouse’s FSA or an HRA
- You are not eligible to be claimed as a dependent for tax return purposes
- You are not enrolled in Medicare, Medicaid or Tricare for Life Insurance

What are the Benefits of Having an HSA?

- You contribute money on a pretax basis, HSA funds accrue tax free, and you can withdraw the funds tax free (if used for qualified health expenses). Currently, California and New Jersey tax both employer and employee HSA contributions.
- Balance rolls over from year to year. No “use it or lose it” rule.
- Funds over a certain dollar amount can be invested.
- You decide how and when to use the money in your HSA: to pay for qualified expenses during the year or to save it for future needs.
- You own the account, which means the money you contributed to the HSA is yours to take if you were to leave the company or retire.

How Much Can I Contribute?

During enrollment, you specify how much you want to contribute to your HSA on an annual basis, through payroll deduction, up to the annual IRS limits.

2023 HSA Contribution Limits	
Single	\$3,850
Family	\$7,750
Age 55+	Can contribute an additional \$1,000

How Do I Use My HSA?

Using your HSA is easy. Simply use your HSA debit card to pay for eligible health care expenses up to the amount available in your account. You can also arrange for payment online or reimburse yourself for eligible expenses you paid out-of-pocket.

Eligible expenses include medical, dental and vision deductibles, coinsurance and copays and prescription drugs costs.

If you use your funds for ineligible expenses, you will be subject to penalties and taxes. After age 65, you can use the funds for any purpose penalty-free.

PayFlex Member Services

Phone: 888-678-8242
(Monday-Friday 7:00am - 7:00pm &
Saturday 9:00am - 2:00pm CT)
Member Website: www.PayFlex.com



Telemedicine

Virtual Care, or telemedicine, is a great alternative to urgent care and emergency room visits because it provides you 24/7/365 access to U.S. board-certified doctors – receive the treatment you need in an easy and timely manner. In addition, you have the ability to send your visit results to your primary care physician.

Telemedicine can Treat Many Common Health Issues

Through virtual care, doctors can diagnose many health issues like cold and flu symptoms, allergies, rash, skin problems and so much more! If medically necessary, a prescription will be sent to the pharmacy of your choice.

- Abdominal Pain/Cramps
- Cold and Flu Symptoms
- Respiratory infection
- Allergies
- Dizziness
- Sinusitis
- Animal/Insect Bites
- Eye Infection/Irritation
- Sore Throat
- Asthma
- Headaches/Migraines
- Sprains and Strains
- Backache
- Laryngitis
- Strep
- Blood Pressure Issues
- Poison Ivy/Oak
- Bronchitis

Telemedicine Offers You:

- 24/7/365 Convenience
- No Emergency Room Waits
- Quality Doctors



Flexible Spending Accounts (FSAs)

This plan can only be elected if you enroll in either the Basic or Enhanced Plan.

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax funds to pay for health care and dependent care expenses. Since these contributions are not subject to federal, state or payroll tax withholding, you keep more of your paycheck.

Each year you wish to participate in the FSAs, you must elect the amount you want to contribute.

- Your contributions will be deducted from your paychecks in equal installments throughout the year and deposited into your account(s).
- You cannot change your contribution amount during the year unless you have a qualifying event.
- Estimate your contribution amounts carefully, as unused funds will be forfeited after the end of the closing date.
- Keep in mind that you cannot transfer from one FSA to another.

Health Care FSA

The Health Care FSA can be used to pay **out-of-pocket medical, dental, vision and prescription drug expenses**.



- **Annual Contribution Limit:** \$3,050
- **Eligible Expenses:** Copays, coinsurance, deductibles, prescription expenses (For a full list, visit www.irs.gov Publication 502)
- **Funds Available:** Full amount is available at the beginning of the plan year
- **Payment or Reimbursement Options:** FSA Debit Card, Direct Deposit, Check
- **Deadline for Services:** 6/30/2024
- **Deadline to Submit Claims for Reimbursement:** Up to 90 days after deadline

Dependent Care FSA

The Dependent Care FSA can be used to pay **eligible day care expenses** for your children under age 13 or a dependent adult to allow you or your spouse to work or attend school full time.



- **Annual Contribution Limit:** \$5,000 (\$2,500 if married and filing separate tax returns)
- **Eligible Expenses:** Day care, after-school care, babysitting (work-related), nanny (For a full list, visit www.irs.gov Publication 503)
- **Funds Available:** You may only use up to the amount of funds you have in your account
- **Payment or Reimbursement Options:** Direct Deposit or Check
- **Deadline for Services:** 6/30/2024
- **Deadline to Submit Claims for Reimbursement:** Up to 90 days after deadline

Limited Purpose FSA

If you are enrolled in a High Deductible Health Plan with a Health Savings Account, you are eligible to enroll in the Limited Purpose FSA for **dental and vision** expenses only. You may contribute up to \$2,850.

Dental

Aetna DPPO

With the Enhanced Aetna PPO Plan, you have the flexibility to choose any provider. You do not have to select a primary care physician (PCP) to oversee your care or give referrals. Keep in mind that benefits are highest when using an in-network provider.

DPPO		
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$50	\$50
Family	\$150	\$150
Calendar Year Plan Maximum		
Per Individual	\$1,250	\$1,250
You Pay		
Preventive Care		
Oral Exams, X-rays, Cleanings, Fluoride, Space Maintainers, Sealants	100%	100%
Basic Services		
Oral Surgery, Fillings, Endodontic Treatment, Periodontic Treatment, Repairs of Dentures and Crowns	80%	80%
Major Services		
Crowns, Jackets, Dentures, Bridge Implants	50%	50%
Orthodontia		
Covered	Not covered	Not Covered
Lifetime Orthodontia Plan Maximum (Per Individual)	Not covered	Not covered

Vision

Aetna Vision Plan

Vision care is essential to your overall health. Getting regular eye exams helps your doctor detect a variety of medical conditions before they become big problems.

- In addition to eye exams, your vision plan provides coverage standard lenses and frames and contact lenses.
- Use in-network services and supplies to receive the highest level of benefits.
- You can enroll yourself and your eligible dependents in coverage.

Vision Plan		
	Participating Provider	Non-Participating Provider
	You Pay	Reimbursement
Exam & Materials		
Exam	\$10 copay	\$32 Allowance
Materials	\$25 copay	Please see below
Lenses		
Single	\$25 copay	\$10 Allowance
Bifocals	\$25 copay	\$25 Allowance
Trifocals	\$25 copay	\$55 Allowance
Lenticular	\$25 copay	\$55 Allowance
Frames		
Frames	\$130 Allowance	\$90 Allowance
Contact Lenses (in lieu of lenses & frames)		
Medically Necessary	\$130 Allowance	\$104 Allowance
Elective	\$130 Allowance	\$104 Allowance
Benefit Frequency		
Exams	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months
Contacts	Once every 12 months	Once every 12 months

Life and AD&D Insurance

Life and Accidental Death & Dismemberment – Hourly Employees

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by I.D. Images. The company provides basic life insurance of \$25,000 at no cost to you.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. I.D. Images provides basic AD&D insurance of \$25,000 at no cost to you. Benefits are reduced to 65% at age 65 and to 50% at age 70. Coverage is discontinued at termination of employment or retirement.

Life and Accidental Death & Dismemberment — Salary Employees

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by I.D. Images. The company provides basic life insurance of one times your Basic Annual Earnings (to a maximum of \$350,000) at no cost to you.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. I.D. Images provides basic AD&D insurance of one times your Basic Annual Earnings (to a maximum of \$350,000) at no cost to you.

Benefits are reduced to 65% at age 65 and to 50% at age 70. Coverage is discontinued at termination of employment or retirement.

Additional Information

To learn more, please see the schedule of benefits for a full list of benefits and costs.

Things to Keep in Mind

Life and AD&D insurance provides many benefits, but there are a few points to keep in mind:

- **Imputed Income:** The value of your company-provided life insurance premiums over \$50,000 is considered taxable. Contact your tax professional for more information.
- **Age Reduction:** Benefit amounts reduce as you age.
- **Portability:** If you leave the company, you can convert your policy to an individual policy and continue your coverage.

Disability Insurance

An unexpected injury or illness can create a financial burden. Disability insurance replaces a portion on your income when you are unable to work.

Life Insurance - Disability benefits are reduced by other income you receive, such as Social Security, state disability benefits, pension benefits, and Workers’ Compensation.

Short Term Disability

Short Term Disability (STD) insurance provides a portion of your weekly income for a non-work-related short-term injury or illness. You automatically receive Short Term Disability coverage at no cost to you.

Coverage	STD Benefit
Weekly Benefit	60% of weekly earnings
Weekly Benefit Maximum	- Full-Time Salaried EE’s: \$1,000 - Full-Time Hourly EE’s: \$500
Elimination Period	7 days
Benefit Duration	13 weeks

Long Term Disability

When your STD benefits end and you are still injured or ill and unable to work, LTD insurance takes over. You will receive a portion of your monthly income for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever comes first. You automatically receive LTD coverage at no cost to you.

Coverage	LTD Benefit
Monthly Benefit	60% of monthly earnings
Monthly Benefit Maximum	- Full-Time Salaried EE’s: \$6,000 - Full-Time Hourly EE’s: \$5,000
Elimination Period	90 days
Definition of Disability	2 years own occupation
Benefit Duration	ADEA Schedule or SSNRA

Helpful Disability Insurance Terms

Qualifying disability: A sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience

Benefit Duration: Maximum amount of time you may receive proceeds for a continuous disability

Elimination or Waiting Period: The time you must wait before you are eligible to receive benefit payments

Lincoln Financial

Phone: (877) 275-5462

Website: www.lincolffinancial.com

Additional Information

To learn more, please see the schedule of benefits for a full list of benefits and costs.

Terms to Know

Take a look at these terms to better understand your benefits.

Beneficiary: A person you designate to receive your financial benefits (i.e. life insurance, 401(k)) in the event of your death.

Calendar Year Maximum: Total amount paid each year by your insurance company for each family member enrolled in the plan.

Claim: A request for payment that you or your health care provider submits to your health insurer after receiving a service or item.

Coinsurance: The percentage you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

Copay: The flat fee you pay toward the cost of covered medical services.

Deductible: The amount you are responsible for paying for covered health care services before the plan pays benefits. Under some plans, the deductible is waived for certain services.

Evidence of Insurability (EOI): The process in which you provide required health documentation in order to receive certain levels of coverage.

Formulary: A list of preferred drugs chosen by a panel of doctors and pharmacists. Both brand and generic medications are included on the formulary.

Guaranteed Issue: The amount of coverage pre-approved by the insurance carrier regardless of health status.

Network: A designated list of health care providers (doctors, dentists, etc.) with whom the health insurance provider has negotiated special rates. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum: The highest amount paid for covered services during a benefit period. Both the deductible and the coinsurance apply towards meeting the out-of-pocket maximum, but copayments may not apply.

Pre-Existing Condition: A health problem you had before the date that new health coverage starts.

Preauthorization: A decision by your health plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Preauthorization may be required for certain services before you receive them.

Premium: The amount you pay for a health plan in exchange for coverage.

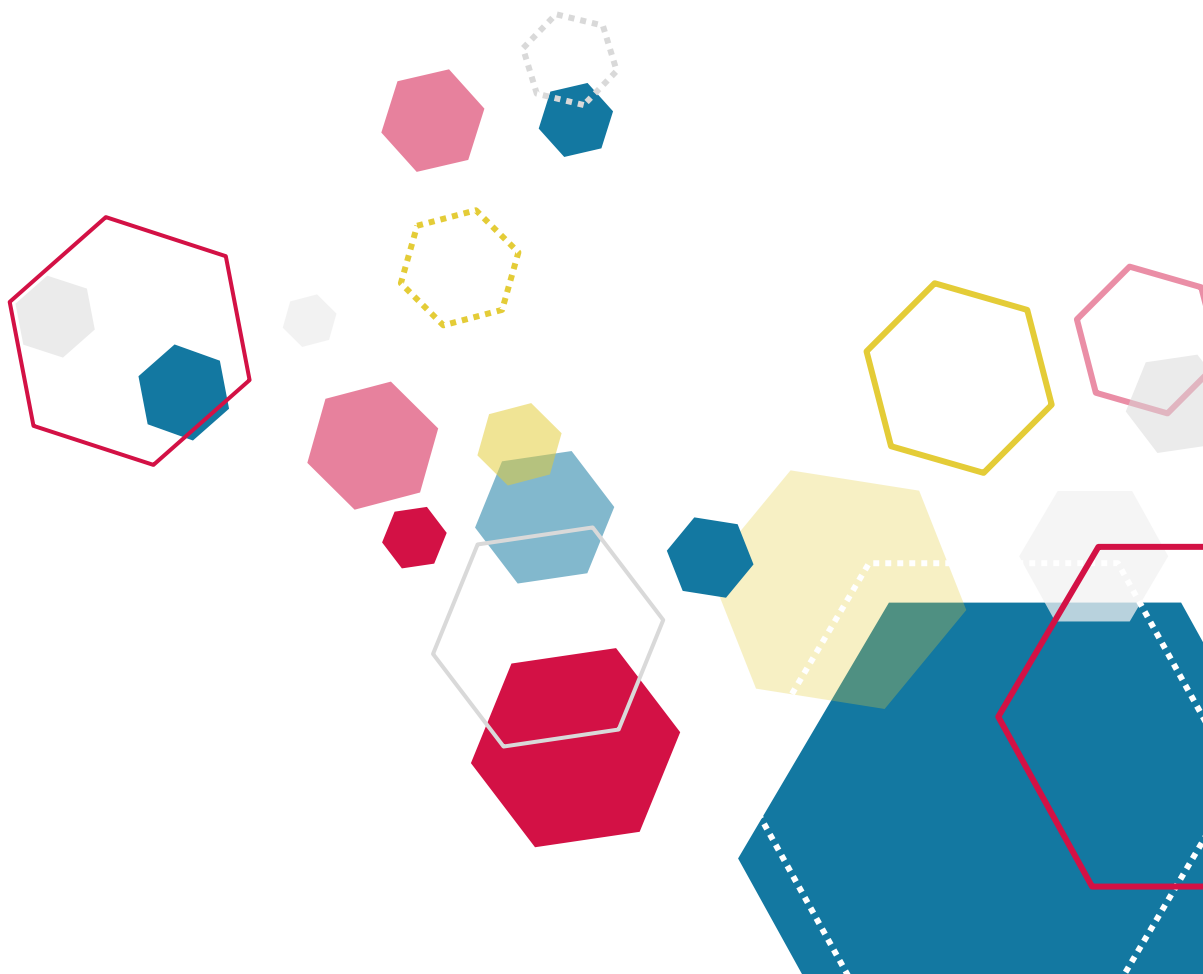
Preventive Care: Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease, or other health problems.

Reasonable and Customary: The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or procedure.



Important Contacts

Coverage	Carrier/Vendor	Phone	Website
Medical	Aetna	833-639-1634	www.Aetna.com
Telemedicine	Aetna Teladoc	855-835-2362	www.Teledoc.com/Aetna
Health Savings Account	PayFlex	888-879-9280	www.PayFlex.com
Dental	Aetna	844-729-1565	www.Aetna.com
Vision	Aetna	866-723-0515	www.Aetna.com
Flexible Spending Accounts	WEX	866-451-3245	customerservice@wexhealth.com
Short Term Disability	Lincoln Financial	877-275-5462	www.lincolnfinancial.com
Life and AD&D	Lincoln Financial	(877) 275-5462	www.lincolnfinancial.com
Disability	Lincoln Financial	(877) 275-5462	www.lincolnfinancial.com
Medicare	My Benefit Advisor (Karen Coia)	(856) 334-4356	Karen.coia@emersonreid.com



Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

- Aetna Open Access Managed Choice: \$6,500 individual / \$13,500 family deductible; 30% coinsurance
- Aetna PPO Open Access Managed Choice: \$1,500 individual / \$3,000 family deductible; 20% coinsurance
- Aetna HDHP Open Access Managed Choice POS: \$3,750 individual / \$7,500 family deductible; 10% coinsurance

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Maria Davis
2991 Interstate Parkway
Brunswick, Ohio United States 44212
330-5588064
mdavis@idimages.com

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from I.D. Images 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 I.D. Images 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. I.D. Images has determined that the prescription drug coverage offered by the I.D. Images Employee Health Care 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.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
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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 I.D. Images coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current I.D. Images coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with I.D. Images 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 I.D. Images changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	July 1, 2023
Name of Entity/Sender:	Maria Davis
Contact--Position/Office:	CHRO
Address:	1120 West 130th Street Brunswick, OH 44212
Phone Number:	(330) 558-8064

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: 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+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.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 Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members rs 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: 1-800-766-9012
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

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

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

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The 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.

¹ An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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.

3. Employer name I.D. Images	4. Employer Identification Number (EIN) 26-0185040	
5. Employer address 2991 Interstate Parkway	6. Employer phone number (330) 558-8064	
7. City Brunswick	8. State OH	9. ZIP code 44212
10. Who can we contact about employee health coverage at this job? Maria Davis		
11. Phone number (if different from above)	12. Email address mdavis@idimages.com	

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

- As your employer, we offer a health plan to:
☒ All employees. Eligible employees are:
Full time Employees working 30 hours per week.

- With respect to dependents:
☒ We do offer coverage. Eligible dependents are:
Legal spouse and children up to age 26

☐ We do not offer coverage.

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

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

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

• An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Notes

[illegible]

ABOUT THIS GUIDE

This benefit summary provides selected highlights of the I.D. Images employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at I.D. Images. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. I.D. Images reserves the right to amend, suspend, or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.