

EMPLOYEE BENEFITS

Hudson Valley Engineering Associates, P.C.

2025-2026 Benefit Enrollment Guide



**MARSHALL
+STERLING**

Secure your Success

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Please Note: This enrollment guide is a summary of the benefits provided to benefit eligible employees Hudson Valley Engineering Associates, P.C. reserves the right to modify, amend, suspend or terminate any plan at any time for any reason without prior notification. The plans described in this guide are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make explanations of the plans in this guide as accurate as possible. However, should there be any discrepancy between this guide and the provisions of the insurance contract or plan documents, the provisions of the insurance contract or plan documents will govern. In addition, you should not rely on any descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

This is the only written summary of benefits. Please consult the Plan Document for more detailed information.



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Dear Employee:

Welcome to our December 2025 to November 2026 Benefits Open Enrollment. Our goal is to provide you and your family with cost-efficient and comprehensive benefits. These programs are reviewed annually to ensure they are in line with the current trends and remain in compliance with government regulations such as the Health Care Reform legislation. Please read this Benefits Guide to gather important details about your benefits and learn about your contributions as an aid to making your final decisions.

The definition of “full-time” for healthcare benefit eligibility purposes is working on average 30 or more hours per week. Hudson Valley Engineering Associates, P.C. will track your hours and notify you if you are eligible for benefits. More information on eligibility to participate in our healthcare plan can be found in the plan documents, which can be obtained by contacting our Human Resources department.

Open Enrollment

Open Enrollment is the window of opportunity to make changes to your benefit elections or enroll if you previously waived coverage. It is the time of year to make sure that you have enrolled in the health benefits that meet your healthcare needs and fit into your overall financial plan. Ask yourself:

- Does your current coverage meet your family’s needs?
- Did you get married, divorced, have a child or another qualifying status change since you last looked at your benefits?
- Were you covered under a spouse and now would like to be covered primarily by your employer?
- Verify that your enrolled dependents meet the definition of an eligible dependent. Medical coverage is provided for dependent children up to their 26th birthday under Health Care Reform. Other benefit plans are subject to plan age limits.

The Summary of Benefits and Coverage (SBC) for our medical plans, along with the Glossary of Health Coverage and Medical Terms, are also available on iNavigator. Upon request a paper copy will be provided at no charge.

Under the Affordable Care Act, you are required to maintain healthcare coverage for yourself and your dependent children.

Changing Your Benefits After Open Enrollment

After open enrollment you may change your benefits only if you have met a qualified status change, such as loss of other medical coverage, the birth of a child, divorce or a child reaching the coverage maximum age limit.

Please do not hesitate to contact Human Resources with any questions or concerns regarding your benefits.

Sincerely,

Cathy Schatz

Human Resources Manager

iNavigator

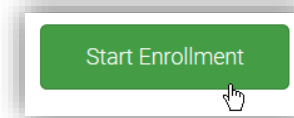


With iNavigator, employees enjoy convenient online access to benefits coverage, 24 hours a day, seven days a week. You can update your personal profile, report life events, make eligible benefits elections and qualifying enrollment changes, and also have access to a complete document library.

- **BEGIN** using iNavigator by going to <https://marshallsterling.employeenavigator.com>
- **FIRST TIME** users will select “Register as a new user” to create a User Name and Password. We highly recommend using a work email for your username, if possible, to help make it easier to remember. You will need your Company Identifier, which is: **hveapc**
- **EXISTING** users will proceed by logging in with their username and password. See below if you have forgotten your username or password.

To Enroll in Benefits

1. If you are a first-time user, after you have completed any onboarding tasks, you will be led to begin your enrollments. If you skip them during registration, or if you are a returning user, click **Start Enrollment** from your home screen.
2. Complete your personal information – please note all fields will be required. Click “Save and Continue”.
3. Complete dependent information. You can “add dependents” and fill out the needed information. When all dependents have been added, click “Save and Continue”
4. From here you will be taken one by one through each benefit your company offers. If a certain benefit allows dependents to be enrolled, you will see a section at the top “Who am I enrolling?”, where you can click off each dependent that you want to enroll on that individual plan.
5. You can select “Compare” to compare plans if more than one is offered or click “Details” for information on an individual plan. There will be a column on the right for helpful resources, which will contain benefit summaries or any other needed information. As you make each selection, click “Save and Continue”
6. If any of your selections require forms to be filled out (i.e. a beneficiary form for a life insurance plan), these forms will immediately pop-up after that benefit has been elected and must be filled out.
7. Lastly, upon completion of enrollment, you will be prompted to sign your benefits, and then may print a copy of your enrollment summary. **Enrollment is not complete until you “Click to Sign” on your enrollment summary and see the checkmark that says, “acknowledged and Submitted”.**



Create Your Account

First, let's find your company record

First Name

Last Name

Company Identifier
(provided by HR)
hveapc

PIN
(Last 4 Digits of SSN / ID)

Birth Date
(mm/dd/yyyy)

Forgot Your Username and/or Password?

1. Click on “Reset Password”
2. Under “Employees”, select “Click Here”
3. Enter your username and select “Next”
 - If you have forgotten your username, click “Don’t know your username?” Otherwise, skip to step #4. You will be asked for your company identifier (see above), first and last name, and your PIN, which is the last four digits of your SSN. Fill in these fields and select “Request a Reset”. You will see “Password Reset Has Started” and you will be prompted to check your email for instructions. Proceed with step #5.
4. Enter your birth year for verification. You will see “Password Reset Has Started” and you will be prompted to check your email for instructions.
5. Go to your email and click on “Password Reset” and enter new password. Select “Change Password” after entering. Don’t forget – passwords must be between 6 and 20 characters and include both a number and a symbol.
6. You should now be logged in and you will receive an email that your password has been reset.



Eligibility & Enrollments

Eligibility

Employees who are regularly scheduled to work at least 30 hours a week are eligible to participate in the Hudson Valley Engineering Associates, P.C.'s Benefits Program. If you enroll in coverage, you may also enroll your "eligible dependents" into the following plans: medical, dental, vision and supplemental life insurance.

Additionally, Variable Part Time employee's who meet the full-time definition defined by the Affordable Care Act (ACA), are eligible to participate in the medical plan(s). If eligible, you may also enroll your "eligible dependents" into a medical plan.

Your "eligible dependents" include:

Eligible Dependents:

- Same or opposite sex spouse or domestic partner
- Unmarried/married dependent children (not their spouse or dependents) to their 26th birthday
- Unmarried/married dependent children (not their spouse or dependents) of any age who are physically or mentally disabled
- Unmarried dependent children to their 26th birthday for life insurance

Termination of Benefits Coverage

Your benefits coverage ends as follows:

Medical, dental, vision, health reimbursement account (HRA), employer paid life/AD&D, long-term disability, short-term disability, and voluntary benefits terminate on the last day of employment.

If you are actively working and you or your spouse is eligible for Medicare benefits, please see the outline below:

Medicare Eligibility Reason	Primary Payor	Secondary Payor
Over 65 years of age	Group Health Plan	Medicare
Due to disability	Group Health Plan	Medicare

New Hires

New hires and newly eligible employees may enroll in the Health and Welfare plans when they first join Hudson Valley Engineering Associates, P.C. New hires must elect benefits within 31 days of their date of hire; otherwise, they will have to wait until the next Open Enrollment period to elect benefits.

The following provides an overview of benefit election requirements and effective dates.

Benefit	Action Required	Benefit Effective Date
Medical, Dental, Vision, HRA,DCA	Associate must actively elect these benefits.	Associates are eligible on their date of hire.
Employer Paid Life/AD&D, LTD, STD, Voluntary Benefits, EAP, & Voluntary Life.	Associate must actively elect these benefits.	Associates are eligible on their date of hire.

The **EPO** (Exclusive Provider Organization) and The **PPO** (Preferred Provider Organization) medical plans, through the Empire network, delivers in-network only benefits. Members must seek care from participating providers, except in the case of a life- or limb-threatening emergency. If care is received from a non-participating provider, the claim will not be paid. **It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.**

Plan Features	Empire Blue Card PPO/EPO	Empire Blue Access EPO
	In-Network Only	In-Network Only
Deductible / Maximum Period	Plan Year (12/1 – 11/30)	Plan Year (12/1 – 11/30)
Plan Year Deductibles (Indiv / Family)	\$3,575 / \$7,150	\$3,575 / \$7,150
Deductible Type	Aggregate	Aggregate
Plan Year Out-of-Pocket Max (Indiv / Family)	\$6,550 / \$13,100	\$6,550 / \$13,100
Out-of-Pocket Type	Embedded	Embedded
Coinsurance (Hospice, DME & Orthotics/Prosthetics)	20%	20%
Medicare Part D Coverage	Creditable	Creditable
Referral Needed	No	No
Network	Blue Card	Blue Access
Preventive Care	Covered in Full	Covered in Full
Primary Care Visit	\$50 Copay after Deductible	\$50 Copay after Deductible
Virtual Visits from LiveHealth Online For urgent/acute medical and mental health and substance abuse care: www.livehealthonline.com	No charge after deductible is met Specialist Care: \$50 copay per visit after deductible	No charge after deductible is met Specialist Care: \$50 copay per visit after deductible
Specialist Visit	\$50 Copay after Deductible	\$50 Copay after Deductible
Diagnostic Lab	Office: \$50 Copay after Deductible Freestanding Lab: Covered in Full after Deductible	Office: \$50 Copay after Deductible Freestanding Lab: Covered in Full after Deductible
X-Rays	Office: \$50 Copay after Deductible Outpatient Hospital: No charge after Deductible	Office: \$50 Copay after Deductible Outpatient Hospital: No charge after Deductible
Complex Images		
Prenatal Office Visit	\$100 Copay after Deductible	\$100 Copay after Deductible
Delivery (Maternity)	\$100 Copay after Deductible	\$100 Copay after Deductible
Inpatient Services (Maternity)	\$500 Copay after Deductible	\$500 Copay after Deductible
Hospital Outpatient Surgery	\$100 Copay after Deductible	\$100 Copay after Deductible
Hospital Inpatient Services	\$500 Copay after Deductible	\$500 Copay after Deductible
Mental Health Outpatient Services	Office: \$50 Copay after Deductible	Office: \$50 Copay after Deductible
Emergency Room	\$150 Copay after Deductible	\$150 Copay after Deductible
Ambulance	\$100 Copay after Deductible	\$100 Copay after Deductible
Urgent Care	\$50 Copay after Deductible	\$50 Copay after Deductible
Retail Pharmacy / RX (30 Day Supply)	\$10 / \$35 / \$70 after Deductible	\$10 / \$35 / \$70 after Deductible
Mail Order Pharmacy / RX (90 Day Supply)	\$20 / \$70 / \$140 after Deductible	\$20 / \$70 / \$140 after Deductible

- Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member.
- Embedded Deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- Inpatient admissions, outpatient surgery, x-rays, high level imaging, mental health and substance abuse require preauthorization. Please refer to your Certificate of Coverage for detailed information.



The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use SydneySM Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICESM Managed Care, Inc. (RIT), Healthy AllianceSM Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem Healthchoice Assurance, Inc. and Anthem Healthchoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trademark of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association, Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar anthem.com/es.



Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.



Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/register to access most of the same features from your computer.

Use the Find Care tool at [anthem.com](https://www.anthem.com) to find an Anthem provider

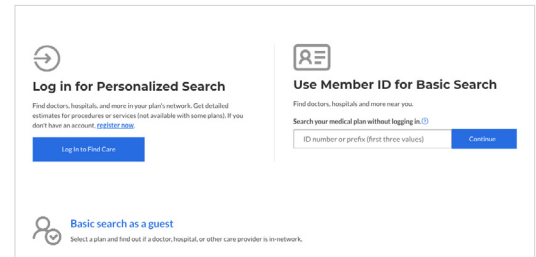
Anthem's Find Care tool was created to make it easy to find the care you need.

Use this quick step-by-step guide to help you find care.

Step 1

Go to [anthem.com/find-care](https://www.anthem.com/find-care).

- For guests — Choose **Basic search as a guest**.
- For members — You can either select **Log in for Personalized Search** on the left or you can search without logging in by selecting **Use Member ID for Basic Search** on the right.



Step 2

Scroll down and complete the following fields:

- Select the type of plan or network — Use the drop-down menu to choose **Medical Plan or Network**
- Select the state — Use the drop-down menu to choose **New York**
- Select how you get health insurance — Use the drop-down menu to choose **Medical Networks**
- Select a plan or network — Use the drop-down menu to choose **Blue Access (Employer Sponsored)**
- Select the **Continue** button.

Basic search as a guest

Select the type of plan or network

Medical Plan or Network (may also include dental, vision, or pharmacy benefits) ▼

Care Providers for Behavioral Health & Substance Use Disorder Services are listed under Medical plan or network.

Select the state where the plan or network is offered. (For employer-sponsored plans, select the state where your employer's plan is contracted in. Most of the time, it's where the headquarters is located.)

Select One ▼

Select how you get health insurance

Select One ▼

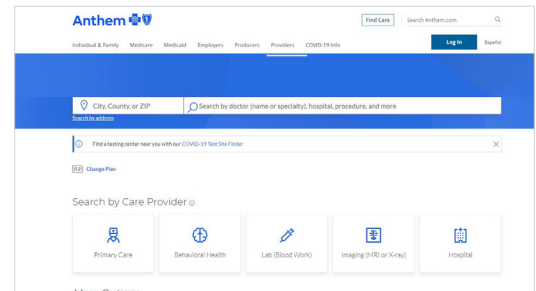
Select a plan or network

Select One ▼

Step 3

Enter the city, county, or ZIP code on the top left. You now have two options to narrow your search:

- **Option 1** — Enter a care provider or hospital by name or specialty in the search box. The results will appear below the *search box*, where you can select the name for more details about the care provider or hospital.
- **Option 2** — **Search by Care Provider**. Select the icon of the type of care provider you're looking for. The results will appear on a new screen, and you can select the care provider or hospital name for additional details.



Step 4

View your search results:

- Choose the printer icon to print the results of your search, or select the email icon to email the search results.
- Select a care provider name to see more details.
- Choose **Back to Find Care** on the upper left or **Back** button at the bottom of the screen to return to your results.



We are here to help

If you have questions, please call Member Services using the phone number listed on the back of your health plan ID card.

Wellbeing Solutions



Focus on your well-being and earn rewards up to \$1,100



The more activities you complete, the greater your reward

The Wellbeing Solutions program connects you with easy-to-use digital health and wellness tools that can help you stay your healthiest. When you complete any of the activities listed below sponsored by your employer, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of \$700 in rewards.

Along with the Wellbeing Solutions activities below, you can earn even more through the Gym Reimbursement program. Simply log your workouts to earn up to \$400 in fitness center reimbursements, for a total of up to \$1,100 in rewards. Details are on the next page.

Activity type	Activity	Amount
 Preventive care	Have an annual preventive wellness exam or well-woman exam with your doctor	\$20
	Get an annual cholesterol test ¹	\$5
	Have a colorectal cancer screening (ages 45 and older)	\$25
	Complete a routine mammogram (women ages 40 to 74)	\$25
	Have an annual eye exam ²	\$20
	Get an annual flu shot	\$10
 Condition management programs	ConditionCare: Work one-on-one with your health coach and earn rewards for participating in and completing the program ³	Up to \$225 (\$90/\$135)
	Building Healthy Families: Receive support through the Sydney SM Health app during your family-planning process. Get help trying to conceive a baby or raising a toddler. Find help through content, tools, and trackers. ⁴	\$125 (\$30/\$35/\$30/\$30)
	Well-being Coach — Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward ⁵	\$60
	Well-being Coach — Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward ⁶	\$60

Activity type	Activity	Amount
 Digital and wellness activities	Log in to your Anthem account	\$5
	Connect a fitness or lifestyle device	\$5
	Complete a health assessment and receive tailored health recommendations	\$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to \$20 (\$4 per action plan)
	Track your steps	Up to \$60 (\$2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins ⁷	Up to \$20 (\$4 per milestone)
	Update your contact information	\$15

Make exercise pay off with the Gym Reimbursement program

Regular exercise is a great way to protect your physical and mental health. It can also earn you cash back. We'll repay you up to \$400 of your fitness membership dues a year through the Gym Reimbursement program.⁸

How the program works:

- 1 Work out at least 35 times in each six-month period during your benefit plan year at a qualifying fitness center or through an online class.
- 2 Track your workouts and send in the completed required forms.
- 3 Be reimbursed up to \$200 every six months, for a total of up to \$400 per benefit plan year.

To learn more about the program, find an eligible gym, and download the reimbursement forms, log in to [anthem.com](https://www.anthem.com) or the Sydney Health app. Then go to *My Health Dashboard*, select **Programs** from the menu, and go to the *Gym Reimbursement* section.

Well-being Coach can help you meet your goals

The Well-being Coach digital coaching app offers you 24/7 personalized support. Well-being Coach can help you maintain a healthy weight; quit tobacco; and improve your nutrition, exercise habits, mindfulness, and sleep. If you need extra support with weight management or quitting tobacco, you can also talk to a certified health coach.

Access Well-being Coach in the Sydney Health app or at [anthem.com](https://www.anthem.com).

Earn rewards

Here's how and when you'll earn rewards for completing the activities in the chart.



Preventive care: Simply visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days.



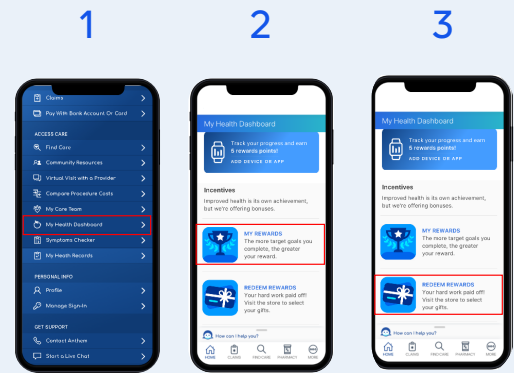
Condition management: Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include ConditionCare (for asthma, diabetes, and heart or lung conditions), Building Healthy Families, and Well-being Coach for weight management and tobacco cessation.



Digital and wellness activities: Log in to the Sydney Health app or [anthem.com](https://www.anthem.com) to complete available activities, such as taking a health assessment, participating in the Well-being Coach digital program, and tracking your steps. Rewards are added to your account as activities are completed.

Use your rewards

- 1 To view your rewards, open the Sydney Health app or go to [anthem.com](https://www.anthem.com). Next go to *My Health Dashboard*.
- 2 Select **My Rewards**.
- 3 Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including Amazon, Uber, Gap Options (all brands), Apple®, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.



Scan this QR code with your phone's camera to download the Sydney Health app.

Do you have questions?

Log in to [anthem.com](https://www.anthem.com) or open the Sydney Health app. Then go to *My Health Dashboard* and select **My Rewards** to learn more. You can also call us at the number on your health plan ID card.

1 Annual cholesterol test eligibility: men 35 years and older, women 40 years and older with a full cholesterol (lipid) panel.

2 Annual eye exam reward is available if employer provides vision coverage through Anthem.

3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), asthma, diabetes, and congestive heart failure (CHF). Rewards include \$90 for program participation and \$135 for program completion.

4 Building Healthy Families (BHF) completion dates: BHF pregnancy screener must be completed in first trimester; at least 1 of 6 mini assessments must be completed by one day prior to delivery; and postpartum assessment must be completed within 56 days after delivery. Rewards include \$30 for profile completion, \$35 for a BHF pregnancy screener, \$30 for completing at least 1 of 6 mini assessments, and \$30 for a postpartum assessment.

5 Well-being Coach Weight Management program (telephonic) is available for members who are identified as high risk based on a body mass index (BMI) of 30 or higher.

6 Well-being Coach Tobacco Cessation program (telephonic) is available for members who are identified as high risk based on any tobacco usage.

7 Members may earn rewards for completing quarterly Well-being Coach digital milestones while logging daily check-in activities on the app. Daily check-in reward values: first check-in is \$4; next 15 check-ins during first quarter of your plan year are \$4; 25 check-ins during second through fourth quarters of your plan year are \$4 for each quarter. Log in to Sydney Health or [anthem.com](https://www.anthem.com) to download the Well-being Coach digital app. Well-being Coach is provided by Lark Health.

8 Members ages 18 and over, including subscribers' adult children ages 18 and older, are eligible for gym reimbursement. Gym reimbursement is paid by check. Payout is per member per benefit year. This program is designed to help you make healthy, safe, and small changes to your lifestyle. Before taking part in this program, talk to your doctor or healthcare provider, especially if you are pregnant or have an injury or medical condition. This program may not be right for everyone.

We encourage you to participate in your rewards program. Rewards should be redeemed before the end of the current plan year. Unused rewards will be forfeited three months after the end of your plan year.

All preventive-care activities are claims based. Your completion is determined after a claim is processed. Medical waivers apply to claim-based activities.

Rewards eligibility applies only to subscribers and their enrolled spouse or domestic partner. Members must be active on the plan, and their activity must take place during the plan year.

A subscriber and spouse or domestic partner may earn rewards when eligible activities are completed. In some instances, they must be verified by an Anthem claim.

The reward amount you receive may be considered income and subject to state and federal taxes in the tax year it's paid. Please consult a tax expert with any questions.

Electronic gift card availability may vary. The list of retailers for electronic gift card rewards redemption is subject to change. Log on to [anthem.com](https://www.anthem.com) or open the Sydney Health app to explore the electronic gift card options available to you.

Anthem Blue Cross and Blue Shield is the trade name of Anthem HealthChoice HMO, Inc. and Anthem HealthChoice Assurance, Inc. Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Embedded vs. Aggregate (non-embedded)

Aggregate (Non-Embedded)

(Family does not meet deductible)



Embedded

(Anna Meets her deductible)



**Gomez Family:
\$6,000 deductible**

Medical bills this year:

- Jamie: \$500
- Lisa: \$250
- Anna: \$5,000

Health Reimbursement Account

Plan Year: December 1, 2025 – November 30, 2026

How your health reimbursement account works:

1 Your employer deposits money into your HRA.
Pro-rated for new hires

2 Show your ID card when you visit the doctor or pick up your prescriptions.

- Pharmacy or Doctor submits services to insurance.



Empire Blue Card PPO/EPO	Single Plan	Family Plan
Deductible	\$3,575	\$7,150
Employer Funding	\$3,575	\$7,150
Employee Responsibility	\$0	\$0
Empire Blue Access EPO	Single Plan	Family Plan
Deductible	\$3,575	\$7,150
Employer Funding	\$3,575	\$7,150
Employee Responsibility	\$0	\$0

3 If you have enough HRA funds, a percentage of the cost will be paid automatically from your account. You will pay out of pocket for the remaining percentage of the cost.



4 The HRA will directly pay your health care provider on your behalf until HRA funds have been exhausted.



Substantiation

Always keep your receipts. According to IRS guidelines, all transactions must be verified for coverage. If we cannot verify your transaction automatically, we may send you a substantiation letter requesting you provide a copy of your EOB, plus an itemized receipt showing what you paid.

Filing Claims

Embedded in the medical plan is what is known as Provider Pay HRA.

With provider pay HRA:

- Members receive one ID card for both the medical and HRA. For this set up there is no separate debit card.
- Members show their ID card when they visit the doctor or pickup their prescriptions.
- Providers are paid directly from the HRA until funds are spent.

Members can also track their HRA on empireblue.com or download the SydneyHealth Mobile App to:

- See your HRA balance and claims.
- View your benefits.
- Find a doctor in your plan’s network.
- Estimate costs before you go for care.



DCA funds are used for dependent care expenses for your dependents, regardless of whether you are covered by your employer's medical plan

Dependent Care Reimbursement Account (DCA)

Participants may elect to contribute up to \$5,000 (or \$2,500 if married and filing separately) on a pre-tax basis via payroll deductions throughout the plan year into a DCA.

DCA funds can be used on any child under the age of 13 or any dependent who is physically or mentally unable to care for themselves:

- The care of the dependent must enable you and your spouse to be employed:
- The amount to be reimbursed must not be greater than your or your spouse's income, whichever is less.
- The services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes (for example, an older child).
- If the services are provided by a daycare facility that cares for 2 or more children simultaneously, the facility must comply with state and local daycare regulations.
- Services must be for the physical care of the child, not for education, meals, etc. Expenses for overnight camps and kindergarten are not eligible for reimbursement.

Claims Run-Out Period:

Any claims that have been incurred during the previous DCA plan year (12/01/2025 – 11/30/2026) can be submitted for reimbursement for 3 months after the end of the Plan year. The member will need to submit their claim form and receipt or Explanation of Benefits (EOB) to MVP by 02/28/2027 for reimbursement under the prior plan.

Stretch your dollars further

With a flexible spending account

Your flexible spending account (FSA) makes it easier to control your healthcare or care costs and save on taxes. That's because the money you set aside for your FSA from your paycheck isn't taxed, so your dollars go further. You can use your FSA funds to pay for qualified expenses throughout the year.

How to use your FSA



1 Set your contribution

Once a year, you can decide how much you want to contribute to your FSA through automatic payroll deductions.¹ For healthcare and limited-purpose FSAs, the funds you contribute to your account over the year are available to spend on day one of the plan. For dependent care FSAs, you can use your funds as they accumulate throughout the year.



2 Look for your debit card in the mail

To activate your card, call the phone number on the card's sticker. Call Member Services at the number on your ID card to request an additional debit card for a spouse or dependent. If you have Apple Pay, Google Pay, or Samsung Pay on your smartphone, you can also add your FSA debit card to your mobile wallet. Simply follow your phone's instructions to add a new debit card. Then, use your phone to pay for qualified expenses where mobile payments are allowed.



3 Pay for qualified expenses

There are two ways to use your FSA to pay for qualified expenses for you or your tax dependent:

- Use your FSA debit card or mobile wallet.
- Pay out of pocket and request reimbursement.



4 Manage your account

Log in to [anthem.com](https://www.anthem.com) or use the SydneySM Health app to:

- Track your claims and FSA spending.
- Check your FSA balance
- Request reimbursement.
- Find a doctor in your plan's network.
- Substantiate claims, if needed (learn more on page 2).



5 Know your carry over, grace period, and run-out period policies

- **Carry over limit:** You can carry over up to \$570 in unused FSA funds at the end of the year to use toward next year's claims.
- **Grace period:** After your plan year ends, you have a two-and-a-half month grace period to spend last year's FSA dollars. If you don't use the funds by the end of your grace period, they'll go back to your employer.
- **Run-out period:** After your plan year ends, you have a 90-day run-out period. During this time, you can still file reimbursement claims from the last plan year.

Helpful FSA facts

Learn more about the three types of FSAs that your Anthem plan offers so you can choose what's best for you.

	Healthcare FSA	Limited-purpose FSA	Dependent care FSA
Maximum annual contribution	\$3,050	\$3,050	\$5,000 ²
What is covered (qualified expenses)	Healthcare costs such as: <ul style="list-style-type: none"> • Prescriptions • Doctor visits • Dental or vision care • Deductibles, copays, and coinsurance (your percentage of the costs) 	Dental and vision care: <ul style="list-style-type: none"> • Fillings • Braces • Eyeglasses • Contacts • Post-deductible covered healthcare expenses 	Care for your child, disabled spouse, elderly parent, or other dependent, including: <ul style="list-style-type: none"> • Before- and after-school care • Day care, adult care, or elder care • Summer day camp
When funds are available	Day one of the plan	Day one of the plan	As your payroll deposits are made

Visit [anthem.com/qme](https://www.anthem.com/qme) for a full list of qualified expenses.

What is substantiation?

When you use your FSA debit card or mobile wallet to pay for care, the merchant or provider gives us the information we need to process your claim. Sometimes, that information is incomplete. Substantiation is when we ask you for more details so we can confirm your FSA funds were used for qualified expenses. It's a simple process, and we'll walk you through it. Here's what you need to know:

- 1 Save your qualified expense receipts — if substantiation occurs, this makes the process faster and easier.
- 2 If we need to substantiate a claim, we'll send you up to three emails or letters to let you know, depending on your communication preferences.
- 3 If you don't substantiate your claim, your FSA debit card might be turned off and the dollar amount of unsubstantiated claims will be reported on your W-2 as taxable income, as required by the IRS.

To learn more about substantiation, log in at [anthem.com](https://www.anthem.com). Then, go to the My Plan tab and select **Spending Accounts**. Next, choose **Manage My Account** and select **Keeping Your FSA/LPFSA Card Active** from the menu.

Dental



The Guardian PPO dental plan allows you the freedom to see the dentist of your choice. You can utilize a large network of participating dentists who accept the Guardian Negotiated Fee Schedule as payment in full after deductible and coinsurance. Out-of-Network dentists may not accept Usual, Customary and Reasonable (UCR) reimbursement as payment in full and may balance bill without limit.

Plan Features	Guardian Dental Guard 2000	
	In-Network	Out-of-Network
Deductible / Maximum Accumulation Period	Calendar year (1/1 – 12/31)	
Dependent Age Limit	To Age 26	
Network	Dental Guard Preferred	N/A
Reimbursement Level	Negotiated Fee Schedule	
Waiting Period (for late entrants)	No	
Plan Deductible (Individual / Family)	\$50 / \$150	
Deductible Waived For	Preventive care	
Preventive Care (Cleanings, Oral Exams, etc.)	100% covered	100% covered
Basic Procedures (Extractions, fillings, etc.)	50% covered	50% covered
Major Procedures (Crowns, dentures, etc.)	50% covered	50% covered
Child Orthodontia (up to age 19)	50% covered	50% covered
Annual Year Maximum Benefit	\$1,500	
Orthodontia Lifetime	\$1,000	

- If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between what the provider charges and the Plan pays.
- Certain procedures may require a pre-treatment review.
- Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan.

The Guardian Life Insurance Company of America vision plan allows you the freedom of seeing the provider of your choice. If you choose an in-network provider, you will have lower out-of-pocket expenses. After you have exhausted your funded benefit, you are also eligible to access significant discounts on materials through participating network providers.

Plan Features	VSP Choice Full Feature	
	In-Network	Non-Network Reimbursement
General Plan Information		
Dependent Age Limit	To Age 26	
Network	VSP Full Feature – Choice B	N/A
Frequency of Service		
Exam	Once Every Calendar Year	
Frames	Once Every Other Calendar Year	
Lenses /Contact Lenses	Once Every Calendar Year	
Vision Exam		
Eye Exam	\$10 Copay	Up to \$39 Copay
Frames		
Frames Benefits	\$130 Allowance + 20% off balance	Up to \$46 Copay
Costco, Walmart, Sam’s Club Frames	\$70 retail max	Not Covered
Basic Lenses		
Single Vision	\$25 Copay	Up to \$23 Copay
Lined Bifocal		Up to \$37 Copay
Lined Trifocal		Up to \$49 Copay
Lenticular		Up to \$64 Copay
Contact Lenses (in lieu of frames & lenses)		
Elective Materials	\$130 Max (Copay Waived)	\$100 Max (Copay waived)
Medically Necessary	Covered after Copay	Up to \$210
Elective Fitting and Evaluation	Included in the Contact Lens Allowance. 15% discount off on fee	Included in contact lens allowance

- Frequency based on last date of service.
- The “frame allowance” or discounts associated with this vision plan may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail or independent provider locations. Members may submit an out-of-network claim for reimbursement on such frames up to the schedule amount indicated in the member’s benefit summary/certificate of coverage.

Basic Life / AD&D

General Plan Information	
Eligibility	All full-time employees work at least 30 hours a week
Employee Contribution	None – 100% Employer Funded
Term Life	
Benefit	\$50,000
Accelerated Life	50% of the death benefit, Minimum:\$10,000, Maximum \$250,000
Accidental Death & Dismemberment AD&D)	
Benefit	100% of Life Benefit to a maximum of \$50,000
Additional Features	
Waiver of Premium	If disabled, insurance will continue until age 65 or no longer disabled
Conversion	Included
Age Reduction Schedule	
At Age 65	35%
At Age 70	50%

Voluntary Term Life and AD&D

Benefit	Employee	Spouse	Dep Child(ren)
Benefit Increment	\$10,000	\$5,000	\$1,000
Maximum Benefit	\$300,000	\$250,000, not to exceed 100% of Employee's amount	\$10,000, not to exceed 10% of Employee's amount
Newly Eligible Guarantee Issue	Employee Less than 65: \$150,000 Employee 65-69: \$50,000 Employee 70+: \$10,000	Spouse Less than 65: \$30,000 Spouse 65-69: \$10,000 Spouse 70+: \$0	\$10,000
Additional Features			
Accelerated Death Benefit	50% of the death benefit, Minimum of \$10,000, Maximum of \$100,000		
Conversion	Included		
Portability	Included, without Evidence of Insurability		
Age Reduction Schedule			
At Age 65	35%	35%	N/A
At Age 70	50%	Coverage Terminates	

Group Short-Term Disability

Plan Features	
Weekly benefit	60% of salary to maximum \$1,000/week
Benefits Begin Accident/Sickness	15 th day / 15 th day
Duration of Benefits	11 weeks
Partial Disability	Greater of direct Reduction or proportionate loss

Group Long-Term Disability

Plan Features	
Monthly Benefit	60% of salary to maximum \$6000/month
Elimination Periods	91 st day / 91 st day
Duration of Benefits	Social Security normal retirement age
Definition of Disability	24 Month Own Occupation/Any Occupation thereafter
Pre-Existing Conditions	3 months prior, 12 months after Limitation, Continuity of Coverage
Partial Disability	Greater of direct Reduction or proportionate loss

* Guarantee Issue on voluntary life & AD&D amounts apply if you elect coverage within 30 days of your initial eligibility date. After 30 days of initial eligibility, you must provide Evidence of Insurability. Evidence of Insurability will be required for any future benefit increases.

* All unmarried dependent children in family unit are covered to from 14 days to age 26.

* Eligible children under 14 days of age receive a \$1,000 benefit

GuidanceResources® - Employee Assistance Program

Sometimes life can feel overwhelming. It doesn't have to.

Guardian's Employee Assistance Program provides confidential counseling, expert guidance, and valuable resources to help you handle any of life's challenges, big or small.

How it can help



Confidential emotional support

- Anxiety, depression, stress



Work and lifestyle support

- Child, elder and pet care



Financial resources and legal guidance

- Retirement planning, taxes
- Wills, trusts and estate planning

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

Legal/financial assistance and resources services are not available in the state of New York.

The Employee Assistance Program is a suite of services solely created and offered by ComPsych. Guardian is not responsible or liable for care or advice given by any provider or any service offering within the Employee Assistance Program. This information is for informational purposes only. It is not a contract. Only the plan service agreement can provide the actual terms, services, limitations and exclusions. Guardian and ComPsych reserve the right to discontinue the Employee Assistance Program at any time without notice. Legal services provided through the Employee Assistance Program will not be provided in connection with or any action against Guardian, ComPsych, or your employer. The Employee Assistance Program, or any individual service offering within the Program, is not an insurance benefit and may not be available in all states.



How to access 24/7 live assistance



Call
1 855 239 0743
TRS: Dial 711



Visit
guidanceresources.com

App: GuidanceNowSM
Organization web ID: Guardian
Note: First-time users will need to register first with the organization web ID: Guardian.

Voluntary Benefits



In case of an accident or illness, Aflac Insurance policies pay cash benefits directly to you, unless assigned, regardless of any other insurance you may have. Use the cash benefits for such expenses as: Deductibles, co-payments, out-of-network charges and any other expenses not picked up by your major medical coverage.

Travel related expenses for treatment in distant medical centers, including airfare, hotels and meals. Everyday living expenses like house (or rent) payments, groceries and utility bills. Lost income, resulting in a “double whammy” if the healthy spouse has to leave work to care for the recuperating one.

Current Policy Holders Please Note: Aflac upgrades its policies from time-to-time and employees are not automatically enrolled in the new plan. Short Term Disability monthly benefits does not automatically increase with a salary increase. An application is required for any coverage change and may require a change in premium. You are strongly encouraged to speak with the Aflac Rep to review your personal plans each year.

Accident Advantage

Provides cash benefits in the event of an accident. Helps with expenses associated with unexpected injuries and throughout recovery.

- Specific Sum Injury Benefits
- Home Modification Benefits
- Emergency Treatment Benefit
- Hospital Confinement Benefits
- Rehabilitation Unit Benefits
- Follow-Up Treatment Benefits
- Physical Therapy Benefits
- X-Ray / Diagnostic Imaging Benefits
- Transportation, Lodging and Ambulance
- Optional Accidental Death & Dismemberment

Cancer Care with Optional Heart Attack and Stroke Rider

Helps protect your income and savings by providing critical cash benefits to care for yourself or a loved one throughout all phases of cancer diagnosis and treatment.

- Initial Diagnosis Benefit
- Chemotherapy and Radiation Benefits
- Hospital Confinement / Surgical Benefits
- Experimental Treatment Benefits
- Transportation, Lodging and Ambulance
- Wellness Benefit Paid Yearly
- Optional coverage for heart attack, stroke, end-stage renal failure and cardiac arrest



To Cancel Existing Coverage an Aflac Cancellation Form must be signed prior to the annual renewal date. If there is no contact with the Rep, coverage will automatically roll over with no benefit or premium change. **Pre-Tax Deductions** can only be changed at open enrollment unless the change is made within 30 days after a qualifying event.



Scan the QR Code below to see the Aflac Insurance Plans

Aflac helps with expenses
health insurance doesn't cover,
so you can care about
everything else.



Or, visit your benefits page at:
www.aflacenrollment.com/HudsonValleyEngineering/NPA713137748



Aflac's family of insurers American Family Life Assurance Company of Columbus and/or American Family Life Assurance Company of New York, and/or Continental American Insurance Company (CAIC) and/or Continental American Life Insurance Company.


Aflac | WWHQ | 1932 Wynnton Road | Columbus, GA 31999

Aflac New York | 22 Corporate Woods Boulevard, Suite 2 | Albany, NY 12211

Continental American Insurance Company | Columbia, SC

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EXP 9/24



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ny529atwork.org



New York's 529 *Direct Plan*

Andrew M. Cuomo, Governor
Thomas P. DiNapoli, State Comptroller

 facebook.com/ny529direct

 twitter.com/ny529direct

 youtube.com/nv529direct

*Tax and other benefits are contingent on meeting other requirements and certain withdrawals are subject to federal, state, and local taxes.

Important legal information

Investment returns are not guaranteed, and you could lose money by investing in the plan.

A plan of regular investment cannot ensure a profit or protect against a loss.

Before you invest, consider whether your or the designated beneficiary's home state offers any state tax or other benefits that are only available for investments in that state's qualified tuition program.

For more information about New York's 529 College Savings Program *Direct Plan*, obtain a Disclosure Booklet and Tuition Savings Agreement by visiting ny529atwork.org or by calling 800-420-8580. This includes investment objectives, risks, charges, expenses, and other information. You should read and consider them carefully before investing.

The Comptroller of the State of New York and the New York State Higher Education Services Corporation are the Program Administrators and are responsible for implementing and administering the *Direct Plan*. Ascensus Broker Dealer Services, Inc., serves as Program Manager and, in connection with its affiliates, provides recordkeeping and administrative support services and is responsible for day-to-day operations of the *Direct Plan*. The Vanguard Group, Inc., serves as the Investment Manager. Vanguard Marketing Corporation markets, distributes, and underwrites the *Direct Plan*.

No guarantee: None of the State of New York, its agencies, the Federal Deposit Insurance Corporation (FDIC), The Vanguard Group, Inc., Ascensus Broker Dealer Services, Inc., nor any of their applicable affiliates insures accounts or guarantees the principal deposited therein or any investment returns on any account or investment portfolio.

New York's 529 College Savings Program currently includes two separate 529 plans. The *Direct Plan* is sold directly by the Program. You may also participate in the *Advisor Plan*, which is sold exclusively through financial advisors and has different investment options and higher fees and expenses as well as financial advisor compensation.



Enroll in LifeLock Identity Theft Protection



WHAT IS IDENTITY THEFT

Thieves pretend to be you to take over or open new accounts, file fake tax returns, rent or buy properties, or do other criminal things in your name.



HOW LIFELOCK WORKS

LifeLock protection alerts you to suspicious activity¹ and helps fix ID theft issues with dedicated US-based specialists. We'll spend up to \$1M to help make things right.²



WHY LIFELOCK

Free credit monitoring services alone aren't enough. DIY identity monitoring isn't realistic. Your bank only monitors transactions on existing accounts. These are just a few reasons to choose LifeLock Identity Theft Protection.

QUESTIONS TO CONSIDER

- **Do I really need to worry about identity theft?**
Yes. Identity theft is America's fastest growing crime.¹ Simply put, it's when someone uses your personal information for their gain and your loss.
- **Why is restoring my identity so difficult?**
Proving that 'you are you' can be time-consuming and expensive. Filing paperwork, disputes, and insurance claims can take weeks, months and even years. LifeLock's team of specialists will work with you to help clear your name, retain lawyers and other experts if needed, and pay court fees.
- **Doesn't my bank's credit card service have me covered?**
Your bank monitors transactions on your existing account. They may not see accounts opened using your identity at another bank – or an application for a student loan, welfare check, or cellular plan in another state either.
- **Can't I just wait for identity theft before getting LifeLock® protection?**
Your identity is exposed every day. If your personal information is stolen, it may show up on the dark web months before you're notified of a data breach. Plus, thieves may wait years before using your personal info.

¹ No one can prevent all identity theft.

² LifeLock does not monitor all transactions at all businesses.

³ Fastest alerts require member's current email address. Phone alerts made during normal local business hours. Whitehouse.gov, (2016). 'FACT SHEET: Cybersecurity National Action Plan', (accessed March 29, 2016)

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When a threat is detected, LifeLock notifies members by phone, text or email.⁵

See reverse for more information and rates.

MPAD137



The relevant, voluntary benefit

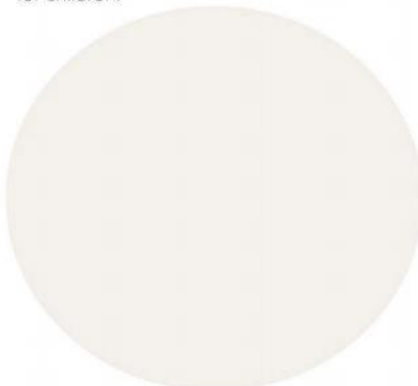
CHOOSE THE LIFELOCK SERVICE THAT'S RIGHT FOR YOU.

LIFELOCK BENEFIT ELITE (only available as a payroll deducted employee benefit) includes searching hundreds of millions of transactions per second for potential threats to your identity and to financial assets – your 401(k) and investment accounts.[†]

Also includes scanning for misuse of your Social Security number, change of address and court records scanning for use of your identity to commit crimes.

LIFELOCK ULTIMATE PLUS™ service provides some peace of mind knowing you have LifeLock's most comprehensive identity theft protection available. Enhanced services include bank account application and takeover alerts, online credit reports and credit scores.[†]

LIFELOCK JUNIOR® (if dependents under age 18 are enrolled) protection helps safeguard your child's Social Security number and good name with proactive identity theft protection designed specifically for children.^{††}



SERVICE PLAN OPTIONS* - \$2 DEDUCTIONS		LifeLock Benefit Elite	LifeLock Ultimate Plus™
	Employee Only [18 and over]	\$1.96	\$5.88
	Employee + Spouse/Domestic Partner	\$3.92	\$11.76
	Employee + Children**	\$5.43	\$8.33
	Employee + Family**	\$5.39	\$14.22

SERVICE FEATURES		LifeLock Benefit Elite	LifeLock Ultimate Plus™
	LifeLock Identity Alert® System†	✓	✓
	Lost Wallet Protection	✓	✓
	Address Change Verification	✓	✓
	Black Market Website Surveillance	✓	✓
	LifeLock Privacy Monitor™ Tool	✓*	✓
	Reduced Pre-Approved Credit Card Offers	✓	✓
	Live Member Service Support	✓	✓
	Identity Restoration Support	✓	✓
	Fictitious Identity Monitoring	✓	✓
	Court Records Scanning	✓	✓
	Data Breach Notifications	✓	✓
	Investment Account Activity Alerts†	✓	✓
	\$1 Million Service Guarantee†	✓	✓
	Credit Card, Checking & Savings with Account Activity Alerts†	✓*	✓
	Stolen Fund Reimbursement†	Up to \$1 Million*	Up to \$1 Million
	Online Annual Credit Report		✓
	Online Annual Credit Score		✓
	Checking and Savings Account Application Alerts		✓
	Bank Account Takeover Alerts†		✓
	Credit Inquiry Alerts†		✓
	Online Annual Tri-Bureau Credit Reports & Scores		✓
	Monthly Credit Score Tracking		✓
	File-Sharing Network Searches		✓
	Sex Offender Registry Reports		✓
	Priority Live Member Service Support		✓

* Feature effective January 1, 2017.

No one can prevent all identity theft. †LifeLock does not monitor all transactions at all businesses.

†† Children under the age of 18 will receive a product designed specifically for minors, LifeLock Junior service. Enrollment in LifeLock service is limited to employees and their eligible dependents.

† LifeLock Junior™ membership is available as an added membership to an adult LifeLock plan.

† Stolen Funds Reimbursement and Service Guarantee benefits for State of New York members are provided under a Master Insurance Policy issued by State National Insurance Company. Benefits for all other members are provided under a Master Insurance Policy underwritten by Unibac Specialty Insurance Company. Under the Service Guarantee LifeLock will spend up to \$1 million to hire experts to help your recovery. Under the Stolen Funds Reimbursement, LifeLock will reimburse stolen funds up to \$100,000 for Benefit Elite membership (up to \$1 million for Benefit Elite membership effective January 1, 2017), and up to \$1 million for Lifetime Plus membership. Please see the policy for terms, conditions and exclusions at LifeLock.com/legal.

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Personal Insurance Solutions

Since 1864, Marshall & Sterling Insurance has been the name synonymous with outstanding insurance coverage and customer service. Marshall & Sterling provides exceptional insurance coverage with unparalleled service and support for our valued clients.

As an employee-owned company, our experienced insurance professionals can assist with virtually any insurance need. Our pride in ownership drives us to be an insurance agency unlike any other.

As one of the largest independent insurance agencies in the nation, Marshall & Sterling Insurance provides affordable personal insurance coverage for any need.

- ◆ Homeowners
- ◆ Condos & Renters
- ◆ Auto
- ◆ Motorcycle
- ◆ Boat and RV
- ◆ Life Insurance
- ◆ Personal Umbrella
- ◆ Vacation Homes
- ◆ Antique Cars
- ◆ Collectibles
- ◆ Unique Risks
- ◆ Wealth Management

Regardless of size, whether you have a large country estate, or a starter home or apartment, Marshall & Sterling is your first choice to find the right insurance protection at the right price. Our breadth of experience and knowledge provides our clients with virtually all forms of insurance, tailored to meet your unique, diverse and particular needs.

New York offices in: Brewster, Croton-on-Hudson, Glens Falls, Hoosick Falls, Kingston, Leeds, Middletown, Millbrook, Monticello, Mount Kisco, New Windsor, New York (Manhattan), Poughkeepsie, Saratoga Springs, Scotia, Troy and Valley Stream. Also in Birmingham, MI, Burbank, CA, Middleburg, VA, Warrenton, VA and Wellington, FL. U.S. Virgin Island offices: Charlotte Amalie and East End Plaza, St. Thomas; Gallows Bay, St. Croix; and Cruz Bay, St. John.

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Kelly Sherman
845-677-3434, office
845-245-8996, cell
ksherman@marshallsterling.com



Resources

Before Enrolling, be sure to:

- **Consider your options.** Make sure you get the coverage that best suits your needs. Discuss with your spouse, partner or other family members to consider all sources of benefits coverage.
- Our insurance carriers offer a number of tools and resources available through their web sites that can help support your decision-making process. You can reach the carriers at:

Keep this guide handy - refer to the information in this guide to help you make wise benefit choices.

Anthem	www.anthembluecross.com	1-800-331-1476
Guardian	www.guardiananytime.com	(866) 569-9900
Guardian Vision (VSP)	www.vsp.com	1-800-877-7195
Guardian Dental	www.Guardianlife.com	(888) 600-1600
Guardian EAP	worklife.uprisehealth.com Access Code: worklife	1-800-386-7055
AFLAC	www.Aflac.com	(845) 351-0080

Marshall & Sterling – CSS: Alicia Mahoney-Ciferri

amahoney@marshallsterling.com



Contact our Team: (866) 573-4768



New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health 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 for coverage starting as early as January 1.

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.

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.

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% of such costs.

How Can I Get More Information?

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

Cathy Schatz
Human Resources Manager
702 Chestnut Ridge Rd
Chestnut Ridge, NY 10977
(845) 414-9300 ext. 205
cschatz@hveapc.com

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% of such costs.

General Group Health Plan Notices

Patient Protection Disclosure Notice

If your health plan generally allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

The Women's Health and Cancer Rights Act of 1998

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis and complications resulting from a mastectomy, including lymph edema? Contact your employer for more information.

The Women's Health and Cancer Rights Act (WHCRA), signed into law on October 21, 1998, contains protections for patients who select breast reconstruction in connection with a mastectomy. Plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy.

Women's Health and Cancer Rights Act (WHCRA):

- Applies to group health plans for plan years starting on or after October 21, 1998.
- Applies to group health plans, health insurance companies or HMOs, if the plan or coverage provides medical and surgical benefits with respect to mastectomy.
- Requires coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient.

Under WHCRA, mastectomy benefits must include coverage 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;
- Prosthesis and treatment of physical complications of the mastectomy, including lymph edema;

Under WHCRA mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage. Therefore, the following **in-network** copays, deductibles and coinsurance apply:

Benefit	Empire Blue Card PPO/EPO	Empire Blue Access EPO
Deductible	\$3,575 / \$7,150	\$3,575 / \$7,150
PCP Office Visit	\$50 Copay after Deductible	\$50 Copay after Deductible
Specialist Office Visit	\$50 Copay after Deductible	\$50 Copay after Deductible
Inpatient Hospital Admission	\$500 Copay after Deductible	\$500 Copay after Deductible
Emergency Room	\$150 Copay after Deductible	\$150 Copay after Deductible

The law also contains prohibitions against:

- Plans and issuers denying patients eligibility or continued eligibility to enroll or renew coverage under the plans to avoid the requirements of WHCRA.
- Plans and issuers providing incentives to, or penalizing, physicians to induce them to provide care in a manner inconsistent with the WHCRA.

If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

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

HIPAA Special Enrollment Rights

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

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

If you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within "30 days" after the marriage, birth, adoption, or placement for adoption.

A special enrollment opportunity may be available in the future if you or your dependent(s) lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependent(s) experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependent(s) become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependent(s) will have sixty (60) days to request special enrollment in the group health plan coverage. An individual must request this special enrollment within sixty (60) days of the loss of coverage described at bullet one, and within sixty (60) days of when eligibility is determined as described at bullet two.

To request special enrollment or obtain more information, contact your HR representative.

Cathy Schatz
Human Resources Manager
702 Chestnut Ridge Rd
Chestnut Ridge, NY 10977
(845) 414-9300 ext. 205
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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 includes states where employees currently reside which offer a premium assistance program as of July 31, 2023. Contact your State for more information on eligibility.

If you reside in a different state, please contact HR for more information on whether or not a premium assistance program is available there, as well as State contact information if applicable.

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

To see if any other states offer a premium assistance program, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor
Employee Benefits Security Administration**
www.dol.gov/agencies/ebsa
1-866-44-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

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer 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.

A plan's prescription drug coverage is considered creditable coverage if the amount the plan expects to pay on average for prescription drugs for individuals covered by the plan is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average.

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. Your Employer has determined that the prescription drug coverage they offer 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 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 your employer 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 Marshall & Sterling at (866) 573-4768.

Notes

MARSHALL +STERLING

*Contact our team for all
your insurance needs!*

www.marshallsterling.com

- Employee Benefits
- Personal Home, Renter's & Auto
- Disability Insurance
- Long-Term Care
- Business Insurance
- Life Insurance
- Wealth Management