WHETSTONE
DISTRIBUTION

Employee Benefits Guide

Plan Year: 09/01/2024 – 8/31/2025

Provided to you by:

HAUSER

What's Inside?

The information in this Enrollment Guide is presented for illustrative purposes and the text contained herein was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Scan to access the benefits site!

SCAN ME

Important Resources

Carriers

Contact Name	Contact Information
Medical & Prescription Drugs **United Healthcare (UHC)**	Phone: 1 (866) 414-1959 Website: www.myuhc.com
Health Savings Account (H.S.A) **Navia Benefit Solutions**	Phone: 1 (866) 987-0031 Website: https://www.naviabenefits.com/
Voluntary Vision **Guardian**	Phone: 1 (877) 814-8970 Website: www.Guardiananytime.com
Voluntary Dental **Guardian**	Phone: 1 (800) 541-7846 Website: www.Guardiananytime.com
Flexible Spending Account (F.S.A) **Navia Benefit Solutions**	Phone: 1 (800) 669-3539 Website: https://www.naviabenefits.com/
Life and AD&D **Guardian**	Phone: 1 (800) 525-4542 Website: www.Guardiananytime.com
Vol. Short Term and Long-Term Disability **Guardian**	Phone: 1 (800) 268-2525 Website: www.Guardiananytime.com
Employee Assistance Program (EAP) **Guardian | ComPsych**	Phone: 1 (855) 239-0743 Website: www.Guidanceresources.com Web ID: Guardian
Benefits Enrollment site **PeopleHub/Tandem**	Phone: (630) 468-9298 Website: https://tan.prismhr.com/tan/auth/#/login?lang=en

Human Resources Team

Contact Name	Title	Phone	Email
Keli Redinger	Chief HR Officer	(708) 815-7033	kredinger@whetstonedist.com
Elena Esparza	HR Manager	(872) 345-3030	eesparza@moeslemeats.com
Benefits Website	**www.whetstonebenefits.com**		

Hauser Team

Contact Name	Phone/E-Mail	Description
Lina Colon Client Executive	(281) 691-1889 lcolon@thehausergroup.com	The day-to-day point of contact for plan questions, eligibility, and assistance in resolving a claim.
Dineka Johnson Senior Consultant	(513) 885-0917 djohnson@thehausergroup.com	Ensures that your health plan runs smoothly and efficiently. Will handle any question or issue that you wish to elevate to a management level.

Eligibility & Enrollment

When to Enroll?

Open Enrollment runs from **July 29th to August 7th, 2024**. Benefits elected during Open Enrollment are effective **September 1st, 2024- August 31st, 2025**. Deadline to submit changes: **Wednesday, August 7th, 2024**.

If you are a newly hired employee or are enrolling due to a qualifying event you must enroll or waive coverage within 30 days of your date of hire or the date of the event.

Who is Eligible?

Employees
If you are a full-time employee, you are eligible to enroll in the benefits described in this guide. The effective date of coverage for new employees is the **first of the month following 60 days of continuous employment**.

Dependents
In addition to enrolling yourself, you may also enroll any eligible dependents under the Medical/Prescription, Voluntary Dental, Voluntary Vision, Voluntary Life and AD&D plans.

Eligible dependents are defined below:

- Spouse: a person to whom you are legally married by ceremony and common law spouses.
- Dependent Children: You or your spouse's biological, adopted, legal dependents (including grandchildren for whom you have legal custody) up to age 26 regardless of student, financial, residential, or marital status. Dependent coverage terminates at the end of the month in which they turn 26.

How to Enroll?

Review the 2024-2025 Employee Benefits Guide to understand the coverage available and changes to the **Whetstone Distribution** Benefit Program.

ACTION REQUIRED: If you wish to enroll in the benefits offered by **Whetstone Distribution**, you **MUST** enroll in PeopleHub.

Your 2023-2024 elections will not carry-over, if you do not act. If you do not log into PeopleHub and elect benefits, you will not have coverage as of September 1, 2024.

Making Changes

You will not be able to make changes to your benefits outside of Open Enrollment unless you, your spouse or dependent children experience an IRS defined qualified life event.

Qualified life events include:

- Marriage
- Divorce
- Legal Separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of spouse, child, or other qualified dependent
- Change in residence due to an employment transfer for you or your spouse
- Change in your spouse's benefits or employment status
- Commencement or termination of adoption proceedings
- Change in employment status or change in coverage under another employer-sponsored plan

If you experience a qualified life event or if you have questions, please contact Human Resources. You have 30 days after a qualifying event to notify HR and request a change to your benefit elections.

Medical & Prescription Drugs

Whetstone Distribution offers a comprehensive benefits program to help you and your family protect your health and financial security. Your benefits are a valuable part of your compensation; we encourage you to learn how your plans work so you can get the most from them. These plans encourage you to seek care from In-Network providers, which provide a higher level of benefit. You may choose to use Out-Of-Network providers, but if you do, your benefits will be reduced, and your out-of-pocket expense will increase.

Medical Key Reminders:

- ✓ To limit your out-of-pocket expenses, please seek services from a UHC provider. To find a provider, visit: https://www.uhc.com/find-a-doctor
- ✓ If services are provided by a non-UHC provider, the member is responsible for any amounts exceeding the "allowable charges", in which case balance billing may occur.
- ✓ Dependent Child Age Limits: Covered to age 26.

Prescription Drug Coverage

When you elect medical coverage, you are automatically covered under the prescription drug plan. We know prescription drug coverage is important to you and your family. You may fill your prescriptions at participating retail pharmacies. The mail order option allows you to buy qualified prescriptions in larger 90-day quantities for the same copay amount as a 60-day supply at the retail pharmacy. Mail order saves you time in trips to the pharmacy because prescriptions are delivered right to your door.

There are several categories of drugs under the plans. The differences between these categories are described below:

- Tier 1 – **Generic**: Frequently prescribed generic drugs.
- Tier 2 – **Preferred Brand**: Lowest cost brand name drugs.
- Tier 3 – **Non-Preferred Brand**: Highest cost brand name drugs.

HELPFUL TIP:

Choose Generics - The member pays the applicable copay (if applicable) only if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between. Be sure to discuss this with your physician when he or she writes your prescription.

Medical & Prescription Drugs

The following chart provides a summary of the main features of the **medical** benefit options offered by **United Healthcare (UHC)**. Complete benefit summaries are available on the **Whetstone Distribution** *benefits website.*

	Nexus PPO $500		Nexus PPO $5,000		Core H.S.A $3,500
Network	**Nexus ACO OAP**				**H.S.A Core**
PCP Required? / **Referrals Required for Specialist?**	**Members must designate a Primary Care Physician in the Tier 1 designated network to receive Tier 1 benefits coverage.**				**N/A**
Services	**In-Network Tier 1**	**In-Network Tier 2**	**In-Network Tier 1**	**In-Network Tier 2**	**In-Network**
Deductible	*Embedded	*Embedded	*Embedded	*Embedded	*Embedded
- Individual	$500	$500	$5,000	$5,000	$3,500
- Family	$1,000	$1,000	$10,000	$10,000	$7,000
Coinsurance	20%	40%	20%	40%	0%
Max. Out-of-Pocket (Includes deductible, coinsurance & copays) - Individual - Family	$4,000 $8,000	$4,000 $8,000	$7,900 $15,800	$7,900 $15,800	$4,000 $8,000
Physician Office Visit (Primary/Specialist)	$15 $50	$45 $125	$15 $50	$45 $125	0% After Deductible
Preventative Care (Adult/Well-Child)	Covered at 100%				Covered at 100%
Emergency Room	$300 per Occurrence + 20% after Ded.		$300 per Occurrence + 20% after Ded.		0% After Deductible
Urgent Care	$50 Copay	$50 Copay	$50 Copay	$50 Copay	0% After Deductible
Inpatient Service	20% After Deductible	$500 per occurrence + 40% after Ded.	20% After Deductible	$500 per occurrence + 40% after Ded.	0% After Deductible
Outpatient Services	20% After Deductible	$250 per occurrence + 40% after Ded.	20% After Deductible	$250 per occurrence + 40% after Ded.	0% After Deductible
Prescription Drugs - Retail *(30-day supply)* - Mail Order *(90-day supply)*	$10/$35/$60 $25/$87.50/$150		$10/$35/$60 $25/$87.50/$150		$10/$35/$60 $25/$87.50/$150 *Copays after Deductible*

**Embedded deductible and out-of-pocket (OOP), means that a "per member" deductible and OOP are embedded within the "per family" thresholds. Each covered family member is subject only to their "per member" deductible or OOP, and the family's exposure as a whole is limited by the family deductible and OOP limits.*

Medical Network Comparison

Whetstone Distribution offers multiple medical plans for your consideration, under various network options. It is important to know the difference between each network, and to confirm that your provider participates in the network.

Check out what's included in the plan	NexusACO OAP $500	NexusACO OAP $5,000	Core H.S.A $3,500
Network coverage only You can usually save money when you receive care for covered health services from network providers.	☐	☐	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑	☑	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☑	☑	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐	☐	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑	☑	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑	☑	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑	☑	☐
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐	☐	☐
Health savings account (H.S.A) With an H.S.A, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐	☐	☑
Find a doctor/Confirm your doctor is in-network Visit www.uhc.com and select the following network:	NexusACO OAP	NexusACO OAP	Core

Health Savings Account (H.S.A.)

When you enroll in the **Core H.S.A $3,500** plan, you can open an H.S.A to help pay for current and future eligible health care expenses. You may contribute to your H.S.A through pre-tax payroll deductions. You can withdraw that money, tax-free, to pay eligible out-of-pocket medical expenses, as well as dental and vision expenses, or you can save that money for future health care expenses, including those incurred in retirement.

What are the benefits of an H.S.A?

A WIN WIN FOR YOUR TAXES

- Your money goes in and grows tax free
- Qualified withdraws are tax free

QUALIFIED EXPENSES INCLUDE:

- Copayments
- Eyeglasses & contacts
- Hearing aids
- Dental Costs
- Prescriptions

The max amount an individual can contribute to an H.S.A in 2024 is $**4,150**

The max contribution per family is **$8,300**

THIS IS NOT "USE IT OR LOSE IT" SAVINGS

Your funds will roll over from year to year.

IT MOVES WITH YOU

You own all the money in your H.S.A It stays with you when you change jobs, change insurance plans, or retire.

NOTE: *If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000.*

Whetstone Distribution partners with **Navia Benefit Solutions** to provide H.S.A services. You will be able to manage your account online to submit eligible claims, review your account balance, review your claim history, and more.

Voluntary Vision and Dental Benefits

The following chart shows the features of the **Vision** benefit option offered by **Guardian**. A complete benefit summary is available on our *benefits website.*

	Network: VSP Choice	
Services	**In-Network Member Cost**	**Out-of-Network Reimbursement**
Annual Eye Exam *(Every 12 months)*	$10 Copay	Up to $39
Standard Frame *(Every 12 months)*	$150 allowance; 20% off additional balance	Up to $46
Standard Plastic Lenses *(Every 12 months in lieu of contact lenses)*		
Single Vision Bifocal Line Trifocal Lenticular	$25 copay $25 copay $25 copay $25 copay	Up to $23 Up to $37 Up to $49 Up to $64
Contact Lenses *(Every 12 months in lieu of frames and lens)*		
Evaluation and Fitting Elective Contacts *(Every 12 months)* Medically Necessary *(Every 12 months)*	Included in the Contact Lens Allowance (15% discount on fee) $150 allowance $25 Copay	Included in the Contact Lens Allowance Up to $100 Up to $210

The following chart shows the features of the **Dental** benefit option offered by **Guardian**. A complete benefit summary is available on our *benefits website.*

Network:	DentalGuard Preferred	
Services	**In-Network**	**Out-of-Network**
Deductible *(Applies to Basic & Major)*	$50 Individual $150 Family	$50 Individual $150 Family
Preventative Services *(Deductible waived)*	100%	100%
Basic Services *(Fillings)*	80%	80%
Major Services *(Bridges, dentures, crowns)*	50%	50%
Annual Maximum	$1,500 plus Maximum Rollover	
Orthodontia (children up to age 19)	50%	50%
Orthodontia Lifetime Max	$1,000	$1,000
Reimbursement	Negotiated Fee Schedule	90th percentile*

Make sure you take advantage of your preventative dental visits. Preventative care visits are not subject to any deductible!

*With a 90th percentile reimbursement plan, benefits for a given dental procedure are calculated according to the usual and customary charge for a particular area. The "90th" indicates that 9 out of 10 dentists in a specific area will charge at or below the plan allowance for a procedure.

Cost of Coverage

Whetstone Distribution pays a portion of your health care premiums; however, we do require employees to contribute toward their health care costs as well. Employees pay a dollar amount based on the level of coverage they select. The following Employee Payroll Deductions will be effective for this plan year and will be reflected on your first paycheck after your effective date.

MEDICAL Plan Payroll Deductions (Per Week)				
	Employee	Employee + Spouse	Employee + Child(ren)	Family
Nexus PPO $500	$47.78	$184.79	$117.07	$257.18
Nexus PPO $5,000	$24.70	$136.33	$77.38	$187.49
Core H.S.A $3,500	$37.15	$162.48	$98.79	$225.09

VISION Plan Payroll Deductions (Per Week)			
Employee	Employee + Spouse	Employee + Child(ren)	Family
$1.08	$2.69	$2.90	$4.66

DENTAL Plan Payroll Deductions (Per Week)			
Employee	Employee + Spouse	Employee + Child(ren)	Family
$7.14	$14.49	$18.92	$28.09

Flexible Spending Accounts (F.S.A.)

Flexible Spending Accounts allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses for you and your family. The amount you designate will be taken from your paycheck in equal amounts throughout the plan year. Keep your receipts and Explanation of Benefits (EOBs) in the event that **Navia Benefit Solutions** or the IRS requests additional information on your transaction.

Enrollment

In order to participate in the F.S.A, you must re-enroll every plan year. Your annual contribution stays in effect for the entire plan year. The only time you can change your election is during Open Enrollment or if you experience a Qualified Life Event.

Use It or Lose It

Unused healthcare F.S.A amounts in excess of $640 will be forfeited if not used by the end of the plan year. **Up to $640** of 2024/2025 unused F.S.A dollars can be used to reimburse eligible F.S.A. expenses next plan year.

End of Employment

Employees who end their employment with Whetstone Distribution will have until their last day of employment to submit claims. The F.S.A account is terminated on the last day of employment.

Claims must be incurred between September 1, 2024, and August 31, 2025.
These claims may be submitted for reimbursement between September 1, 2024, and November 30, 2025

Health Care F.S.A

- Contribution Limit - **$2,000** (2024/2025)
- General Purpose Health Care F.S.A is for those **NOT** enrolled in the **Core H.S.A $3,500 Plan** but having a regular PPO plan. You are eligible to contribute to an F.S.A and use the funds for medical, dental and vision expenses not covered by the plan.
- The Health Care F.S.A contribution will be deducted from your paycheck over the course of the year. Since you pay no taxes on the money placed in the F.S.A, you effectively adjust your annual taxable salary.
- **Contributions are available first day of new plan year.**

Dependent Care F.S.A

- Contribution Limit (2024/2025):
  - **$5,000** if you are a single team member or married filing jointly
  - **$2,500** if you are married and filing separately
  - Money only available as contributed via your payroll deductions

Life/AD&D and Disability Benefits

Group Life and Accidental Death & Dismemberment (AD&D)

Whetstone Distribution provides full-time employees with group Life and AD&D insurance and pays for **100% of the coverage.** Coverage is available through **Guardian** and the amount provided by **Whetstone Distribution** is **$25,000**.

Voluntary Life and Accidental Death & Dismemberment (AD&D)

If you need additional Life Insurance to meet your financial needs, you can purchase Voluntary Life Insurance through after-tax payroll deductions for yourself and your dependents offered by **Guardian**.

Employee	Spouse	Child(ren)
Increments of $10,000 to a maximum of $500,000. (**New Entrants**: Guarantee Issue Amount $200,000)	Increments of $5,000 to a maximum of $100,000. Not to exceed 50% of the employee election. (**New Entrants**: Guarantee Issue Amount $25,000)	Increments of $1,000 to a maximum of $10,000. Not to exceed 50% of the employee election. (**New Entrants**: Guarantee Issue Amount $10,000)

Voluntary Short-Term Disability and Long-Term Disability

If you become disabled and cannot work, no benefit becomes more important to your financial security than Disability Income protection. The short-term and long-term disability coverage is offered by **Guardian.**

Employees have the option to purchase voluntary STD and LTD, via payroll deductions. These benefits are here to help with your income, so you can focus on getting better.

	Short-Term Disability (STD)	Long-Term Disability (LTD)
Benefits Begin	15th day for accident 15th day for illness	90 days
Income Replacement	60%	60%
Maximum Benefit	$1,500 weekly	$6,000 Monthly
Maximum Benefit Period	11 weeks	Social Security Normal Retirement Age (SSNRA)
Pre-Existing Condition	3/12*	3/12*

* Pre-existing Condition: This means if an insured was treated for a medical condition 3 months prior to their effective date, it will not be covered within the first 12 months of coverage.

Added Value Programs

Employee Assistance Program (EAP)

Employees have access to an Employee Assistance Program (EAP) at **no additional cost**. Please mention the employer's name when calling in. The Employee Assistance Program provides a network of experienced professionals who can offer counseling for you and your dependents facing difficult legal, emotional, or financial issues. Counselors and qualified professionals are available 24 hours a day, 365 days a year, and all calls are completely confidential – nothing is reported back to your employer. Services include online resources, 3 in-person, telephonic or video conferencing sessions.

Topics Include:

- ✓ Family
- ✓ Parenting
- ✓ Addictions
- ✓ Emotional
- ✓ Legal
- ✓ Financial
- ✓ Relationships
- ✓ Stress

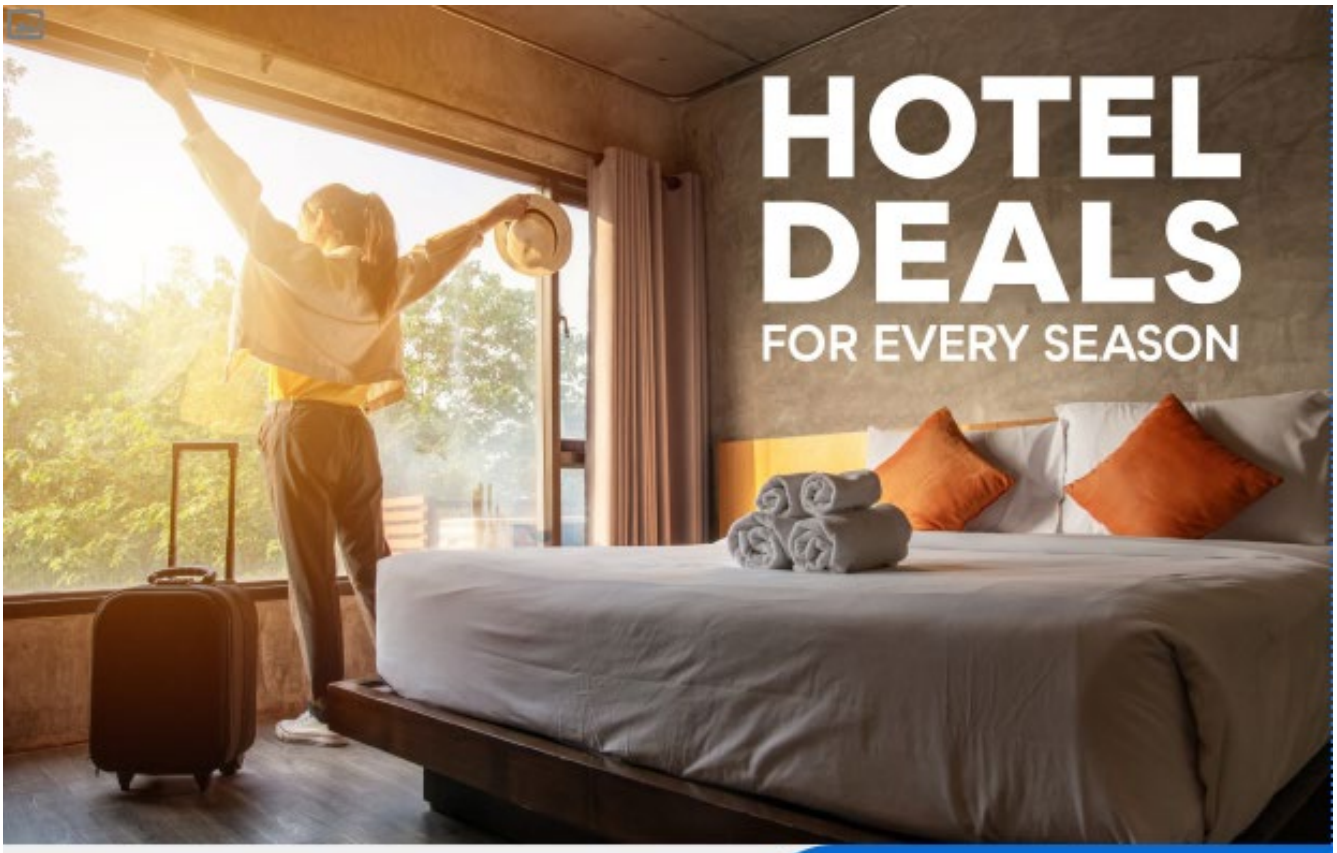
Legal/Financial Assistance & Resources

No matter how well you plan your life, you can be sure a few unforeseen challenges will arise. You have access to the ComPsych GuidanceResource program to help manage these challenges. ComPsych provides access to a wide array of services to help you and your loved ones through life's ups and downs.

ComPsych services include:

- **Legal Consultation** — Unlimited telephonic support and free initial 30-minute face-to-face consultation with an attorney, includes a 25% discount on attorney services thereafter; online legal forms; extensive online law library
- **Financial Consultation** — Unlimited telephonic support for financial problems or planning needs; 30 days of financial coaching; extensive online financial library and calculators
- **ID Theft** — Free consultation with a trained Fraud Resolution Specialist that will assist with ID theft resolution and education, ID theft educational materials available online
- **Will Preparation** — Quickly and easily complete a will on your computer with *EstateGuidance*. Specify guardians, trustees and property division and provide funeral and burial instructions.
- **Legal Document Preparation** — Online self-service documents available on the EAP website
- **Tax Consultation** — Tax questions only can be answered as part of the Financial Consultation offering
- **Online Self-Service Documents** — Examples include, but are not limited to: Living Trust, Will, Power of Attorney, Deeds

For more support or information please visit, guidanceresources.com (WebID: **Guardian**) or talk with a specialist at 1-855-239-0743.



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Important Notices

Notice of Patient Protections & Prior Authorization Procedures

Your **United Healthcare (UHC)** plans allow you to visit any doctor or hospital you choose. However, Prior Authorization is required for certain services. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, certain Specialty Drugs, and Durable Medical Equipment costing $500 or more. Contact **UHC** Customer Service using the number on the back of your medical ID card or online at www.uhc.com to find out which services require Prior Authorization. You can also call the customer service department to find out if your admission or other service has received Prior Authorization. For more information, please refer to your Evidence of Coverage document located online at www.uhc.com.

Women's Health and Cancer Rights Act of 1998

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:

- **Core H.S.A: $3,500 Individual Deductible / $7,000 Family Deductible / 100% Coinsurance**
- **Nexus PPO: $500 Deductible / $1,000 Family Deductible / 20% Coinsurance**
- **Nexus PPO: $5,000 Deductible / $10,000 Family Deductible / 20% Coinsurance**

If you would like more information on WHCRA benefits, call your plan administrator **1-866-801-4409**.

Newborns and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

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 31 days after you 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 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

Important Notices

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Important Notices

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

Important Notices

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website:https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

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)

Notice of Privacy Practices

UHC is required to maintain the privacy of all medical information as required by applicable laws and regulations; provide a notice of privacy practices to all Members; inform Members of the Plan's legal obligations; and advise Members of additional rights concerning their medical information. For more information, please refer to your Evidence of Coverage document located online at www.uhc.com.
All Members will be notified of any changes by receiving a new notice of the Plan's privacy practices. You may request a copy of this notice of privacy practices at any time by contacting **UHC**.

Uniformed Services Employment and Reemployment Rights Act of 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave.

Important Notices

Important Notice from Whetstone Distribution About Your Prescription Drug Coverage and Medicare for plans:

- **Core H.S.A: $3,500 Deductible**
- **Nexus PPO: $500 Deductible**
- **Nexus PPO: $5,000 Deductible**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage **Whetstone Distribution** 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. **Whetstone Distribution** has determined that the prescription drug coverage offered by the **UHC Plans** are, 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.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under your **UHC Plans** are creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 UHC Plan coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.
If you do decide to join a Medicare drug plan and drop your current Whetstone Distribution coverage, be aware that you and your dependents will not be able to get this coverage back until next Annual Open Enrollment or a mid- year qualifying event.

Important Notices

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:	09/01/2024
Name of Entity/Sender:	Quins Buffalo dba Whetstone Distribution
Office Contact/Position:	Keli Redinger/ Chief HR Officer
Phone:	(708) 815-7033
Address:	5115 S Millard Ave Chicago, IL 60632

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

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

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

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **YOUR HUMAN RESOURCES DEPARTMENT**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
Quins Buffalo dba Whetstone Distribution		87-3190602
5. Employer address 5115 S Millard Ave		6. Employer phone number (708) 815-7033
7. City Chicago	8. State IL	9. ZIP code 60632
10. Who can we contact about employee health coverage at this job? Keli Redinger		
11. Phone number (if different from above)	12. Email address kredinger@whetstonedist.com	

Important Notices

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

• As your employer, we offer a health plan to:

[X] All employees. Eligible employees are:

Full-time Employees

[ ] Some employees. Eligible employees are:

• With respect to dependents:

[X] We do offer coverage. Eligible dependents are:

1. Legal Spouses (same sex marriages/unions)
2.Dependents up to age 26

[ ] We do not offer coverage.

[X] 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

[X] **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue) _____

[ ] **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*? [X] Yes (Go to question 15) [ ] No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ 107.04

b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [X] Monthly Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

[ ] Employer won't offer health coverage

[ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $

b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

• 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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)