MARSHALL + STERLING
EMPLOYEE BENEFITS

2024 Benefit Enrollment Guide

Curtis Lumber Company

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Please Note: This enrollment guide is a summary of the benefits provided to benefit eligible employees. Curtis Lumber Company 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.

885 Route 67
Ballston Spa, NY 12020
518-490-1388

Dear Employee:

Welcome to our 2024 Benefits. 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. Curtis Lumber 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. 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,

Lisa Yorks

Benefits and Leave Manager

Eligibility & Enrollments

Eligibility

Employees who are regularly scheduled to work at least 30 hours a week are eligible to participate in the Curtis Lumber Company'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
- 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 voluntary life insurance**

Termination of Benefits Coverage

Your benefits coverage ends as follows:
Medical, dental, vision benefits terminate on the date of employment termination.

Basic Life, AD&D, Disability, Supplemental Life Insurance and Supplemental AD&D will terminate on the date of termination (this also includes any other company-paid or sponsored benefit not listed).

Medicare Eligible

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	Anthem	Medicare
Due to disability	Anthem	Medicare

New Hires

New hires and newly eligible employees may enroll in the Health and Welfare plans when they first join Curtis Lumber Company. 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, Prescription, Dental, Vision,, HSA, Vol Life, Supplementary Benefits	Associate must actively elect these benefits	Associates are eligible 30 days from date of hire
Basic Life & Accidental Death and Dismemberment	Associate does not elect these benefits	Associates are eligible 30 days from date of hire
Short Term Disability and Long Term Disability	Associate must actively elect these benefits	Associates are eligible 30 days from date of hire

Anthem

Medical

The **EPO** (Exclusive Provider Organization) medical plans, through the Anthem network, delivers in-network only benefits. Members choosing out-of-network providers/facilities will have reduced benefits, higher out-of-pocket costs and can be balanced billed without limit. **It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.** You pay less if you use providers that belong to the plan's network.

Plan Features	Hybrid EPO Copay Plan
	In-Network
Deductible / Maximum Period	Calendar Year (1/1-12/31)
Plan Year Deductibles (Indiv / Family)	$500 / $1,000
Deductible Type	Embedded
Plan Year Out-of-Pocket Max (Indiv / Family)	$6,600 / $13,200
Out-of-Pocket Type	Embedded
Medicare Part D Coverage	Creditable
Referral Needed	No
Network	PPO
Preventive Care	Covered in Full
Primary Care Visit	$20 Copay after deductible
Telemedicine Visit	$20 Copay after deductible
Specialist Visit	$50 Copay after deductible
Diagnostic Lab	Covered in Full after deductible
X-Rays	Covered in Full after deductible
Complex Images	Covered in Full after deductible
Prenatal Office Visit	$20 copay for initial visit, then no charge after the deductible
Delivery (Maternity)	$20 copay for initial visit, then no charge after the deductible
Inpatient Services (Maternity)	$350 Copay after deductible
Hospital Outpatient Services	$250 Copay after deductible
Hospital Inpatient Services	$350 Copay after deductible
Mental Health Outpatient Services	Covered in Full after deductible
Emergency Room	$150 copay after deductible
Land/Air Ambulance	Covered in Full after deductible
Urgent Care	$35 Copay after deductible
Retail Pharmacy / RX (30 Day Supply)	$10 / $45 / $60 copay after deductible
Mail Order Pharmacy / RX (90 Day Supply)	$20 / $90 / $120 copay after deductible

Medical

The **EPO** (Exclusive Provider Organization) medical plans, through the Anthem network, delivers in-network only benefits. Members choosing out-of-network providers/facilities will have reduced benefits, higher out-of-pocket costs and can be balanced billed without limit. **It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.** You pay less if you use providers that belong to the plan's network.

Plan Features	Anthem HDEPO (HSA Qualified)
	In-Network
Deductible / Maximum Period	Calendar Year (1/1-12/31)
Plan Year Deductibles (Indiv / Family)	$1,750 / $3,500
Deductible Type	Aggregate
Plan Year Out-of-Pocket Max (Indiv / Family)	$6,600 / $13,000
Out-of-Pocket Type	N/A
Medicare Part D Coverage	Creditable
Referral Needed	No
Network	PPO
Preventive Care	Covered in Full
HSA Funding	See HSA page
Primary Care Visit	$10 Copay after deductible
Telemedicine Visit	$10 Copay after deductible
Specialist Visit	$40 Copay after deductible
Diagnostic Lab	Covered in Full after deductible
X-Rays	Covered in Full after deductible
Complex Images	Covered in Full after deductible
Prenatal Office Visit	Covered in Full after deductible
Delivery (Maternity)	Covered in Full after deductible
Inpatient Services (Maternity)	$250 Copay after deductible
Hospital Outpatient Services	$150 Copay after deductible
Hospital Inpatient Services	$250 Copay after deductible
Mental Health Outpatient Services	Covered in Full after deductible
Emergency Room	Covered in Full after deductible
Land/Air Ambulance	Covered in Full after deductible
Urgent Care	$35 Copay after deductible
Retail Pharmacy / RX (30 Day Supply)	$10 / $45 / $60 copay after deductible
Mail Order Pharmacy / RX (90 Day Supply)	$20 / $90 / $120 copay after deductible

- 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.

Prescription Drug Coverage

Prescription Drug Coverage

Our medical plans include prescription drug coverage from **CVS Caremark,** managed by Meritain Health.

This includes generic, preferred brand name, non-preferred brand name, and specialty drugs.

Manage your Prescriptions online at www.caremark.com. Find network pharmacies, check drug costs, refill prescriptions, and set up **Mail Order for eligible maintenance medications**.

Certain specialty medications may be filled through the **CVS Caremark Specialty Pharmacy**. Visit

http://CVSspecialty.com/go to get started.

CanaRX is an International Prescription Service Provider (IPSP) based in Canada that aims to provide access to affordable maintenance medications. They work with government-licensed pharmacies in Canada, the UK, and Australia to supply brand-name medications with copays as low was $0. This service is voluntary and works in conjunction with AngioDynamics benefits.

Learn more at https://www.canarx.com

Health Savings Account

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is used in conjunction with an HSA-qualified health plan like the Anthem HDEPO (HSA Qualified) offered by Curtis Lumber Company. This unique account allows you to save for medical, dental and/or vision expenses tax-free, or to save for those funds for use in the future.

HSAs offer a **triple tax advantage**. They allow you to:

- Save money – tax-free!
- Accumulate interest and earnings – tax-free!
- Spend on qualified healthcare expenses – tax-free!

You own the money in your HSA! The account is yours, just like a checking or savings account. Any money left over at the end of the year is yours to keep and rolls forward to be used in the future. You keep the account even if you change medical plans, employers, stop working or retire.

Contributing to your HSA

There are certain criteria you must meet to be eligible to contribute to an HSA:

- You must be enrolled in an HSA-qualified medical plan like the Anthem HDEPO (HSA Qualified) offered by Curtis Lumber Company, and you cannot be covered by any other medical plan that is not HSA-qualified.
- You cannot be covered under Medicare; TRICARE or receiving VA benefits.
- You cannot be eligible to be claimed as a dependent on another individual's tax return.
- You must be 18 years or older.
- You must be a U.S. resident.

You can put money (or "make contributions") into your HSA, a few ways:

- **Pre-tax payroll contributions.** You can elect to have an amount regularly deducted from your paycheck.
- **Post-tax contributions.** You can initiate an online transfer, which moves money directly into your HSA from your personal savings or checking account.
- **Transfers from an existing IRA.** You can irrevocably elect to make a once-in-a-lifetime, tax-free, direct trustee-to-trustee transfer of a "qualified HSA funding distribution" from your IRA (traditional or ROTH) into your HSA.

Does Employer contribute to your HSA?

Yes, participants enrolled in the employer-sponsored Anthem HDEPO (HSA Qualified) health plan will receive an employer contribution of up to Funding will be ½ on January 1 (single $437.50/Family $875.00) then monthly contributions of the 1st of each month following. New Hires only receive monthly contributions. Your employer's contributions are added to your contributions and will count toward the annual limits set by the IRS.

The IRS limits the total amount that can be contributed to an HSA each year, based on your age and coverage level (note these limits include the contribution made by Curtis Lumber Company on your behalf)**:**

	2023		2024	
	Single	Family	Single	Family
Contribution Limit	$3,850	$7,750	$4,150	$8,300
"Catch-Up Contributions" for age 55+	$1,000		$1,000	

Health Savings Account *(continued)*

"Catch-Up contributions" provide an opportunity for those age 55+ to put an additional $1,000 into an HSA. If you have high deductible health plan (HDHP) coverage for the full year, you can make the full 55+ contribution regardless of when your 55th birthday falls during the year. If you did not have HDHP coverage for the full year, you must pro-rate your contribution for the number of full months you were "eligible", i.e., had HDHP coverage. However, if you are covered on December 1st, you are treated as if you had HDHP coverage for the entire year and can make the full contribution amount. You may also contribute an additional $1,000 if your spouse is over age 55, but the contributions go into a separate HSA under his or her name and social security number with a separate debit card per IRS guidelines.

Do you already have an HSA? Roll your old plan into your new HSA to keep everything organized in one place. Any money you roll from one HSA to another doesn't' count towards the annual contribution limits. Combining your accounts could save you money since there are no fees to use your new account! Just download the HSA Transfer Form from your WEX Health Portal and send it to your current custodian to get the process started!

How your account works

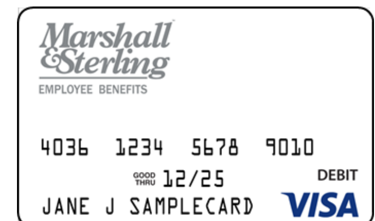
There are two parts to your HSA account: a **Cash Account** and an **Investment Account**. Initially, your money will be held in an interest-bearing cash account that is FDIC insured. Once your balance has reached $1,000 (or another limit you specify), you can choose to use the Investment Account feature to invest the funds in the many mutual funds offered. Any interest or earnings on the account will be added to your account balance and continue to grow tax-free. You control all the investment decisions made for your account.

You **can view and manage your account balances easily on your portal or through the mobile app.**

Using your HSA

You can use your money (or "make distributions") to pay for qualified expenses two main ways:

- **By making purchases using your Flex Debit Card** Your Flex Debit Card is the easiest way to access the money in your HSA. The card links to the available funds in your HSA. When you use the card, payments are automatically withdrawn from your account. It's that easy
- **By requesting reimbursement for payments you've made** You can also pay for expenses out-of-pocket and be reimbursed for the expense after the fact by requesting a distribution from your HSA.



If you receive a bill in the mail, you can still pay with your Flex Debit Card by inputting the debit card information in the credit card payment section or you can pay with your own money and be reimbursed for the expense from your account at a later date by requesting a distribution from your HSA.
Keep in mind, you can only use your Flex Debit Card if you have enough money in the account to cover the payment amount. If you do not have enough funds in your HSA to cover an eligible expense, there are a few options. As long as the account was open when the expense was incurred, you could:

- Pay for the expense out of pocket and then reimburse yourself from your HSA when your account balance has grown
- Pay for the expense out of your pocket and then change your elected HSA contribution amount to increase your balance faster. When you have enough money in your account you can submit for reimbursement of the expense.
- Make an additional contribution to the account online via WEX Health - or by completing an HSA Contribution Form and submitting it, along with a check, to Marshall + Sterling Employee Benefits - Flex.

Health Savings Account *(continued)*

HSA FAQ's

Is an HSA the same as an FSA?

No! Although HSAs (Health Savings Accounts) and FSAs (Flexible Spending Accounts) both use pretax dollars to pay for eligible medical expenses, but there are important differences.

- Any HSA money you don't use in one calendar year carries over to the next, while there are limits to the amount of FSA money you can carry with you into a new year.
- You can only use the HSA funds after they have been deposited into your account, while elected FSA funds are available for use *prior* to contributions being made.
- HSA funds can be used to pay for healthcare costs in retirement, including some medical care premiums. *See the HSA Guide for more information.*

What happens if I leave my current employer?

Your HSA is **portable**, which means it is yours to keep should you change employment. You may choose to roll the funds over to another HSA if offered through your new employer, or you can leave them with Marshall + Sterling Employee Benefits - Flex for a cost of $30 annually.

What happens when I die?

You will assign a beneficiary to your HSA who becomes the account owner if you die. Your HSA can transfer to your spouse tax free upon your death. If you name a non-spouse beneficiary, such as your estate or other entity, the value of the HSA is taxable to them upon your death.

Can I be enrolled in Medicare and have an HSA?

You are not eligible to *contribute* to a health savings account if you are enrolled in Medicare health insurance or are age 65 and collecting, or beginning to collect, Social Security benefits (which automatically triggers your enrollment in Medicare Part A). However, if you have an HSA balance from your previous coverage, you can continue to use those funds to pay for qualified expenses tax-free.

My spouse has a Medical FSA or Health Reimbursement Arrangement (HRA) through his/her employer. Can I still have an HSA?

If your spouse participates in a Health FSA or HRA and those benefits cover your healthcare expenses, then you are not eligible to contribute to an HSA. However, if your spouse has a "limited-purpose" FSA or HRA that covers vision and dental care expenses only then you may participate in an HSA. You can still enroll in your employer's HSA-qualified health plan, but you cannot open or contribute to an HSA.

Need more information?

Find more information about HSAs, as well as tools, calculators, and other resources on the **WEX Health portal** (https://msflex.LH1ondemand.com).

HSA Eligible Health Care Expenses

Please note that Marshall + Sterling does not intend this list to be comprehensive tax advice. For more detailed information, please consult IRS Publication 502 or see your tax advisor.

HSA Eligible Health Care Expenses

- Acne medications and treatments
- Acupuncture
- Alcoholism treatment
- Allergy and sinus, cold, flu and cough remedies (antihistamines, decongestants, cough syrups, cough drops, nasal sprays, medicated rubs, etc.)
- Allergy shots and testing
- Ambulance (ground or air)
- Antacids and acid controllers (tablets, liquids, capsules)
- Antibiotic and antiseptic sprays, creams and ointments
- Anti-itch and insect bite remedies
- Antifungals
- Antidiarrheals
- Anti-gas and stomach remedies
- Artificial limbs
- Baby care (diaper rash ointments, etc.)
- Blind services and equipment
- Braces and supports
- Breast pumps for nursing mothers
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Contact lens solution
- Contraceptives (condoms, gels, foams, suppositories, etc.)
- Crutches, wheelchairs, walkers
- Deaf services -- hearing aid/batteries, hearing aid animal & care, lip reading expenses, modified telephone, etc.
- Dental care (non-cosmetic)
- Dentures
- Diabetic testing supplies/equipment
- Diagnostic tests & products
- Digestive aids
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription Eye examinations and eyeglasses)
- Durable medical equipment (power chairs, walkers, wheelchairs, CPAP equipment and supplies, etc.)
- Eye drops, ear drops, nasal sprays
- Eczema and psoriasis remedies
- First aid kits
- Hemorrhoidal preparations
- Home diagnostic (pregnancy tests, thermometers, blood pressure monitors)
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Laxatives
- Medicated band aids and dressings
- Menstrual products
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices
- Motion sickness remedies
- Nicotine medications (smoking cessation aids)
- Non-medicated band aids, rolled bandages and dressings
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations and surgeries (legal & non-cosmetic)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Over the counter medications
- Oxygen/oxygen equipment
- Pain relievers (aspirin, ibuprofen, acetaminophen, naproxen, etc.)
- Physical exams (except for employment-related physicals)
- Physical therapy
- Psychiatric care,
- PPE (masks, hand sanitizer, and sanitizing wipes)
- Radial keratotomy
- Reading glasses
- Sleep aids and sedatives
- Smoking cessation
- Surgery (non-cosmetic)
- Telephone for the hearing impaired
- Transportation (essentially and primarily for medical care; limits apply)
- Vaccinations
- Wart removal remedies, corn patches
- X-rays

HSA Eligible Health Care Expenses - *Medical Necessity or Prescription Required*

Copy of prescription as well as detailed receipt required for reimbursement:

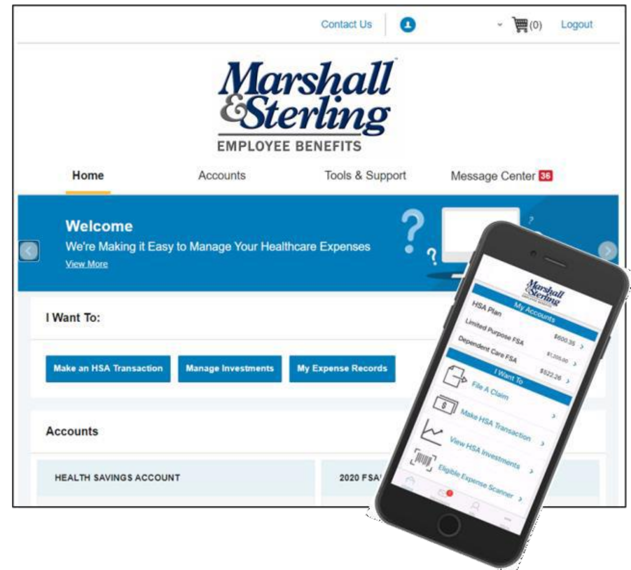
- Antiparasitic
- Birthing Classes
- Car Modifications
- Hydrogen peroxide
- Massage Therapy
- Psychologists, psychotherapists
- Schools and education (special and residential)
- Sexual dysfunction treatment
- Therapy treatments
- Vitamins and Nutritional supplements
- Weight loss programs

Your WEX Health Portal and Mobile App

Marshall + Sterling, in partnership with WEX Health, provides you an online system and mobile app that gives you access to your account information along with any other plans you're enrolled in through Marshall + Sterling.
This is convenient, easy-to-access, customized and secure. Plus, it's available to you 24/7!

With this access you can:

- Check your up-to-the-minute account balances
- Store receipts and documents
- View your investment accounts
- Request distributions to pay yourself back for out-of-pocket expenses
- Sign up for or update your direct deposit information
- And much more!



The portal also has links to calculators, tools and other resources to help you plan and make sure you have all the information you need.

Once you are enrolled, your online account will be set-up by Marshall + Sterling's Flex team (this can take up to a week after the start of the Plan Year).

Your login credentials will be supplied to you. To login, go to **https://msflex.lh1ondemand.com**.

Make sure you download the Mobile App!

Go to the app store on your smartphone or tablet and search for ***MSEB Flex.*** Use the same username and password you use to login online. Upon your initial login, you will create a 4-digit code that you will use to get into the app each time you log in.

With the mobile app you can get on-the-go access to much of the same functionality built into your online portal. The app also has useful tools like a built-in eligibility expense scanner and the option to take and upload photos of your receipts for electronic recordkeeping.

Your Flex Debit Card

Your Flex Debit Card provides easy access to all accounts you are enrolled in through Marshall + Sterling. If you have an HSA, FSA, LPFSA, DCAP, Transit Plan or HRA, you will access all funds using the same Flex Debit Card. This card is equipped with "Smartcard" technology and draws from the appropriate account based on each expense.

Your card arrives already activated. You can continue to use your card until its marked expiration date. Marshall + Sterling Employee Benefits will automatically replace your card with a new one when it expires. Your card is equipped with mobile payment functionality- you can add it to your mobile wallet to pay for eligible expenses right from your smartphone at participating retailers. You can also replace your card or order extra cards on your Wex Health Portal.

Rx Discount Programs

Purchases through a discount program will not apply toward your annual deductible or the annual out-of-pocket max.

BLINK HEALTH

www.blinkhealth.com

Same Medication, Same Pharmacy, Lower Price

No matter if you are insured, uninsured or something in between, we offer some of the lowest prices on over 15,000 medications. Simply pay online before you pick up at your pharmacy to save up to 95%. No membership fees. Fully refundable.

- **Search for Your Prescription**
  Find savings of up to 95% on over 15,000 medications
- **Pay For It Online or Through The App**
  You'll get a Blink Card – that's your proof of purchase. You can print it out. We'll also text it to you.
- **Pick Up At Your Pharmacy**
  When your pharmacist asks for payment, show them your Blink Card. You'll pay nothing at the pharmacy.

GoodRx

www.goodrx.com

Stop Paying Too Much For Your Prescriptions!

Every GoodRx collects millions of prices and discounts from pharmacies, drug manufacturers and other sources.
Here's how you can use it to save:

- **Use GoodRx's Drug Price Search to Compare Prices**
  See which pharmacy near you offers the best price. We don't sell the Medications, we tell you where you can get the best deal on them.
- **GoodRx Will Show You Prices, Coupons, Discounts & Savings Tips**
  Get your prescriptions cheaper with deals at pharmacies near you.
- **Download GoodRx's iPhone or Android App**
  Get drug prices and coupons on the go.
- **Receive A Discount Savings Card**
  Keep your GoodRx card in your wallet for easy access when you need it.

Dental

The Guardian Base insurance 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 Maximum Allowable Charge (MAC) as payment in full after deductible and coinsurance. Dentists who participate in the Guardian network accept Guardian as payment in full after deductible and coinsurance. Non- Guardian dentists may not accept either MAC as payment in full and may balance bill without limit.

Plan Features	Guardian Base Plan	
	In-Network	Out-of-Network
Deductible / Maximum Accumulation Period	Calendar Year (1/1-12/31)	
Dependent Age Limit	Up to Age 26	
Network	PPO	N/A
Reimbursement Level	90th UCR	
Waiting Period (for late entrants)	None	
Plan Deductible (Individual / Family)	$50 / $150	
Deductible Waived For	Preventive care services	
Preventive Care (Cleanings, Oral Exams, etc.)	90% Covered	80% Covered
Basic Procedures (Extractions, fillings, etc.)	90% Covered	80% Covered
Major Procedures (Crowns, dentures, etc.)	50% Covered	40% Covered
Annual Year Maximum Benefit	$1,000	
Orthodontia Lifetime	N/A	

- 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.

Dental

The Guardian Buy Up insurance 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 Maximum Allowable Charge (MAC) as payment in full after deductible and coinsurance. Dentists who participate in the Guardian network accept Guardian as payment in full after deductible and coinsurance. Non- Guardian dentists may not accept either MAC as payment in full and may balance bill without limit.

Plan Features	Guardian Buy-up Plan	
	In-Network	Out-of-Network
Deductible / Maximum Accumulation Period	Calendar Year (1/1-12/31)	
Dependent Age Limit	Up to Age 26	
Network	PPO	N/A
Reimbursement Level	90th UCR	
Waiting Period (for late entrants)	None	
Plan Deductible (Individual / Family)	$50 / $150	
Deductible Waived For	Preventive care services	
Preventive Care (Cleanings, Oral Exams, etc.)	90% Covered	80% Covered
Basic Procedures (Extractions, fillings, etc.)	90% Covered	80% Covered
Major Procedures (Crowns, dentures, etc.)	50% Covered	40% Covered
Child Orthodontia (up to age 19)	50% Covered	50% Covered
Annual Year Maximum Benefit	$1,000	
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.

Vision

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	Guardian Davis Vision	
	In-Network	Non-Network Reimbursement
General Plan Information		
Dependent Age Limit	Up to Age 26	
Network	VSP	N/A
Frequency of Service		
Exam	Once a year	
Frames	Once every other year	
Lenses /Contact Lenses	Once a year	
Vision Exam		
Eye Exam	$20 copay	Amount over: $50
Frames		
	$130.00, 20% discount on amount over $130.00	Amount over: $48
Basic Lenses		
Single Vision	$20 copay	$48 copay
Lined Bifocal	$20 copay	$67 copay
Lined Trifocal	$20 copay	$86 copay
Lenticular	$20 copay	$126 copay
Contact Lenses (in lieu of frames & lenses)		
Conventional	Amount over: $130	Amount over: $120
Planned Replacement / Disposable	Amount over: $130	Amount over: $120
Medically Necessary	$20 copay	Amount over: $210
Evaluation and fitting	15% off professional fee	Included in Contact Lens allowance
Other Discounts		
Cosmetic Extras	Average of 30% Discount	No discounts
Laser Correction Surgery – Usual Charge	Average of 15% Discount	No discounts
Laser Correction Surgery – Promotional Price	Average of 5% Discount	No discounts

- 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.

Vision

Guardian

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	Guardian Davis Vision	
	In-Network	Non-Network Reimbursement
General Plan Information		
Dependent Age Limit	Up to Age 26	
Network	Davis Vision	N/A
Frequency of Service		
Exam	Once a year	
Frames	Once every other year	
Lenses /Contact Lenses	Once a year	
Vision Exam		
Eye Exam	$20 copay	Amount over: $50
Frames		
	$130.00, 20% discount on amount over $130.00	Amount over: $48
Basic Lenses		
Single Vision	$20 copay	$48 copay
Lined Bifocal	$20 copay	$67 copay
Lined Trifocal	$20 copay	$86 copay
Lenticular	$20 copay	$126 copay
Contact Lenses (in lieu of frames & lenses)		
Conventional	$135.00, 15% discount on amount over $135.00	Amount over: $120
Planned Replacement / Disposable	$135.00, 15% discount on amount over $135.00	Amount over: $120
Medically Necessary	Covered in full	Amount over: $210
Evaluation and fitting	15% off professional fee	Included in Contact Lens allowance
Other Discounts		
Cosmetic Extras	No additional charge for: Oversize lens, polycarbonate for kids, polycarbonate for adults with strong prescriptions	No discounts
Laser Correction Surgery – Usual Charge	Up to 25% Discount	No discounts
Laser Correction Surgery – Promotional Price	Up to 25% Discount	No discounts

- 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

Guardian

General Plan Information	
Eligibility	All Full-Time Employees
Employee Contribution	None – 100% Employer Paid
Term Life	
Benefit	$25,000
Maximum Benefit	$25,000
Accelerated Death Benefit	Available
Accidental Death & Dismemberment AD&D)	
Benefit	$25,000
Seatbelt And Airbag Benefit	If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by $10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional $5,000.00, for a total increase of $15,000.00. However, in no event will the total increase exceed 10% of your optional group term life insurance benefit
Additional Features	
Conversion	Yes
Age Reduction Schedule	
At Age 65	35%
At Age 70	50%
At Retirement	Coverage terminates

- 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

Voluntary Term Life and AD&D

Benefit	Employee	Spouse	Dep Child(ren)
General Plan Information			
Eligibility	All Full-Time Employees		
Voluntary Term Life			
Benefit Increment	$10,000	$5,000	$1,000
Maximum Benefit	$500,000	$100,000	$10,000
Newly Eligible Guarantee Issue	Ages 15-64 $150,000 Ages 65-69 $10,000 Ages 70 and up, evidence of insurability is required for all amounts.	Spouse's Age 15-64 $10,000 Spouse's Age 65 and up $5,00	There is no guaranteed issue.
Additional Features			
Accelerated Death Benefit	If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by $10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional $5,000.00, for a total increase of $15,000.00. However, in no event will the total increase exceed 10% of your optional group term life insurance benefit		
Seatbelt * Airbag Benefit	If a dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, we will increase the benefit amount by $5,000.00. And if a dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase the benefit amount by an additional $2,500.00, for a total increase of $7,500.00. However, in no event will the total increase exceed 10% of the dependent's optional group term life insurance benefit.		
Waiver of Premium	Not Offered		
Evidence of Insurability (EOI)	Outside of initial enrollment & above GI Amounts		
Conversion	Offered		
Portability	Not Offered		
Age Reduction Schedule			
At Age 65	35%	35%	N/A
At Age 70	50%	Coverage terminates	

- 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

Voluntary Short-Term Disability

Guardian

1	
General Plan Information	
Eligibility	All Full-Time Employees
Short-Term Disability	
Weekly benefit	60% of pre-tax weekly earnings
Maximum Benefit	$1,154
Guaranteed Issue	There is no guaranteed issue. All amounts are approved.
Waiting Periods	Accident & Illness: 15 days
Maximum Payment Period	13 weeks

Voluntary Long-Term Disability

Guardian

General Plan Information	
Eligibility	All Full-Time Employees
Employee Contribution	None – 100% Employer Paid
Long-Term Disability	
Monthly Benefit	60% of pre-tax monthly earnings
Maximum Benefit	$5,000
Waiting Periods	Accident & Illness: 15 days
Maximum Payment Period	Social Security Normal Retirement

Voluntary Benefits

The following supplemental benefit programs are available for you to choose from. These plans provide cash to help offset any unexpected medical expenses you or your family may experience, as the result of an accident, serious illness, or hospitalization. The money is paid directly to you and can be used to cover your health plan deductible and copays. This is another way to provide yourself financial protection for those unforeseen medical events, along with some peace-of-mind.

These supplemental plans can be used in conjunction with any medical plan. Individual and family coverage are available for each of the plans offered and can all be chosen independent of each other.

Accident

This plan offered through **Guardian** pays money directly to you for care of injuries that happen on or off the job, 24/7. Personal accident care pays for hospitalization, emergency care, ambulatory care, follow up visits and many other benefits.

Critical Illness

This plan provides cash benefits if you or a covered family member is diagnosed with a Heart Attack, Stroke, Cancer, End Stage Renal (Kidney) Failure, Major Organ Failure or Coronary Artery Disease. There is a $50 wellness benefit for certain tests or procedures. You must be enrolled in a medical plan to enroll in this coverage.

ID Watchdog

Protect your identity with ID Watchdog; they are everywhere you cannot be monitoring your credit and helping you better protect your identity. Sign up for their advanced identity monitoring services and protect yourself and your family. Check out IDwatchdog.com for details.

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.anthem.com	(855) 875-1584
Meritain/CVS Caremark	www.caremark.com	(800) 875-0867
Guardian	www.guardiananytime.com	(866) 569-9900
VSP Vision	www.vsp.com	(800) 877-7195
Davis Vision	www.davisvision.com	(800) 999-5431
ID Watchdog	www.idwatchdog.com	(866) 513-1518

Marshall + Sterling – Michelle Conway	mconway@marshallsterling.com
Marshall + Sterling – Nikki Bellavia	nbellavia@marshallsterling.com
Curtis Lumber - Lisa Yorks	Lisa.Yorks@curtislumber.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:

Lisa Yorks
Curtis Lumber Company
885 Route 67
Ballston Spa, NY 12020
518-490-1388
lisay@curtislumber.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	Hybrid EPO Copay Plan	Anthem $20/$50 Copay Plan	Anthem HDEPO (HSA Qualified)
Deductible	$500 / $1,000	$0 / $0	$1,750 / $3,500
PCP Office Visit	$20 Copay after deductible	$20 Copay	$10 Copay after deductible
Specialist Office Visit	$50 Copay after deductible	$50 Copay	$40 Copay after deductible
Inpatient Hospital Admission	$350 Copay after deductible	$500 Copay	$250 Copay after deductible
Emergency Room	$150 copay after deductible	$250 copay	Covered in Full 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.

Lisa Yorks
Curtis Lumber Company
885 Route 67
Ballston Spa, NY 12020
518-490-1388
lisay@curtislumber.com

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

Notes