Guía de Beneficios Para Asociados 2026

Tabla de Contenidos

En Acme Brick, nuestro éxito se lo debemos a ustedes, nuestros asociados trabajadores y dedicados. Por eso, nos complace ofrecerles un programa de beneficios completo y competitivo en el mercado, con más opciones que se adaptan a su vida y respaldan sus necesidades diversas y únicas — tanto en el trabajo como en casa.

Los resúmenes de los planes de beneficios incluidos en esta guía tienen como objetivo proporcionar una descripción general de las pólizas. Los términos completos de cada póliza se encuentran en el certificado de la póliza. Puede solicitar una copia del(los) certificado(s) de la póliza escribiendo a HR@brick.com.

Si existe alguna discrepancia entre este resumen y el lenguaje de los contratos de beneficios o los documentos oficiales del plan, prevalecerá el lenguaje de los contratos o documentos oficiales para determinar sus beneficios..

ACME BRICK COMPANY
a Berkshire Hathaway company

Ed Watson
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Presidente y Director Ejecutivo

Noviembre 1, 2025

Estimados asociados de Acme Brick:

Los equipos de Recursos Humanos y de Liderazgo Ejecutivo desean hacer de **Acme un excelente lugar para trabajar**, donde puedan desarrollar una carrera — no solo tener un empleo — cuidarse mutuamente y sentirse como nuestro recurso más valioso.

Una de las formas en que trabajamos para lograr esto es mediante la mejora continua y expansión de nuestro programa de beneficios para asociados, con el fin de apoyarles a ustedes y a sus seres queridos.

Nos esforzamos por ofrecer una solución accesible que proteja su salud física, emocional y financiera. Nos acercamos rápidamente al período anual de inscripción abierta, y queremos brindarles información útil para tomar decisiones sobre su cobertura médica para el año 2026.

Cambios en los beneficios para 2026

Nos complace dar la bienvenida a Prudential como nuestro nuevo proveedor de beneficios por discapacidad, vida, muerte accidental (AD&D) y beneficios voluntarios (accidentes grupales y enfermedades críticas).

No habrá cambios significativos en los beneficios para 2026, pero queremos destacar los beneficios ya disponibles y animarlos a aprovecharlos:

- Livongo – Programa de manejo de la diabetes
- Examen físico anualPrograma para dejar la nicotina
- Teladoc

Estos beneficios son gratuitos para todos los asociados inscritos en el plan médico de Acme. Al participar en estos programas, pueden mejorar su salud personal, ahorrar dinero y ayudar a reducir el costo total de la atención médica.

Primas para 2026

Aunque utilizamos BlueCross BlueShield of Texas (BCBSTX) para administrar nuestro plan médico, Acme se autoasegura. Con el aumento continuo de los costos médicos y de medicamentos en 2025, los costos del plan también aumentaron. Se proyecta que los costos médicos aumentarán aún más en 2026 (aproximadamente $1 millón), y lamentablemente parte de ese aumento se trasladará a nuestros asociados.

El plan Gold es el más costoso y tiene la mayoría de los reclamos de alto costo, por lo que sus primas aumentarán más que las de los otros dos planes.

También se aplicará un aumento en las primas para los asociados inscritos con la tarifa “Estándar” en los tres planes. Esto se debe a que los asociados con tarifa “Estándar” son usuarios de tabaco o no cumplen con el requisito de tarifa “Select”, que incluye realizarse un examen físico anual.

Ed Watson
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President and CEO

Recomiendo encarecidamente que cualquier persona inscrita con la tarifa “Estándar” considere ahorrar dinero eligiendo la tarifa “Select”, haciéndose un examen físico anual y dejando de usar tabaco. Esto podría ayudarte a vivir una vida más larga y saludable, además de contribuir a mantener bajos los costos de atención médica para todos los asociados.

El máximo de por vida para ortodoncia infantil en el plan Cigna Dental PPO aumentará de $1,000 a $2,000.

No habrá aumentos de costo en los siguientes planes de salud:
- Dental
- Visión
- Discapacidad a corto plazo
- Discapacidad a largo plazo
- Seguro de vida y AD&D (muerte accidental y desmembramiento)

Los detalles sobre las primas y beneficios de todos los planes de salud se explicarán con más detalle durante el proceso de Inscripción Abierta Anual y en esta guía.

Te invito a tomar un momento para reflexionar sobre lo que es más importante para ti y tu familia. No hay mejor momento que ahora para priorizar nuestra salud y bienestar. A lo largo del próximo año, te proporcionaremos información y recursos para ayudarte a ser un consumidor más informado de servicios de salud. Espero que los aproveches y compartas esta información con quienes te rodean.

Gracias por tu contribución a Acme Brick. Mi deseo sincero es que tengas un año 2026 feliz y saludable.

Ed Watson

Cómo inscribirse

Si eres un nuevo empleado, tienes 31 días desde tu primer día de trabajo para completar y enviar tu formulario de inscripción a los beneficios. Tus beneficios serán efectivos el primer día del mes después de cumplir 60 días de empleo. Por ejemplo, si un asociado es contratado el 15 de julio, sus beneficios comenzarán el 1 de octubre.

Antes de inscribirte

- ✓ Revisa cuidadosamente los beneficios incluidos en esta guía y determina la cobertura que sea mejor para ti y tu familia.
- ✓ Asegúrate de que tus dependientes cumplan con los requisitos de elegibilidad. Si inscribes dependientes por primera vez, debes enviar prueba de elegibilidad (por ejemplo, acta de nacimiento, certificado de matrimonio, etc.) a HR@brick.com.
- ✓ Comprende el costo de los planes que seleccionaste.
- ✓ Estima los gastos médicos de tu familia si deseas contribuir a una Cuenta de Gastos Flexibles para Atención Médica (FSA).
- ✓ Determina los costos de cuidado infantil o de adultos si deseas contribuir a una FSA para Cuidado de Dependientes.

Consulta con Recursos Humanos en HR@brick.com si tienes preguntas.

Inscripción en papel para nuevos empleados

- ✓ Completa el formulario de inscripción en papel.
- ✓ Asegúrate de designar a tus beneficiarios para el seguro de Vida y AD&D.
- ✓ Envía el formulario completo a HR@brick.com o al administrador de tu ubicación **dentro de los 31 días posteriores a tu fecha de contratación**.

Inscripción abierta anual

- ✓ Si tienes una dirección de correo electrónico @brick.com, debes iniciar sesión en **Employee Self Service (ESS)** desde la página principal de **Acme Connect**.
- ✓ Si no tienes una dirección de correo electrónico @brick.com, completa el formulario de inscripción en papel y envíalo a HR@brick.com **del 1 al 15 de noviembre de 2025**.
- ✓ Asegúrate de designar o actualizar tus beneficiarios para el seguro de Vida y AD&D.

Requisitos de elegibilidad y períodos de espera

Todos los asociados elegibles para beneficios que trabajen al menos 30 horas por semana califican para los beneficios ofrecidos por Acme Brick. Para los nuevos asociar, la mayoría de los beneficios entran en vigor **el primer día del mes siguiente a completar sesenta días de empleo activo**. También puedes inscribir a tus dependientes elegibles para recibir cobertura. Los dependientes elegibles incluyen:

- Tu cónyuge legalmente casado o pareja doméstica calificada (del mismo o diferente sexo)
- Hijos menores de 26 años, sin importar su estado civil, estatus como estudiante o dependencia económica
- Hijos de 26 años o más que dependan completamente de ti para su manutención debido a una discapacidad mental o física (y que estén indicados como tales en tu declaración de impuestos federal)
- Se requerirá **verificación de dependientes** al momento de la inscripción.

Para obtener más detalles sobre la elegibilidad y cuándo comienzan y terminan tus beneficios, consulta los documentos resumen del plan o comunícate con **HR@brick.com**.

Elegibilidad Para Beneficios: Fechas de Vigencia y Terminación			
Plan de beneficios	**Fecha de entrada en vigor**	**Fecha de terminación**	**Continuación después de termino de empleo**
Médico/ Farmacia	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	Elegible para Continuación de COBRA
Teladoc/Livongo	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	Elegible para Continuación de COBRA
Accidente	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	La portabilidad a una póliza individual está disponible
Enfermedad crítica	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	La portabilidad a una póliza individual está disponible
Dental	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	Elegible para Continuación de COBRA
Visión	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	Elegible para Continuación de COBRA
Cuenta de gastos flexibles (FSA)	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	Elegible para Continuación de COBRA
Básico Vida/AD&D	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	puede convertirse en una póliza individual (se aplican limitaciones)
Voluntario Vida/AD&D	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	puede convertirse en una póliza individual (se aplican limitaciones)
Discapacidad a corto plazo	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	No hay opción de continuar con la cobertura
Discapacidad a largo plazo	el primer día del mes siguiente a los 60 días de empleo	Último día de Empleo	puede convertirse en una póliza individual (se aplican limitaciones)

Cuándo y cómo hacer cambios después del período de inscripción abierta

Durante el año, no puede hacer cambios en sus elecciones de beneficios a menos que experimente un Evento de Vida Calificado (EVC), como matrimonio, divorcio, nacimiento o adopción de un hijo. Si experimenta un EVC (se proporcionan ejemplos a continuación), comuníquese con Recursos Humanos en HR@brick.com dentro de los 31 días posteriores al evento o tendrá que esperar hasta el período de inscripción abierta del próximo año para realizar cambios.

Qualifying Life Event (QLE)	Documentation Required
Matrimonio	Copia del certificado de matrimonio
Divorcio o separación legal	Copia del decreto de divorcio
Muerte de un dependiente elegible	Copia del certificado de defunción
Nacimiento de una recién nacido o adopción	Copia del certificado de nacimiento o copia de los documentos legales de adopción.
Hijastra(o)	Copia del certificado de nacimiento más copia del certificado de matrimonio entre el asociado y el cónyuge
Elegibilidad por ganancias o pérdidas para otra cobertura grupal	Documentación del plan o del emisor sobre el cambio de elegibilidad (debe incluir la fecha de vigencia)
Derecho a Medicare/Medicaid de un asociado, cónyuge o dependiente, o pérdida del derecho a Medicare/Medicaid	Verificación gubernamental de que se obtuvo o perdió la cobertura (debe incluir la fecha de vigencia)

Tiene solo 31 días a partir de la fecha del evento para realizar cambios en sus elecciones de beneficios. Comuníquese con HR@brick.com para iniciar el evento y proporcionar la documentación de respaldo. Si no notifica a Recursos Humanos dentro de los 31 días, su próxima oportunidad para realizar cambios en los beneficios será el período de inscripción abierta anual del próximo año.

Si el evento de vida calificado es el resultado de la elegibilidad para Medicaid o la pérdida de la elegibilidad para Medicaid de un Asociado o dependiente, debe notificar a Recursos Humanos dentro de los 60 días para realizar cambios en sus elecciones.

Costo de la cobertura

Acme Brick cubre la mayor parte del costo de tus beneficios. Puedes ver los costos que aplican para los asociados más adelante en esta guía.

Tarifas médicas Select

Inscripción abierta anual: Para calificar para las tarifas médicas reducidas del plan Select, los asociados y sus cónyuges inscritos deben estar libres de tabaco/nicotina. Solo el asociado debe completar un examen físico anual. Por favor, envía el formulario completo de Declaración de Incentivo de Bienestar a HR@brick.com antes del 1 de diciembre de 2025.

– Si no tienes acceso a Acme Connect, puedes obtener una copia del formulario con tu administrador local.

Para nuevos empleados: Para calificar para las tarifas médicas reducidas del plan Select, envía el formulario completo de Declaración de Incentivo de Bienestar dentro de los 31 días posteriores a la fecha en que tus beneficios entren en vigor.

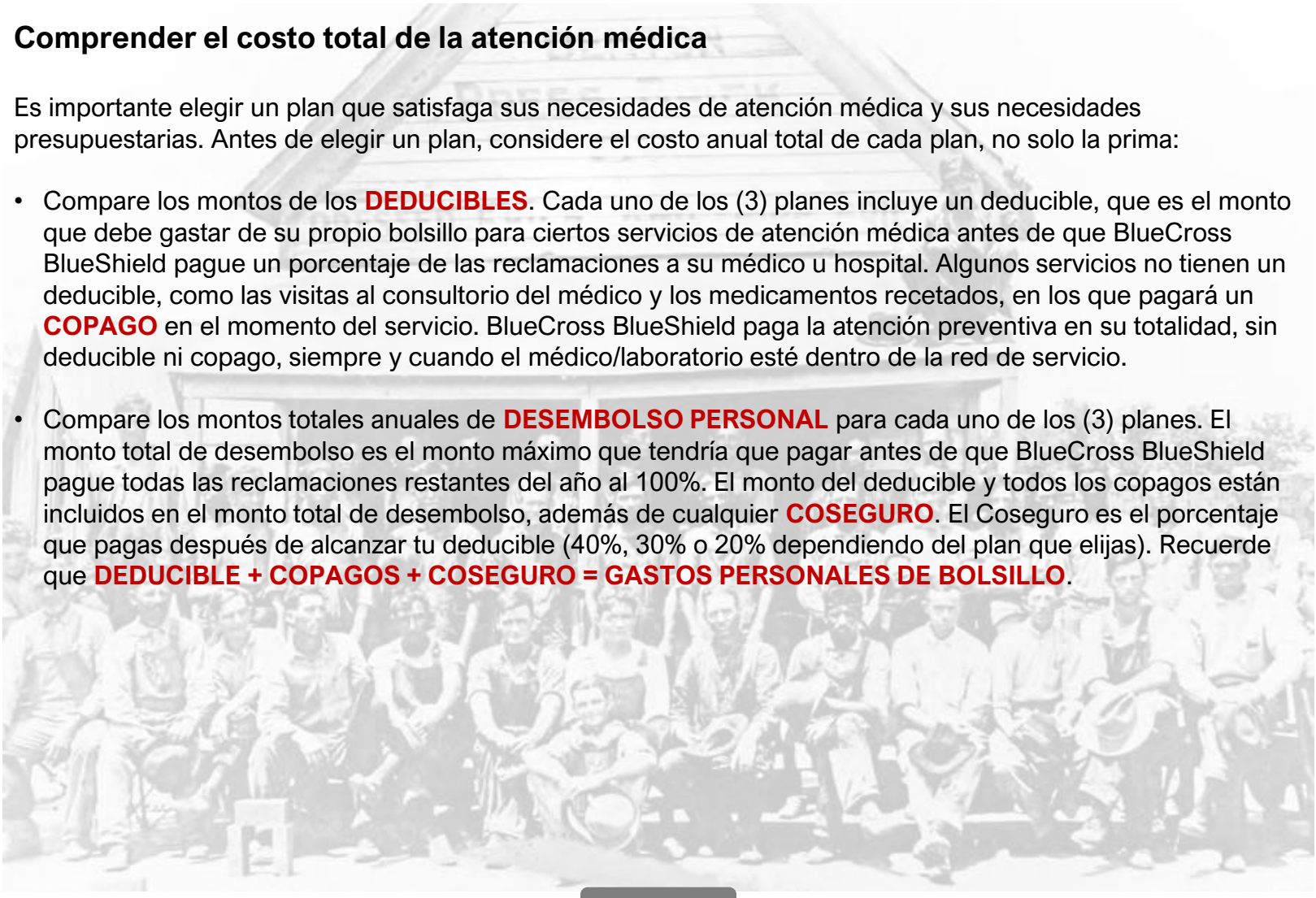
Los usuarios de tabaco/nicotina que no completen el programa para dejar de fumar estarán sujetos a las tarifas del plan médico estándar. Puedes encontrar más información sobre los programas para dejar el tabaco/nicotina disponibles a través de BlueCross BlueShield of Texas en la página 14.

Comprender el costo total de la atención médica

Es importante elegir un plan que satisfaga sus necesidades de atención médica y sus necesidades presupuestarias. Antes de elegir un plan, considere el costo anual total de cada plan, no solo la prima:

- Compare los montos de los **DEDUCIBLES**. Cada uno de los (3) planes incluye un deducible, que es el monto que debe gastar de su propio bolsillo para ciertos servicios de atención médica antes de que BlueCross BlueShield pague un porcentaje de las reclamaciones a su médico u hospital. Algunos servicios no tienen un deducible, como las visitas al consultorio del médico y los medicamentos recetados, en los que pagará un **COPAGO** en el momento del servicio. BlueCross BlueShield paga la atención preventiva en su totalidad, sin deducible ni copago, siempre y cuando el médico/laboratorio esté dentro de la red de servicio.

- Compare los montos totales anuales de **DESEMBOLSO PERSONAL** para cada uno de los (3) planes. El monto total de desembolso es el monto máximo que tendría que pagar antes de que BlueCross BlueShield pague todas las reclamaciones restantes del año al 100%. El monto del deducible y todos los copagos están incluidos en el monto total de desembolso, además de cualquier **COSEGURO**. El Coseguro es el porcentaje que pagas después de alcanzar tu deducible (40%, 30% o 20% dependiendo del plan que elijas). Recuerde que **DEDUCIBLE + COPAGOS + COSEGURO = GASTOS PERSONALES DE BOLSILLO**.



Beneficios Médicos
Administrado por BlueCross BlueShield Texas

Cuando se trata de cobertura médica, Acme Brick le ofrece opciones. Hay tres planes médicos para elegir, junto con otros beneficios voluntarios para Accidentes y Enfermedades Críticas para mejorar su cobertura.

- **Plan Bronce**
  - Deducibles más altos y 40% de Coseguro
  - Máximos gastos/costo del bolsillo personal
  - Costo más bajo por cheque de pago

- **Plan Plata**
  - Deducibles más bajos y 30% de Coseguro
  - Gastos más bajos de bolsillo

- **Plan Oro**
  - Deducibles más bajos y 20% de Coseguro
  - Gastos de bolsillo más bajos
  - El costo más alto por nómina de pago

Estos planes son administrados por BlueCross BlueShield de Texas y cubren los servicios médicos para que usted y sus dependientes elegibles para beneficios se mantengan sanos y controlen su salud.

Cada uno de estos planes le brinda beneficios integrales e incluye copagos cuando acude a su médico de atención primaria, un especialista o incluso atención de urgencia.

No importa del plan que elijas, tendrás acceso a:
- Una amplia red de médicos, especialistas y hospitales
- Los servicios de atención preventiva están con cobertura en su totalidad, sin deducible ni gastos de bolsillo siutilizaun proveedorde la red.

Medicamentos Recetados
Cuando se inscribe en un plan médico de Acme Brick, automáticamente recibe cobertura de medicamentos recetados administrada por Express Scripts. Se aplican los mismos beneficios de medicamentos recetados independientemente del plan médico que elija. El costo de sus medicamentos recetados dependerá de si el medicamento es genérico, de marca preferida, marca no preferida o medicamento especializado y de si compra su receta en una farmacia de la red o a través del programa de entrega a domicilio de Express Scripts.

Conozca su Jerga/Lenguaje de Atención Médica :

- Co-seguro: El porcentaje que adeuda después de su deducible. Por ejemplo, si su plan paga el 80%, usted es responsable de pagar el 20% restante.
- Copago: El monto fijo que paga a su proveedor por un servicio cubierto, como una visita al consultorio o un medicamento recetado.
- Deducible Anual: La cantidad que paga por un servicio de salud antes de que su plan médico comience a pagar.
- Proveedor Dentro de la Red: Un médico o hospital que acepte la asignación de su plan y los costos compartidos como pago en su totalidad. Busque proveedores de Blue Choice PPO en línea en bcbstx.com/find-care .
- Gastos de Bolsillo/Desembolso Anual: Lo máximo que pagará por los servicios médicos con cobertura en cualquier año del plan. Si alcanza esta cantidad, su plan médico paga el 100% de los servicios con cobertura después de eso.
- Lista de medicamentos preferidos (LMP): Una lista de medicamentos recetados con cobertura por su plan de medicamentos recetados. A menudo se le conoce como el Formulario de Medicamentos Recetados.
- Cuidados preventivos: Atención médica de rutina que incluye exámenes de detección, chequeos y asesoramiento al paciente para prevenir enfermedades y dolencias o otros problemas de salud.

Autorización previa: Es posible que se requiera la aprobación de BlueCross BlueShield of Texas para ciertos servicios médicos antes de que estén cubiertos por su plan médico. Es posible que también se requiera autorización previa de Express-Scripts para ciertos medicamentos recetados antes de que estén cubiertos.

Comparación de Opciones de Planes Médicos

BlueCross BlueShield of Texas

Este cuadro compara sus opciones para los servicios dentro de la red. Antes de inscribirse, considere el costo por período de pago y el costo de los servicios y medicamentos recetados que espera gastar durante el año. Evalúe cómo pueden fluctuar sus gastos de bolsillo y considere agregar beneficios voluntarios por accidentes y enfermedades críticas para ayudar a compensar sus gastos médicos de bolsillo.

	PLAN BRONCE	PLAN PLATA	PLAN ORO
	DENTRO DE LA RED, USTED PAGA		
Deducible anual (soltero/familiar)	$3,000 / $9,000	$2,000 / $6,000	$1,000 / $3,000
Co-seguro	usted paga 40%	usted paga 30%	usted paga 20%
Gastos de bolsillo anuales (soltero/familiar)	**$8,000 / $16,000**	**$7,000 / $14,000**	**$6,000 / $12,000**
Visitas al consultorio – Atención Primaria	$30 copago		
Visitas al consultorio – Especialista	$40 copago		
Visitas al consultorio – Salud mental (psicólogo/psiquiatra)	$30 copago / $40 copago		
Atención preventiva – (incluye cuidado de niños sanos, vacunas, mamografías, pruebas de Papanicolaou, exámenes de próstata, otros diagnósticos preventivos, etc.)	cubierto en su totalidad sin deducible ni gastos de bolsillo		
Teladoc – visitas virtuales	$0 copago		
Atención de urgencia	$30 copago		
Sala de Emergencias – Instalación	$350 copago		
Sala de Emergencias – Médico	40% después del deducible	30% después del deducible	20% después del deducible
Laboratorio y Rayos X	40% después del deducible	30% después del deducible	20% después del deducible
Hospitalización - Ambulatoria	40% después del deducible	30% después del deducible	20% después del deducible
Hospitalización - Paciente internado	40% después del deducible	$250 copago + 30% después del deducible	$250 copago + 20% después del deducible
Imágenes de diagnóstico (Resonancia Magnética, Tomografía Computarizada, PET)	40% después del deducible	30% después del deducible	20% después del deducible
Medicamentos recetados (30 días) Nivel- 1 Genérico Nivel -2 Marca preferida Nivel -3 Marca no preferida Nivel -4 Especialidad **Pedido por correo** (90 días)	$10 copago $50 copago $70 copago $125 copago 2 ½ × copago		

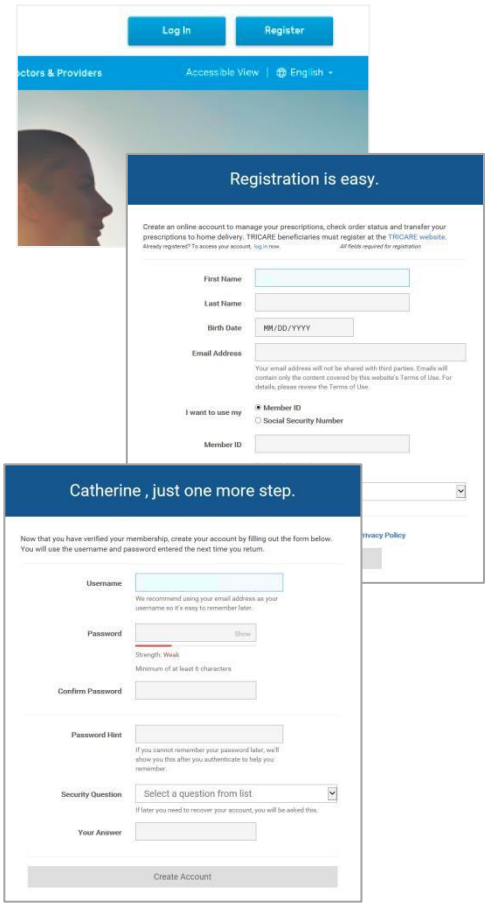
¡Evite las facturas sorpresa! Permanecer dentro de la red significa costos de bolsillo más bajos para usted, porque los proveedores y los centros no pueden cobrar más que los montos permitidos de BCBSTX por los servicios con cobertura. Pídale a su médico que lo refiera a un especialista, hospital o centro quirúrgico que participe en la red Blue Choice de BCBSTX.

Registro con Express Scripts

Acceso en línea para ahorros y conveniencia

EXPRESS SCRIPTS®

Administra tus medicamentos en cualquier lugar y en cualquier momento con express-scripts.com y la aplicación móvil Express ScriptsTM



Regístrese ahora para obtener:

- **Más ahorro.**
  Compare precios de medicamentos en varias farmacias. Obtenga envío estándar gratuito1 en Express Scripts Pharmacy℠.

- **Más comodidad.**
  Reciba suministros de hasta 90 días de su medicamento a largo plazo en su hogar. Recargas de pedidos, verifique el estado de los pedidos y realice un seguimiento de los envíos. Imprima formularios y tarjetas de identificación, si es necesario.

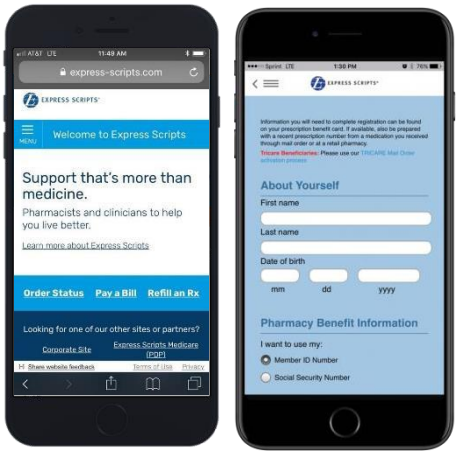
- **Más confianza**.
  Hable con un farmacéutico desde la privacidad de su hogar en cualquier momento y desde cualquier lugar. Encuentre la información más reciente sobre su medicamento, incluidos los posibles efectos secundarios e interacciones.

- **Más flexibilidad.**
  Más flexibilidad. Descarga la aplicación móvil de Express Scripts para administrar tus medicamentos, encontrar farmacias cercanas y obtener direcciones, y usar tu tarjeta de identificación virtual mientras viajas.

¡Empiece hoy mismo!

Registrarse es seguro y sencillo. Su información está protegida y es confidencial. Tenga a mano su número de identificación de miembro o su número de seguro social..

1. Ve a express-scripts.com, selecciona Registrarse o descarga la aplicación móvil de Express Scripts gratis desde la tienda de aplicaciones de tu dispositivo móvil y selecciona Registrarse
2. Complete la información solicitada, incluyendo información personal y número de identificación de miembro o Número de Seguro Social (NSS), cree un nombre de usuario y contraseña, junto con información de seguridad en caso de que alguna vez olvide su contraseña.
3. Haga clic en Registrarse ahora y estará registrado.
4. Para configurar las preferencias², seleccione Preferencias de comunicación en el menú de Cuenta, desplácese hasta Preferencias de comunicación y visualización. Haga clic en Editar preferencias. Las preferencias solo se pueden seleccionar a través del sitio web para miembros..



Los miembros que tengan autenticación Touch ID en sus dispositivos móviles pueden habilitarla para iniciar sesión en su cuenta de Express Scripts en la aplicación móvil, si así lo desean.

los costos de envío estándar están incluidos como parte del beneficio de su plan de medicamentos recetados. ²Las preferencias incluyen la opción de compartir la información de su receta con otros miembros adultos de su hogar (mayores de 18 años) con cobertura de su plan para medicamentos recetados. Todos los adultos con cobertura (mayores de 18 años) en el hogar deben registrarse por separado. Cuando otorga permiso para compartir la información de su receta con otros miembros registrados del hogar, ellos pueden ver su información, realizar pedidos en su nombre y más. La aplicación móvil Express Scripts está disponible para dispositivos móviles iPhone®, iPad® y Android . 2018 Express Scripts. Todos los derechos reservados. Express Script y el logotipo E son marcas comerciales de Express Scripts Strategic Development, Inc. Todas las demás marcas comerciales son propiedad de sus respectivos dueños.

Empezando con la entrega a domicilio de Express Scripts PharmacySM

Acceso en línea a ahorros y conveniencia

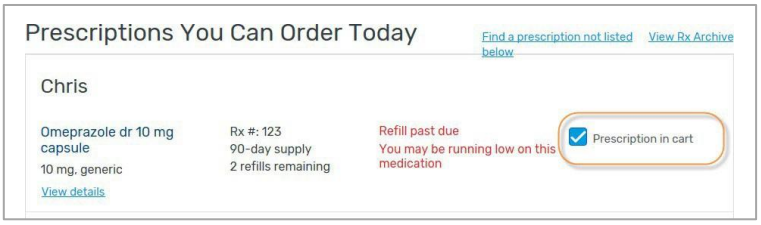
Ya sea que esté viendo el sitio web para miembros o usando la aplicación móvil Express Scripts, puede administrar fácilmente sus recetas con entrega a domicilio:

- Consultar el estado de un pedido
- Rellenar y renovar recetas
- Consultar precios y cobertura
- Encontrar farmacias
- Vea sus reclamos y saldos de recetas
- Pague su saldo utilizando una variedad de opciones de pago
- Ver nuestros centros de recursos terapéuticos para obtener información
- Y mucho más

Para acceder al sitio web de miembros…
Inicie sesión en **express-scripts.com** (Regístrese si es su primera visita. Solo tenga a mano su identificación de miembro o número de seguro social).

Si tiene una receta NUEVA...
Comience por comunicarse con su médico para solicitar una receta de 90 días que él o ella pueda recetar electrónicamente directamente a Express Scripts
O imprima un formulario seleccionando "Formularios" o "Formularios y tarjetas" en el menú bajo "Beneficios", imprima un formulario de pedido por correo y siga las instrucciones de envío.
O llámenos y nos ponderemos en contacto con su médico por usted.
Por favor espere entre 10 y 14 días para que se envíe su primer pedido de receta.

Si ya tiene una receta…
Verifique el estado del pedido en línea o use nuestra aplicación para ver los detalles y realizar el seguimiento del envío. Transfiera las recetas minoristas a la entrega a domicilio. Simplemente haga clic en Agregar al carrito para las recetas elegibles y realice el pago. Nos comunicaremos con su proveedor en su nombre y nos encargaremos del resto. Verifique el estado del pedido para realizar el seguimiento de su pedido.

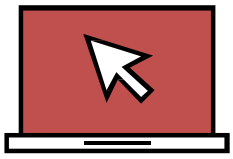


Recargue y Renueve Recetas para usted y su familia mientras está en línea o mientras usa nuestra aplicación. Simplemente haga clic en Agregar al carrito para obtener las recetas elegibles y realice el pago. Nos comunicaremos con su proveedor en su nombre, si se incluyen las renovaciones, y nos encargaremos del resto.

Puedes buscar "Express Scripts" en tu tienda de aplicaciones y descargarlo de forma gratuita. Luego regístrese si es la primera vez que lo visita, o inicie sesión..

Recursos Adicionales de BlueCross BlueShield Texas

Cómo encontrar un proveedor de PPO



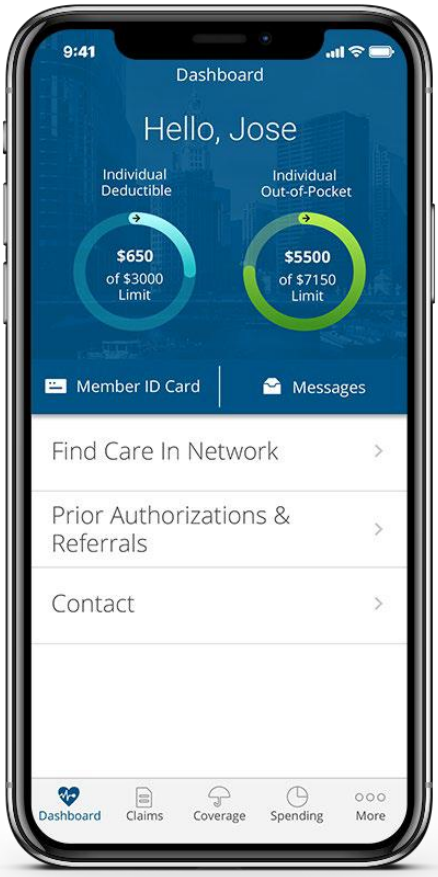
Desde su computadora o dispositivo móvil, inicie sesión en bcbstx.com y haga clic en Buscador de proveedores.

Llame al número de Servicio al Cliente que figura en su tarjeta DNI® **800-521-2227**

Hable con el consultorio de su proveedor

Aplicación de BCBSTX para dispositivos móviles

- Encuentre un médico, hospital o centro de atención de urgencia dentro de la red o busque médicos que hablen español
- Acceda a su información sobre reclamos, coberturas y deducibles
- Acceder a la tarjeta de identificación de miembro digital temporal
- Inicio de sesión seguro con Face ID (solo iOS) y Fingerprint ID
- **Háganos saber sus preferencias de comunicación**



Download on the App Store

Download for Apple

GET IT ON Google Play

Download for Android

Texas

Recursos para dejar el tabaco/nicotina con BlueCross BlueShield of Texas

Hay apoyo disponible para ayudarte a dejarlo

En Acme Brick, queremos que nuestros asociados estén comprometidos con su trabajo y sus comunidades, y que alcancen su máximo nivel de bienestar eliminando la nicotina de sus vidas. Nuestro programa para dejar la nicotina, ofrecido a través de BlueCross BlueShield of Texas, está diseñado para:

- Brindar educación sobre estilos de vida saludables, recursos y apoyo
- Ayudarte a llevar una vida más sana
- Controlar los costos de atención médica para la organización
- Ayudarte a ahorrar en reclamaciones médicas

Calificar para las tarifas Select debes estar libre de tabaco/nicotina, completar un examen físico anual y enviar tu Declaración de Incentivo de Bienestar antes del 1 de diciembre.

Los usuarios de nicotina que no completen el programa para dejar de fumar recibirán las tarifas del plan médico estándar. Si tienes preguntas, comunícate con HR@brick.com.

Aprovecha las herramientas y el apoyo disponibles en tu plan de salud

El uso de asesoría o medicamentos — o ambos — puede formar parte de un plan efectivo para dejar el tabaco/nicotina.

Los servicios para dejar el tabaco/nicotina son parte de los beneficios preventivos disponibles en tu plan de salud, siempre que visites a un médico dentro de la red de proveedores. No hay costos de bolsillo como copagos o coseguro, incluso si no has alcanzado tu deducible. Habla con tu médico sobre los próximos pasos.

Asesoría cubierta

Las sesiones de asesoría para dejar el tabaco/nicotina (incluyendo asesoría telefónica, grupal e individual) dirigidas por médicos calificados están disponibles sin costo para los miembros de planes no protegidos que usan productos de tabaco/nicotina. Consulta tus materiales de beneficios para obtener más información sobre lo que está cubierto sin costo para ti.*

Medicamentos cubiertos

Su plan de salud también cubre dos tratamientos de 90 días para medicamentos para dejar de fumar y consumir tabaco por período de beneficios. Esta cobertura incluye una variedad de medicamentos para dejar de consumir tabaco/nicotina aprobados por la FDA (incluidos los recetados y de venta libre) cuando lo recete su médico.

Medicamentos recetados cubiertos

- Buproban (comprimidos de bupropión SR de 150 mg)
- Chantix
- Inhalador Nicotrol
- Nicotrol NS
- Zyban (comprimidos de bupropión SR de 150 mg)

Medicamentos de Venta Libre con cubiertos

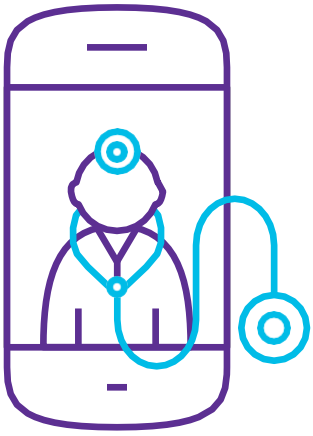
- Commit
- Kits transdérmicos de Nicotina
- Nicoderm CQ y genéricos
- Chicles Nicorette y genéricos
- Pastillas Nicorette y genéricos

Para más Información

Para obtener más información sobre la cobertura para dejar de fumar y dejar la nicotina bajo su plan de salud de BCBSTX, llame al número de Servicio al Cliente que se encuentra en el reverso de su tarjeta de identificación de miembro

Virtual Visits
Provided by Teladoc Health

TELADOC



Teladoc is available to all members enrolled in one of the Acme Brick medical plans administered by BCBSTX.

$0 copay

Your access to Teladoc lets you **talk with a doctor anytime**, anywhere, through phone or through the convenience of online video consults, 24 hours, 7 days a week.

1. Talk to a doctor anytime, anywhere you happen to be
2. Receive quality care via phone, video or mobile app
3. Prompt treatment, talk to a doctor in minutes
4. A network of doctors that can treat every member of the family
5. Prescriptions sent to pharmacy of choice if medically necessary
6. Teladoc is less expensive than the ER or urgent care

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

Talk to a Doctor Anytime!

DOWNLOAD THE APP - Available in the App Store and on Google Play

Teladoc.com

1-800-TELADOC (835-2362)

Available on the iPhone App Store

ANDROID APP ON Google play

Programa de control de la diabetes
Administrado por Livongo/Teladoc Health

Dele la vuelta a la situación con la diabetes.

El programa de control de la diabetes puede ayudarle a controlar sus niveles de azúcar en la sangre para una mejor salud en general.

El nivel normal de azúcar en la sangre es

80-130 mg/dL[1]

antes de comer

"Después de comer, debería ser menos de

180 mg/dL[1]

¿Cuáles son tus niveles de azúcar en la sangre?

Los Niveles Altos y Bajos de Azúcar en la Sangre

Si tiene diabetes, es importante controlar regularmente tu nivel de azúcar en sangre. Al monitorear puede:

- Ver si sus elecciones y estilo de vida están funcionando
- Obtener comentarios inmediatos
- Recopila datos que tu equipo de Livongo puede utilizar para ayudarte

Maneje su Salud en General

- Tome sus medicamentos
- Lleva una dieta equilibrada
- Mantente activo
- Duerma lo suficiente
- Controle su nivel de azúcar en sangre

El programa de control de la diabetes de Livongo brinda el apoyo y las herramientas que necesita para alcanzar sus objetivos de salud. ¡Este programa puede ayudarlo a controlar sus niveles de azúcar en la sangre, lo cual es bastante dulce!

> “Tengo todas estas herramientas geniales. Tienes la posibilidad de descargar y tener acceso a todos tus registros. Es realmente bueno. Ojalá hubiera comenzado a usarlo hace mucho tiempo”. John S.

Empiece para utilizar Livongo hoy mismo
Visita y Únase Livongo.com/ACME/Regístrese o llame al 800-945-4355 o
Descargue la app use su código de registración: ACME

[1]https://medlineplus.gov/bloodglucose.html

¿Qué es Hinge Health?

Ofrecemos a nuestros usuarios planes de terapia de ejercicio personalizados y desarrollados por expertos para obtener un alivio duradero del dolor.

¿Hinge Health es para mí?

Ya sea una lesión nueva o dolores continuos, Hinge Health está diseñado para cualquier persona que tenga dolor en las articulaciones o músculos.

¿Qué incluye mi programa?

- Acceso ilimitado a tus ejercicios y estiramientos personalizados desarrollados por fisioterapeutas
- Prácticas sesiones de ejercicio que puedes hacer en cualquier momento y en cualquier lugar con la aplicación de Hinge Health
- Apoyo personalizado y dedicado de un fisioterapeuta y un coach de salud calificado

¿Quién está en mi equipo de cuidado clínico?

Tu equipo de cuidado clínico incluye un Fisioterapeuta y un Coach de Salud calificado. Puedes comunicarte con ellos por mensaje de texto, correo electrónico, llamada telefónica o video llamada, para hacer preguntas, establecer objetivos y más.

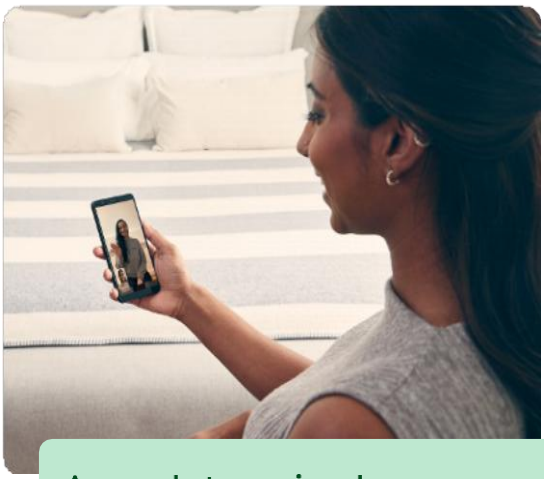
¿Cuánto cuesta el programa?

Hinge Health está disponible para los empleados que cumplan los requisitos sin costo adicional.

¿Quién es elegible?

Son elegibles los empleados y dependientes mayores de 18 años inscritos en el plan de seguro médico patrocinado por la empresa.

Terapia de ejercicio simplificada
Tus sesiones están diseñadas para realizarse en aproximadamente 15 minutos o menos.



Apoyo de tu equipo de cuidado clínico
Obtén ayuda para superar el dolor, recuperarte de una lesión, prepararte para una cirugía y más.

Para obtener más información y postularte, escanea el código QR o visita

hinge.health/acmebrick-25

¿Tienes preguntas? Llama al (855) 902-2777

AIRROSTI
(800) 404-6050 | AIRROSTI.COM

ACME BRICK

Atención musculoesquelética integral.

Aquí están algunas lesiones comunes que nuestros proveedores tratan diariamente.

- Espalda/cuello
- Rodilla
- Hombro
- Pie
- Muñeca
- Y mucho más

99%
SATISFACCIÓN DE LOS PACIENTES

3.2 consultas
DURACIÓN PROMEDIO DEL TRATAMIENTO

Más de 15,000
CIRUGÍAS RECOMENDADAS POR UN MÉDICO EVITADAS

Según resultados informados por los pacientes en la clínica (los resultados de la Recuperación a Distancia varían levemente).

¡Las visitas con Airrosti son un beneficio dentro de la red para todos los empleados, y dependientes de Acme Brick
Plan Oro, Plata y Bronce: copago de $30

Airrosti brinda atención personalizada y altamente efectiva para dolores y afecciones crónicas y agudas en huesos, articulaciones, músculos, tendones y ligamentos. Durante los últimos 17 años, nuestra red de proveedores altamente capacitados ha logrado de manera constante resultados incomparables en nuestros pacientes.

La Recuperación a Distancia de Airrosti ofrece la amplia experiencia clínica de Airrosti en una solución virtual y conveniente.

ELIJA SU CAMINO HACIA LA RECUPERACIÓN.

Cada plan de tratamiento Airrosti, ya sea virtual o presencial, incluye:

DIAGNÓSTICO PRECISO

Evaluación exhaustiva y prueba ortopédica para ayudar a brindar un diagnóstico preciso, junto con educación sobre la lesión.

PLAN DE RECUPERACIÓN PERSONALIZADO

Tratamiento conservador guiado por un proveedor para restaurar la función, aumentar la movilidad y reducir el dolor.

RECUPERACIÓN EFECTIVA DE LAS LESIONES

Ejercicios personalizados, de rehabilitación activa y caseros diseñados para acelerar la recuperación y evitar lesiones futuras.

Costo del Plan Médico
(53 Deducciones Semanales por Nómina)

PLAN BRONCE		
	Precio Selecto	**Precio Estándar**
Solo Asociado	$23.88	$41.73
Asociado + Cónyuge	$86.43	$109.36
Asociado + Hijo(s)	$48.64	$68.50
Asociado + Familia	$109.40	$134.20

PLAN PLATA		
	Precio Selecto	**Precio Estándar**
Solo Asociado	$38.59	$58.87
Asociado + Cónyuge	$123.34	$151.16
Asociado + Hijo(s)	$72.75	$96.07
Asociado + Familia	$158.62	$189.59

PLAN ORO		
	Precio Selecto	**Precio Estándar**
Solo Asociado	$52.75	$75.48
Asociado + Cónyuge	$167.61	$198.36
Asociado + Hijo(s)	$94.72	$121.36
Asociado + Familia	$209.83	$239.49

Flexible Spending Accounts
Administered by Wex Health

Las cuentas de gastos flexibles (FSA) le permiten pagar gastos de atención médica elegibles (incluidos dentales y de la vista) y de cuidado infantil dependiente utilizando dólares
libres de impuestos.

- **FSA para atención médica**: se utiliza para pagar los gastos de bolsillo asociados con planes médicos, dentales y de la vista, como copagos, coseguro, deducibles, gastos de medicamentos recetados, exámenes y pruebas de laboratorio, lentes de contacto y anteojos para usted y sus dependientes elegibles.
- **FSA para el cuidado de dependientes**: se utiliza para pagar los gastos de cuidado de dependientes, como guardería, programas antes y después de la escuela, campamentos de día, preescolar/jardín de infantes, etc., gastos que son necesarios para que usted o su cónyuge trabajen o asistan a la escuela a tiempo completo.

IMPORTANTE: El IRS tiene una regla de "úselo o piérdalo". Si no gasta todo el dinero que eligió depositar en su FSA antes de la fecha límite anual, perderá todo el dinero no utilizado en su cuenta.

Cómo funciona el FSA de salud	Cómo funciona una Cuenta FSA para el Cuidado de Dependientes
Puede contribuir hasta $3,400 por año, antes de impuestos	Puede contribuir hasta $7,500 por año como contribución de nómina antes de impuestos, o $3,750 si está casado y presenta declaraciones de impuestos por separado.
Recibirá una tarjeta de débito para pagar los gastos de atención médica elegibles, incluidos los de atención dental y de la vista.	Usted presenta reclamos de reembolso; no se proporcionan tarjetas de débito; los fondos deben estar disponibles en su cuenta
Los gastos elegibles incluyen copagos, coseguro, deducibles, anteojos, lentes de contacto y algunos medicamentos de venta libre si los prescribe su médico.	Se puede utilizar para pagar gastos de cuidado de dependientes elegibles, incluidos programas de guardería, programas extraescolares y programas de cuidado de personas mayores para sus padres ancianos.
Presentar reclamos hasta el 31 de marzo del 2027 por gastos incurridos desde el 1 de enero de 2026 hasta el 15 de marzo de 2027.	Presentar reclamos hasta el 31 de marzo de 2027 por gastos realizados entre el 1 de enero y el 31 de diciembre de 2026.
Si no gasta todos los fondos que eligió aportar antes del 15 de marzo de 2027, los dólares no utilizados se perderán según las reglas del IRS.	Si no gasta todos los fondos que eligió aportar antes del 31 de diciembre de 2026, esos dólares no utilizados se perderán según las reglas del IRS.

Cómo puedes ahorrar impuestos con una cuenta FSA	
Tus ingresos brutos anuales	$50,000
Gastos totales estimados de atención médica para 2026 (deducibles, copagos, coseguro, gastos dentales y de visión)	$5,000
Tu elección de FSA para el 2026	$3,400
Posibles ahorros en impuestos federales sobre la renta	$396
Ahorros potenciales en el impuesto FICA	$253
Ahorros fiscales totales potenciales	**$649**

Esta ilustración supone que el miembro tiene un mínimo de 3,400 dólares en gastos médicos.

Dental
Administrado por Cigna

Tiene dos opciones de cobertura dental a través de Cigna: el plan DHMO y un plan PPO tradicional. El plan DHMO es un plan con copago y tiene contribuciones más bajas para Asociados. Debe elegir un dentista general que pertenezca a la red Cigna Dental Care Access que pueda derivarlo a un especialista si es necesario. El plan PPO tradicional le permite recibir servicios de cualquier dentista de la red Cigna y disfrutar de descuentos negociados en la red..

	Plan DHMO	Plan PPO	
	Dentro de la red: solo tú pagas	**Dentro de la red: solo tú pagas**	**Fuera de la red: usted paga**
Deducible por año calendario Individual/Familiar	nigun	$50/$150	
Beneficio máximo por año Clase 1, 2, 3	Ilimitado	$2,000	
Clase 1: Diagnóstico y prevención Evaluación oral, limpiezas de rutina, radiografías, flúor, selladores, mantenedores de espacio, atención de emergencia para aliviar el dolor.	Examen, limpiezas, radiografías: $0; selladores: $8 - $12 por diente; mantenedores de espacio: $110-$170	0%	0%
Clase 2: Restaurador Básico Empastes, endodoncias, periodoncias, cirugía oral, anestesia, reparaciones de coronas, dentaduras postizas y puentes, extracciones quirúrgicas de dientes impactados	Empastes: $72; extracciones simples: $12-$53; cirugía oral: $110-$400; periodoncia: $42-$430; endodoncia: $14-$350	20% Después del deducible	20% Después del deducible
Clase 3: Restauración mayor Incrustaciones/onlays, prótesis sobre implantes, coronas, prótesis dentales, puentes	Coronas: $410-$790; incrustaciones/onlays: $390-$460; dentaduras postizas: $525-$680; puentes: $1,200-$2,400	50% Después del deducible	50% Después del deducible
Clase 4: Ortodoncia Para hijos hasta los 19 anos El beneficio máximo $2,000 **nuevo**	$2,040 - $2,376 adultos y niños	50%	50%
Periodos de Espera Restauración mayor de clase 3 Ortodoncia de clase 4	nigun	Nigun	
Nivel máximo de Reembolso	Copagos basados en la tarifa contratada	Basado en tarifas contratadas; el miembro no es responsable de los montos descontados	Basado en el cargo máximo reembolsable (MRC); el miembro es responsable de los montos que excedan el MRC.

Dental (continuación)

Mantener un cuidado bucal adecuado realmente puede tener un impacto en su salud general. Nuestro plan a través de Cigna cubre dos limpiezas al año sin costo.

No se trata sólo de la placa y el mal aliento. ¿Sabías que una mala salud bucal puede contribuir a lo siguiente?

1. Mayor riesgo de enfermedad cardiovascular
2. Mayor riesgo de disfunción eréctil
3. Riesgo de ciertos tipos de cancer
4. Alto nivel de azúcar en la sangre (diabetes): las personas con diabetes existente ya tienen un mayor riesgo de enfermedad de las encías
5. Mayor riesgo de desarrollar enfermedad renal
6. Mayor riesgo de demencia
7. Riesgo de desarrollar artritis reumatoide
8. Mayor tasa de infecciones respiratorias
9. Problemas con la fertilidad
10. Complicaciones de embarazo

Las personas que reciben atención preventiva regular tienen un 22% menos de probabilidades de necesitar atención en una sala de emergencias o un centro de atención de urgencia.

Puede inscribirse usted mismo y sus dependientes elegibles o puede renunciar a la cobertura dental. No es necesario que esté inscrito en una cobertura médica para elegir un plan dental. Acme Brick ofrece cobertura dental a través de Cigna. Para obtener información sobre cómo encontrar un proveedor dental mediante la red Cigna Access Plus o Advantage Network, visite www.myCigna.com y haga clic en Buscar un médico, dentista o centro.

Antes de Inscribirse Considere Esto:

1. La mayoría de las limpiezas y exámenes preventivos dentro de la red están con cobertura al 100%.
2. Puede recibir atención dental dentro o fuera de la red. Sin embargo, cuando recibe atención fuera de la red, el proveedor puede cobrar más y el plan reembolsará hasta las tarifas razonables y habituales.

Opción DHMO

Si decide inscribirse en la opción DHMO por primera vez o agregar nuevos dependientes bajo esta opción, debe seleccionar un dentista de atención primaria. Puede elegir un dentista DHMO diferente para usted y cada dependiente cubierto.

Debe consultar el directorio de proveedores participantes antes de inscribirse. El directorio enumera a los dentistas que son miembros de la red; los servicios prestados por un proveedor que no pertenece a la red no están con cobertura. Para buscar en el directorio de proveedores en línea:

1) visite: www.cigna.com.
2) Haga clic en “Buscar un médico” ubicado en la parte superior de la pantalla
3) Haga clic en “Empleador o escuela” cuando se le pregunte “¿Cómo está cubierto?”
4) Ingrese su dirección y haga clic en su tipo de búsqueda: médico por tipo, médico por nombre o instalaciones de salud
5) Seleccione el tipo de dentista que está buscando, luego seleccione continuar como invitado y haga clic en el botón azul Continuar nuevamente
6) En CIGNA DENTAL CARE DHMO seleccione Cigna Dental Care Access

¿Aún necesita ayuda? Llámenos al 800-Cigna24 (800-244-6224)

Visión
Asegurado por Davis Visión, una compañía de Versant Health/MetLife

La salud de los ojos y la visión clara son una parte importante de su salud general y su calidad de vida. Puede inscribirse usted mismo y sus dependientes elegibles o puede renunciar a la cobertura de la vista. No es necesario que esté inscrito en una cobertura médica para elegir un plan de la vista.

La siguiente tabla resume las características clave del plan de la vista. Consulte los documentos oficiales del plan para obtener información adicional sobre la cobertura y las exclusiones.

Versant Health se dedica a brindar una amplia variedad de opciones a través de sus redes líderes en la industria. Nuestros socios de red incluyen Target Optical, Pearle Vision (ubicaciones seleccionadas) y las tiendas minoristas For Eyes. Es importante confirmar la participación a través del sitio web para miembros en davisvision.com/locator o llamando al 800-999-5431.

	Pagos si está en la Red	Reembolso máximo si es Fuera de la Red
Examen	$10 copago	$45
Materiales	$25 copago	vea abajo
Lente única	$25 copago	$40
Bifocales	$25 copago	$60
Trifocales	$25 copago	$80
Mejoras de lentes Polarizado Tintado Resistente a rayones Recubrimiento ultravioleta Recubrimiento antirreflejante Lentes de policarbonato Lentes progresivas	$0 $0 - $12 $30 $35 - $85 $0 - $30 $50 - $175	aplicada a la asignación por lente correctiva aplicable
Marcos	$160 permitidos + 20% de descuento sobre saldo	$75
Contactos – médicamente necesario	$0	$225
Contactos – electivo	$160 permitidos + 15% de descuento sobre saldo	$100
Examen	una vez cada 12 meses	
Lentes de contacto	una vez cada 12 meses	
Marcos	una vez cada 12 meses	
Contactos (en lugar de lentes)	una vez cada 12 meses	

Costos de Atención Dental y de la Vista
(52 Deducciones semanales por nómina)

Plan Odontológico DHMO	
Asociado Solo	$1.49
Asociado + Cónyuge	$2.73
Asociado + Hijo(s)	$3.13
Asociado + Familia	$4.79

Plan Dental PPO	
Asociado Solo	$2.79
Asociado + Cónyuge	$4.97
Asociado + Hijo(s)	$5.95
Asociado + Familia	$8.34

Plan de Visión	
Asociado Solo	$1.25
Asociado + Cónyuge	$2.51
Asociado + Hijo(s)	$2.63
Asociado + Familia	$3.67

Seguro de vida
Asegurado por Prudential

Seguro de vida básico y seguro por muerte accidental y desmembramiento (AD&D):
Acme Brick proporciona automáticamente a todos los asociados a tiempo completo un seguro de vida básico y seguro por muerte accidental y desmembramiento por un monto de $20,000.

El seguro por muerte accidental y desmembramiento (AD&D) brinda beneficios adicionales si usted muere o sufre una pérdida cubierta en un accidente, como la pérdida de una extremidad o la vista.

Seguro de vida voluntario y seguro por muerte accidental y desmembramiento (AD&D)
Si desea adquirir una cobertura de seguro de vida adicional, puede elegir el seguro de vida voluntario y seguro por muerte accidental y desmembramiento para usted, su cónyuge y sus hijos dependientes.

Seguro de Vida y AD&D Voluntario : Para usted y sus dependientes			
	Asociado	**Cónyuge**	**Hijo(os)**
Monto del beneficio	Incrementos de $25,000 up to $300,000	Incrementos de $5,000 hasta $150,000 que no excedan el 50% del monto elegido por el Asociado	$10,000 ($250 para niños de 14 días a 6 meses de edad)
Emisión garantizada (GI)	$300,000	$50,000	$10,000
Reducción de edad	35% a la edad de 65 60% a la edad de 70 75% a la edad de 75 90% a la edad de 80	35% cuando el Asociado cumple 65 años Termina cuando el Asociado cumple 70 años o se jubila, lo que ocurra primero	N/A

Oportunidad Especial de Inscripción Anual 2026
Solo durante el período de inscripción abierta de 2026, los asociados podrán elegir o aumentar su cobertura actual de Seguro Suplementario de Vida y AD&D sin necesidad de completar el Formulario de Evidencia de Asegurabilidad (EOI). Esta oportunidad única aplica únicamente durante el período de inscripción de 2026. También se extiende a la cobertura para cónyuges, hasta el límite garantizado de $50,000.

Costo del seguro de vida suplementario y AD&D
(deducciones semanales de nómina)

Prudential

OPCIONES DE COBERTURA PARA ASOCIADOS

edad	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
< 25	$0.42	$0.84	$1.26	$1.68	$2.11	$2.53	$2.95	$3.37	$3.79	$4.21	$4.63	$5.05
25 – 29	$0.48	$0.96	$1.44	$1.92	$2.39	$2.87	$3.35	$3.83	$4.31	$4.79	$5.27	$5.75
30 – 34	$0.59	$1.19	$1.78	$2.38	$2.97	$3.57	$4.16	$4.75	$5.35	$5.94	$6.54	$7.13
35 – 39	$0.71	$1.42	$2.13	$2.84	$3.55	$4.26	$4.97	$5.68	$6.39	$7.10	$7.81	$8.52
40 – 44	$0.88	$1.77	$2.65	$3.53	$4.41	$5.30	$6.18	$7.06	$7.94	$8.83	$9.71	$10.59
45 – 49	$1.23	$2.46	$3.69	$4.92	$6.14	$7.37	$8.60	$9.83	$11.06	$12.29	$13.52	$14.75
50 – 54	$1.81	$3.61	$5.42	$7.22	$9.03	$10.83	$12.64	$14.45	$16.25	$18.06	$19.86	$21.67
55 – 59	$3.31	$6.61	$9.92	$13.22	$16.53	$19.83	$23.14	$26.45	$29.75	$33.06	$36.36	$39.67
60 – 64	$4.92	$9.84	$14.76	$19.68	$24.61	$29.53	$34.45	$39.37	$44.29	$49.21	$54.13	$59.05
65 – 69	$8.90	$17.80	$26.71	$35.61	$44.51	$53.41	$62.31	$71.22	$80.12	$89.02	$97.92	$106.82
70+	$12.02	$24.03	$36.05	$48.07	$60.09	$72.10	$84.12	$96.14	$108.16	$120.17	$132.19	$144.21

OPCIONES DE COBERTURA PARA CÓNYUGE

edad	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000	$55,000	$60,000
< 25	$0.08	$0.17	$0.25	$0.34	$0.42	$0.51	$0.59	$0.67	$0.76	$0.84	$0.93	$1.01
25 – 29	$0.10	$0.19	$0.29	$0.38	$0.48	$0.57	$0.67	$0.77	$0.86	$0.96	$1.05	$1.15
30 – 34	$0.12	$0.24	$0.36	$0.48	$0.59	$0.71	$0.83	$0.95	$1.07	$1.19	$1.31	$1.43
35 – 39	$0.14	$0.28	$0.43	$0.57	$0.71	$0.85	$0.99	$1.14	$1.28	$1.42	$1.56	$1.70
40 – 44	$0.18	$0.35	$0.53	$0.71	$0.88	$1.06	$1.24	$1.41	$1.59	$1.77	$1.94	$2.12
45 – 49	$0.25	$0.49	$0.74	$0.98	$1.23	$1.47	$1.72	$1.97	$2.21	$2.46	$2.70	$2.95
50 – 54	$0.36	$0.72	$1.08	$1.44	$1.81	$2.17	$2.53	$2.89	$3.25	$3.61	$3.97	$4.33
55 – 59	$0.66	$1.32	$1.98	$2.64	$3.31	$3.97	$4.63	$5.29	$5.95	$6.61	$7.27	$7.93
60 – 64	$0.98	$1.97	$2.95	$3.94	$4.92	$5.91	$6.89	$7.87	$8.86	$9.84	$10.83	$11.81
65 – 69	$1.78	$3.56	$5.34	$7.12	$8.90	$10.68	$12.46	$14.24	$16.02	$17.80	$19.58	$21.36

Spouse rate is based on employee age. Spouse coverage terminates at age 70.

OPCIONES DE COBERTURA PARA CÓNYUGE (CONTINUADO)

edad	$65,000	$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000	$105,000	$110,000	$115,000	$120,000
< 25	$1.10	$1.18	$1.26	$1.35	$1.43	$1.52	$1.60	$1.68	$1.77	$1.85	$1.94	$2.02
25 – 29	$1.25	$1.34	$1.44	$1.53	$1.63	$1.72	$1.82	$1.92	$2.01	$2.11	$2.20	$2.30
30 – 34	$1.55	$1.66	$1.78	$1.90	$2.02	$2.14	$2.26	$2.38	$2.50	$2.61	$2.73	$2.85
35 – 39	$1.85	$1.99	$2.13	$2.27	$2.41	$2.55	$2.70	$2.84	$2.98	$3.12	$3.26	$3.41
40 – 44	$2.30	$2.47	$2.65	$2.82	$3.00	$3.18	$3.35	$3.53	$3.71	$3.88	$4.06	$4.24
45 – 49	$3.20	$3.44	$3.69	$3.93	$4.18	$4.42	$4.67	$4.92	$5.16	$5.41	$5.65	$5.90
50 – 54	$4.70	$5.06	$5.42	$5.78	$6.14	$6.50	$6.86	$7.22	$7.58	$7.95	$8.31	$8.67
55 – 59	$8.60	$9.26	$9.92	$10.58	$11.24	$11.90	$12.56	$13.22	$13.88	$14.55	$15.21	$15.87
60 – 64	$12.80	$13.78	$14.76	$15.75	$16.73	$17.72	$18.70	$19.68	$20.67	$21.65	$22.64	$23.62
65 – 69	$23.15	$24.93	$26.71	$28.49	$30.27	$32.05	$33.83	$35.61	$37.39	$39.17	$40.95	$42.73

Spouse rate is based on employee age. Spouse coverage terminates at age 70.

Costo del seguro de vida suplementario y AD&D
(deducciones semanales de nómina)

OPCIONES DE COBERTURA PARA CÓNYUGE (CONTINUADO)

edad	$125,000	$130,000	$135,000	$140,000	$145,000	$150,000
< 25	$2.11	$2.19	$2.27	$2.36	$2.44	$2.53
25 – 29	$2.39	$2.49	$2.59	$2.68	$2.78	$2.87
30 – 34	$2.97	$3.09	$3.21	$3.33	$3.45	$3.57
35 – 39	$3.55	$3.69	$3.83	$3.97	$4.12	$4.26
40 – 44	$4.41	$4.59	$4.77	$4.94	$5.12	$5.30
45 – 49	$6.14	$6.39	$6.64	$6.88	$7.13	$7.37
50 – 54	$9.03	$9.39	$9.75	$10.11	$10.47	$10.83
55 – 59	$16.53	$17.19	$17.85	$18.51	$19.17	$19.83
60 – 64	$24.61	$25.59	$26.57	$27.56	$28.54	$29.53
65 – 69	$44.51	$46.29	$48.07	$49.85	$51.63	$53.41

La tarifa para el cónyuge se basa en la edad del asociar. La cobertura para el cónyuge termina a los 70 años

OPCIONES DE COBERTURA PARA HIJOS

	$10,000
Desde recién nacidos hasta los 26 años (si no están casado)	$.51

Seguro voluntario adicional por muerte accidental y desmembramiento para usted y sus dependientes

(además del seguro por muerte accidental y desmembramiento voluntario de la página anterior)

	OPCIÓN 1 Solo Asociado	OPCIÓN 2 Asociado + Cónyuge	OPCIÓN 3 Asociado + Niño	OPCIÓN 4 Asociado + Familia
Beneficio Importe	incrementos de $50,000 hasta $500,000; no exceder el 10× sus ingresos anuales base	50% del monto elegido por el asociado	15% del monto elegido por el asociado hasta un máximo de $20,000	**Esposo:** 40% del monto elegido por el asociado **Niño(s):** 10% del monto elegido por el asociado hasta un máximo de $20,000

Seguro Voluntario Adicional Por Muerte Accidental y Desmembramiento (AD&D)
(deducciones semanales de nómina)

	Monto del beneficio para el asociado	Deducción semanal de nómina
OPCIÓN 1 Solo Asociado	$50,000	$0.27
	$100,000	$0.53
	$150,000	$0.80
	$200,000	$1.06
	$250,000	$1.33
	$300,000	$1.59
	$350,000	$1.86
	$400,000	$2.12
	$450,000	$2.39
	$500,000	$2.65

	Monto del beneficio para el asociado	Monto del beneficio para el cónyuge	Deducción semanal de nómina
OPCIÓN 2 Asociado + Cónyuge	$50,000	$25,000	$0.40
	$100,000	$50,000	$0.80
	$150,000	$75,000	$1.19
	$200,000	$100,000	$1.59
	$250,000	$125,000	$1.99
	$300,000	$150,000	$2.39
	$350,000	$175,000	$2.79
	$400,000	$200,000	$3.18
	$450,000	$225,000	$3.58
	$500,000	$250,000	$3.98

	Monto del beneficio para el asociado	Monto del beneficio para el hijo	Deducción semanal de nómina
OPCIÓN 3 Asociado + Niño	$50,000	$7,500	$0.31
	$100,000	$15,000	$0.61
	$150,000	$20,000	$0.90
	$200,000	$20,000	$1.17
	$250,000	$20,000	$1.43
	$300,000	$20,000	$1.70
	$350,000	$20,000	$1.96
	$400,000	$20,000	$2.23
	$450,000	$20,000	$2.49
	$500,000	$20,000	$2.76

	Monto del beneficio para el asociado	Monto del beneficio para el cónyuge	Monto del beneficio para el hijo	Deducción semanal de nómina
OPCIÓN 4 Asociado + Familia	$50,000	$20,000	$5,000	$0.40
	$100,000	$40,000	$10,000	$0.80
	$150,000	$60,000	$15,000	$1.19
	$200,000	$80,000	$20,000	$1.59
	$250,000	$100,000	$20,000	$1.96
	$300,000	$120,000	$20,000	$2.34
	$350,000	$140,000	$20,000	$2.71
	$400,000	$160,000	$20,000	$3.08
	$450,000	$180,000	$20,000	$3.45
	$500,000	$200,000	$20,000	$3.82

Incapacidad Voluntaria: a Corto y Largo Plazo
Administrado por Prudential

El seguro de discapacidad a corto plazo ofrece un beneficio en efectivo por hasta 24 semanas cuando no puede trabajar debido a una lesión, enfermedad, cirugía o recuperación del parto.

Si después de 24 semanas no puede volver a trabajar a tiempo completo, puede ser elegible para beneficios por discapacidad extendidos si se inscribe en el plan de beneficios por discapacidad a largo plazo. Los beneficios por discapacidad a largo plazo se pagan hasta la Edad de Jubilación Normal del Seguro Social.

Discapacidad a Corto Plazo	
Monto del beneficio semanal	60% de sus ganancias semanales, sin exceder $2,000 por semana
Periodo de eliminación: enfermedad	14 días; los beneficios comienzan el día 15
Periodo de eliminación: lesión	14 días; los beneficios comienzan el día 15
Duración máxima del beneficio	hasta 24 semanas
Limitación preexistente	ninguna

Discapacidad a Corto Plazo	
Monto del beneficio mensual	60% de sus ganancias semanales, sin exceder los $8,667 por mes
Período de eliminación: enfermedad	180 días (después de que finaliza la discapacidad a corto plazo)*
Periodo de eliminación: lesión	180 días (después de que finaliza la discapacidad a corto plazo)*
Duración máxima del beneficio	Edad Normal de Jubilación del Seguro Social (ENJSS)
Limitación preexistente	3/12**
Evidencia de asegurabilidad (EDA)	La cobertura elegida durante el período de inscripción anual no está sujeta a la Evidencia de Asegurabilidad (EDA) siempre que hayan cumplido los siguientes criterios: (1) No ha sido rechazado previamente; y (2) El monto de su beneficio elegido o el monto de su elección aumentada no excede el Beneficio Mensual Máximo.

* Los asociados que no estén inscritos en el plan de discapacidad a corto plazo deben cumplir con el período de eliminación de 180 días y los beneficios se pagarán el día 181.

**Es posible que no se paguen beneficios por ninguna afección tratada dentro de los 3 meses anteriores a su fecha de vigencia hasta que haya estado cubierto por este plan durante 12 meses continuos.

Costo voluntario por discapacidad a corto plazo
(deducciones semanales de nómina)

Use la tabla a continuación para encontrar el costo del seguro de discapacidad a corto plazo. Siga los pasos a continuación para calcular el costo de su cobertura. El monto máximo de su beneficio semanal es de $2,000. Su nivel de cobertura está limitado al salario de $173,333.

Edad del asociado	Tasa
debajo 25	$.315
25-29	$.335
30-34	$.325
35-39	$.365
40-44	$.405
45-49	$.480
50-54	$.645
55-59	$.825
60-64	$.825
65+	$.945

Las tarifas pueden cambiar a medida que el asegurado ingresa a una categoría de edad más alta. Además, las tarifas pueden cambiar si la experiencia del plan requiere un cambio para todos los asegurados.

Cómo calcular el costo semanal total de su seguro de discapacidad a corto plazo (STD

Paso 1	Indica tus ganancias semanales.	= $
Paso 2	Multiplica tus ganancias semanales por 60%	= $
Paso 3	Si la cantidad en el Paso 2 es mayor que $2,000, indique $2,000. De lo contrario, indique el importe del paso 2	= $
Paso 4	Multiplique la cantidad en el Paso 3 por la tasa para su edad y divídala por 10 para obtener su costo mensual total de STD.	= $
Paso 5	Multiplique la cantidad en el Paso 4 por 12 y divídala por 52 para obtener su costo semanal total de ETS.	= $

Costo voluntario por discapacidad a largo plazo
(deducciones semanales de nómina)

Use la tabla a continuación para encontrar el costo del seguro de discapacidad a largo plazo. Si no se anota su salario, siga los pasos a continuación. El monto máximo de su beneficio mensual es de $8,667. Todos los salarios de $ 173,340 y más tienen un costo semanal de $19.00.

Ingresos anuales	Beneficio mensual	Deducción semanal
$12,000	$600	$1.32
$13,000	$650	$1.42
$14,000	$700	$1.53
$15,000	$750	$1.65
$20,000	$1,000	$2.19
$25,000	$1,250	$2.74
$30,000	$1,500	$3.29
$35,000	$1,750	$3.84
$40,000	$2,000	$4.38
$45,000	$2,250	$4.93
$50,000	$2,500	$5.48
$55,000	$2,750	$6.03
$60,000	$3,000	$6.58
$65,000	$3,250	$7.13
$70,000	$3,500	$7.67
$75,000	$3,750	$8.22
$80,000	$4,000	$8.77
$85,000	$4,250	$9.32

Ingresos anuales	Beneficio mensual	Beneficio mensual
$90,000	$4,500	$9.87
$95,000	$4,750	$10.41
$100,000	$5,000	$10.96
$105,000	$5,250	$11.51
$110,000	$5,500	$12.06
$115,000	$5,750	$12.60
$120,000	$6,000	$13.15
$125,000	$6,250	$13.70
$130,000	$6,500	$14.25
$135,000	$6,750	$14.80
$140,000	$7,000	$15.35
$145,000	$7,250	$15.89
$150,000	$7,500	$16.44
$155,000	$7,750	$16.99
$160,000	$8,000	$17.54
$165,000	$8,250	$18.09
$170,000	$8,500	$18.63
$173,340	$8,667	$19.00

Complemente su cobertura médica

Para ayudarlo a administrar los costos médicos de bolsillo, Acme ofrece un seguro voluntario contra accidentes y enfermedades graves a través de Prudential.

Plan de accidentes

En caso de un accidente o lesión con cobertura, este seguro le pagará un beneficio en efectivo en una suma global a usted y a los miembros de su familia elegibles que elija cubrir. El seguro contra accidentes NO es un seguro médico.

Plan de Enfermedades Críticas

Los ataques cardíacos y los accidentes cerebrovasculares son ejemplos de enfermedades graves comunes que a menudo dan lugar a facturas médicas inesperadas. Si está recibiendo tratamiento por una enfermedad tan grave, ¿no debería su principal objetivo ser curarse, en lugar de preocuparse por cómo pagar su atención? El seguro de enfermedades graves puede ayudarlo pagándole una suma global en efectivo para cubrir sus gastos diarios, como facturas de comestibles, pagos de hipotecas, costos de transporte o para pagar sus costos médicos de bolsillo, incluidos deducibles, copagos y costos compartidos. Puede elegir entre $10,000, $20,000 o $30,000 en montos de cobertura para usted y $5,000, $10,000 o $15,000 para su cónyuge, sin exceder el 50% del monto del asociado. El seguro de enfermedades graves NO es un seguro médico.

Cómo inscribirse

Para inscribirse en el plan voluntario de accidentes y/o enfermedades críticas, deberá completar y enviar el "Formulario de inscripción para accidentes y enfermedades críticas de Prudential" que se encuentra en Acme Connect o comunicarse con su administrador local o HR@brick.com para obtener una copia de este formulario.

USTED SE INSCRIBE EN UN SEGURO DE ENFERMEDAD CRÍTICA Y/O ACCIDENTES

SITUACIÓN:
Tiene una enfermedad crítica, como un ataque cardíaco o un derrame cerebral, o una lesión accidental, como una fractura de pierna o pie. Su seguro médico paga sus beneficios médicos.

Recibe tratamiento y se está recuperando - pero ahora las facturas se están acumulando:

- Hipoteca/alquiler
- Alimentos
- Costos de transporte
- Deducibles
- Copagos

SOLUCIÓN: Seguro de Enfermedades crítica y/o Seguro de Accidentes

- Pago único
- Utilícelo como desee
- Ayuda a cubrir los gastos médicos y no medicos
- Paga además del seguro médico

Prestaciones Por Accidente
Asegurado por Prudential

Tratamiento de Emergencia	Sus beneficios en efectivo*
Ambulancia (Tierra o Aire)	Hasta $1,500
Tratamiento de Emergencia	Hasta $200
Rayos X	Hasta $40
Fracturas	**Sus beneficios en efectivo***
Tobillo	Hasta $575
Brazo	Hasta $1,125
Clavícula	Hasta $675
Huesos faciales	Hasta $1,125
Dedos	Hasta $125
Pie (excluye dedos)	Hasta $575
Pierna	Hasta$ 4,500
Dislocaciones	**Sus beneficios en efectivo***
Tobillo	Hasta $1,125
Clavícula	Hasta $1,125
Hombro/Codo/Mano (excepto dedos)	Hasta $575
Pierna/cadera	Hasta $3,600
Lesiones específicas	**Sus beneficios en efectivo***
Sangre, Plasma	Hasta $500
Quemaduras	Hasta $15,000
Conmoción cerebral	Hasta $200
Servicios dentales	Hasta $200
Laceraciones	Hasta $600
Lesión cerebral traumática	Hasta $7,500
Beneficios quirúrgicos	Hasta $2,000
Hospitalización y cuidados continuos	**Sus beneficios en efectivo***
Admisión y confinamiento diario	Hasta $2,000 + Hasta $600 por día
Terapia	Hasta $50 por visita/10 visitas
Asistencia para la recuperación	**Sus beneficios en efectivo***
Alojamiento para acompañantes	Hasta $200 por día
Transporte	Hasta $400 por viaje
Beneficios de un vehículo en movimiento	**Sus beneficios en efectivo***
Lesiones o muertes por vehículos en movimiento	Hasta $5,000
Muerte accidental y desmembramiento	**Sus beneficios en efectivo***
Muerte accidental: usted, su cónyuge o pareja, o su hijo(s)	$75,000, $30,000, $15,000
Desmembramiento	Hasta $60,000
Beneficio para el bienestar	**Sus beneficios en efectivo***
Reciba un incentivo en efectivo cada año que usted y cualquiera de los miembros de su familia bajo su cobertura, completen una prueba de evaluación.	$50 cada uno

*El beneficio a pagar depende de la gravedad y complejidad de la lesión. Este resumen proporciona una descripción general de la póliza. Los términos completos de la póliza se pueden encontrar en el certificado de la póliza.

Prestaciones por Enfermedades Graves
Asegurado por Prudential

Enfermedad Crítica del Asociado	Enfermedad critica del Cónyuge	Enfermedad Crítica de su hijo(s)
Montos de cobertura garantizados. $10,000, $20,000 o $30,000	Montos de cobertura garantizados $5,000, $10,000 o $15,000 (Hasta 50% del monto del Asociado)	Montos de cobertura garantizados: $2,500, $5,000, $10,000 (Hasta 50% del monto del Asociado)

Condiciones con cobertura	Porcentaje de beneficio
Infarto de miocardio/Corazón	100%
Paro cardíaco repentino que resultó en Muerte	100%
Ataque	100%
Cáncer invasivo	100%
Enfermedad renal (de los riñones) en etapa terminal	100%
Insuficiencia orgánica mayor (corazón, pulmón, hígado, páncreas, intestino)	100%
Enfermedad arterial/vascular	25%
Enfermedad de la válvula mitral o aórtica	25%
Cáncer non invasivo (in situ)	25%
Cáncer de piel (distinto del melanoma)	$250 De por vida
Condiciones Suplementarias	**Porcentaje de beneficio**
Enfermedad de Huntington avanzada	100%
EPOC avanzada	100%
SIDA	100%
ELA avanzada/enfermedad de Lou Gehrig	100%
Enfermedad de Alzheimer avanzada	100%
Enfermedad de Parkinson avanzada	100%
Esclerosis múltiple avanzada	100%
Pérdida de la vista, audición y/o habla	50%
Beneficios por Lesiones Accidentales	**Porcentaje de beneficio**
Quemaduras graves, parálisis permanente o lesiones cerebrales traumáticas (incluye coma)	100%
Otras Enfermedades Infantiles	**Porcentaje de beneficio**
Parálisis cerebral	100%
Labio hendido, paladar hendido	100%
Fibrosis quística	100%
Síndrome Down	100%
Distrofia muscular	100%
Espina bífida	100%
Diabetes tipo 1	100%
Beneficio de Bienestar	**Sus beneficios en efectivo***
Reciba un incentivo en efectivo cada año que usted y cualquiera de los miembros de su familia bajo su cobertura, completen una prueba de evaluación.	$50 cada uno

Este resumen ofrece una descripción general de la póliza. Los términos completos de la póliza se pueden encontrar en el certificado mismo de la póliza.

Costo de Accidentes y Enfermedades Critica (Deducciones semanales por Nómina)

Plan de Accidentes	
Asociado Solo	$2.87
Asociado + Cónyuge	$4.74
Asociado + Hijo(s)	$5.21
Asociado + Familia	$7.04

Tarifas del Plan de Enfermedades critica Por Cada $1,000 por edad: Asociado y Cónyuge			
< 25	$.071	**50 – 54**	$.506
25 – 29	$.097	**55 – 59**	$.684
30 – 34	$.127	**60 – 64**	$.963
35 – 39	$.169	**65 – 69**	$1.324
40 – 44	$.248	**70 – 74**	$2.528
45 – 49	$.351	**75+**	$2.528
Niño(s)	$.133		

Cálculo de Prima			
Para calcular la deducción semanal de la nómina, divida el beneficio deseado por 1000. Multiplique el resultado por la tasa aplicable de la tabla anterior.			
Asociado	Divida el monto de beneficio que desea obtener ($30,000, $20,000 o $10,000) por 1,000	= __unidad × _____ tasa	= $ _____
Cónyuge	Divida el monto de beneficio que desea obtener ($15,000, $10,000 o $5,000) por 1,000	= __unidad × _____ tasa	= $ _____
Hijo(s)	Divida el monto de beneficio que desea obtener ($10,000, $5,000 o $2,500) por 1,000	= __unidad × _____ tasa	= $ _____
		Deducción total de nómina semanal (estimada)	**= $_____**

Tenga en cuenta: la cobertura del Cónyuge se basa en la edad del Cónyuge al 1 de enero de 2025

Una descripción general de su ComPsych® GuidanceResources Programa

No importa lo que esté pasando en tu vida,ComPsych® GuidanceResources® está aquí para ayudar. Los problemas personales, la planificación de eventos de la vida o simplemente la gestión de la vida diaria pueden afectar su trabajo, salud y familia.ComPsych® GuidanceResources® es un servicio patrocinado por la compañía que está disponible para usted y sus dependientes, sin costo alguno, para brindar apoyo, recursos e información confidenciales para superar los desafíos de la vida. Estos servicios confidenciales se brindan a todos los asociados de Acme sin costo alguno.

Asesoramiento confidencial sobre asuntos personales

Su Programa de Asistencia al Empleado (EAP) es un programa de asistencia confidencial para ayudar a abordar los problemas personales que usted y sus dependientes enfrentan. Este servicio, atendido por médicos experimentados, está disponible por teléfono las 24 horas del día, los siete días de la semana. Un GuidanceConsultant℠ está disponible para escuchar sus inquietudes y derivarlo a un proveedor local para recibir asesoramiento en persona o a recursos en su comunidad. Llame en cualquier momento con inquietudes personales, que incluyen:

- Depresión
- Estrés y ansiedad
- Conflictos matrimoniales y familiares
- Abuso de alcohol y drogas
- Presiones laborales
- Dolor y pérdida

Información, recursos y herramientas financieras

Los problemas financieros pueden surgir en cualquier momento, desde lidiar con deudas hasta ahorrar para la universidad. Nuestros profesionales financieros están aquí para discutir sus inquietudes y brindarle las herramientas y la información que necesita para abordar sus finanzas, que incluyen:

- Ahorrar para la universidad
- Preguntas fiscales
- Salir de la deuda
- Planificación patrimonial
- Planificación de la jubilación

Información, recursos y consultas legales

Cuando surge un problema legal, nuestros abogados están disponibles para brindar apoyo confidencial con información y asistencia práctica y comprensible. Si necesita representación, también puede ser referido a un abogado calificado en su área para una consulta gratuita de 30 minutos con una reducción del 25% en los honorarios legales habituales a partir de entonces. Llame a cualquier persona con problemas legales, que incluyen:

- Divorcio y derecho de familia
- Quiebra
- Obligaciones de deuda
- Acciones penales
- Problemas de propietarios e inquilinos
- Demandas civiles
- Transacciones inmobiliarias
- Contratos

Información, herramientas y servicios en línea

GuidanceResources® Online es su única parada para obtener información experta para ayudarlo con los problemas que le importan, desde preocupaciones personales o familiares hasta preocupaciones legales y financieras. Crea tu propia cuenta yendo a www.guidanceresources.com. Cada vez que regrese al sitio, encontrará información personalizada y relevante basada en las necesidades individuales de su vida. Puedes:

- Revise las Hojas de Ayuda℠ detalladas sobre los temas que seleccione
- Obtén respuestas a preguntas específicas
- Búsqueda de servicios y referencias
- Utilice herramientas de planificación útiles

ESTAMOS DISPONIBLES LAS 24 HORAS DEL DÍA, 7 DÍAS A LA SEMANA.
Llame al: 800.311.4327
TRS: Marque 711
Online: guidanceresources.com
Tu empresaWeb ID: GRS311

Prudential Beneficiary Advocate℠

Prudential entiende que para aquellos que enfrentan la pérdida de un ser querido, la consejería de duelo puede resultar invaluable. Sin embargo, los seres queridos en duelo pueden requerir muchas otras formas de asistencia, incluidos los servicios legales y financieros y la planificación funeraria y patrimonial. Es por eso que ofrecemos Beneficiary Advocate by Prudential, un programa integral de servicios para beneficiarios, sin importar el problema. Prudential tiene un conocimiento profundo de las responsabilidades y dificultades únicas en estas situaciones. Ya sea que se enfrente al dolor de otros miembros de la familia, luche con problemas relacionados con el patrimonio o coordine las necesidades urgentes de cuidado de niños o ancianos, los beneficiarios pueden beneficiarse de los servicios integrales y de primera clase que ofrece Prudential en asociación con el líder mundial en soluciones de salud conductual, ComPsych® Corporation.

Apoyo integral al beneficiario

Los beneficiarios pueden comunicarse con ComPsych las 24 horas del día, los siete días de la semana. Se puede acceder a todos los servicios a través de una línea gratuita dedicada y lo conectan directamente con un GuidanceExpert ℠, quien realizará una evaluación y lo pondrá en contacto con los servicios apropiados. Nuestro soporte incluye:

Apoyo emocional para el duelo y la pérdida

- Acceso telefónico gratuito ilimitado las 24 horas del día, los 7 días de la semana a médicos de nivel de maestría para brindar apoyo en el momento
- Hasta tres sesiones de asesoramiento presenciales o telefónicas con un proveedor local. Hable con nosotros sobre:
  - Duelo y pérdida
  - Ansiedad, estrés, depresión
  - Orientación sobre el regreso al trabajo y más

Servicios de planificación funeraria

Planificar un funeral puede resultar abrumador. Es un momento estresante y muchas decisiones deben tomarse en un corto período de tiempo. Muchos se sienten abrumados con el proceso y pueden ser vulnerables a que se aprovechen financieramente de ellos. Los servicios de Arreglos Finales pueden evitar eso. Nuestros expertos en planificación funeraria están especialmente capacitados para recopilar información y brindar opciones para que pueda tomar las decisiones correctas. Los servicios incluyen:

- Evaluación exhaustiva de sus necesidades
- Opciones, precios y disponibilidad para funerarias, ataúdes, urnas, cementerios y más
- Paquete de referencia completo con tres referencias detalladas para cada recurso necesario

Servicios de preparación de testamentos en línea

EstateGuidance puede ayudarlo a asegurar su futuro superando las barreras legales, financieras y emocionales para la planificación patrimonial. Este servicio en línea le permite crear un documento legalmente vinculante de Última Voluntad y Testamento, Testamento Vital y Arreglos Finales, sin la molestia o el gasto de contratar a un abogado. EstateGuidance lo guía a través del proceso de documentación y desglosa cada paso en términos fáciles de entender.

Identity Theft Restoration Services

IDResources® incluye asistencia telefónica ilimitada de nuestro personal de abogados, profesionales financieros y consejeros. Los servicios están diseñados para abordar problemas legales, financieros y laborales / personales asociados con la pérdida de identidad, ayudar con la restauración de la identidad y ayudar con el daño al historial crediticio.

Servicios de planificación financiera

FinancialPoint® proporciona orientación objetiva de planificación financiera a los beneficiarios. Este proceso en línea fácil de seguir facilita a las personas la creación de un plan financiero para llevarlos adelante tras el fallecimiento de un ser querido. Un experto de FinancialPoint revisa las respuestas del individuo; se comunica directamente con ellos para obtener información o preguntas adicionales, y proporciona un plan financiero personal detallado y personalizado.

ESTAMOS DISPONIBLES LAS 24 HORAS DEL DÍA, LOS 7 DÍAS DE LA SEMANA.
Call: 800.311.4327
TTY: Marcar711
Online: guidanceresources.com
Tu empresaWeb ID: GRS311

Felicitaciones, ahora tiene acceso a los servicios de asistencia en viaje de IMG, una oferta indispensable disponible para usted y sus dependientes. IMG tiene una amplia experiencia en el manejo de situaciones complejas y remotas de transporte médico, así como en la prestación de apoyo para las inquietudes de viaje cuando surgen. Nuestro equipo de especialistas internacionales y multilingües está acostumbrado a trabajar en diferentes zonas horarias y con diferentes idiomas y monedas. Utilizando la extensa red global de proveedores de atención médica de IMG, nuestro centro de llamadas en el lugar con sede en EE. UU. las 24 horas del día, los 7 días de la semana, los 365 días del año está disponible día o noche para brindar atención de alta calidad en la que puede confiar.

SERVICIOS DE TRANSPORTE MÉDICO DE EMERGENCIA

Envío de un médico	Repatriación de restos
Evacuación médica de emergencia	Regreso del compañero de viaje
$25,000 Hospitalización de emergencia	Servicios de devolución de vehículos
Repatriación médica	Visita de un familiar o amigo

Solo disponible cuando viaja fuera de su país de origen y los EE. UU., y solo se puede usar junto con una evacuación médica elegible

SERVICIOS DE ASISTENCIA MÉDICA

Arreglos de viaje de emergencia	Referencias médicas y dentales
Atención ambulatoria y hospitalaria	Transferencia y envío de recetas
Servicios de interpretación	Telemedicina
Monitoreo médico	Reemplazo de dispositivos médicos

SERVICIOS DE ASISTENCIA EN VIAJE

Transferencia de efectivo de emergencia	Asistencia para pérdida de equipaje / documentos
Ubicación del consulado y la embajada	Alojamiento y devolución de mascotas
Asistencia para robo de identidad	Servicios informativos previos al viaje
Referencias legales	Transmisión urgente de mensajes

SERVICIOS DE ASISTENCIA DE SEGURIDAD

Evacuación política de emergencia / Repatriación	Evacuación por desastres naturales
Aplicación de inteligencia de ubicación	

Llamada gratuita en U.S.:
+1 (855)847-2194
Desde cualquier parte del mundo:**+1**
(317)927-6881

assist@imglobal.com

Seguro Para Mascotas
de Nationwide®

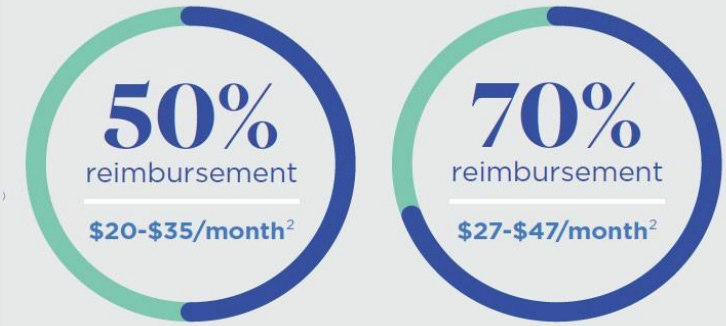
Con dos opciones económicas, nunca ha habido un mejor momento para proteger a su mascota.

Nuestros populares planes de seguro para mascotas My Pet Protection® ahora ofrecen más opciones y más flexibilidad

- Obtenga reembolsos en efectivo en algunas facturas veterinarias (elegibles): Elija su nivel de reembolso de 50% o 70%
- Disponible exclusivamente para asociados: planes con precios preferenciales que solo se ofrecen a través de su empresa
- Use cualquier veterinario, en cualquier lugar: sin redes ni aprobaciones previas
  Utilice cualquier veterinario, en cualquier lugar: sin redes o aprobaciones previas

Nationwide®

Elige tu nivel de cobertura con My Pet Protection®



Cómo utilizar su plan de seguro para mascotas

1. Visite a cualquier veterinario, en cualquier lugar
2. Presente el reclamo
3. Obtenga un reembolso por los gastos elegibles

Obtenga su cotización personalizada **http://www.petinsurance.com/brick**

[1]Pueden aplicarse algunas exclusiones. Algunas coberturas pueden estar sujetas a exclusiones preexistentes. Consulta los documentos de la póliza para obtener una lista completa de exclusiones. Es posible que las opciones de reembolso no estén disponibles en todos los estados. [2]Los Precios iniciales indicados. El costo final varía según el plan, la especie y el código postal. Productos asegurados por Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (todos los demás estados), Columbus, OH. Agencia registrada: DVM Insurance Agency. Todas son subsidiarias de Nationwide Mutual Insurance Company. Nationwide, Nationwide N and Eagle y Nationwide is on your side son marcas de servicio de Nationwide Mutual Insurance Company. ©2021 Nationwide. 21GRP8314

Programa de Descuento Para Asociados
Traído a usted by PerkSpot

Bienvenido a PerkSpot!

Con PerskSpot puede obtener descuentos exclusivos en algunos de merciantes nacionales y locales favoritos!

VIAJE | COMPUTADORAS | CINE | TELÉFONOS CELULARES | COMIDA

1. Comience registrándose o iniciando sesión en https://acmebrick.perkspot.com
2. Acceda a PerkSpot desde el trabajo, el hogar o mientras se desplaza, y explore miles de descuentos.
3. Esté atento a los nuevos descuentos destacados en el correo electrónico semanal de PerkSpot.

and many more!

Boomer Benefits®

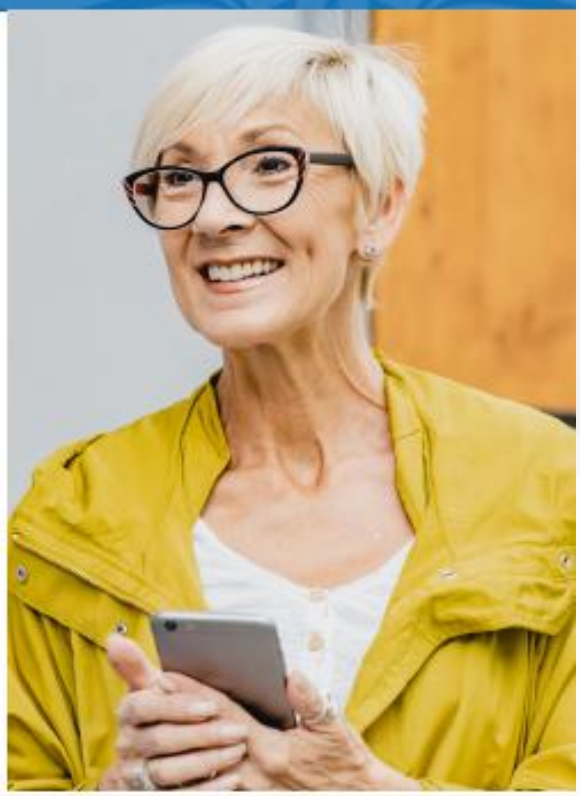
Agencia de Seguros de Medicare Galardonada

Ayuda de Clase Mundial para Navegar Medicare

Fundada en 2005, Boomer Benefits es una agencia de seguros galardonada para compañías de seguros nacionales como Blue Cross Blue Shield, Aetna, Cigna, Mutual of Omaha y muchas otras compañías con calificación A. Somos una empresa familiar y contamos con licencia en 49 estados.

A lo largo de los años, hemos aprendido prácticamente todo lo que hay que saber sobre Medicare. Transmitimos ese conocimiento a usted – absolutamente gratis.

Los empleados de Plexus tienen contactos dedicados en Boomer Benefits: Gabe Gutierrez y Jessica Yant. Boomer Benefits puede ayudarle a comparar cotizaciones de Medigap, la Parte D y los Planes Medicare Advantage en su código postal.



P: ¿En qué se diferencia Boomer Benefits® de otros corredores de Medicare?

Nuestro legendario Equipo de Atención al Cliente. Nuestro servicio después de vender una póliza no tiene comparación en la industria. La razón principal por la que los clientes permanecen con nosotros año tras año es por la increíble ayuda que reciben de este equipo sin costo adicional.

Sus Expertos Dedicados en Medicare

Reserve su Cita Aquí:

o visite **boomerbenefits.com/plexus-groupe**

Gabe Gutierrez

Jessica Yant

MERRILL
A BANK OF AMERICA COMPANY

Be the superhero for your future!

Benefits OnLine® gives you the power to access your 401(k) account.

benefits.ml.com

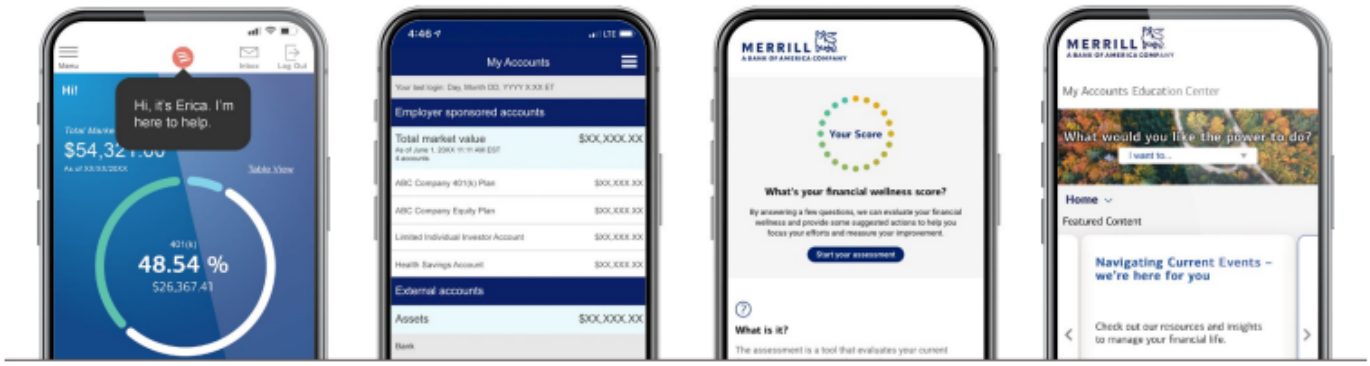
- ✓ Enroll in your 401(k) and start preparing for what's next
- ✓ Check your account balance and see your progress
- ✓ Manage your contributions and investments

Ver el sitio en español
Elija Español en el cuadro
Preferencia de idioma.

Grab your phone and download the app! Your financial future awaits.

As life happens... your needs and goals may change.

Use the Benefits OnLine app* and help build strong financial habits.



Erica®

Your virtual financial assistant is ready to help.

*Check out all that Erica can do for you on the Benefits OnLine app.**

My Financial Picture®

All of your financial information — in one place.

Use this free, secure service to add your external account information to Benefits OnLine. The more information you add, the more complete your financial picture becomes.

Financial Wellness Tracker

See where you stand financially.

Answer a few questions and get a personalized, suggested action plan with steps to help you take control of your finances.

Education Center

Knowledge is key.

Explore articles, videos and planning tools for making smart, informed financial decisions.

* The app is designed to work with most mobile devices in most countries. The mobile feature, Erica, is only available in the English language. Carrier fees may apply. When you use the QRC feature, certain information is collected from your mobile device for business purposes.

Investing involves risk, including the possible loss of the principal value invested.

Merrill provides products and services to various employers, their employees and other individuals. In connection with providing these products and services, and at the request of the employer, Merrill makes available websites on the internet, mobile device applications, and written brochures in order to provide you with information regarding your plan. Under no circumstances should these websites, applications, and brochures, or any information included in these websites, applications, and brochures, be considered an offer to sell or a solicitation to buy any securities, products, or services from Merrill or any other person or entity.

Federal Notices

Federal laws require that Acme Brick provide you with certain notices that inform you about your rights regarding eligibility, enrollment and coverage of health care plans. These notices, SPDs and plan amendments are available in print upon request to the HR department at HR@brick.com.

Notice	What It Means For You
HIPAA Privacy Notice	Describes your rights to health privacy
Special Enrollment Rights	Describes when you can enroll for coverage when you have previously declined coverage.
Premium Assistance Under Medicaid and CHIP	Provides a list of states that have premium assistance programs to help you pay for medical coverage if you are unable to afford health care coverage premiums.
Family and Medical Leave Act (FMLA)	If you or a family member is faced with a health condition that causes you to miss work, you may be able to take up to 12 weeks of job-protected time off under the FMLA.
Summary of Benefits and Coverage (SBC)	Summarizes important information about your health coverage options in a standard format to help you compare each option
Newborns' and Mothers' Health Protection Act	Describes protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.
Women's Health and Cancer Rights Act of 1998	Provides information regarding a woman's rights after a mastectomy
Genetic Information Non-Discrimination Act of 2008 (GINA)	Prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by the law.
Michelle's Law	Prohibits group health plans from terminating the coverage of a dependent child who has lost student status as a result of a medically necessary leave of absence.
Consolidated Omnibus Budget Reconciliation Act (COBRA)	Provides details about how COBRA can provide ongoing health benefits after coverage ends under certain conditions
Your Prescription Drug Coverage and Medicare	The key purpose of this notice is to advise you that the prescription drug coverage you have under the Acme Brick Health and Welfare Plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. (This is known as "creditable coverage.")
Health Insurance Marketplace Coverage Options	Provides basic information about individual health insurance options that will be available through the Marketplace (also referred to as Exchanges) beginning in 2014.
The "No Surprises Act"	Provides protection against balance billing and out-of-network cost sharing with respect to emergency services, non-emergency services furnished by non-participating providers at certain participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services.

ACME BRICK

ANNUAL EMPLOYER NOTICES

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Acme Brick

2026 Annual Employer Notices

Health Care Reform

The new federal health reform law focuses on establishing new state-based mechanisms for obtaining coverage and for establishing federal standards to oversee benefit designs and costs of coverage. Most of the significant reforms, including Exchanges and guarantee issue requirements, became effective in 2014. Other less significant reforms have already been implemented with the 2011, 2012 and 2013 plan years. Some of the changes to health plan benefits include the elimination of pre-existing conditions, no life-time limits or annual limits on certain plan benefits. Recently, the government removed the requirement of the individual mandate. In other words, individuals are not required to purchase health insurance for 2019 and beyond and will not be subject to a potential penalty if health insurance is not purchased.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act ("HIPAA") deals primarily with how Acme Brick can enforce eligibility and enrollment for health care benefits. Examples of some of the HIPAA requirements include:

- Special enrollment periods are available during the year to you and your eligible dependents (in certain circumstances) that lose other health care coverage if you enroll within 30 days after losing the other health care coverage.
- If you are not enrolled for health care coverage and add an eligible dependent (i.e. marriage), you can enroll yourself and your other eligible dependents within 30 days of the event. If you add an eligible dependent (i.e. birth, adoption or placement for adoption), you can enroll yourself and your newly acquired eligible dependents within 30 days of the event.

The Plan will not base eligibility rules or waiting periods on any of the following factors: health status, mental or physical medical condition, and genetic information, evidence of insurability or disability. Evidence of insurability will not be required when health care coverage is requested during a special enrollment period or during an annual enrollment. However, the Plan may continue to provide for the exclusion of specified health conditions and apply lifetime maximums on either specific benefits or all benefits provided under the Plan. These restrictions also do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

Changing Your Elections

In general, your annual pre-tax benefit elections are irrevocable for the plan year, January 1, 2026 through December 31, 2026. However, if you experience a Change in Status or special enrollment event that directly affects your eligibility for coverage; you may change your election within 30 days of the event. Under limited circumstances, an election change based solely on a Change in Status must be consistent with your Change in Status (i.e. if a child is born to you, you add coverage for that child).

In general:

Change in Status events provide more opportunities for you to make an election change than do special enrollment rights.

If your event could be considered both a Change in Status event and a special enrollment right, you may make any change allowed by either a Change in Status or special enrollment right.

Contact the Acme Brick Benefits Department at 800-792-1234, for more information on the requirements for making an election change based on a Change in Status event or special enrollment right.

Change in Status Events that Permit Election Changes for Health Benefits and Life Insurance Benefits:

- Change in marital status: you may elect coverage for yourself and/or your newly acquired spouse or drop coverage for your spouse if you divorce, legally separate, have your marriage annulled or your spouse dies.
- Change in your number of dependents: you may elect coverage for your newborn, adopted child or a child placed with you for adoption. You may drop coverage if a dependent child dies.
- Change in employment status: you may add or drop coverage consistent with a change in employment status of you, your spouse or dependents that affect the benefit eligibility under this plan or under the employee benefit plan of your spouse or dependents. You, your spouse or dependent experience a change in employment status when any of the following occur and benefit eligibility is affected: begin or end employment, take part in a strike or lockout, begin or return from an approved leave of absence, switch from hourly to salaried, switch from union to non-union or vice versa, reduce or increase the number of hours you work or any similar change that affects your eligibility under the plan.
- Dependent eligibility: you may add or drop your child in the event he or she becomes or ceases to be eligible under the plan.
- Change in residence: you may change your coverage option if you move and it significantly affects your benefit availability.

Additional Change in Status Events that Permit Election Changes for Health Benefits Only:

- Family and Medical Leave Act (FMLA) – certain election changes are permitted when you start an FMLA leave or when you return from an FMLA leave.
- Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a “qualified medical child support order” or QMCSO) that requires health coverage for an Associate’s child or foster child.
- You, your spouse or your dependent become entitled to or lose eligibility for Medicare or Medicaid.

- You, your spouse or your dependent gain eligibility under another employer's plan.
- A significant change in your cost for health coverage.
- A Change in Status that results in a "special enrollment right" under the Health Insurance Portability and Accountability Act (HIPAA). Please refer to the section below for more information.

You must complete a Change Form and return it to the Acme Brick Benefits Department within 30 days of the Change in Status. If you miss this 30-day period, you will not be able to change your coverage until the following Annual Enrollment period, unless you have another Change in Status that affects your eligibility under the plan.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to enroll in a group health plan at times other than initial eligibility or the Annual Enrollment period. You have special enrollment rights if you and/or your eligible dependents lose other group health coverage, or you gain a new dependent. If either of these events occurs, you must enroll within the 30-day time limit explained here, or you will lose your special enrollment rights for that event.

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 the medical and/or dental plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of eligibility does not include a loss of coverage that occurs because you fail to pay premiums on a timely basis, if your other coverage is terminated for cause or your voluntary termination of COBRA continuation 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 or your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

You must request enrollment in the medical and/or dental plan no later than 30 days after the event giving rise to your special enrollment right, by completing and returning a new Benefit Enrollment and Change Form. If you fail to request enrollment within the 30-day time period, you and your dependents will lose the special enrollment rights for that event.

If your special enrollment right occurs because you lost other coverage or married, your enrollment is effective on the first day of the month after your Benefits Department receives your properly completed Change Form. If your special enrollment right occurs because of a new dependent child, coverage is effective on the date of the birth, adoption or placement for adoption.

If you or your dependent is eligible, but not enrolled, for health coverage under the Acme Brick medical plan, you and/or your dependent may enroll in the plan if (i) your Medicaid or CHIP coverage is terminated as a result of loss of eligibility or (ii) you and/or your dependent become eligible for premium assistance under Medicaid or CHIP. However, to be eligible for this special enrollment opportunity, you must request coverage under the group health plan within 60 days after the date you and/or your dependent become eligible for premium assistance under Medicaid or CHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends. For more information on Medicaid and CHIP, please see the section below entitled Medicaid/CHIP.

To request enrollment due to a special enrollment right or obtain more information, contact the Acme Brick Benefits Department at 800-792-1234.

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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ARKANSAS – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	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+)	**GEORGIA – 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	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
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KENTUCKY – Medicaid	**MAINE – 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	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
LOUISIANA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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/health-care-coverage/ Phone: 1-800-657-3672	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
NEVADA – Medicaid	**NEW YORK – Medicaid**
Medicaid Website: http://dhcfp.nv.gov	Website: https://www.health.ny.gov/health_care/medicaid/

Medicaid Phone: 1-800-992-0900	Phone: 1-800-541-2831
NEW JERSEY – Medicaid and CHIP	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**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/ or 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 March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act (FMLA), you may be eligible for up to 12 weeks of unpaid leave for certain family and medical reasons and continue your benefits at active employee rates. You are eligible for FMLA leave if you have been employed by Acme Brick for at least one year and worked at least 1,250 hours over the previous 12 months.

You may be eligible to take FMLA leave:

- After the birth or adoption of your child or if a child is placed with you for adoption
- To care for your spouse, child or parent who has a serious health condition (including medical conditions resulting from military service)
- If you have a serious health condition that makes you unable to perform your job

You may choose to either continue benefits on the same basis as if you continued working (were an active employee) or revoke your health benefit election (i.e. cancel your benefits) while you are on FMLA leave. If you revoke your benefit election while on FMLA leave, your election can be reinstated when you return to work. If you continue your benefits while on FMLA leave, you must pay your share of the cost for your benefits coverage during your period of FMLA leave. If your leave is unpaid (or paid and does not cover the entire cost), you are responsible for paying your portion of the premiums directly to the insurer. If you fail to make a premium payment, your coverage will be terminated. If your coverage terminates while you are on FMLA leave, your coverage can resume when you return from your FMLA leave of absence. For more information about FMLA leave and your benefit coverage while on FMLA leave, please contact Acme Brick Benefits Department.

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA)

The Acme Brick medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

MHPA and MHPAEA only apply to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees. Take out if not applicable.

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.

Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Transparency in Coverage (TiC) Machine-Readable Files (MRF) Notice

The Transparency in Coverage (TiC Regulations) and the Consolidated Appropriations Act of 2021 (CAA) (collectively "transparency requirements") impose certain obligations on group health plans, health insurers, and health care providers.

Two of these requirements became effective July 1, 2022:

- Group health plans must make public a MRF with in-network provider rates for covered items and services ("In-network Rate Disclosures);

- Group health plans must make public a MRF with out-of-network allowed amounts and billed charges for certain covered items and services ("Out-of-network Rate Disclosures).

By clicking here, https://www.bcbstx.com/member/policy-forms/machine-readable-file you can find our health plan's in-network and out-of-network rate disclosures as required under the TiC regulations.

Newborns' and Mothers' Health Protection Act (NMHPA)

The Acme Brick medical plan will comply with all required provisions of the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) with respect to health benefits provided under this plan. The plan will 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 cesarean section. You only need to pre-certify maternity hospital stays if the hospital stay will be longer than the periods specified above. However, you must still pre-certify any hospital admission during your pregnancy that is not due to delivery or is in excess of the applicable timeframes outlined above. In addition, the plan will not require that a provider obtain authorization from the plan and insurer for prescribing a length of stay not in excess of the above periods. However, the NMHPA generally does not prohibit the mother's or newborn's attending provider, after consulting with and obtaining consent from the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act (WHCRA)

The Acme Brick medical plan complies with all required provisions of the Women's Health and Cancer Rights Act of 1998 (WHCRA) with respect to health benefits provided under this plan. The plan will cover certain breast reconstruction and other benefits in connection with a mastectomy. If you elect breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your physician for (1) all stages of reconstruction of the breast on which the mastectomy was performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, (3) prosthesis and (4) treatment of physical complications for all stages of mastectomy, including lymphedemas. Such coverage remains subject to the terms of the Plan, including normal deductible, copay and coinsurance provisions.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Acme Brick medical plan will comply with all required provisions of GINA with respect to health benefits and coverage under this plan. The plan will not discriminate on the basis of genetic information, including information about manifestation of a disease or disorder in a family, in addition to information about genetic tests. Furthermore, genetic information will not be requested or required for underwriting purposes or before enrollment, participants and covered dependents will not be required to undergo genetic testing and genetic information will not be used to adjust premiums or contributions for groups under the Acme Brick medical plan. However, the plan and/or employer may use, in accordance with GINA, a minimum necessary amount of genetic testing results in order to make a determination about a claim payment where such information is necessary and/or required. For more information about GINA, please contact your Benefits Department.

Michelle's Law

Subject to future regulations and the Affordable Care Act, the Acme Brick medical plan will comply with all required provisions of Michelle's Law with respect to health benefits provided under this plan to dependent children over the age of 18 who are enrolled in an institution of higher education on a full-time basis. If the dependent child is enrolled on a full-time basis and subsequently loses his/her full-time status at his/her institution of higher education as a result of taking a "medically necessary leave of absence" (as defined under Michelle's Law) due to a serious illness or injury, coverage for the dependent under the Acme Brick medical plan will not terminate until the earlier of (i) the date that is one year after the first day of the medically necessary leave of absence or (ii) the date coverage would otherwise terminate under the plan. The student/dependent on leave is entitled to the same benefits as if he/she had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

Please note that under the Affordable Care Act, group health plans and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. Nonetheless, under some circumstances, such as a plan that provides dependent coverage beyond age 26, Michelle's Law provisions may apply. For more information about Michelle's Law and your dependent's benefit coverage under Michelle's Law, please contact the Acme Brick Benefits Department.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a

service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
Important Information about Your Right to COBRA Continuation Coverage

This contains important information about your right to group health plan continuation coverage, which is a temporary extension of coverage under the Plan after you (and/or your qualified dependent) would otherwise lose group health coverage under the Plan. The right to this continuation coverage (COBRA continuation coverage) was created by Federal law under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you may elect to temporarily continue your group health coverage for yourself and any eligible dependents covered by the Acme Brick group health plans on the day your (or your qualified dependents) group health benefits ceased because of a qualifying event. You and your eligible dependents are eligible to elect COBRA continuation coverage even if you (or they) have health coverage under another group health plan. Please read this section carefully as it generally explains COBRA continuation coverage, when it may be available to you and your eligible dependents and what you (and they) need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

Eligibility for COBRA Continuation Coverage

COBRA continuation coverage is continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each plan participant who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if group health coverage under the plan is lost because of a

qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

Qualifying Events and COBRA Continuation Coverage

The qualifying events for COBRA continuation coverage and the maximum COBRA continuation coverage periods are shown in the charts that follow.

Employee COBRA Continuation Coverage

If you are an employee of Acme Brick and are covered by Acme Brick's health plan you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
Termination of your employment (for reasons other than gross misconduct)	18 months
Reduction in your hours of employment with loss of eligibility for benefits	18 months

Spouse of an Employee COBRA Continuation Coverage

If you are the spouse of an employee of Acme Brick and are covered by Acme Brick's health plan, you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with loss of eligibility for benefits	18 months
The death of the employee	36 months
Divorce or legal separation from the employee	36 months
The employee's entitlement to Medicare	36 months

Dependent Children of an Employee COBRA Continuation Coverage

Dependent children of an employee of Acme Brick who are covered by Acme Brick's health plan have the right to COBRA continuation coverage (for the period stated) if they lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with loss of eligibility for benefits	18 months
The death of the employee	36 months
The employee's divorce or legal separation	36 months
The employee's entitlement to Medicare	36 months
Loss of eligible dependent status (i.e., reach maximum age, lose full-time student status)	36 months

The maximum period of COBRA continuation coverage is measured from the date of the loss of coverage due to the applicable qualifying event specified above.

The plan will offer COBRA continuation coverage to a qualified beneficiary only after the Acme Brick Benefits Department has been properly notified that a qualifying event has occurred.

You must notify the Acme Brick Benefits Department within sixty (60) days of the following qualifying events: divorce or legal separation of the employee; spouse or a dependent child losing eligibility for coverage as a dependent under the plan, or Medicare entitlement. You must provide this notice to the Acme Brick Benefits Department within the sixty (60) day deadline or your right to COBRA continuation coverage will be lost and will not be reinstated. Notice requirements are detailed below.

A special rule applies if you drop coverage for your spouse and/or eligible dependent children because you are planning to divorce. In such a case, your spouse and/or dependent children who had previously been covered under the plan would be entitled to elect COBRA continuation coverage for up to thirty-six (36) months from the date the divorce is final, but only if the Acme Brick Benefits Department is notified of the divorce within sixty (60) days from the date of final judgment. No retroactive coverage before the date of divorce is available.

If it is determined that an individual is not eligible for COBRA continuation coverage, the COBRA administrator, WEX Health, Inc., will notify such individual of his or her failure to qualify for COBRA continuation coverage. This notice will explain why the individual is not entitled to COBRA continuation coverage and will be sent within fourteen (14) days after the receipt of the individual's notice of a qualifying event.

Subsequent Qualifying Event

If a subsequent qualifying event that is not your termination of employment or reduction in work hours (such as your divorce, legal separation, your death or your dependent child ceasing to be eligible under the plan) occurs during an initial eighteen (18) month period of coverage, COBRA continuation coverage may be extended for your eligible dependents who are qualified beneficiaries for up to a maximum period of thirty-six (36) months measured from the date of the first qualifying event. An event shall not be a subsequent qualifying event unless that event would cause a loss of coverage under the Plan independent of the initial qualifying event. The covered employee will not be eligible for an extension of your maximum 18-month period of COBRA continuation coverage for a subsequent qualifying event.

Notice of a subsequent qualifying event must be given to the COBRA administrator, WEX Health, Inc., within a maximum of sixty (60) days in order to extend COBRA continuation coverage. If you fail to inform the COBRA administrator, WEX Health, Inc., you will lose your right to extend your COBRA continuation coverage and this right will not be reinstated. Notice requirements are detailed below. Please see the special COBRA continuation coverage for Disabled Persons section of this guide for information on disability as a subsequent qualifying event.

Notice Requirements

In most cases, the COBRA administrator, WEX Health, Inc., will notify you of your right to elect COBRA continuation coverage. However, if your eligible dependent has a qualifying event as a result of your divorce, legal separation, Medicare entitlement or lose their status as a dependent, you or your covered dependent must properly notify the COBRA administrator, WEX Health, Inc., within a maximum of sixty (60) days of the qualifying event. In addition, if you have a child born, legally adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify the COBRA administrator, WEX Health, Inc., within sixty (60) days of the event in order to cover the child.

Notice must be submitted to the COBRA administrator, WEX Health, Inc., at P.O. Box 2079 Omaha, NE 68103-2079 on the written form approved by the Benefits Department. The form must be completed and submitted to the COBRA administrator, WEX Health, Inc., before the end of the applicable deadline. The forms, information and deadlines for certain events are outlined in the table below.

Event Requiring Notice	Deadline for Notice
Divorce or Legal Separation	Within 60 days from date of final court judgment
Dependent becomes ineligible under the plan	Within 60 days from date of ineligibility
Medicare entitlement	Within 60 days from date of entitlement
Determination of disability	Within 60 days of disability determination and before the end of the maximum 18-month COBRA continuation coverage period
Determination of non-disability status	Within 30 days of the Social Security Administration's determination of non-disability
Marriage	Within 31 days from the date of marriage
Birth, Adoption or Placement for Adoption	Within 60 days from date of the event

Failure to properly provide the required notice may result in loss of any COBRA continuation right and, if lost, this right will not be reinstated.

The COBRA administrator, WEX Health, Inc., is the designated recipient for all COBRA continuation coverage notices. They may be reached at: 866-451-3399, P.O. Box 2079 Omaha, NE 68103-2079.

Electing COBRA Continuation Coverage

Once the COBRA administrator, WEX Health, Inc., receives notice that a qualifying event has occurred, COBRA continuation coverage will then be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, you may elect COBRA continuation coverage on behalf of your spouse and parents may elect COBRA continuation coverage on behalf of their children.

If you wish to elect COBRA continuation coverage, you must notify the COBRA administrator, WEX Health, Inc., within a maximum of sixty (60) days of the later of: (i) the date of the qualifying event or (ii) the date you received your COBRA notice. If you choose to continue benefits for yourself and your eligible dependent, before the maximum sixty (60) day election deadline, your coverage will continue uninterrupted. If you (or your eligible dependent) fail to elect COBRA continuation coverage within the maximum sixty (60) days after you are notified by the COBRA administrator, WEX Health, Inc., you will lose your right to COBRA continuation coverage and that right will not be reinstated.

You must also keep the COBRA administrator, WEX Health, Inc., informed of all the information needed to meet its obligation of both providing notice to you of your right to COBRA continuation coverage and providing the actual COBRA continuation coverage. Such information includes your current contact information and administrative information about yourself, your spouse and/or dependents. You or your spouse's election to take COBRA continuation coverage can also be an election to cover all the other qualified beneficiaries in the family, unless the election is specific as to which qualified beneficiaries are to be covered.

You must notify the COBRA administrator, WEX Health, Inc., to request alternate coverage if you move outside the service area of the benefit network for your elected coverage. Alternate coverage will be made available (if available) to you not later than the date of the relocation or the first day of the month following the month in which the request is made.

Health Care Exchange - Notice

There may be other coverage options for you and your family. For example, you will be able to buy coverage through the Health Insurance Marketplace during the Marketplace's open enrollment period. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Special Enrollment Events and COBRA

If you have a child born to, adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify the COBRA administrator, WEX Health, Inc., and elect coverage within sixty (60) days of the child's birth, adoption or placement for adoption. If you get married during your COBRA continuation coverage, you may add your new spouse to your COBRA continuation coverage if you notify the COBRA administrator, WEX Health, Inc., within thirty-one (31) days of the date of the marriage. A new dependent may be a participant under this coverage for the remainder of your maximum COBRA continuation period (eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the applicable qualifying event).

Cost and Payment of COBRA Premiums

You must pay the full cost for COBRA continuation coverage (plus a two percent (2%) administrative fee). the COBRA administrator, WEX Health, Inc., will determine this cost, but it generally cannot exceed one hundred two percent (102%) of the plan's cost for providing coverage to similar situated covered active employees and their covered dependents. COBRA premiums are subject to change annually. If you and your covered dependents are receiving an additional eleven (11) months of COBRA continuation coverage due to disability as the qualifying event, the COBRA administrator, WEX Health, Inc., will determine COBRA premium which will not exceed one hundred fifty percent (150%) of the plan's cost for providing coverage, if the disabled qualified beneficiary is part of the COBRA continuation coverage group or one hundred two percent (102%) if the disabled qualified beneficiary is not receiving COBRA continuation coverage.

Once an election for COBRA continuation coverage is made, you (or your covered dependents) have a maximum of forty-five (45) days from the date of election to pay the premium for the current month and any retroactive COBRA premiums then due for the elected coverage. Although coverage is retroactive to the date of loss of coverage due to the initial qualifying event, no COBRA continuation coverage benefits will be paid until this first COBRA premium is received by the COBRA administrator, WEX Health, Inc.. If payment is not received within the forty-five (45) day period, then coverage will either be revoked retroactively or not become effective. You will lose your right to COBRA continuation coverage and it will not be reinstated.

All subsequent COBRA premium payments are due on the first day of the month. The plan allows a thirty (30) day grace period for payment of required COBRA premiums (except the first payment previously discussed). Even if you do not receive a bill, you must still submit your COBRA premium payments within the required time period. ***The thirty (30) day grace period does not apply to the forty-five (45) day period for payment of the initial COBRA premium.*** If your COBRA premium payment is not postmarked by the last day of the grace period, your COBRA continuation coverage will end as of the last day of the last month for which a full COBRA premium payment was made.

If timely payment of the COBRA premium is made to the plan in an amount that is not more than fifty dollars ($50) or ten percent (10%) less than the required COBRA premium payment, then the amount paid is deemed to satisfy the plan's requirement for full COBRA premium payment, unless the COBRA administrator, WEX Health, Inc., notifies the qualified beneficiary of the amount of the deficiency and allows thirty (30) days for payment of the deficiency to be made.

COBRA premiums can be paid by you or by a third party on your behalf. Here are a few other details about COBRA premium payments you need to be aware of:

- No late or reminder notices will be sent for payments that have not been made.
- Once COBRA continuation coverage is terminated, it cannot be reinstated.
- All terms and conditions that apply to active participants in the plan are also applicable to COBRA continuation coverage participants.
- All rules and procedures for filing and determining benefit claims and appeals under the plan that apply to active employees also apply to COBRA continuation coverage.

Trade Act Credit

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PGBC) (eligible individuals) and pay for health coverage. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Responses to Information Regarding a Qualified Beneficiary's Right to Coverage

Upon request, the plan must inform health care providers regarding the qualified beneficiary's right to coverage during the applicable grace periods. In addition, the plan is required to respond to inquiries from health care providers regarding the qualified beneficiary's right to coverage during the election period and his or her right to retroactive coverage if COBRA continuation coverage is elected.

Changes in Benefits under COBRA

If you or any covered dependents elect COBRA continuation coverage, benefits will be the same as were in effect at the time of your qualifying event. You will be able to change your plan coverage option during annual enrollment to the same extent as similarly situated active employees. If the group health plan benefits of active employees change, benefits for qualified beneficiaries on COBRA continuation coverage will also change in the same manner.

Special COBRA Continuation Coverage for Disabled Persons

If you (and your covered dependents) are receiving eighteen (18) months of COBRA continuation coverage and your qualifying event is a termination of employment or a reduction of hours, your maximum COBRA continuation coverage period may be extended by eleven (11) months to up to a maximum of twenty-nine (29) months in total provided the following requirements are met:

- The Social Security Administration determines that you (or your dependent who is a qualified beneficiary) are disabled within the meaning of the Social Security Act;
- This disability exists as of the date of the qualifying event or at any time during the first sixty (60) days of COBRA continuation coverage following the qualifying event; and
- The disability lasts at least until the end of the eighteen (18) month period of COBRA continuation coverage.

Notice of the determination of disability under the Social Security Act must be provided to the COBRA administrator, WEX Health, Inc., within the initial eighteen (18) month coverage period and within sixty (60) days after the latest of: (1) the date of the Social Security Administration determination of disability; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the notice of disability. If you fail to properly notify the COBRA administrator, WEX Health, Inc., within the deadline above, you will lose your right to the extension of COBRA continuation coverage and this right will not be reinstated. Please refer to the Notice Requirements section above for information about proper notice to the plan.

If the Social Security Administration determines later that the qualified beneficiary is no longer disabled, the COBRA administrator, WEX Health, Inc., must be properly notified within thirty (30) days of the Social Security Administration's determination. This notice will end the extended COBRA continuation coverage for all qualified beneficiaries within the coverage group. Failure to notify the COBRA administrator, WEX Health, Inc., that a qualified beneficiary is no longer disabled will result in termination of COBRA continuation coverage for all qualified beneficiaries within the coverage group effective on the date of the Social Security Administration determination and such coverage will not be reinstated. When the disabled qualified beneficiary becomes eligible for Medicare, the COBRA administrator, WEX Health, Inc., must be properly notified to end the extended coverage for the affected disabled qualified beneficiary. Please refer to the Notice section above for information about proper notice to the plan.

COBRA Continuation Coverage and Medicare

If your dependent is receiving COBRA continuation coverage and you become entitled to Medicare benefits, your coverage will end but COBRA continuation coverage for your qualified dependents may continue for up to thirty-six (36) months measured from the date of the initial qualifying event.

In addition, if you become entitled to Medicare and then later terminate employment (for reasons other than gross misconduct) or have a reduction in hours, your qualified dependents who are eligible for COBRA continuation coverage will be eligible for thirty-six (36) months of COBRA continuation coverage measured from the date you became entitled to Medicare. However, you will only be eligible for eighteen (18) months of COBRA continuation coverage measured from the qualifying event.

Termination of COBRA Continuation Coverage

COBRA continuation coverage shall not be provided beyond the earliest of the following dates:

- The date the maximum COBRA continuation coverage period expires based upon the qualifying event;
- The date the plan is terminated, and no other group health plan is provided to active employees;

- The last day of the month preceding the month for which the qualified beneficiary fails to pay the premium for COBRA continuation coverage by the last day of the grace period;
- The date the qualified beneficiary first becomes entitled to Medicare, including Medicare entitlement due to End Stage Renal Disease (ESRD), after the person elects COBRA continuation coverage;
- The date that initial payment is not received within a maximum of forty-five (45) days after the election of COBRA continuation coverage is made;
- The date the qualified beneficiary first becomes covered under another group health plan or policy after the date the person elects COBRA continuation coverage; or
- For a disabled qualified beneficiary receiving COBRA continuation coverage during the eleven (11) month disability extension period (and their covered family members), the date the disabled person receives a final determination by the Social Security Administration that he or she is no longer "disabled." This final determination shall end COBRA continuation coverage for all qualified beneficiaries as of the later of either: (a) the first day of the month following thirty (30) days from the final determination date; or (b) the end of the COBRA continuation coverage period based on the initial qualifying event without regard to a disability extension.

If your COBRA continuation coverage is terminated for any of the reasons noted above, your coverage will end and will not be reinstated.

In the event that your COBRA continuation coverage is terminated before the end of the maximum coverage period, the COBRA administrator, WEX Health, Inc., will notify you of the termination of your coverage as soon as administratively possible. This notice will explain why and when COBRA continuation coverage has ended.

Contact Information for COBRA Administrator

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

Keep the Plan Informed

In order to protect your family's rights, you should keep the COBRA administrator, WEX Health, Inc., informed of any changes in the address of family members. You should also keep a copy of all COBRA notices that you receive or send in your own records.

Plan Contact Information

Information about the plan may be obtained by contacting the COBRA administrator, WEX Health, Inc., at P.O. Box 2079 Omaha, NE 68103-2079.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and we will provide you with a copy.

If you have any questions about this Notice, please contact the Privacy Officer at Acme Brick. The contact information for the Privacy Officer is as follows:

Privacy Officer

Acme Brick

3024 Acme Brick Plaza

Fort Worth, TX 76109

Important Notice from Acme Brick 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 Acme Brick 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. Acme Brick has determined that the prescription drug coverage offered by the Acme Brick medical plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Acme Brick coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Acme Brick coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Acme Brick and do not 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 Acme Brick's Benefits Department at 800-792-1234 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Acme Brick changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC Updated April 1, 2011 - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 will 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).

Acme Brick
Position/Office: Benefits Department
3024 Acme Brick Plaza
Fort Worth, TX 76109
800-792-1234

Health Insurance Marketplace Coverage Options and Your Health Coverage

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 Employer 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 8.39% of your annual household income in 2024 or 9.02% in 2025, 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 8.39% in 2024 or 9.02% in 2025 of the employee's household income. 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.

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Acme Brick's Benefits 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 Acme Brick	4. Employer Identification Number (EIN) Contact your Benefits Department
5. Employer address 3024 Acme Brick Plaza , «Employer-Address2»	6. Employer phone number 800-792-1234
7. City, 8. State, 9. Zip Code Fort Worth, TX 76109	
10. Who can we contact about employee health coverage at this job? Acme Brick's Benefits Department	
11. Phone number (if different from above)	12. Email address (optional)

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

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

  ☑Full-time employees working 30 or more hours per week

- With respect to dependents:

  ☑

  We do offer coverage. Eligible dependents are:

  - Your legal spouse or your domestic partner

- Your children up to age 26, including your natural–born children, stepchildren, any children who are under your legal guardianship, who are in your custody under an interim court order of adoption, or who are placed with you for adoption
- Your children, of any age, who are physically or mentally disabled and incapable of supporting themselves, and can be claimed as a dependent on your U.S. federal income tax return

☑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.

Notice Regarding Wellness Program

Acme Brick is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Employees who choose to participate in the wellness program will receive an incentive of lower medical plan contributions for completing an annual physical, being nicotine free* and submitting a Wellness Incentive Affidavit. Although you are not required to participate, only employees who do so will receive lower medical plan contributions.

You may request a reasonable accommodation or an alternative standard by contacting the Acme Brick Benefits Department at 800-792-1234.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Acme Brick may use aggregate information it collects to design a program based on identified health risks in the workplace, Acme Brick Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Acme Brick Wellness Plan Administrator in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Acme Brick Benefits Department at 800-792-1234.

*Nicotine free: In order to be considered nicotine free, you must not be using any nicotine products, or you must complete the no cost tobacco cessation program through BlueCross annually. If you complete to tobacco cessation program in lieu of being nicotine free, you must submit proof of completion of the program from BlueCross with your Wellness Incentive Affidavit by December 1st of each year or within 31 days of your insurance effective date. However, if you complete the tobacco cessation program after the dates above, you should submit the proof of program completion to HR@brick.com. If you completed the annual physical requirement and submitted your affidavit verifying completion timely, you will be moved to the Select rates retroactive to date your coverage was effective for the current plan year .

(January 1st or the date you were 1st covered after January 1st).

Important Contacts

Coverage	Administrator	Phone	Email/Website
Human Resources	Acme Brick	800.792.1234	HR@brick.com
Medical Benefits	BlueCross BlueShield Of Texas	800.521.2227	bcbstx.com
Pharmacy Benefits	Express Scripts	855.686.9784	express-scripts.com
Smoking Cessation	BlueCross BlueShield Of Texas	877.806.9380	bcbstx.com
Telemedicine/ Virtual Visits	Teladoc Health	800.TELADOC	TeladocHealth.com
Diabetes Management	Livongo by Teladoc Health	800.945.4355	Livongo.com
Accident Benefits	Prudential	877.507.4778	mybenefits.prudential.com
Critical Illness Benefits	Prudential		
Flexible Spending Accounts (FSA)	Wex Health	866.451.3399	WexInc.com
Dental Benefits	Cigna	800.244.6224	mycigna.com
Vision Benefits	Davis Vision	800.999.5431	DavisVision.com
Life/AD&D Benefits	Prudential	877.507.4778	mybenefits.prudential.com
Disability Benefits	Prudential		
Employee Assistance Program (EAP)	ComPsych and Guidance Resources	855.327.4463	GuidanceResources.com Web ID: GRS311
Pet Insurance	Nationwide	877.738.7874	petinsurance.com/brick
Associate Discount Program	PerkSpot	n/a	acmebrick.perkspot.com
Retirement Savings	Bank of America Merrill Lynch	800.228.4015	benefits.ml.com (Acct # 605900)
Pension Plan	Berkshire Hathaway Consolidated Pension Plan	877.459.2403	eepoint.com/bhcpp


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