



2025 BENEFITS GUIDE



HELPING YOU UNDERSTAND
Your Benefit Choices



This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your employer's benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the "Notices" Section in the back of this benefits booklet.

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WELCOME

BENEFITS MENU | ENROLLMENT GUIDE

BENEFITS OFFERED

MY HEALTH

Medical | **Blue Cross Blue Shield NC**

Dental | **Delta Dental**

Vision | **Blue Cross Blue Shield NC**

Health Savings Account | **Optum**

Flexible Spending Account | **Optum**

MY LIFE

Life and AD&D | **The Hartford**

Disability | **The Hartford**

Voluntary Life and AD&D | **The Hartford**

Your Benefit Period

January 1, 2025 – December 31, 2025

ENROLLMENT

All team members have access to our online benefits enrollment platform 24/7 where you can enroll, select or change your benefits online during the annual open enrollment period, new hire orientation, and for qualifying events.

- ✓ **Accessible 24/7;**
- ✓ **View all benefit plan options and your elections;**
- ✓ **View important carrier forms and links;**
- ✓ **Report a qualifying life event; and**
- ✓ **Make changes to beneficiary designations and more.**

ENROLLMENT INSTRUCTIONS:

1. Go to www.paycor.com
2. Login.
3. Select "Enroll Now" from alerts in dashboard.
4. Make sure to save your elections and print your confirmation statement.



Helpful Tips To Consider Before You Enroll

- 1. Do you plan to enroll an *eligible dependent(s)*?**
If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
- 2. Have you recently been *married/divorced or had a baby*?**
If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
- 3. Did any of your covered children reach their *26th birthday this year*?**
If so, they may no longer be eligible for benefits, unless they meet specific criteria.

ELIGIBILITY

RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are full-time and work a minimum of 30 hours per week. Your coverage will be effective the 1st of the month following your date of hire.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse/domestic partner** and/or **'dependent child(ren)'** of the plan participant or the spouse.

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

**A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.*

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualifying life event, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner; or
- Disabled dependents may be eligible if requirements set by the plan are met.



HEALTH

MEDICAL | PRESCRIPTION DRUGS | ADMINISTERED BY BLUE CROSS BLUE SHIELD OF NC*

*Solve Industrial Motion Group will be transitioning to BCBSNC as of January 1, 2025

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., \$30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the health plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all usual and customary in-network services at 100% until the end of the plan year.

OUT-OF-NETWORK charges in the above plans are subject to reasonable and customary limitations, which means you are responsible for charges over this amount in addition to separate deductible and coinsurance.



Click on the above picture for more information on Common Insurance Terms.

PPO | In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

HDHP | In-Network & Out-of-Network Benefits Available

The HDHP is similar to the PPO Plan in that you have the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs.

All expenses are your responsibility until the deductible is reached, with the exception of preventive care, which is covered at 100% when you visit a physician in the network. Once the deductible is met, you are responsible for coinsurance for medical expenses and a copay for prescription drug expenses.

Enrolling in this plan allows you to contribute tax free dollars to a health savings account (HSA). Any dollars that you (and your employer) wish to contribute can be used towards any eligible medical, Rx, dental and vision expenses that you may incur while covered under the plan. See HSA section of this guide for additional details.



Click on the above picture for more information about the difference between HDHP and PPO plans.

Did You Know?

- ✓ Preventive Services are covered at **100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider**.

How do I find an In-Network Provider?

In-Network providers can be found on your provider's website (www.bluecrossnc.com) under "Find a Doctor". Select Group Health Plans and choose the network based on the plan type you are choosing.

MEDICAL

HEALTH | PLAN COMPARISON | ADMINISTERED BY BLUE CROSS BLUE SHIELD OF NC*

*Solve Industrial Motion Group will be transitioning to BCBSNC as of January 1, 2025

Note: Members will have access to BCBS's Nationwide network of providers under BCBSNC

	PPO Buy-Up Copay	PPO Base Copay	PPO HSA/HDHP
In-Network			
Deductible			
Individual	\$2,000	\$3,500	\$3,300
Family	\$4,000	\$7,000	\$6,400
Plan Coinsurance	80%	70%	80%
Out-of Pocket Maximum			
Individual	\$6,000	\$7,000	\$6,500
Family	\$12,000	\$14,000	\$13,000
Hospitalization	20% after deductible	30% after deductible	20% after deductible
Emergency Room Visit	20% after deductible	30% after deductible	20% after deductible
Urgent Care Centers	\$50 copay	\$50 copay	20% after deductible
Office Visit (Copay or Coinsurance)			
Primary Care Office Visits	\$25	\$25	20% after deductible
Specialist Office Visits	\$50	\$50	20% after deductible
Preventive Care	100%	100%	100%
Prescription Drugs (Copay or Coinsurance)			
Tier 1	\$10	\$10	Ded + 20%
Tier 2	\$35	\$35	Ded + 20%
Tier 3	\$60	\$60	Ded + 20%
Tier 4	25% up to a max of \$100	25% up to a max of \$100	Ded + 20%
Out of Network			
Deductible			
Individual	\$4,000	\$7,000	\$6,000
Family	\$8,000	\$14,000	\$12,000
Plan Coinsurance	50%	50%	50%
Out-of Pocket Maximum			
Individual	\$12,000	\$14,000	\$13,000
Family	\$24,000	\$28,000	\$26,000

Your Care Options and When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center over an Emergency Department for everyday health concerns could save you hundreds of dollars.

PRESCRIPTION DRUGS

Rx | PLAN COMPARISON | ADMINISTERED BY BLUE CROSS BLUE SHIELD OF NC*

*Solve Industrial Motion Group will be transitioning to BCBSNC as of January 1, 2025

TRADITIONAL DRUGS

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 | Highest copay: In this category are nonpreferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay. **Make sure to check for mail order discounts that may be available.**

TIER 4 (Specialty Drugs) | This category includes medications that require special handling, special administration, or monitoring; or, is a high-cost oral medication.

	PPO Buy-Up Copay	PPO Base Copay	PPO HSA/HDHP
TIER 1 (Value/Generic)	\$10	\$10	Ded + 20%
TIER 2	\$35	\$35	Ded + 20%
TIER 3	\$60	\$60	Ded + 20%
TIER 4	25% up to a max of \$100	25% up to a max of \$100	Ded + 20%

Save Money With Generic (Tier 1) Drugs

Ask your doctor if it's appropriate to use a generic drug rather than a brand.

Generic drugs are less expensive, and according to the FDA, they contain the same active ingredients and are identical in dose, form and administrative method as a brand name.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER - Many drugs are available in a 90-day supply, rather than the 30-day retail supply. Typically, you will pay less if you choose to get a mail order 90-day supply.

GOOD Rx - There are many tools online that you can use in order to save on prescription costs, one being GoodRx.com – an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR – Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times, there are generic or different manufacturers that will save you money at the pharmacy.

WHERE CAN I FIND A DRUG LIST?

A full listing of covered drugs is found on www.bluecrossnc.com. A drug list, also called a formulary, is a list of generic and brand-name drugs covered by a health plan. Although a drug may be on the drug list, it might not be covered under every plan. Review the plan materials for details on specific benefits.

You can use drug lists to see if a medication is covered by your health insurance plan. You can also find out if the medication is available as a generic, needs prior authorization, has quantity limits and more.

Go to www.bluecrossnc.com

1. Click on "find care"
2. Click on "look up doctor or drug"
3. Click on "browse as a guest of an employer plan."

From here you can click on "Doctor or facility" "Drug" or "Pharmacy"

- "Drug": click on Essential 5 Tier C = "C2 or 2C, C3 or 3C, C4 or 4C, C5 or 5C". This will load on Prime's website and will indicate "Essential C". You can then search by drug name to see if it is covered, as well as under which tier. This link will also provide alternative medication options.
- "Pharmacy": you will select the first one, "Broad Network." Then, enter your zip code and/or Pharmacy name.



**BlueCross BlueShield
of North Carolina**

ONLINE HEALTHCARE

24/7 | VIRTUAL DOCTOR VISITS | ADMINISTERED BY
Teladoc as part of your BCBSNC health plan.

**No crowded
waiting rooms.
No Driving.
See a doctor when
you need a doctor.**

A virtual visit lets you see and talk to a doctor from your mobile device or computer. When you use one of the provider groups in our virtual visit network, you have benefit coverage for certain non-emergency medical conditions. Costs must be paid by you at the time of the virtual visit and will apply toward your deductible and out-of-pocket maximum.

For questions regarding online health care, contact:
1-855-549-2214 or
www.Teladoc.com



WHEN CAN I USE A VIRTUAL VISIT?

When you have a non-emergency condition and:

- your doctor is not available;
- you become ill while traveling;
- When you are considering visiting a hospital emergency room for a non-emergency health condition.

**Your covered children may also use Virtual Visits when a parent or legal guardian is present for the visit.*

Examples of Non-Emergency Conditions:

- | | |
|---------------------|-------------------|
| ✓ Bladder infection | ✓ Rash |
| ✓ Bronchitis | ✓ Seasonal flu |
| ✓ Diarrhea | ✓ Sinus |
| ✓ Fever | ✓ Sore throat |
| ✓ Pink eye | ✓ Stomach illness |

HOW DOES IT WORK?

The first time you use a Virtual Visits provider, you will need to set up an account with that Virtual Visits provider group. You will need to complete the patient registration process to gather medical history, pharmacy preference, primary care physician contact information, and insurance information.

Each time you have a virtual visit, you will be asked some brief medical questions, including questions about your current medical concern. If appropriate, you will then be connected using secure live audio and video technology to a doctor licensed to deliver care in the state you are in at the time of your visit. You and the doctor will discuss your medical issue, and, if appropriate, the doctor may write a prescription* for you.

Virtual Visits doctors use e-prescribing to submit prescriptions to the pharmacy of your choice. Costs for the virtual visit and prescription drugs are based on, and payable under, your medical and pharmacy benefit. They are not covered as part of your Virtual Visits benefit.

**Prescription services may not be available in all states.*

3 ways to sign up today

So it's ready when you need it!



Download the Teladoc mobile app
(iOS- / Android™-supported)



Go to Teladoc.com and click "Log in/Register"



Call 1-855-549-2214

Please Note:

You must wait until your health plan effective date before registering for telehealth services.



FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE | ADMINISTERED BY OPTUM

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year (**January 1st through December 31st**). The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

IMPORTANT NOTICE :

Your Flexible Spending Account will be effective on January 1, 2025 – December 31, 2025

Any claims that are incurred prior to January 1, 2025, will not be eligible.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at www.irs.gov.
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at www.fsastore.com.

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | \$3,300

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general-purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account is active on the first day of the plan year.

LIMITED PURPOSE FSA | ADDITIONAL REQUIREMENTS

- If you open or contribute to a Health Saving Account (HSA), you may only enroll in a Limited Purpose FSA.
- If you enroll in a HDHP (High Deductible Health Plan) and elect a Health FSA, you will automatically be enrolled in the Limited Purpose FSA.
- A limited purpose FSA will reimburse you for dental and vision expenses, but you cannot claim the same expense on both the FSA and HSA Accounts.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **\$5,000** annually in pre-tax dollars, or **\$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

HEALTH CARE FSA ROLLOVER

Health Care FSA's have a **\$660 roll over** feature, which allows any amount of \$660 or less remaining in your account at the end of the plan year to roll over into the new plan year.



Click on the above picture for more information about Flexible Spending Accounts

*ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:

1. 'Care' for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. 'Care' for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. 'Care' for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

'Care' is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE | ADMINISTERED BY OPTUM

HERE'S HOW IT WORKS

An employee earning \$30,000 elects to place \$1,000 into a Health Care FSA. The payroll deduction is \$101.92 based on a 26 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of \$574.

	Without FSA	With FSA
Gross Income	\$30,000	\$30,000
FSA Contributions	\$0	-\$2,650
TAXABLE INCOME	\$30,000	\$27,350
Estimated Taxes		
Federal	\$3,090*	-\$2,817*
State	\$1,104**	\$1,106**
FICA	\$2,295	\$2,092
AFTER TAX EARNINGS	\$23,511	\$21,435
Eligible Out-Of-Pocket Expenses	\$2,650	\$0
AVAILABLE/SPENDABLE INCOME	\$20,861	\$21,435

That's a savings of \$574 for the year!

IMPORTANT NOTICE :

Your Flexible Spending Account will be effective on January 1, 2025 – December 31, 2025

Any claims that are incurred prior to January 1, 2025, will not be eligible.

OVER-THE-COUNTER (OTC) MEDICATION REMINDER

Effective for purchases on or after January 1, 2025, thousands of items, including pain relievers, cold and flu medications, antacids, acne remedies, and allergy medicines are now reimbursable from an FSA, Section 213 HRA, or HSA without a prescription.

In addition to eliminating the prescription requirement on OTC drugs and medicine, the new CARES Act has added hundreds of menstrual products to the list of approved expenses, including tampons, pads, liners, cups, sponges and similar items. As was the case prior to the passage of the ACA, vitamins and supplements will continue to require a physician's "prescription" indicating that they are being taken to treat a diagnosed medical condition (e.g., anemia) rather than for general health and wellness.

ELIGIBLE HEALTH FSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Artificial teeth/dentures
- Blood pressure monitors
- Braces
- Braille-books & magazines
- Breast pumps & lactation supplies
- Chiropractors
- Co-insurance, co-pay & deductibles
- Cost of operations & related treatments
- Crutches
- Diabetic supplies
- Drug addiction treatment
- Eye exams, eyeglasses, contacts
- Hearing devices & batteries
- Hospital services
- Operations
- Pregnancy tests
- Radial keratotomy & lasik eye surgery
- Smoking cessation programs
- Speech therapy
- Surgical fees
- Vaccines
- Walkers & wheelchairs
- X-rays and more.

*A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

IMPORTANT: PAYING FOR ELIGIBLE SERVICES & EXPENSES

Visit the FSA Store at www.FSAstore.com, where you can purchase FSA-eligible products without a prescription online.

Although you do not need to file for reimbursement when using your FSA debit card, you may be required to submit documentation, so be sure to save your receipts.

If you use a personal form of payment to pay for eligible expenses out-of-pocket, you can submit an FSA claim form along with your original receipts for reimbursement.

This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

*Varies, assumes 10.30%;
**Varies, assumes 3.68%

For questions regarding your FSA, or for additional online resources go to: www.Optum.com

HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE | ADMINISTERED BY Optum

ENROLLED IN AN HSA ELIGIBLE HEALTH PLAN?

A Health Savings Account (HSA) is a tax-free savings account owned by you, is 100% vested from day one, and lets you build up savings for future needs. The funds may be used to pay for qualifying healthcare expenses not covered by insurance or any other plan for yourself, your spouse, or tax dependents. You decide how much you would like to contribute, when and how to spend the money on eligible expenses, and how to invest the balance.

Take charge of your health care spending with a Health Savings Account (HSA).

Contributions to an HSA are tax-free, and no matter what, the money in the account is yours!

UNDERSTANDING YOUR HSA

- Pre-tax contributions are deducted through payroll and deposited into your HSA account;
- You can use your HSA available funds to pay for qualified medical and prescription expenses tax-free;
- HSA funds can be used for non-eligible expenses but will be subject to regular income taxes and a 20% excise tax penalty;
- Unused funds remain in your account for future use and roll over each calendar year;
- HSAs remain with you even if you change health plans or companies. If you open an HSA and later become ineligible to make contributions, you can still use your remaining funds; and
- You can change your HSA contribution at any time during the plan year for any reason.

Employer Contributions

If you are enrolled in the HDHP, Solved Industrial Motion Group will contribute \$1,000 for employee only coverage, \$1200 for employee/spouse coverage, employee/child(ren) and \$1,400 family coverage for 2025!

Please note If you are hired after March 31, 2025 the amount that Solve contributes will be pro-rated.

- Associates enrolling in the HDHP April 1 to June 30, Solve Industrial Motion Group will contribute \$750 for employee only, \$900 for employee/spouse coverage, employee/child(ren) and \$1,050 for family coverage.
- Associates enrolling in the HDHP from July 1– Sept. 30, Solve Industrial Group will contribute \$500 for employee only, \$600 for employee/spouse coverage, employee/child(ren) and \$700 for family coverage.
- Associates enrolling in HDHP from October 1 – November 30, Solve Industrial Motion Group will contribute \$250 for employee only, \$300 for employee/spouse coverage, employee/child(ren) and \$350 for family coverage.



Click on the above picture for more information about Health Savings Accounts

2025 | HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts.

HSA Contribution Limits

Employee	\$4,300
Two Person/Family	\$8,550

HSA "Catch-Up" Contributions

Age 55 or older	\$1,000 a year
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HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE | ADMINISTERED BY OPTUM

HSA ELIGIBILITY REQUIREMENTS

To have an HSA and make contributions to the account, you must meet several basic qualifications.

- ✓ To be eligible to open and contribute to an HSA, you must have coverage under a qualified High Deductible Health Plan (HDHP).
- ✓ Participants cannot be covered by any other health insurance plan (this exclusion does not apply to certain other types of insurance, such as dental, vision, disability or long-term care coverage);
- ✓ Participants cannot participate in a Healthcare FSA or spouse/domestic partner's Healthcare FSA unless it is a Limited Purposed FSA.
- ✓ Participants cannot be enrolled in Medicare or Medicaid.
- ✓ You cannot be eligible to be claimed as a dependent on someone else's tax return.
- ✓ You have not received Department of Veterans Affairs Medical benefits in the past 90 days, unless the Veteran has a disability rating. (*There may be additional special circumstances, check with your tax preparer*).

MAINTAINING RECORDS

To protect yourself in the event that you are audited by the IRS, keep records of all HSA documentation and itemized receipts for at least as long as your income tax return is considered open (subject to an audit), or as long as you maintain the account, whichever is longer.

The IRS requires HSA funds to be used for qualified expenses only. If you use HSA funds for non-eligible expenses, you will be subject to regular income taxes and an additional 20% excise tax penalty.

ELIGIBLE HSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limb
- Automobile modifications for a physically handicapped person
- Birth control pills
- Blood pressure monitoring device
- Braille books & magazines
- Chiropractic care
- Christian science practitioner
- COBRA premiums
- Contact lenses & related materials
- Crutches
- Dental treatment
- Dentures
- Diagnostic services
- Drug addiction treatment
- Eye examination
- Eyeglasses & related materials
- Fertility treatment
- Flu shot
- Guide dog or other animal aide
- Hearing aids
- Hospital services
- Immunization
- Insulin
- Laboratory fees
- Laser eye surgery
- Long-term care premiums or expenses
- Medical testing device
- Nursing services
- Obstetrical expenses
- Organ transplant
- Orthodontia (not for cosmetic reasons)
- Oxygen
- Physical exam
- Physical therapy
- Prescription drugs
- Psychiatric care
- Retiree medical insurance premiums
- Smoking cessation program
- Surgery
- Transportation for medical care
- Weight loss program
- Wheelchairs and more*.

**A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.*

For questions regarding your HSA, or for additional online resources go to: www.Optum.com

DENTAL

COVERAGE OVERVIEW | ADMINISTERED BY DELTA DENTAL NC*

*Solve Industrial Motion Group will be transitioning to Delta Dental NC as of January 1, 2025

COMMON TERMS

PRE-TREATMENT ESTIMATE

If your dental care is extensive and you want to plan for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE

You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS

Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider.

You have the freedom to select the dentist of your choice; however, when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

	PPO Network	Out-of-Network
PLAN FEATURES		
Network Details	PPO Dentists	Dentists who do not participate in either network.
Benefit Period	Calendar Year	
DEDUCTIBLE		
Single	\$50 In-network / \$50 out of network	
Family	\$150 In-network / \$150 out of network	
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive services)	
COVERED SERVICES		
CLASS I: Preventive Services <i>Routine oral exams and cleanings, x-rays (bitewing), sealants & fluoride treatments</i>	Covered at 100%	Covered at 100% <i>With possible balance billing</i>
CLASS II: Basic Services <i>Periodontics (surgical & non-surgical), endodontics (root canals), oral surgery, fillings, prosthetic maintenance & x-rays (full mouth)</i>	Covered at 90%	Covered at 90% <i>With possible balance billing</i>
CLASS III: Major Services <i>Prosthodontics, crowns, inlays/onlays, dentures, implants & bridges</i>	Covered at 60%	Covered at 60% <i>With possible balance billing</i>
ANNUAL MAXIMUM		
Maximum Benefit <i>Allowed per Benefit Period</i>	\$2,500 per covered individual	



How do I find an In-Network Provider?

This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found at www.deltadentalnc.com under "Find a Dentist". Choose the Delta Dental PPO Plus Premier network to locate a dentist.

VISION

COVERAGE OVERVIEW | ADMINISTERED BY BLUE 20/20 utilizing the EYEMED Network*

*Solve Industrial Motion Group will be transitioning to BLUE 20/20 as of January 1, 2025

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

BLUE 20/20 VISION (EyeMed Network)	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PLAN FEATURES		
Vision Exam	\$10 copay	Up to \$39 after \$0 copay
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	\$10 copay	Up to \$25
Bifocals	\$10 copay	Up to \$39
Trifocals	\$10 copay	Up to \$63
Frames	\$130 retail allowance; then 20% discount	Up to \$65
COVERED SERVICES		
Contact Lenses (Elective)	\$130 Allowance	Up to \$104
Contact Lens Standard Fitting	Discounted to \$55	Included in Exam Reimbursement
Medically Necessary Lenses:	Covered in full	Up to \$200
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 12 Months	Once every 12 Months
Contacts	Once every 12 Months <i>(contacts in lieu of frames/lenses)</i>	Once every 12 Months



Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating In-Network provider?

Visit www.bluecrossnc.com/members/vision, then Find A Doctor under the Blue 20/20 plan. Blue 20/20 utilizes the EyeMed network.

Search by location, doctor name, or office name.

EMPLOYEE CONTRIBUTIONS

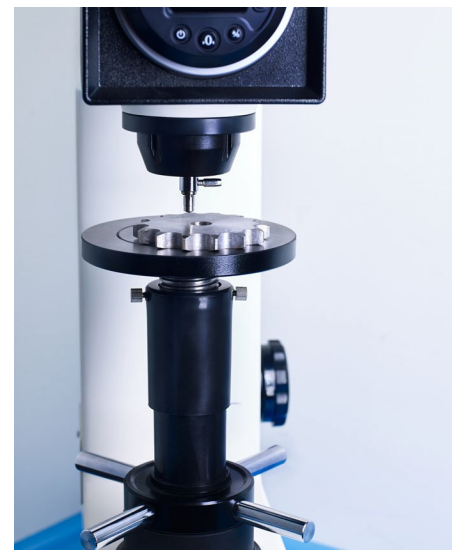
The costs below are employee cost, on a pre-tax deduction per Bi-Weekly pay period

Employee Bi-weekly Contributions will be effective January 1, 2025

	Base Plan (PPO)	Buy-Up (PPO)	HDHP
Bi-Weekly Deductions			
Employee Only	\$59.51	\$88.49	\$50.69
Employee + Spouse	\$318.48	\$390.25	\$189.57
Employee + Child(ren)	\$262.83	\$322.02	\$155.96
Family	\$457.05	\$560.15	\$273.30

	Dental Plan
Bi-Weekly Deductions	
Employee Only	\$10.14
Employee + Spouse	\$28.24
Employee + Child(ren)	\$23.27
Family	\$41.90

	Vision Plan
Semi-Monthly Deductions	
Employee Only	\$1.57
Employee + Spouse	\$3.76
Employee + Child(ren)	\$3.54
Family	\$5.92



BASIC LIFE

COVERAGE OVERVIEW | ADMINISTERED BY THE HARTFORD*

*Solve Industrial Motion Group will be transitioning to The Hartford as of January 1, 2025

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A **Beneficiary** is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary**. A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

BASIC LIFE INSURANCE

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost

Coverage Amount 1x your annual salary up to \$250,000

Accidental Death and Dismemberment (AD&D) Amount equal to your Life benefit

Benefit Reduction Schedule Your insurance will reduce to:
– 65% of the original amount at age 65
– 80% of the original amount at age 70

ADDITIONAL PLAN PROVISIONS

Conversion When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.



WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

DISABILITY

SHORT-TERM | LONG-TERM | ADMINISTERED BY THE HARTFORD*

*Solve Industrial Motion Group will be transitioning to The Hartford as of January 1, 2025

SHORT-TERM DISABILITY (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs.

Short Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

LONG-TERM DISABILITY (LTD)

Serious illnesses or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months – even years.

Long Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

PLAN FEATURES	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Elimination Period <i>This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.</i>	Benefits begin on the 1st day of an accident and the 8th day of an illness (including pregnancy)	Your elimination period is 90 days (if elected, this will be the benefit duration of Short Term Disability)
Benefit Duration <i>The maximum number of weeks you can receive benefits while you are sick or disabled.</i>	Payments may last up to 13 weeks You must be sick or disabled for the duration of the waiting period before you can receive a benefit payment.	Social Security Normal Retirement Age (SSNRA)
Coverage Amount	Covers 66.67% of your earnings , up to a maximum benefit of \$1,500 per week .	Covers 66.67% of your earnings , up to a maximum benefit of \$10,000 per month .
What's covered?	A variety of conditions and injuries. Typical claims would include: pregnancy, injuries, joint, back and digestive disorders.	A variety of conditions and injuries. Typical claims would include: cancer, back disorders, injuries and poison, cardiovascular, joint disorders.
Definition of Earnings	Base Wage	Base Wage

ADDITIONAL PLAN PROVISIONS		
Benefit Payment Frequency	Weekly benefit may be reduced or offset by other sources of income.	Monthly benefit may be reduced or offset by other sources of income.
Cost Calculation	Employer Paid	Employer Paid
Waiver of Premium	If you're disabled and receiving benefit payments, your cost may be waived until you return to work.	If you're disabled and receiving benefit payments, your cost may be waived until you return to work.
Pre-Existing Condition Limitation	You have a pre-existing condition if you have received: medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and the disability begins in the first 6 months after your effective date of coverage.	You have a pre-existing condition if you have received: medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 12 months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

Certain exclusions and any pre-existing condition limitations may apply. Please refer to the Provider's detailed benefit summary for details.

SUPPLEMENTAL LIFE

COVERAGE OPTIONS FOR YOU & THE FAMILY | ADMINISTERED BY THE HARTFORD*

*Solve Industrial Motion Group will be transitioning to The Hartford as of January 1, 2025

SUPPLEMENTAL LIFE INSURANCE

Employees have the opportunity to enroll in supplemental life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents.

PLAN OPTIONS

Cost of Coverage	Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.		
Coverage Options	Employee Coverage Choose in \$10,000 increments up to \$300,000	Spouse Coverage Choose in \$5,000 increments up to \$100,000	Dependent Coverage \$10,000 Dependent children under 14 days old receive a \$1,000 benefit
Do I have to take a health exam to get coverage?	If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.		
Guaranteed Issue	Employee <ul style="list-style-type: none"> Under the age of 70: \$100,000 70 or older: \$10,000 	Spouse <ul style="list-style-type: none"> Spouse under age of 70: \$30,000 Spouse 70 or older \$10,000 	Dependent \$10,000

PLAN PROVISIONS

Cost Calculation	Age Rated Benefit (Spouse Life based on employee's age)	
Benefit Reduction Schedule	Employee Coverage Will Reduce To: <ul style="list-style-type: none"> 65% of the original amount at age 65 80% of the original amount at age 70 	Spouse Coverage Will Reduce By: The same amount and at the same time your coverage reduces
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.	
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.	



*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). Annually, you are able to increase elections 2 increments, up to GI without proof of good health.

Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

EMPLOYEE ASSISTANCE PROGRAM (EAP) ADMINISTERED BY THE HARTFORD*

*Solve Industrial Motion Group will be transitioning to The Hartford as of January 1, 2025



EXTRAS THAT SUPPORT AND ASSIST

For access over the phone, simply call toll-free

800-96-HELPS
(800-964-3577)

Visit guidanceresources.com to access hundreds of personal health topics and resources for child care, elder care, attorneys or financial planners.

If you're a first-time user, click on the **Register** tab.

1. In the Organization Web ID field, enter: **HLF902**
2. In the Company Name field at the bottom of personalization page enter: **ABILI**
3. After selecting "Ability Assist program", create your own confidential user name and password.



Snap a photo with a mobile device to capture information above.

For employees covered under a fully insured Group policy or Leave Management services with The Hartford.

Life presents complex challenges. If the unexpected happens, you should have simple solutions to help cope with the stress and life changes that may result. That's why The Hartford Ability Assist® Counseling Services, offered by ComPsych®,¹ can play such an important role. Our straightforward approach takes the complexity out of benefits when life throws you a curve.

COMPASSIONATE SOLUTIONS FOR COMMON CHALLENGES

From everyday issues like job pressures, relationships and retirement planning to highly impactful issues like grief, loss, or a disability, Ability Assist is your resource for professional support.

You and your family, including spouse and dependents can access Ability Assist at any time, as long as you are covered under a fully insured Group policy or Leave Management Services with The Hartford.

SERVICE FEATURES

The service includes up to three face-to-face emotional counseling sessions per occurrence per year. This means you and your family members won't have to share visits. You can each get counseling help for your own unique needs. Work-life services and counseling for your legal, financial, medical and benefit-related concerns are also available by phone.

ABILITY ASSIST COUNSELING SERVICES

Emotional or Work-Life Counseling

Helps address stress, relationship or other personal issues you or your dependents may face. It is staffed by GuidanceExperts™ – highly trained master's-level clinicians – who listen to concerns and quickly make referrals to in-person counseling or other valuable resources. Situations may include:

- Job pressures
- Relationship/marital conflicts
- Stress, anxiety and depression
- Work/school disagreements
- Substance abuse
- Child and elder care referral services

Financial Information and Resources

Provides unlimited telephonic support for the complicated financial decisions you or your dependents may face. Speak by phone with a Certified Public Accountant and Certified Financial Planners on a wide range of financial issues. Topics may include:

- Managing a budget
- Retirement
- Getting out of debt
- Tax questions
- Saving for college

Legal Support and Resources

Offers unlimited telephonic assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your dependents. If you require representation, you'll be referred to a qualified attorney in your area with a 25% reduction in customary legal fees thereafter. Topics may include:

- Debt and bankruptcy
- Guardianship
- Buying a home
- Power of attorney
- Divorce

Health and Benefit Services

HealthChampion™ is a service that supports you through all aspects of your health care issues.² HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern. Situations may include:

- One-on-one review of your health concerns
- Preparation for upcoming doctor's visits/lab work/tests/surgeries
- Answers regarding diagnosis and treatment options
- Coordination with appropriate health care plan provider(s)
- An easy-to-understand explanation of your benefits-what's covered and what's not
- Cost estimation for covered/non-covered treatment
- Guidance on claims and billing issues
- Fee/payment plan negotiation

GLOSSARY OF TERMS

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term “charges” means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Domestic Partner – a person who shares a residence with a sexual partner without a legally recognized union.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits – The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

In-Network – The term “in-network” refers to health care services or items provided by participating provider(s) in the BCBSNC. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of “emergency services” and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term “out-of-network” refers to care that does not qualify as in-network.

Maximum Out of Pocket – The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all usual and customary expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.









Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term “Primary Care Dentist” means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term “Primary Care Physician” means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

IMPORTANT CONTACT INFORMATION

PROVIDER	CONTACT INFORMATION	
BlueCross BlueShield of NC Medical Pharmacy	(888) 206-4697 www.bluecrossnc.com	 BlueCross BlueShield of North Carolina
Delta Dental of NC Dental	(800) 662-8856 www.deltadentalnc.com	
Blue 20/20 Vision	(888) 206-4697 www.bluecrossnc.com/members/vision	 BlueCross BlueShield of North Carolina
The Hartford Employee Assistance Plan (EAP)	(800) 854-1446 www.metlifeeap.lifeworks.com	
The Hartford Life Voluntary Supplemental Life	(800) 523-223 www.thehartford.com	
The Hartford Short Term Disability Long Term Disability	(800) 523-223 www.thehartford.com	
Optum Flexible Spending Accounts	(866) 234-8913 www.Optum.com	
Optum Health Savings Accounts	(866) 234-89137 www.Optum.com	

Have Questions?

Please see the chart above for provider customer service phone numbers and website addresses.

If you need any other assistance, contact HR at 704-247-7885.

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