ATECH
Logistics & Distribution

2024
Employee Benefits Booklet

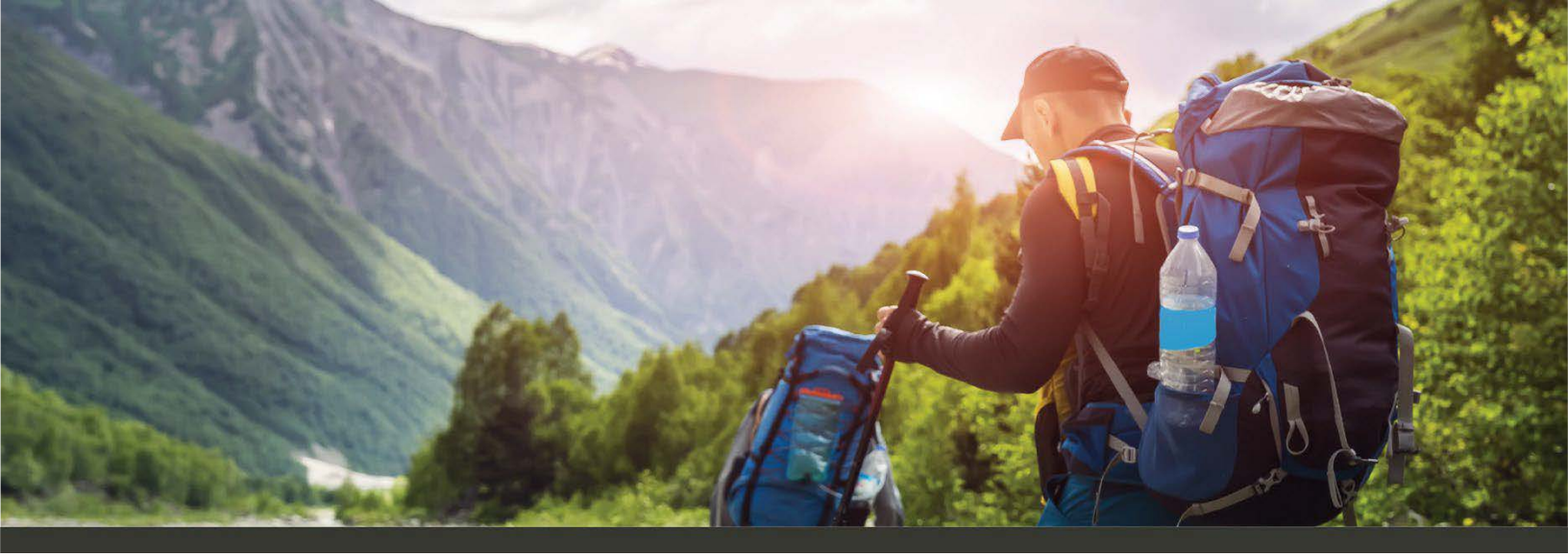


Table of Contents

Helpful Hints

1. If you have a question or claims issue, please contact your carrier first. If you don't receive resolution from the carrier, please contact George Petersen Insurance Agency at 707-525-4150 and ask for a representative in the Employee Benefits Department. Please be sure to note who you spoke with from the carrier.
2. In order to receive the most benefit from your plan, make sure you use a network provider. You can obtain information on providers on each of your carriers' websites.
3. Remember to update your providers' offices of your current medical and dental plan information. Give them the most current copy of your ID card.
4. Keep copies of your bills and Explanation of Benefits (EOBs) for all services in case there is a question.
5. Remind your physician of the medical carrier you are enrolled with so that he/she may prescribe the correct prescriptions and/or direct you to the correct facilities in order to receive the best value from your plan.

Medical Insurance:
Cigna
$1000 PPO Plan

	In Network	Out of Network
Individual Deductible	$1,000	$2,000
Family Deductible	$2,000 embedded*	$4,000 embedded*
Individual Out-of-Pocket Max (including deductible)	$4,950	$9,900
Family Out-of-Pocket Max (including deductible)	$9,900 embedded*	$19,800 embedded*
Hospital In-Patient	$100 per admit + 20% after deductible	40% after deductible
Outpatient Surgery (facility)	20% after deductible	40% after deductible
Emergency Room	$100 per visit + 20% after deductible	$100 per visit + 20% after deductible
Urgent Care	$30 copay	40% after deductible
Preventive Care	Covered 100%	40% after deductible
Office Visit	$30 copay PCP $40 Specialist	40% after deductible
Lab & X-Ray	20% after deductible	40% after deductible
Rx Generic	$10 copay after Rx deductible	N/A
RX Brand Formulary	$30 copay after Rx deductible	N/A
Rx Brand Non-Formulary	$50 copay after Rx deductible	N/A
Prescription Deductible	$100/indiv; $300/family	N/A

**Embedded: Each family member becomes eligible for copayments after meeting his/her individual deductible.*

Medical Insurance:
Cigna
$4,500 EPO Plan

	In Network	Out of Network
Individual Deductible	$4,500	Not covered
Family Deductible	$9,000 embedded*	Not covered
Individual Out-of-Pocket Max (including deductible)	$6,500	Not covered
Family Out-of-Pocket Max (including deductible)	$13,000 embedded*	Not covered
Hospital In-Patient	30% after deductible	Not covered
Outpatient Surgery	30% after deductible	Not covered
Emergency Room	30% after deductible	Not covered
Urgent Care	$50 copay	Not covered
Preventive Care	Covered 100% **no** deductible	Not covered
Office Visit	$30 PCP/ $40 Specialist	Not covered
Lab & X-Ray	30% after deductible	Not covered
Rx Generic	$15 copay	Not covered
RX Brand Formulary	$30 copay	Not covered
Rx Brand Non-Formulary	$60 copay	Not covered
Prescription Deductible	None	N/A

**Embedded: Each family member becomes eligible for copayments after meeting his/her individual deductible.*

Medical Insurance:
Cigna
$6,900 HSA Plan

	In Network	Out of Network
Individual Deductible	6,900	$13,800
Family Deductible	$13,800 embedded*	$27,600 embedded*
Individual Out-of-Pocket Max (including deductible)	$6,900	$17,800
Family Out-of-Pocket Max (including deductible)	$13,800 embedded*	$35,600 embedded*
Hospital In-Patient	Covered 100% after deductible	Covered 50% after deductible
Outpatient Surgery	Covered 100% after deductible	Covered 50% after deductible
Emergency Room	Covered 100% after deductible	Covered 100% after deductible
Urgent Care	Covered 100% after deductible	Covered 50% after deductible
Preventive Care	Covered 100% **no** deductible	50% after deductible
Office Visit	Covered 100% after deductible	50% after deductible
Lab & X-Ray	Covered 100% after deductible	Covered 50% after deductible
Rx Generic	$7 copay after deductible	N/A
Rx Brand Formulary	$25 copay after deductible	N/A
Rx Brand Non-Formulary	$45 copay after deductible	N/A
Prescription Deductible	Medical deductible applies	N/A

**Embedded: Each family member becomes eligible for copayments after meeting his/her individual deductible.*

Medical Insurance:
Kaiser Permanente – California Only
$2,500 DHMO Plan

Individual Deductible	$2,500
Family Deductible	$5,000 embedded*
Individual Out-of-Pocket Max (including deductible)	$5,000
Family Out-of-Pocket Max (including deductible)	$10,000 embedded*
Hospital In-Patient	30% per admit after deductible
Outpatient Surgery	30% per procedure after deductible
Emergency Room	30% per visit after deductible
Urgent Care	$40 copay
Preventive Care	Covered 100%
Office Visit	$40 copay
Lab & X-Ray	$10 copay after deductible
Rx Generic	$10 copay
RX Brand Formulary	$30 copay
Rx Brand Non-Formulary	Kaiser Wholesale Price
Prescription Deductible	None

**Embedded: Each family member becomes eligible for copayments after meeting his/her individual deductible.*

Medical Insurance:
Kaiser Permanente – California Only
$4,500 HSA Plan

Individual Deductible	$4,500
Family Deductible	$9,000 embedded*
Individual Out-of-Pocket Max (including deductible)	$6,250
Family Out-of-Pocket Max (including deductible)	$12,500 embedded*
Hospital In-Patient	40% per admit after deductible
Outpatient Surgery	40% per procedure after deductible
Emergency Room	$250 copay after deductible
Urgent Care	$50 copay after deductible
Preventive Care	Covered 100% **no** deductible
Office Visit	$40 copay after deductible
Lab & X-Ray	40% after deductible
Rx Generic	$15 copay after deductible
RX Brand Formulary	$35 copay after deductible
Rx Brand Non-Formulary	Kaiser Wholesale after deductible
Prescription Deductible	Medical deductible applies

**Embedded: Each family member becomes eligible for copayments after meeting his/her individual deductible.*

Dental Insurance & Life Insurance

Dental - Cigna

	In-Network:	Out-of-Network:
Calendar Year Maximum	$1,000	
Individual Deductible	$50	
Family Deductible	$150	
Deductible Waived for Preventive?	Yes	Yes
Preventive Services • 2 services per 12 months • Bitewing x-rays • Fluoride (children only) • Full Month X-ray	100%	100%
Basic Services • Sealants (children only) • Periodontics • Endodontics • Fillings • Extractions	80%	80%
Major Services • Bridges • Cast Crowns, Onlays, Inlays • Dentures	50%	50%
Orthodontia – Children Only	50% up to $1,000 Lifetime Allowance per child	

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

New York Life

Death Benefit Amount	$25,000
Reduction of benefits: Age 75	50%

Vision:
Cigna- EyeMed

	EyeMed Network:	Out-of-Network Allowance:
Benefit Frequency • Exam • Lenses or Contact Lenses • Frames	12 months 12 months 24 months	
Copays • Exam • Materials	$10 copay $10 copay	N/A
Exam	Covered 100% after copay	Up to $45
Lenses • Single Vision • Bifocal • Trifocal • Lenticular	Covered 100% after copay	Up to $32 Up to $55 Up to $65 Up to $80
Progressive Lenses	20% discount	Not covered
Lens Options – UV Coating, scratch coating, polycarbonate, anti-reflective, etc.	20% discount	Not covered
Frames Allowance	$130 allowance	Up to $71
Contact Lense Allowance • Conventional/Disposable • Medically Necessary	$130 allowance Covered 100%	$105 $210

Health Savings Account Information

Optum Bank HSA Account

You must be enrolled in an HSA-qualified high deductible health plan (HDHP) in your own name to open or contribute to a Health Savings Account (HSA) in your own name. Atech's HSA-qualified plans are the Cigna $6,900 Plan and the Kaiser $4,500 Plan.

Atech uses Optum Bank as our HSA vendor to administer the HSA program. (www.optumbank.com)

The money you save in premiums can be deposited into your HSA. The money in your HSA is entirely your own. Since it is your money, it also stays with you when you change jobs.

You are in charge of your HSA funds, making you and your doctor the decision-makers, not a third party. Spending your own money also means that you will likely inquire more about the cost of your healthcare expenditures, helping to introduce marketplace competition into the world of healthcare.

There is no limit as to when you can reimburse yourself for your healthcare expenses; you just need to keep legible receipts and records in case you do reimburse yourself or if you are audited by the IRS.

You decide whether and how much to spend from the HSA account for your medical expenses; whether to spend out-of-pocket or to save the HSA money for the future. Just like a 401(k), earnings that compound tax- free for several years have the potential to grow exponentially into a supplemental retirement nest egg. After age 65 (or if you are disabled), funds can be withdrawn for non-qualified expenses without being subject to the 20% penalty, but ordinary income taxes still apply.

The tax benefit from such a contribution is gained by the person receiving the contribution, not the person giving the contribution.

IRS Publication 502 provides a list of most allowable HSA expenditures. This list is on page 12 of this booklet.

2024 HSA Contribution Limits:
Single: $4,150
Family: $8,300
Catch-up: Additional $1,000 per individual 55 and older

IRS Code Section 213(d) Eligible Medical Expenses

An eligible expense is defined as those expenses paid for care as described in **Section 213 (d)** of the Internal Revenue Code. Below are two lists which may help determine whether an expense is eligible. For more detailed information, please refer to **IRS Publication 502** titled, "Medical and Dental Expenses," If tax advice is required, you should seek the services of a competent professional.

Deductible Medical Expenses

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Birth Control Pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium Therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Eligible Over-the-Counter Drugs

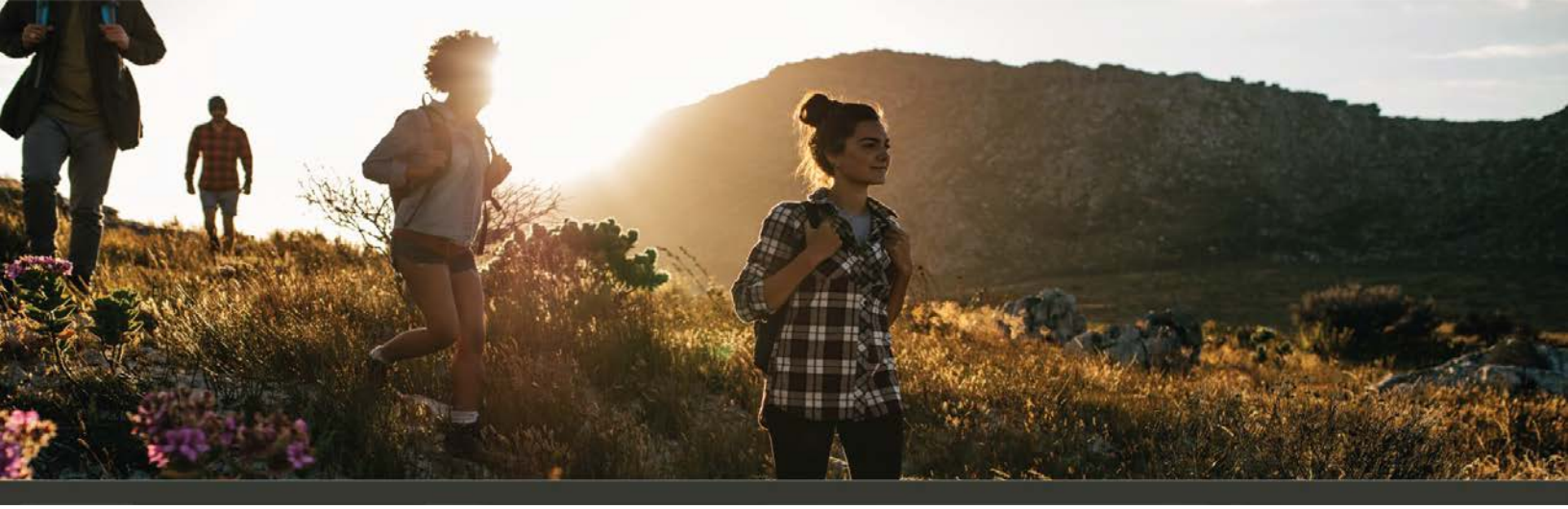
- Antacids
- Allergy Medications
- Pain Relievers
- Cold medicine
- Anti-diarrhea medicine
- Cough drops and throat lozenges
- Sinus Medications and Nasal sprays
- Nicotine medications and nasal sprays
- Pedialyte
- First aid creams
- Calamine lotion
- Wart removal medication
- Antibiotic ointments
- Suppositories and creams for hemorrhoids
- Sleep aids
- Motion sickness pills

Non-Deductible Medical Expenses

- Advancement payment for services to be rendered next year
- Athletic Club membership
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Bottled Water
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Funeral, cremation, or burial expenses
- Health programs offered by resort hotels, health clubs, and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Maternity clothes
- Non-prescription medication
- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Scientology counseling
- Social activities
- Special foods and beverages
- Specially designed car for the handicapped other than an autoette or special equipment
- Stop-smoking programs
- Swimming pool
- Travel for general health improvement
- Tuition and travel expenses a problem child to a particular school
- Weight loss programs

Ineligible Over-the-Counter Drugs

- Toiletries (including toothpaste)
- Acne treatments
- Lip balm (including Chapstick or Carmex)
- Cosmetics (including face cream and moisturizer)
- Suntan lotion
- Medicated shampoos and soaps
- Vitamins (daily)
- Fiber supplements
- Dietary supplements
- Weight loss drugs for general well being
- Herbs



401(k) Information – Vanguard

Online enrollment in an instant

Your Vanguard Retirement Website is a convenient 24-hour tool that allows you to enroll in your retirement plan and easily manage your account. The benefits of online enrollment are clear:

- Provides ease of use with a user-friendly format and navigation
- Enables you to enroll at the time of day that is convenient for you
- Tracks progress if you need to complete enrollment over multiple sittings
- Allows you to make informed decisions with easy access to plan highlights, fund information and election options
- Allows for timely electronic communication to your employer for payroll processing

How to register and access the participant website for the first time:

Go to **https://my.vanguardplan.com**. Select *"Register Here"* on the homepage and click the *"Register Me Now"* link.

1. Enter your SSN, date of birth and zip code
2. Create a valid *Web User ID* 8-15 characters long, consisting of letters and numbers only
3. Choose a security question from the options provided and supply an answer
4. Enter your email address
5. Select a security image and enter a security phrase. This will help protect you and your personal information.
6. Create a secure and unique password 8-25 characters long. For security purposes, your password must contain at least three of the following:
   - Upper case letter
   - Lower case letter
   - Number
   - Symbol
7. Click *"Submit"*. A confirmation email will be sent to the email address you provide

How to enroll in your company's retirement plan

When you log in to the participant website, you will be able to enroll in your plan. Enrolling is an easy six-step process. To begin, click *"Start Enrollment"*.

Helpful tips

As you finish each step, *"Status"* will change from *"Not Complete"* to *"Completed"*. You can return and review the completed steps at any time prior to finishing online enrollment.
Information will be available to you at the bottom of the ***Enrollment*** screen on the status of having full access to the Vanguard Retirement Website.

Employee Medical Plan Costs- January 1, 2024 through December 31, 2024

MEDICAL PLANS

Cigna $6,900 HSA Plan

	Monthly Rate	Per Paycheck
Employee Only	$130.00	$65.00
Employee + Spouse	$700.46	$350.23
Employee + Child(ren)	$442.88	$221.44
Employee + Family	$1,030.20	$515.10

Kaiser HSA – California Only

	Monthly Rate	Per Paycheck
Employee Only	$130.00	$65.00
Employee + Spouse	$537.54	$268.77
Employee + Child(ren)	$442.70	$221.35
Employee + Family	$872.80	$436.40

Cigna $4,500 EPO

	Monthly Rate	Per Paycheck
Employee Only	$216.24	$108.12
Employee + Spouse	$860.46	$430.23
Employee + Child(ren)	$563.56	$281.78
Employee + Family	$1,240.58	$620.29

Kaiser HMO – California Only

	Monthly Rate	Per Paycheck
Employee Only	$235.62	$117.81
Employee + Spouse	$730.18	$365.09
Employee + Child(ren)	$611.70	$305.85
Employee + Family	$1,149.14	$574.57

Cigna $1000 PPO

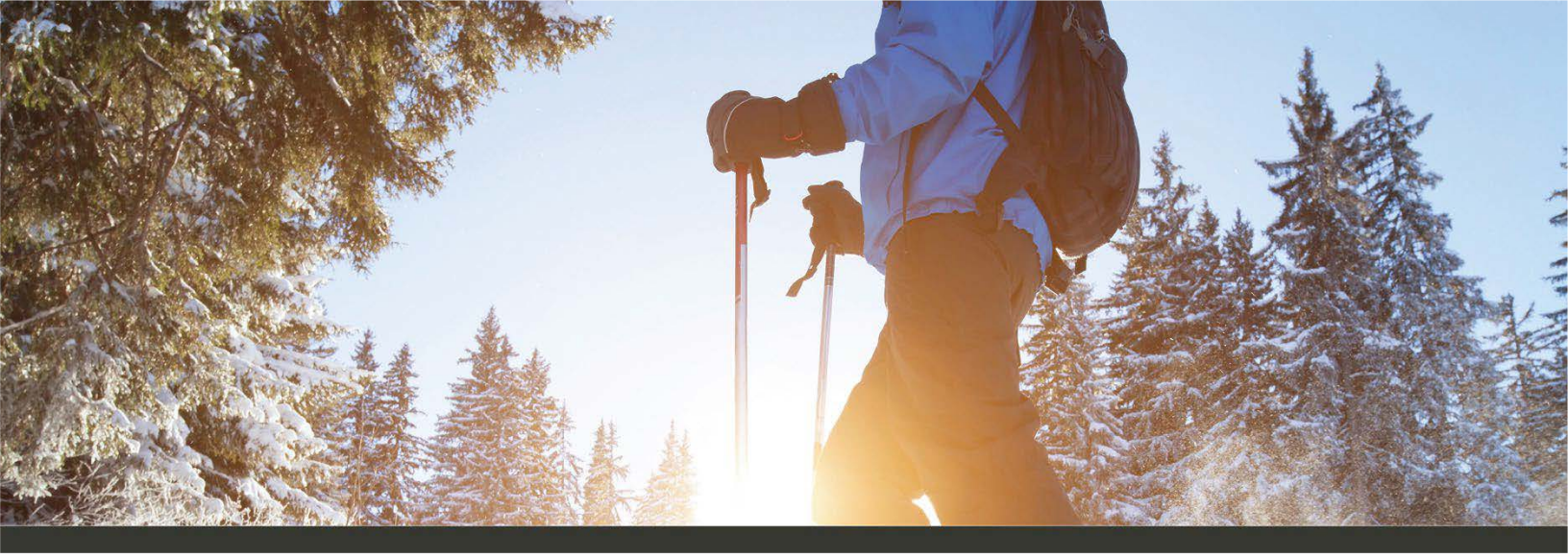
	Monthly Rate	Per Paycheck
Employee Only	$323.74	$161.87
Employee + Spouse	$1,059.98	$529.99
Employee + Child(ren)	$714.10	$357.05
Employee + Family	$1,502.92	751.46

DENTAL

	Monthly Rate	Per Paycheck
Employee Only	$19.48	$9.74
Employee + Spouse	$51.22	$25.61
Employee + Child(ren)	$64.08	$32.04
Employee + Family	$97.34	$48.67

VISION

	Monthly Rate	Per Paycheck
Employee Only	$6.94	$3.47
Employee + Spouse	$13.88	$6.94
Employee + Child(ren)	$14.02	$7.01
Employee + Family	$22.38	$11.19



Employee Assistance Program (EAP)

An Employee Assistance Program (EAP) program is available to ALL employees. This program is provided by New York Life.

When you have questions, concerns or emotional issues surrounding either your personal or work life, there are resources that can help you. Through your EAP, you have unlimited CONFIDENTIAL access to consultants by telephone, resources and tools online and up to three face-to-face visits with counselors for help with a short- term problem.

You and your dependents are eligible for:

- Free and confidential assistance with stress, anxiety, depression, grief, marriage difficulties, quitting tobacco, alcohol or drug use, financial and legal issues and more
- Unlimited number of phone consultations with the EAP licensed mental health professionals
  and other counselors
- **Up to three face-to-face counseling visits, per issue, per year**
- Detailed information on local child and elder care resources
- Referrals to community resources
- 24-hour, 7 days a week toll-free number

1-800-344-9752

Website: Guidanceresources.com, Web ID: NYLGBS

UltiPro – Online Benefits Enrollment Login Instructions

To Enroll or Change your benefit elections you will need to go through the UltiPro online system

Instructions to set up/access your personal benefits:
Go to this website URL: ***https://ew33.ultipro.com*** OR visit the company website ***www.atechlogistics.com/employees*** and under Helpful LInks click on "UltiPro".

User Name: Atech + 00 + 4 digit employee number
Password: Date of birth (MMDDYYYY) *Do not include dashes*

Changing your password:
After your first login you will be required to change your password. Remember this password as it will be required to access the system.

- **Current Password:** Date of birth
- **New Password:** Follow onscreen instructions for password specifications
- **Confirm Password:** Re-enter new password

Challenge Questions:
Once you change your password you will be required to select and answer challenge questions:

Validating system information:
Once you gain access to the system it is important to confirm the following information:

- Direct Deposit information
- Contact Information: Dependents, Beneficiaries & emergency contacts
- W4 withholding allowances
- Address information

New Hire Benefits Enrollment:
It is very important for new employees to elect their benefit options. Even if you do not want to enroll in benefits, you must go through this process to be enrolled in the employer provided Life Insurance

- Hover over "Myself" and select "Life Events"
- Click on "I am a new employee" and follow the steps to complete registration.
- If you have any questions about online enrollment, you can contact your manager or Michelle Feeney in the Atech HR Department at 707-755-3113 or email mfeeney@atechlogistics.com

Eligibility Policies

Full-time employees who work at least 30 hours per week are eligible for all benefits.
For eligible employees, the effective date will be the first of the month following 60 days after the date of hire. Eligible dependents include spouses and your or your spouse's dependent children up to age 26.

Non-Open Enrollment Additions
Open Enrollment is the only time that you can add yourself or your eligible dependents unless:

- You have a qualifying event (marriage, birth, adoption, etc.)
- You go from part-time to full-time employment
- You lose coverage from your spouse's group plan, or government sponsored plan
- Your child becomes an overaged dependent

You will have 30 days from the date of the qualifying event to add yourself or eligible dependents, otherwise you may have to wait until the next open enrollment period.

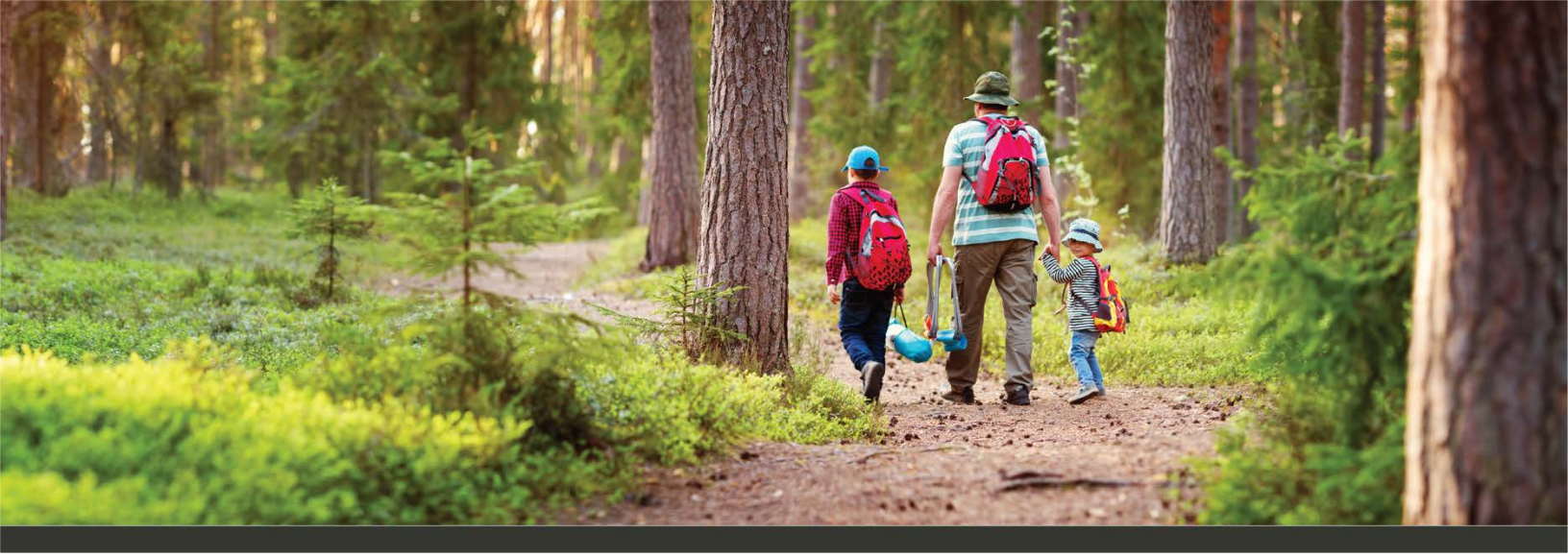
COBRA Coverage Information

In accordance with federal law, all employees and their families who lost their medical coverage under certain circumstances will be given the option of purchasing a continuation of their benefits for at least 18 months at group rates plus 2% for COBRA administration. This option will be available to you when you, your spouse, or your dependent children would otherwise lose medical coverage as a result of a "qualifying event" (reduction in hours, layoff, termination, divorce, death, over aged child).

Your Obligations:
You, your spouse or your over aged child must notify your employer within 60 days from the date of the "qualifying event". You will be notified at that time of your benefits and rates. If you notify your employer after the 60-day timeframe, you will not be eligible for COBRA benefits.

Carrier Contact Information

Medical: Cigna Medical	
Group #	628195
Member Services / Claims	1-866-494-2111
Website:	www.mycigna.com
Medical: Kaiser Permanente	
Group #	604602 (N. CA), 232293 (S. CA)
Member Services / Claims	N. CA: 1-800-464-4000/ So. CA: 1-800-464-4000
Website:	www.kp.org
Dental & Vision: Cigna	
Group #	628195
Member Services / Claims	1-800-244-6224 (dental) 1-877-478-7557 (vision)
Website:	www.mycigna.com
Group Term Life: New York Life	
Group #	FLX970319
Member Services / Claims	1-800-362-4462
Website:	www.newyorklife.com/group-benefit-solutions/forms
Agent: George Petersen Insurance Agency	
Senior Account Executive	Elaine Madson 707-525-5658 or emadson@gpins.com
Website	www.gpins.com



Annual Notices

ACA Section 1557 Nondiscrimination Notice
Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Plan Administrator.

If you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Plan Administrator in person or by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue, SW
Room 509F, HHH
Building Washington,
D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

To request special enrollment or obtain more information, contact Human Resources.

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

Women's Health and Cancer Rights Act:
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan.

Genetic Information Nondiscrimination Act Of 2008
The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health Parity & Addiction Equity Act Disclosure
The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Michelle's Law Notice
Pursuant to Michelle's Law, you are being provided with the following notice because The Company's group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of The Company's group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, The Company's group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under The Company's group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The Company's group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

Notice of Patient Protections
The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.
For children, you may designate a pediatrician as the primary care provider.

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

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact The Company.

Premium Assistance under MediCal and the Children's Health Insurance Program (CHIP):
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact you State for more information on eligibility -

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Programhttp://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center:1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840

IOWA-Medicaid and CHIP (Hawki)	MINNESOTA-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
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: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

NORTH CAROLINA-Medicaid	VERMONT-Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.htmlPhone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com /Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, 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

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 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. Your carrier has determined that the prescription drug coverage offered by all plans EXCEPT the Health Savings Account (HSA) plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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 coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will only be able to get this coverage back during the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with your carrier and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage contact Human Resources.

NOTE: You'll 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 your carrier changes. You also may request a copy of this notice at any time.
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there is now a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to 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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. **All company offered medical plans are "minimum value" standard set by the Affordable Care Act.**

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed on the Internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1- 866-487-2365.

ATECH
Logistics & Distribution

2024
Employee Benefits Booklet

ATECH Logistics and Distribution reserves the right to add to, change, or discontinue fringe benefits offered at any time without notice. This booklet is intended to be an accurate summary of benefits, however, in the event of a discrepancy, the terms of the applicable plan document, insurance policy, or company policy and procedure will prevail.