



Benefits Guide

Your Benefits, Your Choice

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Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

Welcome

We understand that your life extends beyond the workplace. That’s why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

How to Enroll

New Hires: Once eligible, you must complete your enrollment within 60 days.



Enroll online through Employee Navigator!

Scan QR code or visit
www.employeenavigator.com/benefits/account/login

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child’s dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan





**Medicare
Part D Notice:**

If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **28** for details.



Contacts

Zimmerman Transfer Benefits Contact

Sarah McCormick	608-935-5572	sarahm@zimmermantransfer.com
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Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	Fairos Occunet	(855) 426-1100	www.occunet.com/solutions/fairos
Pharmacy Benefit	MedOne	866-335-9057	www.medone-rx.com
International Rx Program	CanaRx	(866) 893-6337	www.canarx.com
State & Federal Program Assistance	FedLogic	(877) 837-4196	www.fedlogicgroup.com
Wellness Program	HealthCheck360	(866) 511-0360	mycare360@healthcheck360.com
Dental Insurance	Principal Insurance	800-986-3343	www.principal.com
Vision Insurance	VSP	1-800-877-7195	www.vsp.com
Life Insurance	Principal Insurance	800-986-3343	www.principal.com
Disability Insurance	Principal Insurance	800-986-3343	www.principal.com
Retirement Advisor- Charlie Munkwitz	American Funds	262-524-6020	www.capitalgroup.com



Enroll through Employee Navigator!

Scan QR code or visit www.employeenavigator.com/benefits/account/login



Eligibility

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have 60 days from your initial start date to enroll in benefits.

- **Medical, Dental, Vision:** These coverages will take effect on the first of the month following 60 days of employment.
- **Other Coverages:*** All other coverages will take effect on the first of the month following 60 days of employment.

* **IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of “Eligible Dependents”

Medical, Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, “spouse” shall not mean a common law spouse or domestic partner.
- **Your dependent children under age 26.** This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your paycheck each week. Please contact Human Resources regarding any questions or concerns.

Medical	
Employee Only	Covered by Zimmerman
Employee + Spouse	\$253.40
Employee + Child(ren)	\$148.18
Family	\$377.13

Vision	
Employee Only	\$1.20
Employee + Spouse	\$2.70
Employee + Child(ren)	\$2.91
Family	\$4.75

Dental	
Employee Only	\$11.23
Family	\$29.89

Basic Life/AD&D	Covered by Zimmerman
Short Term Disability	Covered by Zimmerman

HOW TO ENROLL THROUGH EMPLOYEE NAVIGATOR

Access your employee benefits from your computer, tablet, or smartphone!



Save Time

Manage your benefits whenever and wherever you are.



Find Resources

Search providers, carrier customer service numbers, and your company contacts.



Access Benefits

View your benefits, plan documents, and other educational materials.



Download/Print Materials

Download and print generic ID cards, benefit materials, and forms.



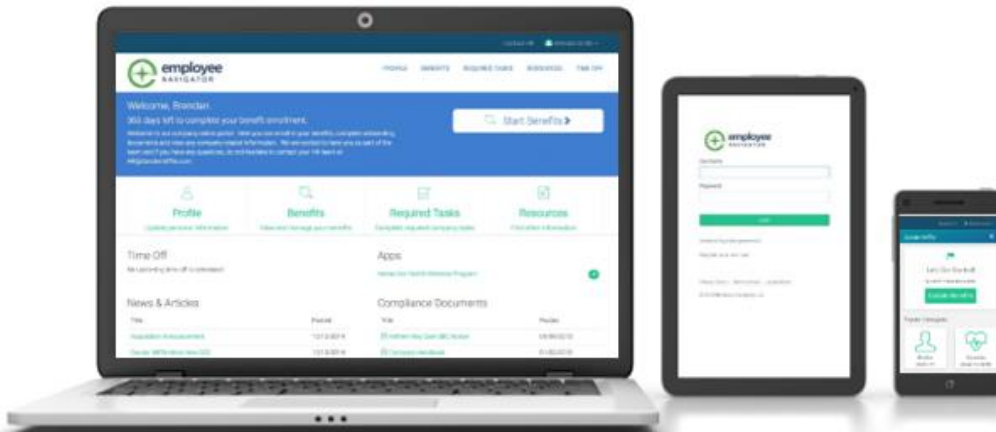
Make Decisions

Decide which benefits you want to elect, change, or decline.



Make Changes

Update dependents and beneficiaries if you experience a life-changing event.



Get Started Today!

<https://employeenavigator.com/benefits/Account/Login>

Log in using your Username and Password or click “Register as a new user” to get started.

Medical

Fairos/Occunet



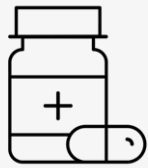
For assistance locating a provider, contact the member advocacy team by calling 888-306-0905

To find an in-network pharmacy, visit [MyCigna.com](https://www.mycigna.com)

This coverage allows you to visit any doctor or facility you choose!

Medical	Zimmerman Transfer Health Plan
	In-Network
Annual Deductible	
Individual	\$3,000
Family	\$6,000
Coinsurance (Plan Pays/You Pay)	70%/30%
Annual Out-of-Pocket Maximum	
Individual	\$6,250
Family	\$13,500
Services	In-Network
Preventive Care	Covered 100%
Primary Care Office Visit	30% After Deductible
Specialist Office Visit	30% After Deductible
Urgent Care	30% After Deductible
Emergency Room	30% After Deductible
Hospitalization	30% After Deductible
Prescription Drugs	In-Network
Annual Out-of-Pocket Maximum	
Individual	Included with Medical
Family	
Tier 1	30% after deductible
Tier 2	30% after deductible
Tier 3	50% after deductible
Tier 4	30% after deductible

Please review the full plan documents for details **including out-of-network coverage**. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



Start here for your prescription drug needs:

866-335-9057

LIVE chat online:
www.medone-rx.com

Pharmacy Benefit Solutions

MedOne

All benefit eligible employees will transition to a new prescription benefit plan with MedOne Pharmacy Benefit Solutions. MedOne is a pharmacy benefit administrator that works directly with clients, pharmacies, prescribers, and partners to help members conveniently access the most appropriate prescription at the most affordable price.

ID Card

You will receive a new Rx/Medical ID card. This card will contain MedOne prescription processing information. Please show this card to your pharmacist when you get a prescription filled on or after your go-live date so your prescriptions are processed through MedOne.

Mail-Order Enrollment

Go to www.medone-rx.com and click on **MAIL ORDER**. Follow the step-by-step enrollment process to enter your prescriptions, preferences, and payment information to start receiving your medications delivered on time, right to your door.

Member Portal

Go to www.medone-rx.com and click on **MEMBER PORTAL**. The MedOne Member Portal allows you to access everything you need concerning your pharmacy benefits, including:

- View claims details & Rx history
- Look up in-network pharmacies in your area
- Obtain pricing for your potential medications
- Review out of pocket maximum
- Access drug information directory
- Gather ID card processing information
- Enroll in MedOne mail order



\$0 Copay Prescriptions

CanaRx International | 866-715-6337 |

www.canarx.com

CanaRx International

CanaRx International is a voluntary international mail order prescription program available to eligible members and their dependents enrolled on the medical plan. All member copayments have been waived for this program only. By enrolling in this program you will save your health plan substantially on the cost of these medications.

Getting Started

Enrollment forms and prescriptions can be submitted online, via fax or mail.

As a safety measure, CanaRx only accept prescriptions that are **faxed directly from your doctor's office**. In order to have a continuous supply of medication on hand, they request that you submit a prescription for a **3-month quantity, with 3 refills**. If your prescription does not cover a full year, CanaRx can still accept it – but it must be written for a minimum 3-month supply.

If you did not contact CanaRx prior to enrolling, they will call you once they receive your paperwork and welcome you to the program! CanaRx will confirm the following:

- Your personal information
- Medication availability
- Shipping time
- Refill schedule
- And answer any questions you may have

Enroll only once – and at any time! There is no need to enroll now, unless you are ready to order through the program.

Looking for More Information?

Visit www.canarx.com and enter your WebID: CONTROLRX to review frequently asked questions (FAQs), the formulary, and download additional forms.

Submit your Enrollment Form



Fax:

1-866-715-6337



Mail:

235 Genie St. West, Suite 105D
Windsor, ON, Canada, N8X 2X7

Contact CanaRx

- (866)-893-6337

Monday– Friday: 7:30AM – 5:30PM CST

Saturday: 8:00AM – 4:30PM CST

\$0

CO-PAY*

Pack Sizes

Our program **ONLY** supplies Brand Name medications, dispensed in the manufacturer's original sealed container. Pack sizes vary from country to country. For example, a standard container quantity might be 84. CanaRx factors this in when scheduling your refill call.

Refills

Refills are not automatic, but they're easy – CanaRx calls you! As an added safety measure before processing a refill, they need to confirm how much medication you have on hand and whether you've had any health or medication changes. CanaRx will contact you one month prior to ensure you always have sufficient supply of medication on-hand.

Generic Medications

Generic medications provide the greatest savings to your health care plan. Therefore, if you are currently taking a Generic medication, you are not eligible to order the Brand Name medication through this program.

Shipping

Your medication will be shipped directly from an international pharmacy to your home **AT NO COST TO YOU**, via regular mail. Please allow 20 business days (1 month) for your package to arrive.

Condition Management

HealthCheck360

What is Condition Management?

Condition Management is a tool for you to more effectively manage your health. The Condition Management program is designed to provide personalized education and treatment support to participants on the health plan who have one of the designated medical conditions.

If you are identified as an individual with one of these conditions, a health nurse will reach out to you with a recommended program of care. We have partnered with an external vendor (HealthCheck360) to ensure that all of your personal health information will remain strictly confidential. The only information that will be shared with your employer is the percentage of members who are identified for each program and the overall rates of compliance with the care recommendations.

How Do I Enroll?

Enrollment in the Condition Management Program is automatic. Once an individual has been identified as having one of the four chronic conditions, the individual is enrolled in the program and will be contacted by the condition management program. There are NO FORMS that are needed to be filled out.

How Will I be Contacted?

You may be contacted by phone, email or mail. Each quarter you will be contacted by our Condition Management staff. If you are meeting the program criteria, you will receive a letter informing you that you are current with the requirements. If you are not current with program criteria, you will be contacted by phone. In addition to quarterly outbound contacts, you are encouraged to call HealthCheck360 anytime they can be of assistance.

Why Should I Participate?

It is important for individuals with a chronic condition to comply with their physician-recommended medications and receive regular diagnostic services. If you have been identified by HealthCheck360 as having a chronic condition and elect NOT to participate OR NOT to comply with the specific program criteria, it could affect your 2027 health plan incentive/penalty.

Chronic Condition

A chronic condition is an illness that may never go away-and may cause symptoms all the time or once in a while.

It can affect your life in many ways, such as:

- You may be physically unable to do the things you want to do
- You may feel sick, tired or in pain
- You may not be able to perform your job and have many sick days
- You may feel stress, anxiety and anger about your situation

Condition Management helps people cope with chronic conditions by taking action to improve their health.

Does it work?

Yes! Studies show that people who learn to manage their health conditions can avoid unnecessary emergency room visits and hospital stays, and miss less work.

Who is HealthCheck360?

HealthCheck360 is a medical management firm made up of doctors, nurses and other professionals working to ensure you receive the support you need to make the best health care decisions at the most appropriate level of care. HealthCheck360's Condition Management nurse specialists work closely with participants to empower and engage them to take control of their condition.

Why offer Condition Management?

The goal is to help employees and their dependents be as healthy as possible. Condition Management is part of the overall wellness and preventive care program.

Telemedicine

Teladoc



Available to all employees enrolled on the health plan.

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions. Using your computer, tablet or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

In some cases, doctors can write a prescription to a local pharmacy near you.*

How Does It Work?

Log in to your account or register if you don't have one set-up. Then, contact Healthiest You from anywhere—and let the doctor come to you!

Three Ways to Use:

- Download the Teladoc App
- Visit www.teladoc.com
- Call 800-835-2362

Teladoc doctors can then diagnose non-emergency medical problems, recommend treatment, and can even call in a prescription to your pharmacy of choice, when necessary.*

*Prescription services may not be available in all states.

When Can I Use It?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.



Common Conditions We Treat

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore Throat
- Pink eye
- Urinary tract infections
- And more!

Save Money and Time!

With extremely low or no consult cost, Healthiest You provides significant savings over urgent care and emergency room visits. Plus, you can use it from the convenience of home or work, allowing you to avoid the hassle of sitting in a waiting room.

Meet Our Doctors!

- U.S. board-certified with an average of 15 years of practice experience
- U.S. residents and licensed in your state

Scenarios and Questions:

03042025

What if my doctor or hospital has questions about my insurance plan?

- Your doctor/hospital should call the provider line on the back of your ID card.
- Provider support will handle any questions regarding your Fairos benefit plan.

What happens if the provider won't accept my insurance?

- Call SisCo at (800) 457-4726 for further assistance.

What happens if the provider requests payment at time of service?

- Confirm with the provider that they called the provider line to verify benefits.
- Any applicable co-pays will need to be paid at time of service.

Federal Benefits Advocacy

Your Very Own Personal Navigator

Dugan Truck Line has partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members. This service is confidential, unlimited, and **free to all employees and their families** whether enrolled in benefits or not.

Below is a partial list of categories FEDLogic can assist with...

- Medicare
- Medicaid
- Disability
- Social Security Retirement
- Child Benefits
- Widow Benefits
- Supplemental Security Income (SSI)
- Veterans Benefits
- Healthcare.gov (COBRA alternatives)
- ESRD (End Stage Renal Disease)
- ALS (Lou Gehrig's Disease)
- Cancer or Terminal Illness

It's All About You

We're passionate about providing highly personalized, easy, and practical phone consultation guidance to individuals and families. We never promote, endorse, or sell any type of product or insurance.

Contact

- (877) 837-4196
- www.fedlogicgroup.com (Employee Access Code: **gre24**)
- services@fedlogicgroup.com



Here's How it Works

1 Make a phone consultation appointment: Call us at 877-837-4196 to schedule a phone consultation appointment with one of our federal and state benefits experts. Be sure to make the appointment at a time when family members are available to listen and ask questions. Calls typically last an hour.

2 Tell us your story, ask questions and learn: You don't have to wade through tons of complex and confusing information to try to figure out what applies to you. We take the time to listen to your story and understand your needs, concerns, and goals. Then we empower you with the unbiased information you need so you can maximize your benefits and make the best decision for your situation.

3 Enroll for benefits: Once you feel confident you have the information you need to make the best decision for you and your family, we'll walk you through the application and approval process.

Alternative Health Plan Options

Next Level Planning

Alternative Family Health Coverage

If your spouse and/or children are covered under the health plan, you may want to explore whether you could save money by considering an Exchange Plan.

Every state offers a Health Insurance Marketplace (or “Exchange”) for individuals to find affordable and quality health insurance.

A family member may be eligible for a subsidy if the cost of family coverage offered by your employer is more than 9.12% of your entire household income.

With the passage of the Inflation Reduction Act, the number of families with access to subsidies was significantly increased with the lowering of the income thresholds to qualify. The expansion of these subsidies is available at least through 2025. What could this mean for you?

Examples of Subsidized Medical Plan Rates Available through HealthCare.gov:

Annual Household Income	Family Size	Subsidized Silver Plan Monthly Premium*	Family Size	Subsidized Silver Plan Monthly Premium*
\$20,000	4	Medicaid (Free)	2	Medicaid (Free)
\$40,000	4	\$4	2	\$133
\$60,000	4	\$158	2	\$311
\$80,000	4	\$409	2	\$567
\$125,000	4	\$885	2	\$681



* Rates shown above are an example only, your specific rates will be determined based on your personal information. Silver coverage on the Exchange is approximately a \$3,000 deductible plan.

How to find out if you could save?

If you would like assistance in reviewing coverage. Please use the following link, and a member of the Next Level Planning team will review.



<https://app.smartsheet.com/b/form/4366d0be024a44e4a715b3db6bb1c6>

Dental

Principal

Dental	In-Network
Annual Deductible	\$50 per individual \$150 per family
Annual Benefit Maximum	\$1,000
Lifetime Orthodontia Maximum	\$1,500
Plan Pays	
Preventive Care (Deductible waived)	100% Covered
Basic	80%
Major	50%
Orthodontia	50%



Locate an in-network provider near you at principal.go2dental.com or call 800-986-3343.

Dental Weekly Cost	
Employee Only	\$11.23
Family	\$29.89

Vision

Principal (VSP Network)

Vision	In-Network
Exam	\$25 copay
Lenses	Standard progressive lenses covered once every 12 months with a \$0 copay ¹
Frames	\$130 allowance
Contact Lenses	\$60 copay
Frequencies	
Exams	1 per 12 months
Lenses or Contacts	1 per 12 months
Frames	1 per 12 months



Locate an in-network provider near you at www.vsp.com or call 800-877-7195.

Vision Weekly Cost	
Employee Only	\$1.20
Employee + Spouse	\$2.70
Employee + Child(ren)	\$2.91
Family	\$4.75

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



Life/AD&D

Principal

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D	
Benefit Amount	Employee: \$20,000
Benefit Cost	Employer-provided

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.



Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.



Short-Term Disability

Principal

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Short-Term Disability	
Benefit Amount	Replaces 66% of earnings, up to a \$1,000 benefit per week
Benefit Begins	Injury: after 1 day Illness: after 8 days
Benefit Duration	Up to 26 weeks

Short-term disability excludes work-related injury or illness.

Pre-Existing Condition Limitations:

If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Statutory Benefits Offset:

Your short-term disability benefit will be reduced by benefits from State Disability/Paid Family & Medical Leave for which you may be eligible.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Help handling life's ups and downs

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the employee assistance program (EAP), provided by Magellan Healthcare, is all about.

With an EAP, you and your family have access to **free, confidential** resources to help handle life's everyday—and not so everyday—challenges.

You might use your EAP to help: manage stress, handle relationship issues, balance work and life, work through grief, cope with anxiety, and more. Plus, your EAP gives you access to discounts on major brands and everyday needs.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things.

In-person or virtual counseling

One valuable way to work through personal or work issues is by talking with a professional. You and your family can meet with a licensed, EAP professional in person, via text message, or by live chat, video, or phone sessions. Three counseling sessions per year are included.

Legal, financial, and identity theft services

You and your family have access to these services:

- **Legal services.** Receive a free 60-minute consultation to help deal with issues such as car accidents or family law.

- **Financial wellness.** Receive three free 30-minute consultations. This may include help with budget planning, debt consolidation, or retirement planning.
- **Identity theft resources.** Receive a free 60-minute consultation to help restore your identity if stolen.

Work-life web services

You and your family can access webinars, live talks, and articles on topics such as child and elder care, education, parenting, and more.

Help when and where you need it—day or night

Life's challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.



800-450-1327

International: 800-662-4504

TTY: 711



Member.MagellanHealthcare.com

When you create an account, enter **Principal Core** as the program name.

Discount Program

PerkSpot through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Discount Program

Shop for a Variety of Coupons & Deals from these Categories:	Apparel	Home & Garden
	Auto Buying	Home Services
	Automotive	Insurance & Protection Services
	Beauty & Fragrance	Jewelry & Watches
	Books, Movies, & Music	Movie Tickets
	Business Perks	Office & Business
	Cell Phones	Pets
	Education	Real Estate & Moving Services
	Electronics	Sports & Outdoors
	Financial Wellness	Tickets & Entertainment
	Flowers & Gifts	Toys, Kids & Babies
	Food	Travel
	Health & Wellness	
	Hobbies & Creative Arts	

Popular Discounted Brands*	Avis	Dell	Home Chef
	Canon	Enterprise	HP
	Casper	Holiday Inn	Ray-Ban
	Columbia		

Benefit Cost	Included in our partnership with Cottingham & Butler
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* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at <https://cottinghambutler.perkspot.com>.



Unlock discounts for you and your family!

Visit: <https://cottinghambutler.perkspot.com>

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers

Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alters: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category
- Local Discounts: shop by location

Retirement/401K

RecordkeeperDirect® participant resource



How to enroll in your retirement plan

You can enroll in your plan online or through a mobile app. Here's a step-by-step enrollment guide for your plan, provided by Capital Group, home of American Funds.



To learn how to enroll online, turn to the next four pages.



To learn how to enroll through our mobile app, see the back page.

Questions? Contact your employer or call us at (800) 421-4120.

Ongoing support for your retirement journey

Customer service

Call (800) 421-4120 Monday through Friday from 8:00 a.m. to 7:00 p.m. ET.

Automated phone

Call (877) 833-9322 to manage your account by phone.

Participant website

americanfunds.com/retire

Mobile app

App store: American Funds RKDirect 401k

Google Play: American Funds RecordkeeperDirect 401k

Contact your employer's retirement plan representative or your plan's financial professional for additional information and support.

Investments are not FDIC-insured, nor are they deposits of or guaranteed by a bank or any other entity, so they may lose value.

Investors should carefully consider investment objectives, risks, charges and expenses. This and other important information is contained in the fund prospectuses and summary prospectuses, which can be obtained from a financial professional and should be read carefully before investing.

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American Funds Distributors, Inc., member FINRA.

Healthcare Tips

Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.



Where Should I Go for Care?

www.cbmicrosite.com/video/knowwheretogo

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.

Provider The patient receives treatment. The doctor then sends the bill to the insurance company.	>	In-Network Discount Appropriate discount for using an in-network provider is applied.	>	Bill The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.
Patient Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.	<	Insurance Company Payments, Explanation of Benefits (EOB) Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.		



Take advantage of preventive care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.



Know Where to Go for Care



Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs \$1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room (\$\$\$\$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Uncontrollable bleeding
- Shortness of breath
- Poisoning

Urgent Care (\$\$\$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office (\$\$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a \$1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is \$800. Because John hasn't paid anything toward his deductible yet this year, and because the \$800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Zimmerman Transfer Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2025. V 0.4.0. The most recent CHIP notice can be found at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra>. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://dhss.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+ Website: <https://hcpf.colorado.gov/child->

health-plan-plus

CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website: <https://www.mychihibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: <https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: [Iowa Medicaid | Health & Human Services](http://www.iowa.gov/health-human-services)
Medicaid Phone: 1-800-338-8366
Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](http://www.iowa.gov/health-human-services)
Hawki Phone: 1-800-257-8563
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](http://www.iowa.gov/health-human-services)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kynect.ky.gov>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – 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)

MAINE – Medicaid

Enrollment Website:

Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine Relay 711

Private Health Insurance Premium Webpage:

Website: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIPWebsite: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspreassistance@accenture.com**MINNESOTA – Medicaid**

Website:

Website: <https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

MISSOURI – MedicaidWebsite: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – MedicaidWebsite: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HSHIPPProgram@mt.gov**NEBRASKA – Medicaid**Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – MedicaidMedicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MedicaidWebsite: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program:

1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov**NEW JERSEY – Medicaid and CHIP**Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website:

Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – MedicaidWebsite: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – MedicaidWebsite: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – MedicaidWebsite: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIPWebsite: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid

Website:

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIPWebsite: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>

Phone: 1-800-692-7462

CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://www.dhs.pa.gov/childrens-health-insurance-program-chip)

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIPWebsite: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347 or

401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – MedicaidWebsite: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – MedicaidWebsite: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – MedicaidWebsite: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance

(UPP) Website: <https://medicaid.utah.gov/upp/>Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website:

Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website:

Website: <https://medicaid.utah.gov/buyout-program/>CHIP Website: <https://chip.utah.gov/>**VERMONT – Medicaid**Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIPWebsite: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select><https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – MedicaidWebsite: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIPWebsite: <https://dhhr.wv.gov/bms/http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone:

1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIPWebsite: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – MedicaidWebsite: <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 July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565 ❖

Patient Protection Notice

If the Zimmerman Transfer Health Plan generally requires 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. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

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

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

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

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New 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, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new

Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

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

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 8.39% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit. *

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

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

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

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)

If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The ZIMMERMAN TRANSFER Group Medical Plan (the “Plan”), which includes medical, dental and vision coverages offered under the ZIMMERMAN TRANSFER Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA’s privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures ZIMMERMAN TRANSFER has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual’s Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA’s privacy rule) for:

1. Payment and Health Care

Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual’s coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan’s participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or

disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:

As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:

When required to do so by any federal, state or local law.

4. Health Oversight Activities:

To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:

As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual’s health or safety or to the health and safety of the public.

6. Judicial and Administrative

Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:

To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or

Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:

If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:

For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers’ Compensation:

As necessary to comply with workers’ compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services:

To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach

ZIMMERMAN TRANSFER is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan’s legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does

Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to

Personal Health Information: Each individual has the following rights under the Plan’s policies and procedures, and as required by HIPAA’s privacy rule:

Right to Request Restrictions on Uses

and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information.

The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at ZIMMERMAN TRANSFER, 810 S. Lindsey Street, Dodgeville WI 53533 , 608.935.5572.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at ZIMMERMAN TRANSFER, 810 S. Lindsey Street, Dodgeville WI 53533 , 608.935.5572. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at ZIMMERMAN TRANSFER, 810 S. Lindsey Street, Dodgeville WI 53533 , 608.935.5572. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or

health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at ZIMMERMAN TRANSFER, 810 S. Lindsey Street, Dodgeville WI 53533 , 608.935.5572. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at ZIMMERMAN TRANSFER, 810 S. Lindsey Street, Dodgeville WI 53533 , 608.935.5572. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at ZIMMERMAN TRANSFER, 810 S. Lindsey Street, Dodgeville WI 53533 , 608.935.5572 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate

with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at ZIMMERMAN TRANSFER, 810 S. Lindsey Street, Dodgeville WI 53533 , 608.935.5572. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Zimmerman Transfer Health Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ZIMMERMAN TRANSFER 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. ZIMMERMAN TRANSFER has determined that the prescription drug coverage offered by the ZIMMERMAN TRANSFER Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is

therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current ZIMMERMAN TRANSFER] coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current ZIMMERMAN TRANSFER] coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with ZIMMERMAN TRANSFER] 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 the person listed below for further information. **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 ZIMMERMAN TRANSFER] changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 08/11/2025

Name of Entity/Sender: ZIMMERMAN TRANSFER]

Contact--Position/Office: Human Resources

Address: 810 S. Lindsey Street, Dodgeville WI 53533

Phone Number: 608.935.5572 ❖

