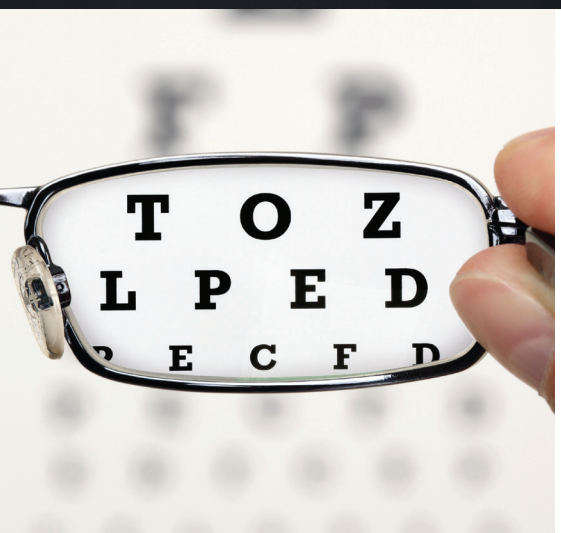
GEON®
Performance Solutions

BENEFITS GUIDE

2023

Important Benefit Information

Use this guide to help you make informed decisions for you and your family.



Visit www.geonbenefits.com to view all information on your GEON benefit and retirement package

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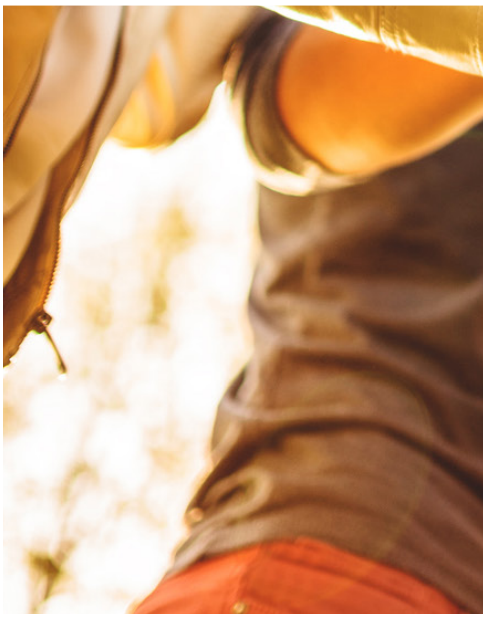


To view a copy of this guide in Spanish visit www.geonbenefits.com

Para ver una copia de esta guía en español visite www.geonbenefits.com

ELIGIBILITY

Eligibility for You and Your Dependents

Eligibility for You

Employees who are regularly scheduled to work a minimum of 30 hours a week for GEON are considered full-time and are eligible for health and welfare benefits.

Qualifying Life Event Changes During the Plan Year

According to IRS regulations, elections you make during annual enrollment will be in effect during the entire 2023 calendar year.

Changes to your plan may occur if you have a qualifying life event. You have 31 days from the time of the event to provide documentation of the qualifying life event and make the appropriate changes to your benefits.

Qualifying Life Event
Marriage, divorce
Birth, legal adoption
Death
Change in your spouse's or child's employment status
Loss or gain of coverage
Change in your dependent child's status
Change in your residence or worksite coverage
Judgment decree or court order

For Your Dependents

You have the option of covering your dependents under the Medical, Dental, Vision, Dependent Life, AD&D, Accident Insurance, Critical Illness Insurance and Hospital Indemnity Insurance plans. In general, your dependents include your spouse, domestic partner, and your children under age 26.

Coverage may also be extended if your child is mentally or physically disabled and depends on you for support. If your child is disabled, you need to apply for extended coverage before the child's 26th birthday. Covered expenses incurred by your tax dependents may be reimbursed by your flexible spending and health savings accounts.

Dependent Eligibility Verification

Enrolling ineligible dependents increases the total cost of health care benefits. Removing ineligible dependents is one of the steps you and GEON can take to help limit future increases to your benefit contributions.

Of equal importance, the Department of Labor regulates company provided health and welfare benefit plans, such as Medical and Dental. As part of our ongoing due diligence, GEON is required to ensure that dependents enrolled in the plans meet the eligibility criteria for coverage.

To ensure that GEON plans comply with federal regulations and that only eligible dependents are enrolled, eligibility for newly added dependents must be certified. Documentation listed below must be provided for each individual named as a covered dependent on GEON's benefit plans and the newly added dependent will have a pending status until certification is completed.

Spouse

Page 1 of your most recent tax return (Form 1040) with spouse listed AND Marriage License

Child

Birth Certificate OR Court papers showing legal guardianship or custodianship

Domestic Partner

Document of financial interdependence (i.e. joint checking account, joint lease, etc.) AND Affidavit of Domestic Partnership

MEDICAL

Anthem

Website:
www.anthem.com

Mobile App:
Sydney Health App

Plan Coverage Options

Anthem is GEON's Medical Plan administrator. Your plan options and in-network benefits are shown below for employees and dependents. Note, you can go out-of-network but your cost will be greater and service is subject to balance billing.

DEFINITIONS FOR THE MEDICAL PLANS

Preventive Care: The plan pays 100% for in-network preventive care.

Annual Deductible: For non-preventive care there is an annual deductible that must be met. If you cover Dependents (other family members) under this Plan, the "Family" amounts apply. Family deductible amounts can be satisfied by any combination of family members but one family member would never need to satisfy more than the single deductible amount. Once the single deductible amount is met that individual will pay coinsurance until they reach the Out-of-Pocket Maximum.

Coinsurance: Your percentage share of the costs of a healthcare service, for example 20%. You start paying coinsurance after you've paid your plan's deductible.

Out-of-Pocket Maximum: This is the most that you will have to pay for covered services in a plan year.

In-Network coverage is shown below for employees and dependents. Both Anthem medical plans utilize the Blue Access Network.

Services	HSA	PPO
Medical Deductible	$3,000 individual / $6,000 family	$900 Individual / $2,200 family
Prescription Deductible	(combined with medical)	(combined with medical)
Medical - Annual Out-of-Pocket Maximum	$4,000 individual / $8,000 family	$3,600 individual / $7,200 family
Prescription - Annual Out-of-Pocket Maximum	(combined with medical)	(combined with medical)
Physician Office Visit Specialist Office Visit Urgent Care Emergency Room	20% after deductible 0% after out of pocket maximum is met	20% after deductible 0% after medical out of pocket is met
Preventive Care	$0	$0
Employer Health Savings Account (HSA) Contribution	$600 individual / $1,300 family	N/A

Anthem

Website:
www.anthem.com

Mobile App:
Sydney Health App

PRESCRIPTION DRUGS

Prescription drug benefits are part of your health care program. Benefits are administered by Anthem.

Participants in both the PPO and HSA Plan can obtain certain preventative drugs at no cost. However, the HSA Medical Plan offers a more extensive list of $0 preventive medications.

Covered Services	HSA Plan	PPO Plan
Generic	20% after deductible 0% after out-of-pocket maximum met	20% after deductible; 0% after out-of-pocket maximum met
Brand Formulary		25% after deductible; 0% after out-of-pocket maximum met
Brand Non-Formulary		40% after deductible; 0% after out-of-pocket maximum met
Specialty		30% after deductible ($200 maximum); 0% after out-of-pocket maximum met

MEDICAL RATES & PLAN TOOLS

Medical Plan Rates

PAYING FOR BENEFITS

You pay for your benefit elections with pre-tax dollars through payroll deductions. The exceptions are Optional Life, Optional AD&D, Critical Illness Insurance, Hospital Indemnity Insurance and Accident Insurance for yourself or dependents which you pay for with after-tax dollars.

WELLNESS INCENTIVES

Wellness incentives will be provided via premium reductions for activities like completion of preventive medical exam, completion of flu shot and challenges. Refer to Wellness Section on page 9 for details.

TOBACCO FREE INCENTIVE

Certification of your Tobacco Free status is still a premium reduction. The $20.77 per pay reduction will be taken off your medical premium each pay period.

2023 SPOUSAL SURCHARGE

If you cover your spouse/domestic partner under the GEON Medical Plan, and they have access to coverage through their own employer, a $34.62 per pay spousal surcharge will apply. You must certify during annual enrollment that your spouse does not have other coverage available through their own employer in order to waive this surcharge. Failure to certify will result in the $34.62 per pay surcharge being applied to your premium.

Per Pay Pre-Tax Contribution Coverage Levels*	HSA	PPO
Employee Only	$52.28	$108.39
Employee + Spouse	$147.32	$253.32
Employee + Child(ren)	$118.81	$213.06
Family	$188.90	$343.74

Rates shown include the Tobacco Free incentive

Medical Plan Tools

Sydney Health App

The Anthem.com site and Sydney Health mobile app are the one place to keep track of your health and your benefits. With a few clicks or taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

- Find in-network doctors, facilities and medical services
- View ID card information
- Review your coverage
- See how much your medication will cost you at the different pharmacies in your network
- Manage and track claims
- or download a digital ID card via the Sydney Health mobile app

You can use Sydney Health mobile app for virtual care

With our LiveHealth Online and virtual care visits, you can connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker, then consult with a doctor through a video visit or text session.

SpecialOffers@Anthem

Get discounts on the health products and programs you use every day for:

- Weight management and nutrition
- Fitness clubs and equipment
- Mind/body programs and equipment
- Vision and hearing care
- Alternative medicine
- Health and wellness products

Log on to Anthem.com, click care, click discounts to view all the discounts available to you & how to redeem.

Anthem Health & Wellness Programs

If weight, tobacco or stress is affecting your health or your ability to live an active life, it may be time to make some changes.

- Learn to manage your weight using a non-diet approach that helps you build confidence, change habits, eat healthier and become more active
- Develop a personal quit plan to become and remain tobacco-free
- Your emotional health is an important part of your overall health. With Emotional Well-being Resources, administered by Learn to Live, you can receive support to help you live your happiest, healthiest life. Take a quick assessment to find the program that's right for you. To access our Emotional Well-being Resources, use the Sydney Health app, go to My Health Dashboard, choose Programs & select Emotional Well-being Resources.

You can use an online or telephone coaching program– or both – for the support you need. To learn more about all of your Anthem programs, call your Anthem Health Guide at 833-952-2042.

Preventive care

Overall good health is important. That's why your Anthem BlueCross BlueShield medical plans include coverage for eligible preventive care services at no additional cost to you, when you receive them from a doctor who participates in your plan's network. This means no money taken from your account and no out-of-pocket costs to you. Covered preventive care services can include, but are not limited to:

- Blood pressure screenings
- Cholesterol screenings
- Diabetes screenings
- Testing for colon/rectal cancer
- Clinical breast exams
- Pap tests
- Mammograms

Looking for more tools?

Visit the GEON benefits website for even more information.

www.geonbenefits.com

ANTHEM HEALTH GUIDE

Anthem

Website:
www.anthem.com

Mobile App:
Sydney Health App

A caring team to help guide you.

Anthem Health Guide is a concierge service for your health and health care.

Health care benefits can seem complicated or confusing at times. To make the most of your benefits, you need to understand them. That is why you have a team of concierge-level customer service experts — ready to answer questions, advocate for your health and explain how to use your benefits. You can call a health guide or chat from your mobile device using our Sydney Health app.

Anthem health guides are here to help

Health guides are Anthem team members hand-picked for their kindness and understanding, their ability to listen and find a solution, all while also helping you feel less overwhelmed. They are experts at:

- **One-call resolution.** Anthem guides use advanced technology to see your whole health care picture while talking to you or advocating for you. They understand you are busy and may not have time for multiple conversations so they find the solution in the first call. Health guides take a comprehensive and personal approach, not only to help with your immediate needs but also anticipate future questions.
- **Advocating for you.** Health guides bring knowledge and experience to help make sure you are receiving the care you need. They will help break down barriers and eliminate "homework" for you, like calling providers about billing discrepancies, so you can focus on your health. If you need help finding a provider, guides can match you with an in-network provider that suits your needs. They can also help you save money by comparing costs for care at different hospitals and save on your prescription drugs, by switching to generic from brand-name, if available.
- **Coordinating care for better health.** Many people see more than one doctor. Health guides can connect you to health professionals who will help coordinate with doctors and other members of your care team. They can remind you of important preventive care, and even help schedule appointments for you, when possible. They also have in-depth knowledge about the programs and preventive care services that are part of your benefits, and they work closely with nurses, health coaches and social workers to provide support uniquely suited to you.

Anthem Health Guide is here to give you personalized help when you need it most. That way you can focus on what is most important: your health.

Reach out to an Anthem Health Guide

Connect from your Anthem Blue Cross and Blue Shield Sydney Health mobile app or by logging in at anthem.com. Then choose ***Customer Support***, then ***Contact Us***.

Call us at 833-952-2042, Monday through Friday.

Anthem

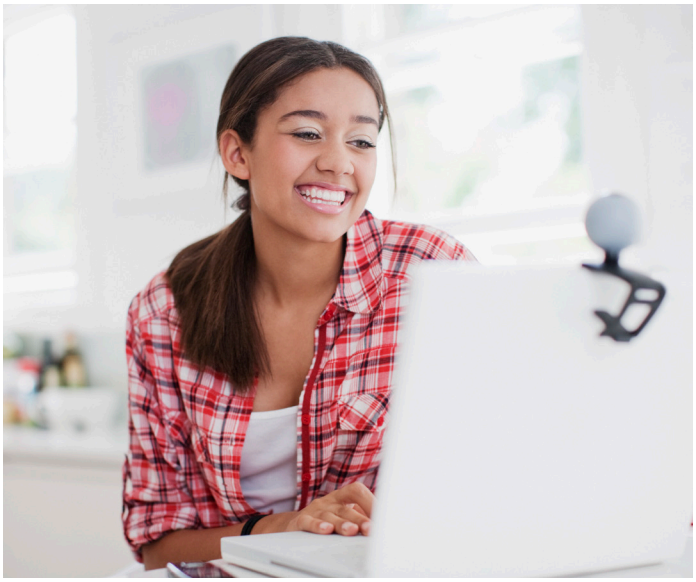
Website:
www.anthem.com

Mobile App:
Sydney Health App

ANTHEM LIVEHEALTH ONLINE

LiveHealth Online makes it easy for you to access the care you need when you need it most!

Visit Anthem.com or download theSydney Health mobile app to search for and access a telehealth provider 24/7/365.



Doctors:

You have 24/7 access to care from an in-network board-certified provider that can treat a variety of common non-urgent concerns, such as sinus infections, ear pain, pink eye and more!

Psychology:

Psychologists and Therapists are here to help if you are feeling stressed, anxious or need to talk to someone.

LiveHealth Online
• Visit doctors immediately through live video
• Doctors available 24 hrs/day, 7 days/wk
• Register TODAY so you are ready when you need it!

WELLNESS INCENTIVES

All GEON employees enrolled in the Anthem medical plan have an opportunity to participate in the 2023 Wellness Program. You have until December 31, 2023 to complete the activities outlined and earn your premium reduction.

Wellness Incentives			
Preventive Medical Exam	Incentive issued through payroll	Once Per Year	$150
Flu Shot	Incentive issued through payroll	Once Per Year	$50
Additional Anthem Programs	Gift cards through Anthem's app	Varies	$200 Annual Maximum
Total Annual Incentives for Premium Reduction		$400	

Must be enrolled in the GEON Medical Plan to receive incentives.

HEALTH SAVINGS ACCOUNT & FLEXIBLE SPENDING ACCOUNTS

Health Savings Account (HSA) HealthEquity

A Health Savings Account (HSA) is an interest-bearing checking account that you can fund with pre-tax contributions. You can use the money in your HSA to pay for your Qualified Medical Expenses including your prescriptions, medical, dental, and vision expenses. You can even use the money to pay for COBRA premiums and retirement health care expenses and premiums. Once you have $1,000 in your HSA, you can begin to invest those dollars, increasing your tax-free earning potential!

The HSA is administered by Health Equity. GEON will make a contribution to your HSA if you open an account. The annual contribution from GEON is $600 if on Single coverage and $1,300 if on Family coverage. Note the GEON contribution amount will be pro-rated based on your date of hire and money is deposited each pay period.

To be eligible to open an HSA you must meet the following criteria:

- You cannot be covered by any other medical plan that is not an HSA-compatible health plan, including your spouse's medical plan or health care flexible spending account
- Be enrolled in the Anthem HSA Medical Plan on the first day of the month
- Cannot be enrolled in Medicare. However, you may withdraw money from your HSA after you enroll in Medicare to help pay for medical expenses, including Medicare premiums (this does not include Medigap) as long as you are age 65 or older
- Cannot be eligible to be claimed as a dependent on another individual's tax return
- Be a U.S. resident, and not a resident of American Samoa
- If you are a veteran, you may not have received veterans' benefits within the last three months

Flexible Spending Accounts (FSA) HealthEquity

GEON offers two contributory flexible spending accounts administered through HealthEquity — one account for health care expenses and one account for dependent care expenses. If you enroll in one or both of these accounts, you can contribute money on a tax-free basis and use it throughout the year to reimburse yourself for eligible expenses.

Health Care Flexible Spending Account

- Maximum contribution of $3,050 for January 1, 2023 - December 31, 2023
- You may not be enrolled in GEON's HSA Medical Plan or a High Deductible Health Plan
- Reimburses eligible health care expenses including amounts not paid by your medical, dental or vision plan for you, and your tax dependents

Dependent Care Flexible Spending Account

- Enrollment in a health plan is not needed
- The IRS sets the annual contribution limit which for 2023 is $5,000 per household.
- Reimburses eligible dependent day care expenses, including adult day care if incapacitated, so that you and/or your spouse, can work, look for work, or be a full-time student

HSA VS FSA COMPARISON

	HSA	FSA
In which medical plan must I be enrolled?	HSA Medical Plan	PPO
What is the minimum I can contribute pre-tax annually?	$0	$50
What is the most I can contribute, pre-tax, if I only cover myself?	$3,850	$3,050
What is the most I can contribute, pre-tax, if I cover myself and my dependents?	$7,750	$3,050
I am age 55 or older, can I contribute more?	Yes, $1,000 more	No
How much will GEON contribute if I only cover myself?	$600	$0
How much will GEON contribute if I cover myself and my dependents?	$1,300	$0
When is the money available in my account?	Money is deposited each pay period	January 1, 2023
What happens to my money at the end of the year?	Money rolls to next year	Money forfeits
What happens to my money if I terminate my employment?	Account goes with you	Account stays with GEON and you can continue to be reimbursed if you continue to contribute
Do I need to open the account?	Yes, you must open the bank account to receive the money from GEON and your election	No
Can I invest the funds in the account?*	Yes	No
Do I receive a debit card?	Yes	Yes
Do I receive checks?	No	No
Do I need to submit receipts in order to be reimbursed?	No	Yes
Where do I go to check the balance of my account?	myhealthequity.com	myhealthequity.com

**Funds in an HSA can be invested and grow tax free!*

DENTAL

DELTA DENTAL

Website:
www.Deltadentaloh.com

Mobile App:
Delta Dental Mobile App

Delta Dental is GEON's dental insurance provider. If you have any questions regarding the dental plan or want to find a network provider, visit Delta Dental at deltadentaloh.com or call 1-800-524-0149.

Things to Consider About the Dental Plan

When you need dental care, you can go to any provider you choose. However, using network providers can save you money in two ways:

- Participating network providers agree to accept Delta Dental's fee based on their agreement with Delta Dental, which is typically lower than a provider that does not participate in a Delta Dental Network
- You do not have to pay any amount above Delta Dental's allowed fee when you receive care from a provider that participates in one of Delta Dental's networks (PPO Network or Premier Network)

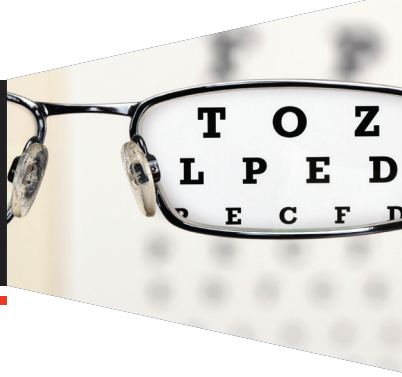
	PPO Network	Premier Network	Out-Of-Network
Preventive Services: Includes two exams per year. May also include cleanings (2 per year), X-Rays (bitewings 1 per year), sealants, fluoride treatments up to age 14 and space maintainers	100%	90%	80%
Basic Services: Includes amalgam and resin filling, root canal, oral surgery, repairs of crowns, bridgework and dentures, and periodontal services affecting gums and other tissues surrounding teeth	80%	70%	60%
Major Services: Includes crowns, bridges, dentures and implants	50%	45%	40%
Orthodontic Services: Children age 19 and under only	50%		
Maximum lifetime limit for Orthodontia	$1,500		
Annual Deductible*	$50 per person | $150 per family		
Annual Maximum Benefit (Excludes Preventive Services)	$1,350 per person		

**$50 per person to a maximum of $150 per family*

Per Pay Pre-Tax Contribution Coverage Levels	Rate
Employee Only	$6.25
Employee + Spouse	$12.49
Employee + Child(ren)	$16.02
Family	$24.55

Website:
www.eyemed.com

VISION



EyeMed is GEON's vision insurance provider. If you have any questions regarding the vision plan or want to find a network provider, visit the EyeMed website at eyemed.com or call 1-866-800-5457.

Through EyeMed's Freedom Pass Program you can receive frames at $0 at Target, Sears, or LensCrafters.

	In-Network	Out-of-Network
Exam	$10 copay per person	Up to $40
Frames	$0 copay; 20% off balance over $130 allowance	Up to $91
Benefit Frequency		
Examination	Once every plan year	
Lenses (in lieu of contacts)	Once every plan year	
Frames	Once every plan year	
Contacts (in lieu of lenses)	Once every plan year	
Vision		
Single Vision Lenses	$20 copay	Up to $30
Bifocal Lenses	$20 copay	Up to $50
Trifocal Lenses	$20 copay	Up to $70
Contact Lenses		
Conventional	$0 copay; 15% off balance over $130 allowance	Up to $91
Disposable	$0 copay; 15% off balance over $130 allowance	Up to $91
Medically Necessary	$0 copay; Paid-in-Full	Up to $210

Per Pay Pre-Tax Contribution Coverage Levels	Rate
Employee Only	$2.24
Employee + Spouse	$4.27
Employee + Child(ren)	$4.50
Family	$6.61

LIFE AND AD&D

Lincoln Financial Group

Website:
www.lincolnfinancial.com

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance

GEON provides basic life and accidental death & dismemberment insurance equal to one times your eligible pay* at no cost to you with a maximum coverage of $1.75 million. However, you pay imputed income tax on the value of life insurance coverage over $50,000. AD&D pays a full benefit in the event of your death due to an accident, and a portion is paid for serious injury. Basic life benefit over $500,000 requires completion of evidence of insurability.

Optional Life Insurance

In addition to basic life insurance, you can choose two types of optional life insurance:

- For yourself. You can purchase additional coverage of one to six times your eligible pay up to $1.25 million—with a maximum coverage of $1.75 million total coverage (basic and optional). Your rates depend on your age. You receive GEON group rates, and you pay for coverage with after-tax dollars.
- For your dependents. You can also purchase coverage for your spouse and/or children. Keep in mind, your spouse's coverage may not be more than 50% of your coverage amount. You receive GEON group rates, and you pay for coverage with after-tax dollars. An Evidence of Insurability form will be required if electing coverage for a spouse over $50,000. You have the following dependent coverage options:

Spouse	Children (coverage for each child)
$10,000	$5,000
$25,000	$10,000
$50,000	$15,000
$75,000	$20,000
$100,000	$25,000

Proof of good health or Evidence of Insurability may be required when you elect an amount greater than one level increase over your prior.

Optional Accidental Death & Dismemberment (AD&D) Insurance

You can purchase optional AD&D coverage of one to seven times your eligible pay* with a maximum coverage of $1.25 million. AD&D pays a full benefit in the event of your death due to an accident, and a portion is paid for serious injury. If you elect family coverage, your spouse is covered at 50% of your coverage amount, up to $625,000, and your children are covered at 20% of your coverage amount, up to $10,000.

**Eligible Pay: Includes base pay plus annual incentive at target or 10%, whichever is greater.*

Lincoln Financial Group

Website:
www.lincolnfinancial.com

DISABILITY

GEON provides a base level of disability protection, both short-term and long-term. For Long Term Disability, employees may purchase additional coverage with pre-tax dollars.

Short Term Disability (STD)

GEON provides you STD coverage at no cost to you. The STD benefit is through Lincoln Financial and you are eligible for STD benefits after 90 days of employment. If you become disabled from your job, Lincoln provides basic STD coverage equal to 66 2/3% of your basic weekly earnings to a maximum of $2,000 per week.

Long Term Disability (LTD)

There are two levels of LTD coverage administered through Lincoln Financial:

- Basic LTD coverage. GEON provides basic LTD coverage equal to 50% of your eligible pay*, with a $100 minimum monthly benefit and $15,000 maximum monthly benefit. There is no cost to you
- Optional LTD coverage. You may purchase additional LTD coverage up to 66 2/3% of eligible pay*, with a maximum monthly benefit of $20,000.
- You are eligible for LTD benefits after 26 weeks and approval from Lincoln Financial. Benefits may continue until your recovery, retirement, you reach Social Security normal retirement age or death, or are offset by other disability benefits, including Social Security, state disability and Workers' Compensation.

It is your responsibility to submit a claim and make sure your physician has submitted necessary documentation to Lincoln Financial, and to follow up with Lincoln Financial with questions on your claim.

**Eligible Pay: Includes base annual earnings plus 10% of target annual incentive*

EMPLOYEE ASSISTANCE PROGRAM

impactsolutions

Website:
www.myimpactsolution.com

Impact is GEON's confidential provider of Employee Assistance Program (EAP) and Work/Life Services. The program is company paid. Impact is available 24/7 with LIVE support and guidance.

You do not need to be enrolled in GEON's medical plan to utilize EAP services through Impact. However, if you are enrolled in GEON's medical plan or another medical plan through your spouse and you need services beyond the 5 pre-paid sessions, Impact will coordinate your continuing care with your medical provider.

To take advantage of this program, call Impact at 1-800-227-6007 or visit: myimpactsolution.com

Resources

- Up to 5 pre-paid counseling sessions per incident
- Continuing care and benefits coordination with your medical provider
- Unlimited telephone support and coaching for employees and family members
- Unlimited crisis intervention and emergency assistance
- Web-based network of resources and educational content on addiction relapse and recovery
- Resource links to community support programs such as Alcoholics Anonymous and Narcotics Anonymous

Identity Theft Recovery Feature

- Integrated ID Recovery
- Toll free telephonic ½ hr. consultation
- Assess your situation
- Create an action plan
- Provide tools to implement the plan

Legal

- Unlimited access
- National coverage
- Free telephonic advice
- Local referral services with free ½ hour appointment
- Discounts on legal services for on-going legal services
- On-line educational resources

Financial Assistance

- Toll-free information line
- Financial counseling
- Debt management
- Bankruptcy prevention
- Access to certified financial planners
- Housing education
- Credit report view

Confidentiality
Participation in Impact is voluntary, and the relationship between you and the Impact counselors is completely confidential. No information about you or a family member will be released by Impact without your prior written consent.

Eligibility
Impact provides EAP and Work/Life Services to you and your family (dependents anywhere within the US and Canada, non-dependents living within your home and parents and in-laws outside of your home).

ADDITIONAL BENEFITS

Accident Insurance

Voya is GEON's Accident Insurance provider. Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident. The amount paid depends on the type of injury and care received. This plan also offers a $50 wellness benefit for completing certain annual and preventive exams. For a list of qualified claims please visit the benefits website.

Some of the most common covered items:	
• ER treatment	• Follow-up doctor visits
• Stitches	• Physical therapy
• X-rays	

Hospital Indemnity

GEON's Hospital Indemnity through Voya pays a benefit of $1,000 or $2,000 if you are admitted to the hospital and confined for at least 20 consecutive hours. It then pays a daily confinement benefit of $100 or $200, depending on your plan selection. Hospital admissions for childbirth or inpatient mental wellness and addiction recovery also trigger your base benefits. If you are admitted to an ICU, your daily confinement benefit is doubled.

Examples of Covered Services
• Hospital Confinement
• Critical Care
• Rehabilitation Facility

**Hospital does not include certain facilities including: hospice care, convalescent home, nursing facility, mental health, drug or alcohol addiction. See the certificate for specific exclusions.*

Critical Health Events Insurance

Voya is GEON's Critical Illness Insurance provider. Critical Illness Insurance pays benefits of up to $30,000 for employees, $30,000 for spouses and $15,000 for children for the most common, serious health events. You can choose your benefit amount when you enroll in the program.

Your maximum benefit amount refills annually. You can claim benefits for new diagnoses if you experience any additional covered health events from the list below. This plan also offers a $100 wellness benefit for completing certain annual and preventive exams. For a list of qualified claims please visit the benefits website.

What Critical Illness benefit am I eligible for?

GEON provides you with the opportunity to purchase a Critical Illness benefit of $10,000, $20,000, or $30,000. In addition, you also may purchase a Critical Illness benefit for your spouse at 100% of the employee benefit and for your children (up to age 26) at 50% of the employee benefit.

Common conditions covered:	
• Heart attack	• Cancer
• Stroke	• Major organ transplant
• Coronary artery bypass (25%)	

Sample benefit amounts:	
Heart attack	100%
Cancer	100%
Stroke	100%
Sudden cardiac arrest*	25%
Kidney failure**	100%
Coronary artery bypass	25%
Carcinoma in situ	25%

** A sudden cardiac arrest is not in itself considered a heart attack.*
***This is a preview of benefits please refer to the certificate for a full plan details.*

Voluntary Group Auto and Homeowners Insurance

We know you work hard. That's why GEON has partnered with Farmers to offer you exclusive savings on quality auto and home insurance tailored for the way you live today. Sign up through Farmers to access discounts for your Auto and Home. Enjoy the convenience of having Farmers auto deduct your premium from your bank account so no need to remember to make payments.

Personal Travel Assistance

GEON provides Personal Travel Assistance services through TravelConnect for use when traveling 100+ miles from home. The policy provides services 24 hrs/day, 7 days/wk, every day of the year.

In addition to the services noted above, you can also access Medical Intelligence Reports and World Watch for information on your country of destination!

ACCESSING THE PORTAL

1. Navigate to mysearchlightportal.com
2. Enter your Searchlight Group ID number (LFGTravel123)

1-866-525-1955 from the U.S. and Canada (toll-free)

Services Provided
• Medical Assistance Services
• Medical Evacuation and Repatriation Services
• Travel Assistance Services
• Translation services
• Emergency travel arrangements
• Replacement of lost documents
• Worldwide Destination Intelligence
• Travel Information
• Security Intelligence

RETIREMENT SAVINGS PLAN

The GEON 401(k) plan can help you prepare for a secure retirement. The plan allows you to contribute a portion of your salary towards your retirement. To help you achieve your financial goals, GEON will match your contribution up to certain limits.

Take some time during the annual enrollment process to consider if you want to make any changes to your 401(k) elections. It's personal! Think about your goals and your situation.

Ask yourself these questions to help identify positive steps you can take towards your retirement:

- What kind of retirement do you want to have?
- When do you want to retire?
- How much risk are you willing to take to achieve your goals?
- Has your life situation changed recently? A new house, illnesses, children, care for loved ones, and more can all impact your approach.
- Have your personal finances changed?

Beneficiaries	Investments	Contributions
Make sure your beneficiary is up to date.	Make sure your investments are consistent with your risk appetite and with your life situation.	Consider increasing your contribution rate.
Without a beneficiary on file, you lose control over what happens to your account if you pass away.	The plan provides a menu of diverse options that allows you to take total control or to take a hands-off approach.	If you are contributing less than 6%, you're missing out on matching contributions from GEON.
Even if you have a will, it cannot indicate your 401(k) beneficiary. Make sure your money is handled according to your wishes.	Options include stock and bond mutual funds, target date funds, brokerage account and managed savings.	Even a 1% increase will get you closer to your retirement goals.

To change or update any of these elections, please contact Fidelity using the information below.

Do you need help? Do you want more information?

Fidelity Investments administers our 401(k) plan. You can change your contribution rate, update your investments, request account statements, get information about the plan and much more when you contact them by phone or online. Fidelity is available to provide guidance, education and assistance as you consider changes to your 401(k).

By phone: 1-800-835-5095 8:30 am–8:30 pm, eastern time zone, most business days

Online: netbenefits.com, 24 hours a day

CONTACTS

Line of Coverage	Whom to Call	Phone Number / Website
Medical / Prescription Drugs	Anthem	833.952.2042 www.anthem.com
Health Savings Account	HealthEquity	866-346-5800 www.myhealthequity.com
Flexible Spending Accounts	HealthEquity	888.678.4861 www.healthequity.com
Dental	Delta Dental	800-524-0149 www.deltadentaloh.com
Vision	EyeMed	866-800-5457 www.Eyemed.com
Life and AD&D	Lincoln Financial	888-408-7300 www.lincolnfinancial.com
Disability	Lincoln Financial	888-408-7300 www.lincolnfinancial.com
Employee Assistance Program	Impact	800-227-6007 myimpactsolution.com
Personal Travel Assistance	TravelConnect	866-525-1955 mysearchlightportal.com
Voluntary	Voya	877-236-7564 presents.voya.com/EBRC/GEON
Auto and Homeowners Insurance	Farmers	800-438-6381 www.myautohome.farmers.com
Retirement	Fidelity	800-835-5095 www.fidelity.com
Online Medical Services	MDLive	888-726-3171 www.Mdlive.com

Visit www.geonbenefits.com to view all information on your GEON benefit and retirement package

GEON Performance Solutions

2023 OPEN ENROLLMENT & PLAN PARTICIPANT NOTICES

Notice Regarding Wellness Program

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

If you choose to participate in the wellness program, depending upon that program, it may include a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include blood tests or other diagnostic tests. Please note that this is voluntary, and you are not required to participate in these evaluations or examinations.

In certain wellness programs, employees who choose to participate in the wellness program will receive an incentive that is disclosed to you in the open enrollment information for the Constituent Benefit Program. Although you are not required to complete the assessments or participate in the biometric screening, only employees who do so will receive the incentive. Additional incentives up to the maximums permitted by law, may be available for employees who participate in certain health-related activities or those who achieve certain health outcomes. If so, these will be described in your program materials or otherwise communicated to you.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator listed in your Summary Plan Description. The information from any assessment and any results from your examinations or screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Consistent with the disclosures in this Notice regarding the protection of your health and personally identifiable health information, any information gathered in the Constituent Benefit Program that is a wellness program will be confidential. The wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, but it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Also, your health information will not be sold, exchanged, transferred, or otherwise disclosed (except as permitted or required by law) to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving any incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a wellness program nurse, or physician or other health coach staff for purposes of the wellness program. You may inquire about who specifically has access to your information in this regard.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Precautions deemed appropriate will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Finally, you may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. Any questions should be directed to the Plan Administrator as listed in your Summary Plan Document.

Credible Rx Coverage

ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!

Notice of Creditable Coverage

Your prescription drug coverage provided under The GEON Performance Solutions Health and Welfare Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage".

Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

When Are You Eligible for a Medicare Drug Plan?

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends 3 months after the month in which he or she turned age 65.If you choose not to enroll in Medicare Part D during your Initial Enrollment Period, *when you finally do enroll* **you may be subject to a late enrollment penalty** added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases *based on the number of full, uncovered months* during which you went without either Medicare Part D or else without "creditable" prescription drug coverage obtained from another source.

When May You Join A Medicare Drug Plan?

Eligible individuals may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable 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.

You should also know if you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (at least 1%) to join a Medicare drug plan later. Carefully coordinating your transition between plans is therefore essential.

Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available.

For More Information Regarding Your Options Under Medicare Prescription Drug Coverage

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit socialsecurity.gov. Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to the Plan Administrator.

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). For information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan.

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions). An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

R**ight to Receive Confidential Communications of PHI).** An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Optional if covered entity engages in underwriting **Genetic Information** An individual's genetic information will not be used for under writing except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 2020

HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

In addition, if you have a new dependent, as a result of your 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, please contact the Plan Administrator listed in the Summary Plan Description, or contact the Human Resources department staff for further information.

Genetics Information Notice

The Genetic Information Nondiscrimination Act of 2008 (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/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborns' and New Mothers Care Disclosure

This Plan generally does not, consistent with applicable 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, consistent with that same Federal law, this Plan 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, this Plan does not, in accordance with Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description, or contact the Human Resources department staff for further information.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility.

ALABAMA - Medicaid	Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA - Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS - Medicaid	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 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+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA - Medicaid	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA - Medicaid	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA - Medicaid	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
IOWA – Medicaid and CHIP (Hawki)	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
KANSAS - Medicaid	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
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: 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

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: 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
MASSACHUSETTS - Medicaid and CHIP	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
MISSOURI - Medicaid	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
MISSOURI - Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA - Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - 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
NEW JERSEY - Medicaid and CHIP	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
NEW YORK - Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA - Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON - Medicaid	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH - Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669 Phone: 1-877-543-7669
VERMONT - Medicaid	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA - Medicaid	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING - Medicaid	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, 2023, 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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to 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 2013 for coverage starting as early as January 1, 2014.

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.[1]

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.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Human Resources, GEON Performance Solutions Address: 25777 Detroit Ave. Suite #202, Westlake, OH 44145, Phone: 1-800-438-4366.

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

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2023 BENEFITS GUIDE

October | 2022