ATLANTIC PACKAGING

Benefit Enrollment Guide

2025-2026

Notes

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A Message from Human Resources

At Atlantic Packaging, we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Atlantic Packaging offers health, dental, vision, life and disability plans as well as accident, critical illness, hospital indemnity, and identity theft. This Benefit Summary Guide will give you information on your health & welfare benefit options for the 2025-2026 plan year. Please read this information carefully. For full details about our plans, please refer to the summary plan descriptions.

This document contains a very general description of the benefits to which you may be entitled as an employee of Atlantic Packaging. This general explanation is not intended to provide you with all the details of these benefits. Your rights can be determined only by referring to the full text of the official plan documents, which are available for your examination by request to the HR Department. If any of the information contained in this document is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases. This document is not intended to be a Summary Plan Description.

Please note that nothing contained in the benefit plans described in this document shall be held or construed to create a promise of employment or future benefits, or a binding contract between the company and its employees or their dependents, for benefits or for any other purpose. All employees shall remain subject to discharge or discipline to the same extent as if these plans had not been put into effect and are also free to resign at any time. Benefits are for eligible employees only – part-time employees or employees of third-party staffing agencies are not eligible for employee benefits.

Eligibility

Eligible Employees:

You may enroll in the Atlantic Packaging Employee Benefits Program if you are a regular, full-time employee working at least 30 hours per week.

New Hires are eligible for benefits 1st of the month following 60 days of continuous service

Eligible Dependents:

If you are eligible for our benefits, then your dependents are, too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children and children obtained through court- appointed legal guardianship.

When Coverage Begins:

Newly hired employees and dependents will be eligible for Atlantic Packaging's benefits programs the first of the month following 60 days of continuous service. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status change event.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

Benefits Website

Please visit Atlantic's HR benefits website at https://atlanticpkg.hrbenefits.net/ to learn more about our benefits, wellness program, and ways to enroll for benefits. There are also links to plan documents, benefits summaries, and more!

Medical Insurance

Atlantic Packaging offers two medical plans administered through our Third-Party Administrator, Health Plans, Inc. The chart below provides a brief outline of what is offered. Please refer to the summary plan descriptions for complete plan details.

	Health Plans, Inc. (TPA)		
	RBR Plan Benefits	Network Plan Benefits Cigna PPO Network	
Annual Deductible		**In-Network**	**Out of Network**
Individual	$500	$1,500	$3,000
Family	$1,000	$3,000	$6,000
Coinsurance	20%	20%	40%
Maximum Out-of-Pocket*			
Individual	$2,500	$5,000	$10,000
Family	$5,000	$10,000	$20,000
Physician Office Visit			
Primary Care	$25 copay	$35 copay	40% after deductible
Specialty Care	$50 copay	$75 copay	40% after deductible
Teladoc	$0 copay	$0 copay	Not Available
Preventive Care			
Adult Periodic Exams	100% Covered	100% Covered	40% after deductible
Well-Child Care	100% Covered	100% Covered	40% after deductible
Diagnostic Services			
X-ray and Lab Tests	100% Covered	100% Covered	40% after deductible
Complex Radiology	20% after deductible	20% after deductible	40% after deductible
Urgent Care Facility	$50 copay	$100 copay	40% after deductible
Emergency Room Facility Charges	$250 copay for first visit, then 20% after deductible for subsequent visits	$500 copay for first visit, then 20% after deductible for subsequent visits	
Inpatient Facility Charges	20% after Deductible	20% after deductible	40% after deductible
Outpatient Facility and Surgical Charges	20% after deductible	20% after deductible	40% after deductible
Mental Health			
Inpatient	20% after deductible	20% after deductible	40% after deductible
Outpatient	$25 copay	$35 copay	40% after deductible
Substance Abuse			
Inpatient	20% after deductible	20% after deductible	40% after deductible
Outpatient	$25 copay	$35 copay	40% after deductible
Other Services			
Chiropractic	$50 Copay (30 visits combined with other outpatient therapies per plan year)	$75 Copay (30 visits combined with other outpatient therapies per plan year)	40% after deductible
Acupuncture	$50 Copay	$75 Copay	40% after deductible

Prescription Coverage

Our prescription benefits are provided by OptumRx and administered by RxBenefits, Inc. There are more than 64,000 pharmacies in your pharmacy network. You may access a copy of the most recent preferred drug list and formulary exclusions at www.optumrx.com or by contacting RxBenefits at 1-800-334-8134.

	RBR Plan	Network Plan
Retail Pharmacy (30 Day Supply)		
Generic (Tier 1)	$10 copay	$10 copay
Preferred (Tier 2)	30% to $100	30% to $100
Non-Preferred (Tier 3)	50% to $250	50% to $250
Retail Pharmacy (90 Day Supply)		
Generic (Tier 1)	$30 copay	$30 copay
Preferred (Tier 2)	30% to $300	30% to $300
Non-Preferred (Tier 3)	50% to $750	50% to $750
Mail Order Pharmacy (90 Day Supply)		
Generic (Tier 1)	$20 copay	$20 copay
Preferred (Tier 2)	30% to $200	30% to $200
Non-Preferred (Tier 3)	50% to $500	50% to $500
Specialty Medications (30 Day Supply)		
Specialty medications must be ordered through Briova Rx at 1-800-850-9122 and are limited to a 30 day supply	50% to $250	50% to $250

Employee Contributions

Weekly Employee Contributions				
	RBR Plan		Network Plan	
	Standard Rate	Wellness Rate*	Standard Rate	Wellness Rate*
Employee	$43.02	$19.79	$43.02	$19.79
Employee & Spouse	$122.52	$84.54	$122.52	$84.54
Employee & Child(ren)	$93.85	$61.95	$93.85	$61.95
Employee & Family	$221.08	$168.02	$221.08	$168.02
Monthly Employee Contributions				
	RBR Plan		Network Plan	
	Standard Rate	Wellness Rate*	Standard Rate	Wellness Rate*
Employee	$186.44	$85.76	$186.44	$85.76
Employee & Spouse	$530.91	$366.33	$530.91	$366.33
Employee & Child(ren)	$406.70	$268.43	$406.70	$268.43
Employee & Family	$958.01	$728.09	$958.01	$728.09

*Wellness premiums are based on program participation

Pathways Concierge Member Advocacy

HPI's Concierge Care program, Pathways, helps you navigate the complexities of healthcare. Pathways works for ***you*** and coordinates ***your care needs*** with doctors, caregivers and pharmacists.

Pathways Concierge Services

MedWatch

Empowering People. Improving Lives.

Frequently Asked Questions

Pathways Concierge: Your PERSONAL ADVISOR to Navigating Your Benefits Plan

Call Pathways Concierge First when you need help with:

- Identifying the best options for providers & convenient service locations
- Making or changing an appointment with a care provider
- Referrals to available health related programs (such as wellness, diabetic monitoring, employee assistance programs, telemedicine & more)
- Billing questions and support (claim status, balance billing, grievances, appeals, explanation of benefits & more)
- Precertification support for upcoming medical procedures*
- Questions about your medications
- Understanding your diagnosis & proposed treatment
- Education, resources and support for you, your family & your care support system
- Managing self-care needs, including education & skill training

Navigating your benefits plan shouldn't be stressful.

Call Pathways Concierge to get assistance with understanding your benefits and provide you with options that will help you get the most out of your health plan.

Has your physician recommended surgery or a medical procedure?

BEFORE you schedule any elective inpatient or outpatient medical service, **CALL** your Pathways Concierge. Experienced benefits experts are ready to assist you.

To receive your bi-monthly issue of the Healthy Living Newsletter, please provide your current email address to your HR department!

**Precertification helps determine if the proposed procedure or treatment is medically necessary and covered by your benefit plan.*

Contact Pathways Concierge by phone or email:
(888) 296-7179 · PathwaysConcierge@urmedwatch.com

Members Asked, Pathways Answered!

What is the Pathways Concierge Program?

Pathways is your "go-to" service when you have questions about your benefits, need help finding a physician, have questions on your medical bills, and more. They are your advocate and will help you navigate your healthcare options effectively.

What can my Pathways Concierge help me with?

- Finding participating providers
- Assisting with appointments
- Understanding your benefits, copays & deductibles
- Accessing benefits & related services
- Billing questions
- Questions about your diagnosis, treatment, or medication
- Educational resources
- Self-care education & skill training
- And more!

Can I ask questions about my health or diagnosis?

Yes! Your Concierge has access to the resources of our clinical staff and are available to answer questions about your medical condition, care plans, and other related topics.

Can I get assistance with scheduling appointments?

Of course! Your Pathways Concierge can assist with scheduling appointments and confirm that you are going to the right location for the care you need.

Can Pathways help me find a provider for an upcoming surgery or procedure?

Absolutely! Your Pathways Concierge can help you access medical services that are provided by quality physicians and surgeons at appropriate prices.

What does Pathways Concierge cost me?

Not a penny! The Pathways Concierge program is part of your benefit plan, so there's no additional cost to speak with your Pathways Concierge or care team. Call them as often as you like. They are here to help.

Is my information kept confidential?

YES! Every precaution is taken to make sure your information is secure. Your data is securely encrypted and your records are never shared with your employer or other entity without your written approval unless required by law.

When should I call my Pathways Concierge?

Whenever you have a question about your benefits, or know you may have an upcoming medical procedure, **call your Pathways Concierge first.** The earlier you make the call, the more assistance your Pathways Concierge can provide.

How do I contact my Pathways Concierge?

Call the number on your ID Card or shown below.

"I wasn't expecting to speak with someone who was so knowledgeable and helpful with my benefits. Today it seems that customer service is nonexistent, but working with my Pathways Concierge was a great experience. When I got off the phone, I told all my coworkers what a great service this is!"

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Pathways Concierge Services

(888) 296-7179

PathwaysConcierge@urmedwatch.com

Precertification Process

Precertification is a beneficial process that helps ensure the medical care you and your family receive is necessary and appropriate. Many inpatient and outpatient medical procedures require precertification to make sure you have the best options and services that meet nationally approved medical necessity guidelines.

Utilization Management Program

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Frequently Asked Questions

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The PRECERTIFICATION PROCESS and What You Should Do

1 Confirm that your provider has initiated the precertification process:

- 7 to 10 days prior to an inpatient or outpatient elective surgery or high dollar procedure being performed
- Within 24-48 hours of an emergency hospital admission occurring**

2 Your provider will need the following information:

- Plan member/patient name, address, and date of birth
- Plan member ID
- Name and address of the physician and facility/hospital
- Admission/procedure date
- Proposed procedure/procedure code

3 A Utilization Management Specialist will:

- Review the precertification request to determine medical necessity and appropriateness of treatment
- Review treatment options that may be more appropriate/beneficial to your care
- Coordinate the service with the facility/hospital
- Determine the appropriate length of stay when required

4 If admitted for a hospital stay, our nurse will:

- Contact your provider to confirm services have taken place and if surgery was required
- Confirm prescribed treatment is being followed
- Coordinate discharge to minimize your inpatient hospital stay

** Check with your benefit plan for outpatient precertification requirements. ** Check your benefit plan for specific time requirements.*

Members Asked, Our Specialists Answered!

What is Precertification?

Precertification, also known as Utilization Review or Utilization Management, is a beneficial process that helps ensure the medical care you and your family receive is necessary and appropriate. Your benefit plan may require the precertification process for many inpatient and outpatient medical procedures to make sure you have the best options and services that meet nationally approved medical necessity guidelines.

Why is Precertification necessary?

Precertification is a safeguard that is put in place to protect you from medical procedures that may not be medically necessary, appropriate, or approved by medical guidelines.

What are Medical Necessity and Medical Guidelines?

Medical Necessity means that the services, supplies, or drugs being prescribed are necessary for the prevention, diagnosis, or treatment of your medical condition. Medical guidelines help determine if the proposed services are approved for use and if they meet accepted standards of medical practice.

How do I know if my services need Precertification?

You should review your benefit plan for a complete listing of services that require precertification. Most providers will precertify services on your behalf, however, it is your responsibility to ensure this task has been completed prior to the service being rendered or penalties may apply. Once the request has been precertified, a copy of the approval will be faxed to your provider's office/facility.

Do I still have the freedom to choose my own physician or hospital?

Yes. The decision of which physician or hospital to use is always yours, however, receiving care from a non-participating provider of your benefit plan may result in greater out of pocket expenses for you.

Is it my responsibility to call? When should I call?

Yes! Although your provider will generally call and request the precertification, you should call your provider to confirm that they have initiated the process at least 7 to 10 days prior to the scheduled service. For emergency admissions, the call should be made withing 24-48 hours following your admission. If you receive medical services that require precertification but fail to have precertification completed in advance, it could result in additional out-of-pocket costs to you.

Questions about your benefits should be directed to your Human Resources department or Concierge Service when available.

For questions concerning the precertification process, please call the number provided on your member benefits card or discuss with your Human Resources representative.

"I wanted to thank you for going above and beyond to make sure that I had all the correct authorizations for the various medical test that needed to be done prior to my procedure. In addition to being so thorough, your kindness and willingness to explain everything to me was greatly appreciated. I was truly blessed to have you as my advocate. I am as good as new after my procedure; everything went really well."

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Utilization Management Program

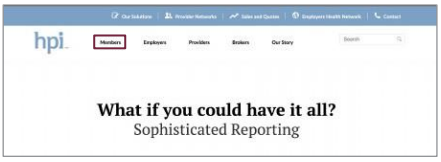
1-800-432-8421

How to Find a Cigna PPO Provider

Find a Cigna PPO Provider Online

Already an HPI member? For quick access to your provider network search tool, use your member ID number to register for ***My Plan***.

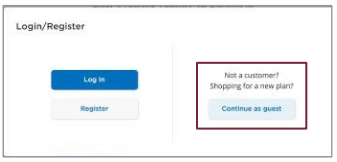
1. Go to ***hpiTPA.com*** and select ***Members***.



2. Click ***Search for a Provider***, and then choose ***Cigna PPO Network*** from the All other networks list.

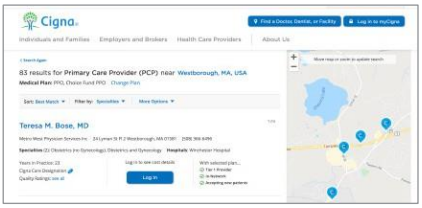
3. To find a provider near you, enter an address, city or ZIP Code, and then choose from the search options:
   - Doctor by Type
   - Doctor by Name
   - Locations

4. Click ***Continue as guest***.



5. Enter the city, state or ZIP Code you live in and click ***Continue***. Then, click the ***PPO, Choice Fund PPO*** option.

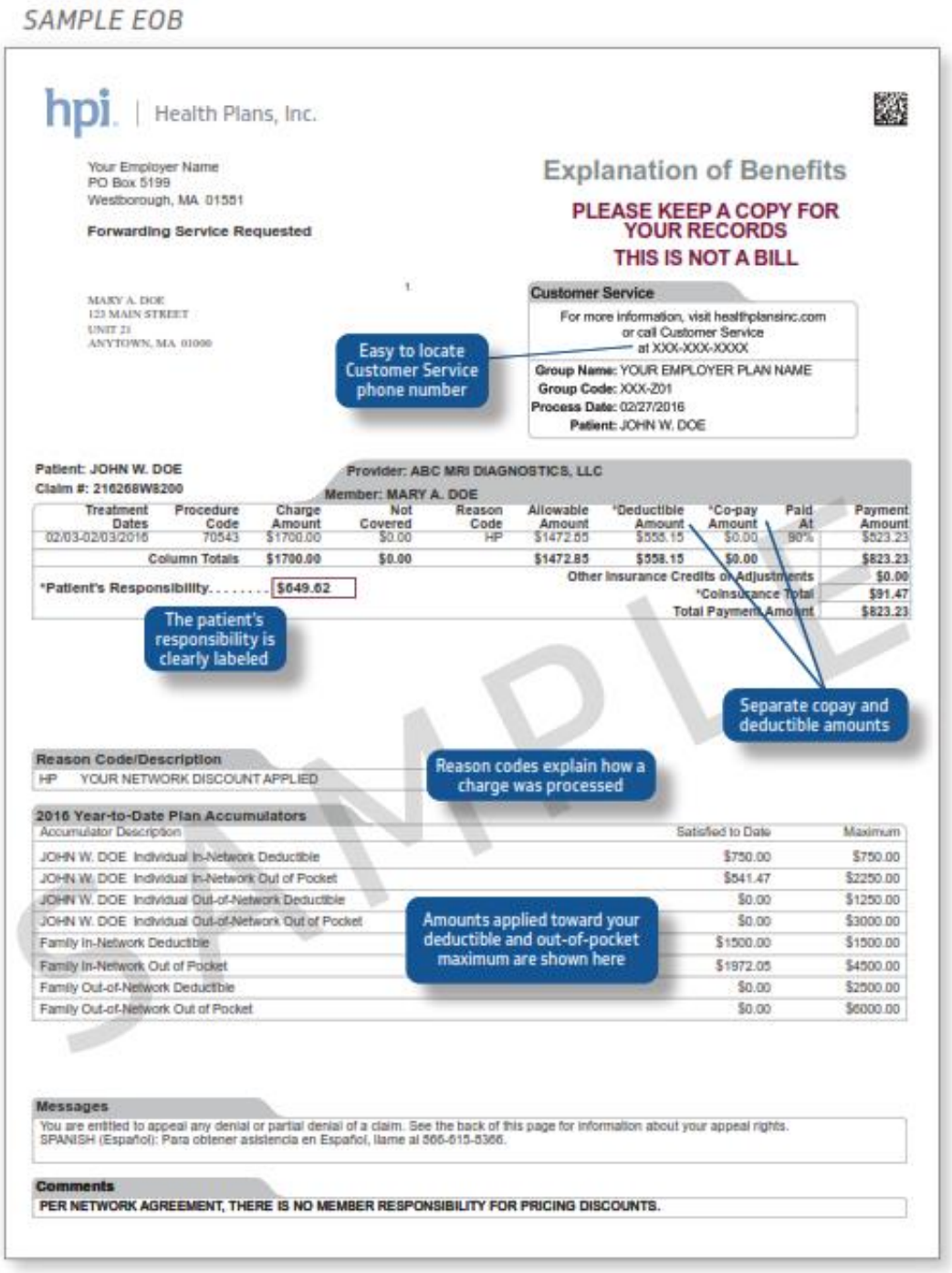
6. View your results. You can refine your results by clicking ***Sort, Filter by*** or ***More Options***.



Have questions? Contact HPI Customer Service at 800-532-7575 or visit us online at hpiTPA.com

How to Read an Explanation of Benefits (EOB)

If you receive a bill that says you owe more than your EOB, this is a balance bill. Balance bills need to be sent to the Pathways Concierge, along with your EOB. They work directly with the Patient Advocacy Center (PAC) at HST to resolve your balance bill. Continue to send in any bills you receive after you send in the initial bill. If you feel you are not receiving the appropriate level of attention from our partners, reach out to Eryn Johnson at Erynt@atlanticpkg.com or 910-398-6174.



Atlantic Packaging's Wellness Initiatives

Your Health Matters at Atlantic

At Atlantic Packaging, your health and well-being are a top priority. Whether you're aiming to boost your energy, manage stress, improve your diet, or lose weight, the Atlantic Wellness Program is here to support you every step of the way. We view wellness as a vital part of our overall benefits package—and we're committed to helping you live a healthier, more balanced life.

We believe the best healthcare is **preventive healthcare**. That's why it's important for every employee to have a trusted healthcare provider who can establish a baseline for your health and help detect early signs of chronic conditions.

To support this, we offer a **Medical Plan Incentive Program**, which gives you the opportunity to earn a discount on your medical premium by completing four preventive activities by **August 31, 2026**:

Wellness Incentive Requirements:

1. **Biometric Screening**
   - Onsite screenings are available at most branches in **October and November 2025**.
   - If you cannot attend an onsite event, make sure to use the Physician Form when going to your doctor and submit to WellRight. You can get this form on the WellRight portal.
2. **Annual Physical**
   - Schedule with your primary care provider.
   - If you are a Tabor City employee, you can use the Carter Wellness Center.
3. **One Preventive Exam (based on age/gender), Dental Cleaning, or Eye Exam**
   - Qualifying exams include:
     - Mammogram
     - Colonoscopy
     - Well-woman exam
     - Prostate exam
     - Dental exam/screening
     - Skin check
     - Vision (eye) exam
4. **One Health Coaching or Behavioral Health Appointment**
   - Meet with a **Marquee Health Coach** by phone or email.
     Call **1-800-882-2109** or email **coaching@mywellportal.com** to schedule

Once you've completed each activity, upload **proof of completion** in the **WellRight portal**.
This can be an:

- Explanation of Benefits
- Confirmation email
- Screenshot from your provider portal
- Or a verification form

To receive the wellness insurance premium discount for the **2026–2027** plan year, you must meet all program requirements during the **2025–2026** plan year. If you miss the August 31st deadline, as soon as you complete the four activities in the new plan year, your rate will be switched to receive the wellness discount.

In addition to our program that helps you earn a discount on your medical premiums; we also offer a Wellness Incentive Program! By participating in activities like step challenges, wellness webinars, and more, you can earn **raffle tickets** for a chance to win **BIG cash prizes** in our year-end drawing.

The Atlantic Packaging Wellness Program is administered by **WellRight**. Visit https://atlanticpkg.app.wellright.com/ or scan the QR code to learn more.

For full details on our Medical Incentive Program and other Wellness Initiatives, visit our wellness page on the benefits website: https://atlanticpkg.hrbenefits.net/wellness

Mental Health Support and Employee Assistance

Spring Health

ATLANTIC WELLNESS

Life is easier with the right support.

You don't need to wait for a crisis to prioritize your mental health. Atlantic Packaging partners with Spring Health to provide personalized care and resources to support you through any of life's challenges.

Spring Health can support your mental health with easy access to:

Therapy* and coaching
Get support when it's convenient for you. Each member gets 6 free therapy sessions and 6 coaching sessions per year.

Dedicated guidance
Your Care Navigator can walk you through your care plan, help you find the right therapist, and provide support whenever you need it.

Personalized care
Take a short online assessment and get care recommendations to support your immediate needs and long-term goals.

Diverse providers
Choose an experienced therapist you feel comfortable with Browse recommendations or search by specialty, gender, ethnicity, or language.

Wellness exercises
Moments is a library of self-guided exercises that can help you manage stress, calm anxiety, beat burnout, improve, sleep, and be more mindful.

Work-life services
Access expert guidance and resources to navigate legal or financial maMers, child care, elder care, pet care, travel, household services, and more.

*Spring Health offers both virtual and in-person therapy session options

Learn more and get started:

atlanticpkg.springhealth.com

Work-life code: atlanticpkg

Contact Spring Health:
careteam@springhealth.com

1-855-629-0554

General support: M-F, 9am-5pm Local Time

Crisis support: 24/7 (press 2)

Spring Health is available at no cost to all Atlantic Packaging employees and their dependents.

Your care with Spring Health is private and confidential.

Telemedicine

Teladoc is an innovative service available to any employee who is enrolled in Atlantic Packaging's medical plan, and their covered dependents. Teladoc provides 24/7 access to qualified doctors and pediatricians through the convenience of phone or video consult at no cost to you!

Teladoc is not intended to replace your primary care physician but is a convenient option for quality non-emergency care. The Teladoc doctors can treat many conditions, including:

- Cold & Flu Symptoms
- Bronchitis
- Respiratory Infection
- Poison Ivy
- Ear Infection
- Allergies
- Urinary Tract Infection
- Sinus Problems
- Pink Eye
- And More!

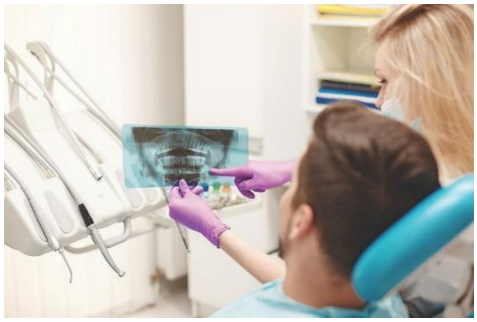
After you 'visit' with Teladoc, they will be happy to provide information about your consult to your primary care physician, if you consent.

General medical, dermatology, and nutrition consultations are all covered at $0 for members enrolled in Atlantic's medical plan.

You can request a consult by calling 1-855-835-2362, via their website at www.teladoc.com or by downloading the Teladoc mobile app.

Dental Insurance

Atlantic Packaging offers a dental program through Delta Dental. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details. While the coverage is the same in- and out-of-network, you will pay less out of pocket if you visit an in-network provider with Delta Dental. Visit www.deltadentalnc.com to find a dentist in their network.



	Delta Dental	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$50	$50
Family	$150	$150
Waived for Preventive Care?	Yes	Yes
Annual Maximum		
Per Covered Person	$1,500	$1,500
Diagnostic & Preventive* - oral examination, cleaning, all x-rays, topical application of fluoride solution for dependent children up to age 19, space maintainers, sealants for children up to age 16	100%	100%
Basic – extractions, fillings, oral surgery, lab services required for procedures, general anesthesia, endodontic and periodontal care	80%	80%
Major – crowns, inlays/onlays, bridges, dentures, implants	50%	50%
Orthodontia (covered dependent children up to age 19)		
Benefit Percentage	50%	50%
Lifetime Maximum	$1,000	$1,000

*Preventive Incentive – Diagnostic and Preventive Services do not count toward the annual maximum

Employee Contributions	Monthly	Weekly
Employee	$31.23	$7.21
Employee & Spouse	$69.29	$15.99
Employee & Child(ren)	$66.87	$15.43
Employee & Family	$121.78	$28.10

Vision Insurance

Atlantic Packaging provides employees and their eligible dependents the option to purchase vision insurance through Superior Vision. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

	Superior Vision
Copay	
Routine Exams (Annual)	$10
Vision Materials	
Materials Copay	$25
Lenses	Benefit varies by type of lens. Covered every 12 months
Contacts *Covered in lieu of frames.* Medically necessary contacts may be covered at a higher benefit level	Elective contacts covered $150 every 12 months
Frames	Covered at $150 every 12 months

Employee Contributions	Monthly	Weekly
Employee	$6.90	$1.59
Employee & Spouse	$13.11	$3.03
Employee & Child(ren)	$13.80	$3.18
Employee & Family	$20.18	$4.66

Flexible Spending Accounts

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Better Benefits Partner.

Flexible Spending Accounts help you save money by providing a way to pay for certain types of health care and dependent care on a pre-tax basis. There are two types of Flexible Spending Accounts:

Health Care Flexible Spending Accounts (FSA)

Allows employees to set aside pre-tax dollars taken through a payroll deduction to pay for expenses not covered by any insurance plan in which you may be enrolled. These pre-tax dollars are set aside in a personal flexible spending account until needed. You may contribute up to $3,300 during the benefit plan year – October 1 through September 30.

Dependent Care Flexible Spending Accounts (DCFSA)

Allows employees to set aside pre-tax dollars taken through a payroll deduction to pay for work-related childcare expenses or adult dependent care. DCFSAs may be used to pay for the care of dependent children under age 13 or any disabled dependent who lives with you and who you claim on your taxes. Your total savings will depend upon your family income, tax status, and total expenses. If you have Dependent Care expenses, you may choose to claim a tax credit when you file your Federal taxes rather than contribute to a Dependent Care FSA. The annual maximum amount you may contribute is $5,000 (or $2,500 if married and filing separately) per calendar year. All DCFSA participants are required to complete IRS form 2441 when preparing their tax return.

HOW AN FSA OR DCFSA WORKS

During Open Enrollment, you decide how much money to contribute to the FSA and/or DCFSA for the next plan year. This amount will be deducted in equal increments from your paycheck pre-tax.

Expenses must be incurred during the plan year (October 1 – September 30) and must not be eligible for reimbursement from insurance policies or any other source.

You will have 90 days after the end of the plan year to submit claims for reimbursement.

To find the appropriate forms such as the No-Wait Dependent Care, FSA Medical Reimbursement, or Direct Deposit, visit www.flores247.com

Eligible and Ineligible Expenses

For a complete listing of eligible and ineligible expenses, visit www.irs.gov and refer to Publication 502.

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

Atlantic Packaging provides Basic Life and AD&D benefits to eligible employees at no cost to the employee. The life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Lincoln Financial	
Employee Basic Life & AD&D	
Benefit Maximum	$50,000
Guaranteed Issue	$50,000

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

Lincoln Financial	
Employee Supplemental Life & AD&D	
Benefit Increments	$1,000
Benefit Maximum	$500,000
Guaranteed Issue	$350,000
Spouse Supplemental Life & AD&D	
Benefit Increments	$1,000
Benefit Maximum	50% of Employee election or $250,000
Guaranteed Issue	$50,000
Dependent Supplemental Life (No AD&D)	
Benefit Maximum	$20,000
Guaranteed Issue	$20,000

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability.

You may purchase additional life and AD&D insurance with Lincoln Financial if you want more coverage. Your contributions will depend on your age and the amount of coverage you elect.

All eligible employees have the option to purchase $1,000 increments to a maximum of $500,000. As a new hire, you can elect up to $350,000 without providing evidence of insurability. The AD&D benefit must match the life benefit.

Employees can also elect life and AD&D insurance coverage on their spouse and dependents up to age 26. All eligible employees have the option to purchase $1,000 increments to the lesser of 50% of the employee life election or $250,000 on their spouse. As a new hire, you can elect $50,000 for your spouse without providing evidence of insurability. The AD&D benefit must match the life benefit.

Supplemental life coverage for your dependents under the age of 26 can be selected for $20,000. The cost to insure your children is $2.90 per month or $0.67 per week. This cost is the same regardless of how many children you have.

You must elect coverage on yourself in order to elect coverage for your spouse and dependents.

Below is a chart of age banded rates per $1,000 of coverage for the employee and spouse life. The premium for supplemental spouse life insurance is based on the employee's age.

Supplemental Life & Accidental Death and Dismemberment (AD&D)		
Rates per $1,000		
Age	**Weekly Rate**	**Monthly Rate**
<30	$0.014	$0.06
30-34	$0.014	$0.06
35-39	$0.026	$0.11
40-44	$0.028	$0.12
45-49	$0.037	$0.16
50-54	$0.037	$0.16
55-59	$0.104	$0.45
60-64	$0.134	$0.58
65-69	$0.254	$1.10
70+	$0.409	$1.77

Note: if your child is also an employee of Atlantic, then your child is not eligible for coverage as a dependent. If both parents are employees of Atlantic, only one parent may cover the child(ren) under the dependent life benefit.

During open enrollment for the 2025-2026 plan year, new and current enrollees are eligible to elect or increase employee supplemental life up to the guaranteed issue limit of $350,000, without Evidence of Insurability. New and current enrollees are also eligible to elect or increase the spouse supplemental life insurance benefit up to the guaranteed issue limit of $50,000, without Evidence of Insurability.

Outside of this year's annual enrollment, EOI may be required for any increase in coverage.

Important Reminder!

Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.

Beneficiary

Remember to keep your beneficiary updated for both the basic and supplemental life insurance, which can be done anytime throughout the year. If you are married and living in a community property state, your insurance carrier may require that you designate your spouse (or in some cases a registered domestic partner) for at least 50% of the benefit unless you have a waiver notice on file from your spouse. Consult your legal or tax advisor for further guidance on this issue. The beneficiary can be different between the basic and supplemental life insurance.

Voluntary Disability

As an employee of Atlantic Packaging, you may choose to enroll in the Short-Term Disability and/or Long-Term Disability Plan. The Disability Plans provide financial protection for you by paying a portion of your income while you are disabled from an accident or illness. The amount you receive is based on the salary you earned before your disability began. During open enrollment for the 2025-2026 plan year, eligible employees can elect STD and LTD without providing evidence of insurability. If you waive coverage during this open enrollment period, evidence of insurability will be required for a future election.

Short-Term Disability Insurance

This benefit covers 60% of your weekly base salary up to $2,000/week. The benefit begins after 7 days of injury or illness and lasts up to 12 weeks. Please see the summary plan description for complete plan details.

Short-Term Disability Premium Calculation Example:

Let's assume an annual base salary of $30,000 for a 35-year-old employee as of 10/1.

1. $30,000 / 52 weeks = $576.92 weekly salary
2. $576.92 * .60 = $346.15 weekly benefit

Note: if your weekly benefit is more than the $2,000 weekly benefit maximum, use $2,000 to continue the calculations in step 3.

3. $346.15 / 10 (rate calculated based on $10 of weekly benefit) = $34.62
4. $34.62 x $0.067 (age 35 weekly rate per chart) = $2.32 cost per week

Short Term Disability		
Rates per $10 of Weekly Benefit		
Age	**Weekly Rate**	**Monthly Rate**
≤29	$0.074	$0.32
30-39	$0.067	$0.29
40-44	$0.069	$0.30
45-49	$0.076	$0.33
50-54	$0.092	$0.40
55-59	$0.127	$0.55
60+	$0.145	$0.63

Long-Term Disability Insurance

Long-term disability insurance provides income protection in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 60% of your monthly base salary up to $10,000. Benefit payments begin after 90 days of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details.

Long Term Disability Premium Calculation Example:

Let's assume an annual base salary of $30,000 for a 35-year-old employee as of 10/1.

1. $30,000 / 12 months = $2,500 monthly salary

Note: if your monthly salary is more than $16,667, please use $16,667 to continue the calculations in step 2.

2. $2,500 / 100 (rate calculated based on $100 of monthly benefit) = $25
3. $25 x $0.072 (age 35 weekly rate per chart) = $1.80 cost per week

Long Term Disability		
Rates per $100 of Monthly Salary		
Age	**Weekly Rate**	**Monthly Rate**
<25	$0.030	$0.13
25-29	$0.035	$0.15
30-34	$0.048	$0.21
35-39	$0.072	$0.31
40-44	$0.099	$0.43
45-49	$0.157	$0.68
50-54	$0.222	$0.96
55-59	$0.279	$1.21
60+	$0.279	$1.21

Additional Voluntary Benefits

As a benefit eligible employee with Atlantic Packaging, you can purchase voluntary accident, critical illness, and hospital indemnity insurance through Lincoln Financial.

Accident Insurance	Accident insurance pays you benefits for specific injuries and events resulting from a covered accident that occurs on or after your effective date. The benefit amount depends on the type of injury and care received. Features include: • **Guaranteed Issue:** no medical questions or tests are required • **Flexible:** you can use the benefit payments for any purpose you like • **Portable:** if you leave your current employer or retire, you can take your coverage with you. • Includes a $75 wellness benefit for completing a health screening test
Critical Illness Insurance	Critical illness insurance pays a lump-sum benefit if you are diagnosed with a covered illness or condition on or after your coverage effective date. Coverage is available for yourself and your eligible dependents. Features include: • **Guaranteed Issue:** no medical questions or tests are required • **Flexible:** you can use the benefit payments for any purpose you like • **Portable:** if you leave your current employer or retire, you can take your coverage with you. • Includes a $75 wellness benefit for completing a health screening test
Hospital Indemnity Insurance	Hospital indemnity insurance provides a fixed daily benefit payment if you have a covered stay in a hospital, critical care unit, or rehabilitation facility beginning on or after your coverage effective date. Features include: • **Guaranteed Issue:** no medical questions or tests are required • **Flexible:** you can use the benefit payments for any purpose you like • **Portable:** if you leave your current employer or retire, you can take your coverage with you. • Includes a $75 wellness benefit for completing a health screening test

Allstate Identity Protection Plan

Allstate IDENTITY PROTECTION

Since so much of our daily life is now spent online, it's more important than ever to stay connected. But more sharing online means more of your personal data may be at risk. In fact, 1 in 6 Americans were impacted by an identity crime in 2020.

Identity theft can happen to anyone. That's why Atlantic offers Allstate Identity Protection as a benefit. So, you can be prepared and help protect your identity and finances from a growing range of threats.

Atlantic offers two plan options with Allstate. With Allstate Identity Protection Pro+ Cyber, you get the same benefits of the Pro+ plan plus protection for your electronic devices.

Allstate Identity Protection Pro+

- Allstate Digital Footprint®, our proprietary privacy tool, shows where your data lives online and how it might be exposed
- Comprehensive identity and financial monitoring, such as high-risk transaction and financial account monitoring and more
- Identity Health Status gives you at-a-glance insight into your risk
- Allstate Security Pro® delivers updates and education on scams relevant to you
- Social media account takeover monitoring
- Robocall blocker‡
- Ad blocker‡
- Family digital safety tools‡ with screen time management, location tracking, and web filtering∆
- Auto-on tri-bureau credit monitoring* with annual reporting and credit score
- Lock your TransUnion credit report in a click and get credit freeze assistance
- Dark web monitoring
- Full-service U.S.-based restoration support available 24/7
- Up to $1 million reimbursement for identity theft expenses & stolen funds†, includes coverage for:
  - 401(k)/HSA fraud
  - deceased family member fraud∆
  - home title fraud
  - professional fraud expense reimbursement

Allstate Identity Protection Pro+ Cyber
All the features of Pro+, and also:

- Cyber protection tools for up to 5 enrolled devices, including:
  - Anti-virus protection
  - Safe browsing
  - Missing and stolen device tools (Android and Windows)
  - Safe Pay (Windows, macOS)
  - Webcam protection (Windows)
  - Firewall (Windows)
  - Anti-tracker (Windows, macOS, iOS)
  - Phishing protection (Windows, Android, iOS)
  - Android smart watch protection
  - File Shredder (Windows)
- Premium VPN with 4000+ servers to stay safe without slowing down
- Military-standard encrypted password manager
- Family digital safety tools‡ expand to monitor 30+ apps and websites for signs of danger such as cyberbullying∆
- Extended reimbursement coverage for identity theft expenses and stolen funds† includes personal ransomware§ expense reimbursement
- With a family plan, extend reimbursement coverage† up to $2 million

§ Does not cover cyber ransom payments to hackers

∆ Only available with a family plan.

* Level of automatic monitoring dependent on enrollment method and information shared with Allstate Identity Protection

‡ Some features require additional activation. Privacy management features cover up to five email addresses in a family plan. Robocall blocker and ad blocker can only be used by primary subscriber, even in a family plan. Cyber and family digital safety features are managed through the primary subscriber's account in family plans.

† Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Product may be updated or modified. Certain features require additional activation.

Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

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Employee Contributions	Pro+		Pro+ Cyber	
	Monthly	Weekly	Monthly	Weekly
Employee	$7.95	$1.83	$9.95	$2.30
Employee & Family	$13.95	$3.22	$17.95	$4.14

Medicare Resource

Personal service to make Medicare easier for you is available through My Benefit Advisor. Patty Norton is a Medicare Specialist who can guide you through your Medicare options, assist you with enrollment, and help you secure Medicare coverage.

You can reach Patty by calling 954-607-4151. You can also book an appointment directly with Patty by visiting https://calendly.com/patty-norton.

Patricia Norton
Account Executive
Licensed Medicare Sales Agent
Direct: (954) 607-4151
patty.norton@mybenefitadvisor.com

Holidays

Atlantic Packaging provides two (2) paid holidays during your 90-day orientation period, all holidays paid thereafter (10 per the below schedule)

- New Year's Day
- Good Friday
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving (2 days)
- Christmas (2 days)

Paid Time Off (PTO)

Paid time off benefits are intended to provide employees with an annual rest and change of activities in order to promote optimal physical and mental well-being. All employees are encouraged to take their full accrued vacation time each year.

After an 18-month phase-in, each full-time employee will receive 15 days of PTO (includes vacation, sick, and personal leave) with an additional 5 days awarded after 15 years of service.

Maternity Leave Policy

Maternity leave under this policy is paid leave to be used with the birth of an employee's child. Full-time employees with at least one full year of service as of the date of the birth are eligible.

Eligible employees may take up to eight (8) weeks of maternity leave. The maternity leave varies based on delivery type and integration with Short Term Disability coverage (if applicable):

Normal Vaginal Delivery

- Week 1 – 100% of base pay using employee PTO
- Weeks 2-6 – 100% of base pay with Short Term Disability paying 60% and Atlantic paying 40%
- Weeks 7-8 – 100% of base pay from Atlantic

C-Section Delivery:

- Week 1 – 100% of base pay using employee PTO
- Weeks 2-8 – 100% of base pay with Short Term Disability paying 60% and Atlantic paying 40%

If employee does not have Short Term Disability Coverage:

- Week 1 – 100% of base pay using employee PTO
- Weeks 2-8 – 100% of base pay from Atlantic

Cafeteria Plan Benefits: Insurance benefits will continue to be provided during maternity leave

Requirements of Obtaining Paid Leave: The employee must provide their supervisor with at least sixty (60) days written notice of pending maternity leave.

Integration with FMLA: FMLA will run concurrently with maternity leave. In the event the employee requires more than eight (8) weeks of leave for the birth, four (4) weeks of unpaid FMLA will remain available. See Policy IV-8 for FMLA details.

Retirement Plan

Atlantic Packaging offers employees the option to contribute to a 401K plan. You can contribute up to 100% per pay period immediately. The company matches 30% on the first 6% deferred and is 100% vested immediately. An array of diversified investment options is available. Employees are eligible for match on next entry date following one (1) year of service as a full-time employee. Entry dates are January 1st and July 1st. Two deferral options available – Traditional 401K (pre-tax) and Roth (post-tax).

New hires have 30 days from their date of hire to make a deferral election before being AUTO ENROLLED at 6%. To make your deferral elections, log onto the Principal website at www.principal.com or call 800-986-3343 to speak with customer support.

Additional Benefits

EMPLOYEE DISCOUNT MARKETPLACE - LIFEMART

LifeMart is an online discount marketplace where you can save money on all types of products and services such as flowers, computers, theme park tickets, and much more. It is a one-stop shopping resource with hundreds of discount partners and thousands of discount offers. To access LifeMart, go to: discountmember.lifecare.com and enter the registration code: USI.

DIRECT DEPOSIT OF PAYROLL

Employees must have a checking or savings account for your payroll check to be direct deposited. This is mandatory unless in the state of Michigan.

Contact Information

Atlantic Packaging is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0835 or via e-mail at BRCSouth@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Carrier / Human Resources Contacts

BENEFIT	CARRIER	PHONE NUMBER	WEBSITE/EMAIL
Medical Concierge	Pathways	1-888-296-7179	hpiTPA.com
Prescriptions	OptumRx	1-800-334-8134	www.optumrx.com
Telemedicine	Teladoc	1-800-835-2362	www.teladoc.com
Wellness Program	Wellright	https://atlanticpkg.app.wellright.com/	
Dental PPO	Delta Dental	1-800-662-8856	www.deltadentalnc.com
Vision	Superior Vision	1-800-507-3800	www.superiorvision.com
Flexible Spending Accounts	Flores	1-800-532-3327	www.flores247.com
Life and AD&D	Lincoln Financial	1-800-790-7790	LincolnFinancial.com
Voluntary Life			
Short Term Disability (STD)	Lincoln Financial	1-800-790-7790	LincolnFinancial.com
Long Term Disability (LTD)			
FMLA			
EAP/Behavioral Health Support	Spring Health	1-855-629-0554	atlanticpkg.springhealth.com
Critical Illness	Lincoln Financial	1-800-790-7790	LincolnFinancial.com
Hospital Indemnity			
Accident			
401(k)	Principal	1-800-986-3343	www.principal.com
Medicare Resource	Patty Norton	1-954-607-4151	patty.norton@mybenefitadvisor.com
Atlantic HR Team Contacts			
HR Benefits Website	https://atlanticpkg.hrbenefits.net		
Eryn Johnson	Company Wide	910-398-6174	erynt@atlanticpkg.com
Lynn Vann	Company Wide	910-398-6135	lynnv@atlanticpkg.com
Sarah Klein	Company Wide	910-398-6140	sarahkl@atlanticpkg.com
Renee Windham	Tabor City	910-343-0624	reneew@atlanticpkg.com
Robby Daniels	Tabor City	910-653-7450	robbyd@atlanticpkg.com
Becca Schusler	Wellness Director	704-909-5731	beccas@atlanticpkg.com

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $500 deductible and 20% coinsurance to a $2,500 out-of-pocket max.

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

NOTICE REGARDING WELLNESS PROGRAMS

Atlantic Packaging's wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" 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 will also be asked to complete a biometric screening, which will include a blood test for lipid and glucose measurements. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a lower premium on the medical plan. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the lower medical premium.

The information from your HRA and the results from your biometric screening 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, such as meeting with Marathon Health. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 910-398-6174.

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory

or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Eryn Johnson
910-398-6174
erynt@atlanticpkg.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests

- Respond to lawsuits and legal actions

Your Rights

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

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Pay for your health services

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

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

Administer your plan

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

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

Run our organization

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

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

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

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

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

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

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities

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

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

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective October 1, 2025
- Contact Human Resources at 910-398-6174

Important Notice from Atlantic Packaging About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Atlantic Packaging 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. Atlantic Packaging has determined that the prescription drug coverage offered by the Atlantic Packaging Medical 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 Atlantic Packaging medical plan coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Atlantic Packaging medical plan coverage, be aware that you and your dependents will only be able to get this coverage back during open enrollment or in the case of a special enrollment opportunity.

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 Atlantic Packaging 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 Atlantic Packaging 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:	October 1, 2025
Name of Entity/Sender:	Atlantic Packaging
Contact--Position/Office:	Human Resources
Address:	806 North 23rd Street, Wilmington, NC 28405
Phone Number:	910-398-6174

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	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program 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+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	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)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: 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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 | TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-296-7179. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at healthcare.gov/sbc-glossary or call 1-888-296-7179 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Single Plan: $500 employee Family Plan: $500 person/$1,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services and physician office visits are some of the services covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov /coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Single Plan: $2,500 employee Family Plan: $2,500 person/$5,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit is met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You may see a specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Physician and Facility-Based Services		Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible waived		You may have to pay for services that aren't preventive. Ask your provider if services are preventive. Then check what plan will pay.
	Specialist visit	$50 copay/visit; deductible waived		
	Preventive care/Screening/Immunizations	No charge; deductible waived		
If you have a test	Diagnostic test (X-rays, Blood Work) Mammogram & bone density services	No charge; deductible waived	20% coinsurance	Preauthorization required for Imaging
	All other tests	20% coinsurance		
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at hpiTPA.com	Generic drugs— Retail (30 days) Retail*(90 days) Mail Order (90 days)	$10 copay/prescription $30 copay/prescription $20 copay/prescription		Deductible waived. *maintenance drugs only Certain prescription drugs are subject to Step Therapy. You may be required to use a different prescription drug or pharmaceutical product(s) first.
	Preferred brand drugs— Retail (30 days) Retail*(90 days) Mail Order (90 days)	30% coinsurance $100 max 30% coinsurance $300 max 30% coinsurance $200 max		
	Non-preferred brand drugs— Retail (30 days) Retail*(90 days) Mail Order (90 days)	50% coinsurance $250 max 50% coinsurance $750 max 50% coinsurance $500 max		
	Specialty drugs— Retail/Mail Order (30 days)	50% coinsurance $250 max		
If you have outpatient surgery	Facility fee (Ambulatory Surgical Center, etc.) Diagnostic colonoscopies	No charge; deductible waived		Preauthorization required
	All other services	20% coinsurance		
	Physician/surgeon fees	20% coinsurance		
If you need immediate medical attention	Emergency room care First visit/yr All Subsequent Visits/yr	$250 copay/visit; deductible waived 20% coinsurance		Copay waived if admitted
	Emergency medical transportation	20% coinsurance		None
	Urgent care	$50 copay/visit; deductible waived		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance		Preauthorization required
	Physician/surgeon fees			
Preauthorization required for all hospital admissions & Facility-Based Services provided at a hospital, surgical center, outpatient facility or dialysis center				

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Physician and Facility-Based Services	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, substance abuse services	Outpatient services--- Office Visit Intensive outpatient treatment	$25 copay/visit; deductible waived No charge; deductible waived	Preauthorization required for Intensive outpatient treatment & Inpatient services
	Inpatient services	20% coinsurance	
If you are pregnant	Office visits--- Prenatal Care Postnatal Care	No charge; deductible waived 20% coinsurance	Maternity care may include tests & services described in the SBC (i.e. ultrasound). Requires prenotification prior to delivery and preauthorization for stays over 48 hrs (normal delivery) or 96 hrs (caesarean)
	Childbirth/delivery professional services	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Preauthorization required.
	Rehabilitation services— Inpatient Outpatient	20% coinsurance $50 copay/visit; deductible waived	Preauthorization required for Inpatient. 30 visits/yr combined for Occupational, Physical therapies & Chiropractic services. Preauthorization required after 13 visits each for Occupational, Physical & Speech therapies
	Habilitation services— Early Intervention Developmental Delay	20% coinsurance 20% coinsurance	To age 3 Preauthorization & visit limits based on services provided
	Skilled nursing care	20% coinsurance	60 days/yr. Preauthorization required
	Durable medical equipment--- All other DME Diabetic Supplies	20% coinsurance 20% coinsurance; deductible waived	Preauthorization required for equipment over $2,500
	Hospice services	20% coinsurance	Preauthorization required
If your child needs dental or eye care	Children's eye exam	No charge; deductible waived	1 exam/yr
	Children's glasses	Not covered	n/a
	Children's dental check-up	Not covered	n/a

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Non-emergency care when traveling outside U.S. • Weight loss programs	• Dental care (routine child & adult) • Private duty nursing	• Long term care • Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Hearing aids (1 aid/ear/3 yrs)	• Bariatric Surgery • Infertility treatment ($25,000/lifetime for medical & $10,000/lifetime for Rx)	• Chiropractic care (30 visits/yr with Physical & Occupational therapies) • Routine eye care (adult-1 exam/yr)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact the plan at 1-888-296-7179. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall *deductible*	$500
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *no charge*	

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,170**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall *deductible*	$500
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,180**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall *deductible*	$500
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *copayment*	$50

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-296-7179. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at healthcare.gov/sbc-glossary or call 1-888-296-7179 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network---Single Plan: $1,500 employee Family Plan: $1,500 person/$3,000 family Out-of-network---Single Plan: $3,000 employee Family Plan: $3,000 person/$6,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services and physician office visits are some of the services covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov /coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network---Single Plan: $5,000 employee Family Plan: $5,000 person/$10,000 family Out-of-network---Single Plan: $10,000 employee Family Plan: $10,000 person/$20,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit is met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See hpiTPA.com or call 1-888-296-7179 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You may see a specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit; deductible waived	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if services are preventive. Then check what plan will pay.
	Specialist visit	$75 copay/visit; deductible waived	40% coinsurance	
	Preventive care/Screening/Immunizations	No charge; deductible waived	40% coinsurance	
If you have a test	Diagnostic test (X-rays, Blood Work) Mammogram & bone density services All other tests	No charge; deductible waived 20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required for Imaging
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at hpiTPA.com	Generic drugs— Retail (30 days) Retail*(90 days) Mail Order (90 days)	$10 copay/prescription $30 copay/prescription $20 copay/prescription		Deductible waived. *maintenance drugs only Certain prescription drugs are subject to Step Therapy. You may be required to use a different prescription drug or pharmaceutical product(s) first.
	Preferred brand drugs— Retail (30 days) Retail*(90 days) Mail Order (90 days)	30% coinsurance $100 max 30% coinsurance $300 max 30% coinsurance $200 max		
	Non-preferred brand drugs— Retail (30 days) Retail*(90 days) Mail Order (90 days)	50% coinsurance $250 max 50% coinsurance $750 max 50% coinsurance $500 max		
	Specialty drugs— Retail/Mail Order (30 days)	50% coinsurance $250 max		
If you have outpatient surgery	Facility fee (Ambulatory Surgical Center, etc.) Diagnostic colonoscopies All other services	No charge; deductible waived 20% coinsurance	40% coinsurance	Preauthorization required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care First visit/yr All Subsequent Visits/yr	$500 copay/visit; deductible waived 20% coinsurance		Copay waived if admitted
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	$100 copay/visit; deductible waived	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
Preauthorization required for all hospital admissions & Facility-Based Services provided at a hospital, surgical center, outpatient facility or dialysis center				
If you need mental health, behavioral health, substance abuse services	Outpatient services--- Office Visit	$35 copay/visit; deductible waived	40% coinsurance	Preauthorization required for Intensive outpatient treatment & Inpatient services
	Intensive outpatient treatment	No charge; deductible waived	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits--- Prenatal Care	No charge; deductible waived	40% coinsurance	Maternity care may include tests & services described in the SBC (i.e. ultrasound). Requires prenotification prior to delivery and preauthorization for stays over 48 hrs (normal delivery) or 96 hrs (caesarean)
	Postnatal Care	20% coinsurance		
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization required.
	Rehabilitation services— Inpatient	20% coinsurance	40% coinsurance	Preauthorization required for Inpatient.
	Outpatient	$75 copay/visit; deductible waived	40% coinsurance	30 visits/yr combined for Occupational, Physical therapies & Chiropractic services.
	Habilitation services— Early Intervention	20% coinsurance	40% coinsurance	To age 3
	Developmental Delay	20% coinsurance	40% coinsurance	Preauthorization & visit limits based on services provided
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days/yr. Preauthorization required
	Durable medical equipment--- All other DME	20% coinsurance	40% coinsurance	Preauthorization required for seat lifts, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators, including TENS
	Diabetic Supplies	20% coinsurance; deductible waived	40% coinsurance	
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required
If your child needs dental or eye care	Children's eye exam	No charge; deductible waived	40% coinsurance	1 exam/yr
	Children's glasses	Not covered		n/a
	Children's dental check-up	Not covered		n/a

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Dental care (routine child & adult)	• Long term care
• Non-emergency care when traveling outside U.S.	• Private duty nursing	• Routine foot care
• Weight loss programs		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric Surgery	• Chiropractic care (30 visits/yr with Physical & Occupational therapies)
• Hearing aids (1 aid/ear/3 yrs)	• Infertility treatment ($25,000/lifetime for medical & $10,000/lifetime for Rx)	• Routine eye care (adult-1 exam/yr)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact the plan at 1-888-296-7179. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall *deductible*	$1,500
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Hospital (facility) *coinsurance*	20%
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This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall *deductible*	$1,500
Specialist *copayment*	$75
Hospital (facility) *coinsurance*	20%
Other *copayment*	$75

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

This brochure summarizes the benefit plans that are available to Atlantic Packaging eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.