BENEFITS GUIDE

INTERTEK
BENEFITS
Your blueprint for wellness.

2025

This publication contains important information about your employee benefit program.

This publication includes your Medicare Part D notice.

Please read thoroughly.

Table of Contents

Intertek has made it a priority to maintain quality and affordable benefits year over year. In an effort to keep our plans both valuable and affordable, we are making some changes to both medical plans. You will see these changes later in this guide. Additionally, we are newly offering a voluntary legal insurance plan to make legal resources more accessible to our employees. Please review the legal insurance section of this guide to understand the uses for this benefit.

Our annual enrollment will be passive this year, and if you are happy with your current elections, then you will only need to update FSA or HSA elections, if you choose to enroll. All other benefits will carry over to the 2025 plan year if no changes are made during this enrollment period.

Our Values

Our commitment to be "Ever Better" is about energizing each other to take the company to new heights. We have a passionate culture and our values are really true to what has always differentiated us from our competitors:

- We are a global family that values diversity.
- We always do the right thing. With precision, pace, and passion.
- We trust each other and have fun winning together.
- We own and shape our future.
- We create sustainable growth. For all.

Our aim is to live our values with a 10X culture—a culture of doing everything we do 10X better than our competitors—every day, everywhere.

Our Purposes

Bringing Quality and Safety to Life.

Our Mission

"Our mission is to exceed our customers' expectations with innovative and bespoke Assurance, Testing, Inspection and Certification services for their operations and supply chain. Globally. 24/7."

Our Vision

"To become the world's most trusted partner for Quality Assurance"

Benefits at a Glance

Benefit	Employee Paid	Company Paid	Eligibility
Medical	✓	✓	1st of the month following 30 days of service
Pharmacy	✓	✓	
Dental	✓	✓	
Vision	✓	✓	
Health Savings Account (HSA)	✓		
Flexible Spending Accounts (FSA)	✓		
Short Term Disability (STD)		✓	1st of the month following 180 days of service
Long Term Disability (LTD)	50% by employee	50% by Company	
Basic Life		✓	1st of the month following 30 days of service
Accidental Death and Dismemberment (AD&D)		✓	
Dependent Life Coverage		✓	
Employee Optional Life	✓		
Spouse Optional Life	✓		
401(k) retirement savings plan	✓	✓	
Employee Assistance Program (EAP)		✓	1st day of employment
Business Travel Accident		✓	1st of the month following 30 days of service
Voluntary Legal Insurance	✓		
Voluntary Critical Illness Insurance	✓		
Voluntary Accident Insurance	✓		
Other Benefits		✓	1st day of employment

Intertek employees are our most valuable assets. We offer a very comprehensive set of benefits designed to be the blueprint for your personal and financial health. This guide contains a quick glance of our employee benefits package so you can begin considering which plans best meet your needs and the needs of your family members.

Benefits Enrollment

Annual Look Back Period

Each year Intertek is required under the Affordable Care Act to complete an annual review of hours worked by each employee which is not benefit eligible and determine if the employee is eligible for benefits for the next plan year. For any employee who averaged 30 or more hours per week during the look back period is eligible to participate in open enrollment. For employees who are currently eligible for benefits and no longer working an average of 30 hours per week based on our look back period, those employees will become ineligible for benefits for the next calendar year. The look back period for the 2025 plan year is from October 4, 2023 – October 3, 2024.

Newly Hired Employees

New hires who are scheduled to work more than 30 hours per week are considered benefit eligible and will be able to participate in benefits upon completion of the new hire waiting period. Newly hired employees have 30 days from your date of hire to enroll. If you miss this new hire enrollment opportunity, you must wait until annual enrollment to elect or change your coverage. You may also change your coverage if you experience a qualifying life event. Intertek will conduct a New Hire Look Back review for all employees who were not deemed benefit eligible as a new hire. The New Hire Look back period will review the first 10 months of employment and determine if the employee worked an average of 30 or more hours per week during that time. If yes, then the employee will be offered an enrollment window to add any benefits they choose. If not eligible, the employee will be annually reviewed under the Annual Look Back period each year to determine eligibility for the next plan year.

Rehired Employees

When an employee leaves Intertek for more than 13 weeks, the employee will have to go through the benefit eligibility period once again.

When an employee leaves Intertek for less than 13 weeks and had benefits prior to leaving employment, the employee will be reinstated with their previous benefits with no new waiting period. Should the employee want to discontinue benefits upon rehiring with Intertek, then the employee must contact the Employee Service Center within 30 days of their rehire date to request a change in their benefits.

Dependent Audit

You can cover certain eligible family members in our program. Newly added dependents will be subject to an audit after enrolling. You will receive a letter from our auditors which details the appropriate documentation and deadline to provide. If documentation is not received, the dependent will be deemed ineligible and dropped from coverage. An appeal process will be made available should you miss the deadline and a dependent is dropped.

Qualifying Events

A qualifying event is a change in your personal life which may impact your eligibility or dependent's eligibility for benefits. Common examples include marriage, birth, adoption, or change of job status.

It is your responsibility to contact the Employee Service Center at **866.213.8919** within 30 days of the qualifying life event. Failure to notify the Employee Service Center within 30 days will prohibit your ability to change your benefits election(s).

Spousal/Domestic Partner Employer Coverage Certification

Intertek is committed to offering a comprehensive benefit package to you and your family, but also realizes many spouses/domestic partners have medical coverage available to them through their own employer. For this reason, spouses/domestic partners with coverage available through their employer will be required to take that coverage. A Q&A is provided to explain the provisions of the certification requirement.

Frequently Asked Questions Regarding Spousal/ Domestic Partner Coverage Certification

Q What is spousal/domestic partner employer coverage certification?

A Spousal/domestic partner employer coverage certification requires working spouses/domestic partners of eligible employees to enroll in their employer's medical plan.

Q Who must complete a spouse/domestic partner coverage verification form?

A Anyone enrolling a spouse/domestic partner must complete and return a verification form. The verification form is located under the benefits tab, company links, and benefits information. Please return the completed form to **usa.benefits@intertek.com**

Q Is my spouse/domestic partner required to enroll other family members into his/her employer-sponsored coverage?

A No, only the spouse/domestic partner is required to enroll in their employer's medical plan.

Q My spouse/domestic partner's employer-sponsored medical plan have open enrollment later in the year. What should we do?

A Your spouse/domestic partner has a "special enrollment right" under his/her employer's medical plan upon loss of coverage under our plan. The employer must allow your spouse/domestic partner to enroll immediately if application for coverage is made within 31 days after losing coverage under our plan.

Q My spouse/domestic partner's employer offers coverage but it is not a comprehensive major medical plan and limits the number of primary care visits and hospital services my spouse/domestic partner can receive in a year. Can my spouse/domestic partner remain on Intertek's plan?

A If your spouse/domestic partner's employer does not offer a comprehensive major medical plan, your spouse/domestic partner may remain on Intertek's medical plan. A comprehensive major medical plan is defined as a medical plan that includes unlimited physician visits, hospitalization and prescription drug coverage. Note that a comprehensive major medical plan may include visit limits on certain coverages such as physical and occupational therapy.

Eligibility

Eligible Employees

You may enroll in the Intertek Employee Benefits Program if you are a regular full time employee who is actively working a minimum of 30 hours per week. Should you terminate employment with Intertek, all of your benefits will cease at midnight on the date of termination for you and any spouse/dependents covered on the plan. A COBRA event will be initiated to continue coverage.

Employee Status Changes During the Plan Year

Full Time to Part Time

If an employee moves from full time/regular part time (meaning the employee works more than 30 hours per week) to a part time status working less than 30 hours per week and is enrolled in benefits, then the employee does not have to drop benefits. Intertek will leave your benefits in place until the end of the plan year. However, the employee has the option to contact the Employee Service Center to drop benefits within 30 days of changing to part time status working less than 30 hours per week. The employee will also be reviewed during the Annual Look Back Period for continued eligibility each plan year.

Part Time to Full Time

If an employee moves from a part time non benefit eligible status to a full time or regular part time (working more than 30 hours per week) during the year, then the employee will automatically have an enrollment window open to add any benefits the employee chooses. The employee must complete their elections within 30 days of the change in status.

Transfer From or to an Intertek Business in Another Country

If an employee transfers into the US from another country, and has been with Intertek for longer than the initial benefit waiting period (1st of the month following 30 days from hire) then the employee is immediately eligible for benefits. Benefits will be effective the date of the transfer into the US. The employee will have 30 days to enroll.

If an employee transfers from the US to another Intertek country, benefits will end at midnight on the effective date of the transfer.

ALL DEPENDENTS MUST HAVE A VALID SSN ON FILE

Make sure your dependents' Social Security Numbers (SSN) are accurately entered in the ADP portal. Employers are required to provide names and Social Security Numbers to the federal government for each individual enrolled for medical coverage. This reporting requirement helps the federal government verify compliance with the Affordable Care Act. If your dependent is on a Visa with no SSN, you may use their ITIN number in lieu of a SSN.

Dependent Eligibility

In general, eligible dependents include your spouse and same-sex domestic partner, who do not have access to medical benefits through their own employer, and children up to age 26. Children may include natural, adopted, step-children, children obtained through court-appointed legal guardianship, as well as children of same-sex registered domestic partners.

If an employee has a life event such as a birth, marriage, death, gain of other coverage, or loss of other coverage, then the employee has 30 days from the date of the event to request a benefit enrollment window to add or drop benefits in the Intertek plan. *If your spouse/domestic partner is offered comprehensive medical coverage through their employer, they will be required to take that coverage. They will not be eligible to participate in the Intertek medical plans.*

If an employee becomes eligible for or has a loss in coverage from Medicaid or Medicare, then the employee has 60 days to request a change in benefits in the Intertek plans.

Enrollment

Once you've reviewed your choices and confirmed which benefits best meet your needs and the needs of your family members, follow the instructions below to complete your enrollment process.

1. Go to **https://my.adp.com**.
2. For first time users, please click Register Now and use the registration code INTERTEKNA-ADP to login and set up your account.
3. Click YES to setup an account.
4. Identity Type—Enter First Name, Last Name, enter your SSN, and date of birth and select "I'm not a robot."
5. Click I'm not a robot box and answer questions. Once verified click NEXT.
6. When you get the message which says "Help us verify your identity." Click NEXT.
7. Then answer the questions to identify yourself. These are questions only you will know.
8. Message will appear "We found you!" Click Register now.
9. Enter your contact information Create User ID (Check availability) and Create Password. If you want to be contacted via text, enter your mobile number and click to Authorize text messages.
10. Select 3 Security questions to assist with password reset.
11. Scroll down to bottom of terms and conditions and check "I have read and agree." Click Register Now.
12. Activate your email

Once Registration is complete with User ID created, and security questions completed you will receive another email from **SecurityServices_NoReply@adp.com** with your user ID. If you click on the link with this email, it will take you right into My ADP with your employee information.

Medical Benefits

Classic & CDHP plans

Medical Coverage with UnitedHealthcare

Our partnership with UnitedHealthcare helps ensure you have the coverage, broad access to providers, and the resources you need. Visit **www.myuhc.com** to learn more.

Register Your Member Account at **myuhc.com**

When it comes to managing your health plan, **myuhc.com** lets you see what's covered, manage costs and so much more.

Use **myuhc.com** to:

- Find the average cost of care
- See what's covered
- View claim details
- Check your plan balances
- Find network providers

Get started today:

- Go to **myuhc.com** > Register Now
- Have your ID card handy and follow the step-by-step instructions

On-the-Go Access to Your Health Plan

DOWNLOAD THE UNITEDHEALTHCARE APP

When you're out and about, you can do everything from managing your plan to getting convenient care. You have 24/7 digital access with **myuhc.com** and the UnitedHealthcare app.

Visit **myuhc.com** and select "Register Now." Or scan this code with your phone's camera to get started.

24/7 VIRTUAL VISITS

UnitedHealthcare's 24/7 Virtual Visits make it easier than ever to get treated by a doctor. Whether using **myuhc.com**® or the UnitedHealthcare® app, 24/7 Virtual Visits let you video chat with a doctor anytime—without setting up additional accounts or apps.

Use a 24/7 Virtual Visit for these common conditions:

- Cold/flu
- Bronchitis
- Fever
- Eye infections
- Rash
- Sore throat
- Stomachaches and more

WHAT DOES IT COST?

- Classic plan members—$30 copay
- CDHP plan members—average cost of visit is $54 (member responsibility is 20% after deductible is met)

You have fast, easy access to a doctor 24 hours a day, 365 days a year the next time you need it.

Sign in at **myuhc.com/virtualvisits** | Call **855.615.8335**

Download the UnitedHealthcare app.

Get A Second Opinion From An Expert Specialist

2nd.MD Specializing in Medical Certainty

2nd.MD helps you feel confident about your medical decisions. As part of your benefits, you can get an expert second opinion from a leading specialist at no additional cost to you. Connect directly with experts by video from the comfort of your home. Ask questions, get answers, and feel empowered to make the best healthcare decisions.

To activate your account and request a consultant call **1.866.269.3534** or visit **2nd.MD/intertek**.

Surest Medical Coverage with UnitedHealthcare

This plan offers you predictable costs by using a copay-only model—that means, no deductible. Find doctors or treatments using Surest's app or website, search and know your price upfront, and continue using the same UnitedHealthcare network that you know today.

Clear Answers About Your Costs, Your Coverage, Your Options.

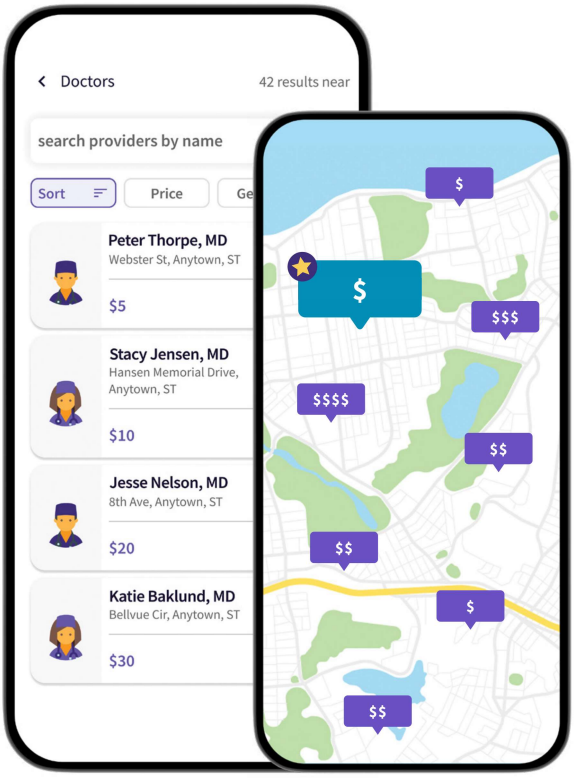
Plan Highlights	
Deductible	$0
Out-of-Pocket Limit	
Employee	$5,500
Family	$11,000
Prescription Drugs—30-day	
Preventive Drugs	$0
Tier 1	$10
Tier 2	$90
Tier 3	$120

Your Copays	
Preventive Visit	$0
Office Visit	$20-$125
Virtual Visit (primary and urgent)	$0
Virtual Visit (specialty)	$0-$125
Mental Health Office Visit	$20
Urgent Care Visit	$80
Emergency Room Visit	$750
Basic Diagnostic Lab Tests, X-Rays and Ultrasounds	$0
Physical Therapy*	$20-$90
Maternity Labor and Delivery	$1,300-$2,750

* See plan description for visit limit details. In-network costs shown. For out-of-network costs, exclusions and limitations, see website.

"EVERYTHING IS JUST EASY AND AFFORDABLE. I FEEL IN CONTROL OF MY HEALTH PLAN FOR THE FIRST TIME."

Jaime A., Surest member



Providers, locations and prices are fictional. Prices are representative of member copays, no deductible.

Get Started

https://britehr.app/Intertek-2025

surest

	Classic		CDHP		Surest	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible	Medical/Rx Non-Embedded					
Individual	$2,000	$6,000	$3,500	$6,000	$0	$0
Family	$4,000	$12,000	$7,000	$12,000	$0	$0
Out-of-Pocket Maximum	Medical Only, Includes Deductible		Medical/Rx Combined, Includes Deductible			
Individual	$5,000	$15,000	$5,500	$15,000	$5,500	$11,000
Family	$11,000	$25,000	$9,200	$25,000	$11,000	$22,000
Physician Office Visits						
Primary Care	$30 copay	40% after deductible	80% after deductible	40% after deductible	$20 to $125 copay	$375 copay
Specialist	$60 copay	40% after deductible	80% after deductible	40% after deductible		
Virtual Visit	$30 copay	Not covered	$54 charge until deductible, then 80% after deductible	Not covered	*Primary & Urgent* $0 *Specialty* $0 to $125	Not covered
Preventive Care						
Preventive Services	100%	40% after deductible	100%	40% after deductible	100%	$190 copay
Hospital Services						
Inpatient	70% after deductible	40% after deductible	80% after deductible	40% after deductible	$300 to $3,500 copay	Up to $10,000 copay
Outpatient	70% after deductible	40% after deductible	80% after deductible	40% after deductible	$150 to $1000 copay	$3,000 copay
Emergency Room	$350 copay (waived if admitted)		$300 copay after deductible (waived if admitted)		$750 copay	
Urgent Care	$75 copay	40% after deductible	80% after deductible	40% after deductible	$80 copay	$240 copay
Prescription Drugs (In-network coverage only)						
Deductible						
Individual	$100		Medical/Rx deductible		N/A	
Family	$250		Medical/Rx deductible			
Out-of-Pocket Maximum	Prescription Only					
Individual	$1,500		Medical/Rx maximum		Medical/Rx maximum	
Family	$3,000		Medical/Rx maximum		Medical/Rx maximum	
Retail Supply Limit	30 days		30 days		30 days	
Generic	$10 copay		Not applicable		$10 copay	Not applicable
Preferred	$40 copay		Not applicable		$90 copay	Not applicable
Non-Preferred	$80 copay		Not applicable		$120 copay	Not applicable
Mail Order Supply Limit	90 days		90 days		90 days	
Generic	$20 copay		Not applicable		$25 copay	Not applicable
Preferred	$80 copay		Not applicable		$225 copay	Not applicable
Non-Preferred	$160 copay		Not applicable		$300 copay	Not applicable
Specialty Retail Pharmacy	Separate tier structure doesn't apply		Separate tier structure doesn't apply		30 days	
Tier 1	See Retail section above		See Retail section above		$330 copay	Not applicable
Tier 2					$370 copay	Not applicable
Tier 3					$400 copay	Not applicable

Your cost of coverage is summarized when you enroll online through **https://my.adp.com**.

Prescription Drug Coverage with CVS/Caremark

Our prescription drug coverage is administered by CVS/Caremark.

Maintenance Choice: 90-Day Supplies

Your plan offers Maintenance Choice, a program which gives you the option to pick up or get delivery of 90-day supplies of the medication you take regularly (for things like diabetes, high blood pressure, asthma, etc.) at select participating pharmacies.

These maintenance medications will need to be filled in 90-day supplies at a select participating pharmacy. If you refill at another pharmacy, or in 30-day supplies, you'll pay the full cost.

If you want to keep filling your prescriptions at your current pharmacy in 30-day supplies without paying the full cost, you can call the number on your member ID card to opt out once your new plan starts. If you opt out during the plan year, you will need to opt out again when your plan benefits renew.

To find a participating pharmacy, visit **Caremark.com/PharmacyLocator** or scan the code.

Prior Authorization

Prior Authorization requirements help ensure drugs are used in the proper way and in doses that are right for each person as recommended by the U.S. Food and Drug Administration. While most prescriptions can be filled immediately by the pharmacy, some require further review. If you encounter a prescription that requires prior authorization, your pharmacy will let you know and either the pharmacy or your doctor will work with CVS/Caremark to determine if your prescription will be approved as requested.

Step Therapy

After clinical studies of many different drugs, CVS/Caremark has selected certain drugs to be the first options tried when treating some conditions. These drugs have been selected as the "first step" because studies have shown they are proven to work well for most people and are more affordable. Your pharmacy will alert you if a prescription is included in a step therapy category.

Tobacco Cessation

Your pharmacy plan covers many tobacco cessation drugs at 100% when received in-network. Talk to your pharmacist about your coverage and take advantage of this opportunity to start living tobacco free.

PrudentRx Copay Program

FOR MEMBERS TAKING SPECIALTY MEDICATIONS

Specialty medications are used to treat complex chronic conditions; they mimic compounds found within the human body. These high-cost medications are typically highly complex. Intertek is offering the PrudentRx Co-Pay program to help you manage the cost of these medications by applying financial copay assistance from drug manufacturers. By enrolling in the PrudentRx program, your out-of-pocket costs for covered medications would be $0.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx. The PrudentRx patient advocate will help you enroll in the PrudentRx Copay Program, along with other available manufacturer copay assistance programs.

If you do not enroll in this program, the cost of your specialty medication will be 30% coinsurance. We highly encourage you to enroll so that your cost will be $0.

Livongo by Teladoc Health

Virtual healthcare programs to help you live well.

Get support for conditions with personalized guidance and care plans.

Diabetes Management

A personalized way to manage diabetes.

- Receive a connected blood glucose meter
- Unlimited strips and lancets
- Tips, action plans and one-on-one coaching
- Real-time support for out-of-range readings

Diabetes Prevention Program

Reduce your risk of type 2 diabetes.

- Team of expert coaches to support you
- Receive a smart scale that syncs to the app
- All-in-one weight, activity and food-tracking program

Hypertension Management

Make managing your blood pressure easier.

- Receive a connected blood pressure monitor
- One-on-one support from expert coaches
- Personalized tips on nutrition and activity

myStrength Digital

Dedicated support for stress, anxiety, depression, sleep and more.

- Personalized plan tailored to your needs
- Activities and content designed for you
- Tools to help reduce stress in the moment

The program is available at no cost to you or your spouse, with eligible health condition(s) and enrollment in the Intertek medical plan

ENROLL NOW

Visit **Go.Livongo.com/INTERTEKUSA/register** or call **800.945.4355** and use registration code: **INTERTEKUSA**.

Las comunicaciones del programa Livongo están disponibles en español. Al inscribirse, podrá configurar el idioma que prefiera para las comunicaciones provenientes del medidor y del programa. Para inscribirse en español, llame al **800.945.4355** o visite **Hola.Livongo.com/INTERTEKUSA**

Program includes trends and support on your secure Livongo account and mobile app but does not include a phone or tablet. You must have an iPhone or Android smartphone and install the Livongo app to participate in the Livongo program.

This program is offered at no cost to you by your health plan or employer.

Health Savings Account

What is a Health Savings Account?

An HSA is a tax-favored account you can use to pay for eligible current and future healthcare expenses with tax-free dollars. You must enroll in the Consumer Driven Health Plan (CDHP) to be eligible to open a HSA. There is no use it lose it rule. Any unused money will remain in your HSA for future use.

Intertek does not own the account. You own the account. If you leave the company, you keep the funds.

Funds may be withdrawn at any time to pay for qualified medical expenses tax-free for most medical, dental, and vision care.

HSA expenses can be incurred by you, your spouse, and dependents claimed on your personal tax return even if the dependents are not enrolled in the CDHP plan. For a complete list of eligible expenses, please refer to the HSA page on **healthequity.com** or IRS Publication 502 at **irs.gov**.

Funding Your Account

You may contribute up to the amounts listed in the chart below.

Coverage Tier	Contribution IRS Annual Limit*
Employee	$4,300
Employee + 1 or Family	$8,550

* Individuals age 55 and older or individuals who reach age 55 by December 31, 2025 can make a catch-up contribution of up to $1,000.

Employee contributions are divided by the 26 pay periods.

YOU NEED TO KNOW FOR A HEALTHIER YOU

- You must enroll in the CDHP coverage option under the Intertek health plan to be eligible to open a HSA
- If you enroll in the CDHP, you will receive a welcome kit outlining how to manage, contribute to, and use your HSA
- Download the HealthEquity mobile app from your smartphone's app store to manage your account online

Flexible Spending Account

Administered by HealthEquity

An FSA allows you to set aside before-tax dollars from your paycheck to use toward qualified expenses that you would normally pay out of your pocket with after-tax dollars.

Healthcare FSA			Dependent Care FSA
Ideal program for employees enrolled in our Classic plan or waiving medical coverage			Ideal program for all employees regardless of other benefit coverage
Used to Help Pay for			Used to Help Pay for
■ Doctor's visit copays ■ Prescription drug copays ■ Medical and dental deductibles ■ Over-the-counter medications (with a written prescription)	■ Hearing aids ■ Eye glasses ■ Contacts ■ Dental services ■ Orthodontia ■ Laser vision correction surgery		■ Cost of child or adult day care ■ Nursery school ■ Preschool (excluding kindergarten) ■ Dependent Care FSA is not for medical expenses for your dependents, it is for care associated with child care or adult day care

IRS Annual Contribution Maximums	
Healthcare FSA	Dependent Care FSA
$3,300 per year	$5,000 per year*

* $2,500 if married and filing separately.

HealthEquity MOBILE APP

EZ Receipts lets you submit healthcare and dependent care claims and upload receipts right from your smartphone. Get EZ Receipts from your smartphone's app store.

ELIGIBILITY

You are not eligible to contribute to a healthcare FSA if you are contributing to a health savings account.

Manage your FSA claims and payments through **healthequity.com**. Contact HealthEquity for more information on submitting claims for reimbursement.

Funds you elect to contribute to the Healthcare FSA are available in full on the first day of the plan year, and the funds contributed toward the Dependent Care FSA cannot be used until accumulated. Plan your contributions carefully as you will lose any funds you do not use at the end of the year. You also cannot change your FSA election during the plan year unless you experience a qualifying life event. Terminated employees have 90 days from the date of termination to request reimbursement for services incurred during the dates you were covered.

Grace Period

Intertek offers a grace period until March 15 each year to incur claims which can be reimbursed from the prior year's plan. You have until March 31 each year to submit your claims for reimbursement from your prior year FSA election.

Dependent Care

Dependent Care FSA (DCFSA) – is a pre-tax benefit that can be used to pay for eligible dependent care expenses, such as preschool, summer day camp, before or after school programs, and child or adult daycare for a qualifying 'dependent' which may be a child under age 13, a disabled spouse or an older parent in eldercare.

Healthcare FSA

Healthcare FSA – is a pre-tax benefit you can use to pay for IRS – qualified eligible qualified expenses such as – co-payments, deductibles, prescription drugs, and other health costs. For an up-to-date list, please visit **https://www.wageworks.com/eligible-expenses**.

Dental

Dental Coverage with Delta Dental

Choose a Delta Dental PPO dentist to ensure you receive the deepest discounts. Choose a Delta Premier dentist and receive discounts, although they may not be as deep as the PPO network. If you receive care outside of Delta's PPO or Premier network you will likely pay a greater amount for dental care and the provider may balance bill you.

To find a Delta Dental network provider in your area, go to **deltadentalins.com** or call **800.521.2651**.

	Delta Network	Out-of-Network
Deductible/Maximum		
Individual Deductible	$50	$50
Family Deductible	$150	$150
Calendar Year Maximum	$1,500	$1,500
Coinsurance		
Preventive Services (exams, X-rays, cleanings)	100% no deductible	100% no deductible
Basic Services (fillings, root canals, oral surgery)	80% after deductible	80% after deductible
Major Services (bridges, crowns, dentures)	50% after deductible	50% after deductible
Orthodontia		
Coinsurance	50%	50%
Lifetime Maximum	$1,500	$1,500
Eligibility	Dependent children to age 26	

Your cost of coverage is summarized when you enroll online through **https://my.adp.com.**

Vision

Vision Coverage with VSP

We know your eye sight is precious to you so we make vision benefits available for you to elect to ensure your trip to the eye doctor is reasonably priced. To locate an in-network VSP provider in your area, go to **vsp.com** or call **800.877.7195**.

	VSP In-Network	Out-of-Network
Vision Exam		
Exam Copay	$10 copay	Up to $50
Lenses		
Single Lens	$25 copay	Up to $50
Bifocal Lens	$25 copay	Up to $75
Trifocal Lens	$25 copay	Up to $100
Lenticular Lens	$25 copay	Up to $125
Frames		
Frame Benefit	$150 allowance	Up to $70
Contact Lenses		
In Lieu of Glasses	$150 allowance, copay does not apply	Up to $105
ProTec Safety Goggles		
Frame and Lenses (employees only)	$25 copay	Not covered
Frequency		
Exams	12 months	
Lens	12 months	
Contacts (in lieu of glasses)	12 months	
Frames	24 months	

SAFETY GOGGLES INCLUDED IN COVERAGE

Safety goggles are in addition to your frames and contacts, not in lieu of.

According to the US Bureau of Labor Statistics, approximately 60% of people who incur eye injuries at work are not wearing proper protective wear. You can receive the right protective eyewear as part of your vision insurance coverage. Covered employees can select from the ProTec Eyewear safety frames collection. Visit **vsp.com** or contact OnGuard (Hilco) at **800.955.6544** for more details.

Your cost of coverage is summarized when you enroll online through **https://my.adp.com**.

Life Insurance

Basic Life Insurance

Intertek provides basic life insurance with accidental death and dismemberment insurance at no cost to you.

Basic Life Benefit

- Two times your base annual earnings up to a maximum of $500,000
- You may opt out of this level of coverage and elect a flat $50,000 benefit to avoid imputed income
- A flat payment of $5,000 for your spouse or same-sex domestic partner
- A flat payment of $2,000 for dependent children
- Guaranteed issue

You can also purchase voluntary life coverage for your spouse or same-sex domestic partner if you've also purchased voluntary life coverage for yourself. This coverage is available in $10,000 increments not to exceed the lesser of 50% of your employee election or $120,000.

Age Band	Rate per $1,000 of Benefit Coverage
18–29	$0.06
30–34	$0.08
35–39	$0.09
40–44	$0.13
45–49	$0.21
50–54	$0.35
55–59	$0.59
60–64	$0.72
65-69	$1.27
70+	$2.06

Optional life insurance rates for you and your spouse or same-sex domestic partner. Spouse rates are based on spouse's age band.

Voluntary Life Insurance

Intertek offers you the ability to purchase voluntary life insurance at competitive group rates. Voluntary Life Insurance can be purchased from 1 to 6 times your base annual salary.

Evidence of Insurability (EOI) or proof of good health is required under the following circumstances.

- Late entrant: you have previously waived the opportunity to elect this coverage and are now electing coverage for the first time
- Current participant: you currently have this coverage and are requesting an increase to your current coverage amount
- Newly eligible: you have never been offered this coverage previously or waived this coverage previously and you are requesting over the guaranteed issue amount of 3× earnings or $250,000, whichever is less

Disability

Employees are eligible for disability benefits on the 1st of the month following 180 days of service as an Intertek employee.

Short Term Disability

Short Term Disability (STD) provides you with a percentage of your weekly income while you are unable to work due to a non-work related accident or illness. Intertek offers an STD plan at no cost to you. Coverage is determined by your length of service with Intertek.

Years of Service STD Benefit	Less Than 2 Years of Service
Up to 6 Weeks of Disability	100% of earnings—Max of $2,000 per week
7 to 26 Weeks of Disability	60% of earnings—Max of $1,200 per week
2 to 9 Years of Service	
Up to 13 Weeks of Disability	100% of earnings—Max of $2,000 per week
14 to 26 Weeks	60% of earnings—Max of $1,200 per week
10 or More Years of Service	
Up to 26 Weeks of Disability	100% of earnings—Max of $2,000 per week

FMLA AND DISABILITY LEAVE

Your physical and financial wellness is important to Intertek. Intertek helps provide financial protection benefits which support you and your dependents should you become disabled and unable to work. To file a disability or Family and Medical Leave Act (FMLA) claim, please contact Lincoln Financial at **888.408.7300** or go online to **mylincolnportal.com**.

Long Term Disability

Long Term Disability (LTD) protects your income by providing you with a percentage of your income while you are disabled. You have the option of purchasing Voluntary LTD coverage. Intertek contributes 50% of the cost and you pay the remaining 50%. If you do not want to enroll for voluntary LTD coverage you can opt out of the benefit during enrollment.

LTD Benefit	
Benefit Percentage	60%
Monthly Benefit Minimum	Greater of $100 or 10%
Monthly Benefit Maximum	$15,000
Benefit Waiting Period	180 days or end of STD benefits
Benefit Duration	Until you no longer meet the definition of disability or you reach the maximum benefit duration
Monthly Rate	$0.35 per $100 of covered payroll

LTD Payment Example

The cost for LTD coverage is $0.35 per $100 of monthly covered payroll. If your monthly salary is $4,000 then the LTD cost is: $4,000/100 × $0.35 = $14.00 of monthly premium. You pay 50% of the monthly premium.

Retirement Savings Plan

401(k) with Fidelity

A consistent savings plan throughout your career is the foundation for security during your retirement years. Intertek's 401(k) Plan is designed to help you reach your investment goals.

How the Plan Works

You can elect to contribute up to 75% of your gross salary subject to IRS maximums. If you are age 50 or older you can contribute an additional catch-up contribution. Intertek offers a discretionary match of 50% up to 6% of your compensation. To enroll or change your 401(k) deferral or asset allocation log-on to your Fidelity account at **401k.com** or call **800.835.3361**.

Fidelity Tools

Fidelity offers retirement calculators and investment services which allow you to choose your own investments options or use a managed account plan which does the hard work for you. You can also add beneficiary information from the convenience of Fidelity's online beneficiary tool.

Vesting

You are always 100% vested in your contributions to the Plan, as well as any earnings on them. The Company's matching contributions, Company Discretionary Contributions, and any earnings vest according to your years of service with Intertek.

Years of Service	Vested Percentage
1	25
2	50
3	75
4	100

AUTO ENROLLMENT

Any individual who becomes employed or is reemployed and who does not, on or before the 30th day after their date of employment or date of reemployment, make either an affirmative election or change their deferral to not make employee contributions shall be automatically deemed to reduce their compensation by 4% for each payroll period and shall have that amount contributed to the plan as employee contributions effective as of the first applicable payroll period beginning on or after the 30th day after his date of employment or date of reemployment.

Contact Fidelity
401k.com
800.835.3361

Legal Insurance

What is Legal Insurance?

Legal coverage isn't just for the serious issues, it's for your everyday needs, too. Legal insurance helps you address common situations like creating wills, transferring property, or buying a home.

Bi-weekly Rate For All Family Types (with, or without dependents)
$8.86

What Does Legal Insurance Cover?

An UltimateAdvisor legal insurance plan from ARAG® covers a wide range of legal needs like the examples shown below—and more—to help address life's legal situations:

Consumer Protection

- Auto repair
- Buy or sell a car
- Consumer protection for goods or services
- Home improvement
- Small claims court

Debt-Related Matters

- Debt collection
- Garnishments
- Personal bankruptcy
- Student loan debt

Driving Matters

- License suspension/ revocation
- Traffic tickets

Tax Issues

- IRS tax audit
- IRS tax collection

Family

- Adoption
- Guardianship/ conservatorship
- Name change
- Divorce

Services for Tenants

- Contracts/lease agreements
- Eviction
- Disputes with a landlord

Real Estate and Home Ownership

- Buying a home
- Foreclosure
- Contractor issues
- Selling a home

Wills and Estate Planning

- Powers of attorney
- Trusts
- Wills

Critical Illness Coverage

Why Critical Illness Coverage?

Critical illnesses can be a major detriment to your income, health insurance expenses, and daily living. Voya's critical illness plan pays a lump sum directly to you for any of the conditions shown in the chart.

Features

- Guaranteed Issue: No medical questions or tests are required for coverage
- Flexible: You can use the benefit payments for any purpose you like
- Portable: If you leave Intertek or retire, you can take your coverage with you (provision may vary by state) amount you elect

WELLNESS BENEFIT

This benefit pays $75 per calendar year per insured individual (employee and spouse) if a covered health screening test is performed, including blood tests, chest X-rays, stress tests, mammograms and colonoscopies. A full list of covered tests will be provided in your certificate.

Covered Conditions and Benefits

You may elect to purchase critical illness coverage up to the limits shown in the chart.

Covered Person	Limits
Employee	You may elect a benefit amount of $10,000, $20,000, or $30,000
Spouse	You may elect a spouse benefit amount of $5,000, $10,000, or $15,000
Child(ren)	25% of employee-elected coverage for no additional premium

	Percent of Benefit Paid
Heart Attack	100%
Stroke	100%
Coronary Artery Bypass Surgery	25%
Cancer	100%
Carcinoma in Situ	25%
Benign Brain Tumor	100%
End Stage Renal (kidney) Failure	100%
Major Organ Failure	100%
Coma (as the result of a severe traumatic brain injury)	100%
Blindness	100%
Permanent Paralysis (as the result of an accident)	100%
Additional Covered Conditions for Dependent Children: Cerebral Palsy, Cystic Fibrosis, Down Syndrome.	100%

For a complete description of benefits, exclusions and limitations, refer to your certificate of insurance and riders.

Critical Illness Monthly Rates

	Employee*			Spouse**		
Member Age	$10,000	$20,000	$30,000	$5,000	$10,000	$15,000
<25	$4.90	$9.80	$14.70	$2.45	$4.90	$7.35
25–29	$5.50	$11.00	$16.50	$2.75	$5.50	$8.25
30–34	$6.10	$12.20	$18.30	$3.05	$6.10	$9.15
35–39	$7.20	$14.40	$21.60	$3.60	$7.20	$10.80
40–44	$10.50	$21.00	$31.50	$5.25	$10.50	$15.75
45–49	$14.80	$29.60	$44.40	$7.40	$14.80	$22.20
50–54	$21.60	$43.20	$64.80	$10.80	$21.60	$32.40
55–59	$30.20	$60.40	$90.60	$15.10	$30.20	$45.30
60–64	$45.20	$90.40	$135.60	$22.60	$45.20	$67.80
65–69	$64.90	$129.80	$194.70	$32.45	$64.90	$97.35
70+	$72.20	$144.40	$216.60	$36.10	$72.20	$108.30

* Child(rens) Benefit Amount: 25% of Employee Benefit is included in Employee Rate.
** Spouse's rates are based on the age of the Spouse.

Accident Coverage

Why Accident Coverage?

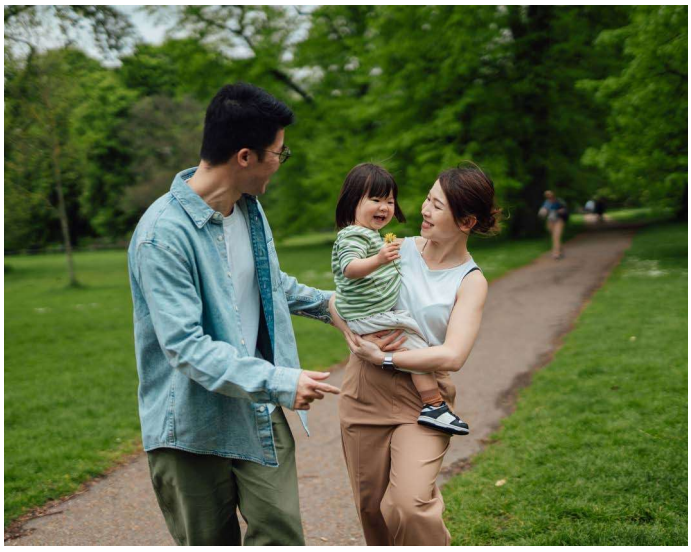
Accident coverage applies to non-work-related accidents only. If you elect to purchase accident coverage, Voya's plan pays a tax-free benefit directly to you to help offset unexpected expenses associated with an accident (off the job only) for yourself or a covered family member.

WELLNESS BENEFIT

This benefit pays $50 per calendar year per insured individual (employee, spouse, and children) if a covered health screening test is performed, including blood tests, chest X-rays, stress tests, mammograms, and colonoscopies.

A full list of covered tests will be provided in your certificate.

Plan Pays You	
Monthly Premium	
Employee	$9.98
Employee + Spouse	$16.85
Employee + Children	$19.03
Family	$25.90



Features

- Guaranteed issue: No medical questions or tests are required for coverage
- Flexible: You can use the benefit payments for any purpose you like
- Portable: If you leave Intertek (or retire), you can take your coverage with you

Here is a brief summary of the covered medical treatment or service. A full list of covered services will be provided in your certificate.

Event	Benefits
Accident Hospital Care	
Surgery Open Abdominal, Thoracic	$1,200
Hospital Admission	$1,250
Hospital Confinement per Day, Up to 365 Days	$375
Transportation per Trip, Up to Three per Accident	$750
Lodging per Day, Up to 30 Days	$180
Accident Care	
Initial Doctor Visit	$90
Urgent Care Facility Treatment	$225
Emergency Room Treatment	$225
Ground Ambulance	$360
Air Ambulance	$1,500
Outpatient Surgery (one per accident)	$225
X-ray	$45
Common injuries	
Burns Second Degree, at Least 36% of the Body	$1,250
Emergency Dental Work	$350 crown, $90 extraction
Eye Injury Surgery	$350
Ruptured Disk Surgical Repair	$800
Concussion	$225
Dislocations	Closed/Open Reduction
Hip Joint	$3,850/$7,700
Knee	$2,400/$4,800
Fractures	Closed/Open Reduction
Leg	$2,500/$ 5,000
Ankle	$1,800/$3,600

Additional Benefits

Employee Assistance Program (EAP)

Managed by Lucet, your EAP offers free counseling, legal and financial planning guidance, referrals and assistance with work/life issues. Anyone living in your household can utilize these services and anyone up to 26 living outside of your home. This program is free and confidential. You can access this service by phone at **800.624.5544** or visit **eap.lucethealth.com** and login with the information: user name: Intertek.

Intertek Perks

Enroll for a variety of employee discounts at **https://www.perksatwork.com**.

Ticketsatwork.com

For access to exclusive savings on movie tickets, theme park tickets, etc. Visit **ticketsatwork.com** and enter company code: Intertek.

VIP.RocketMortgage.com/Intertek

Whether you want to refinance your mortgage or buy a new home, the dedicated VIP team of experts at Rocket Mortgage will help guide you through the process with clarity and simplicity. They provide a home buying experience designed for you—giving you certainty that you will achieve your homeownership goals. Visit **VIP.RocketMortgage.com/Intertek** or call **800.609.3755**.

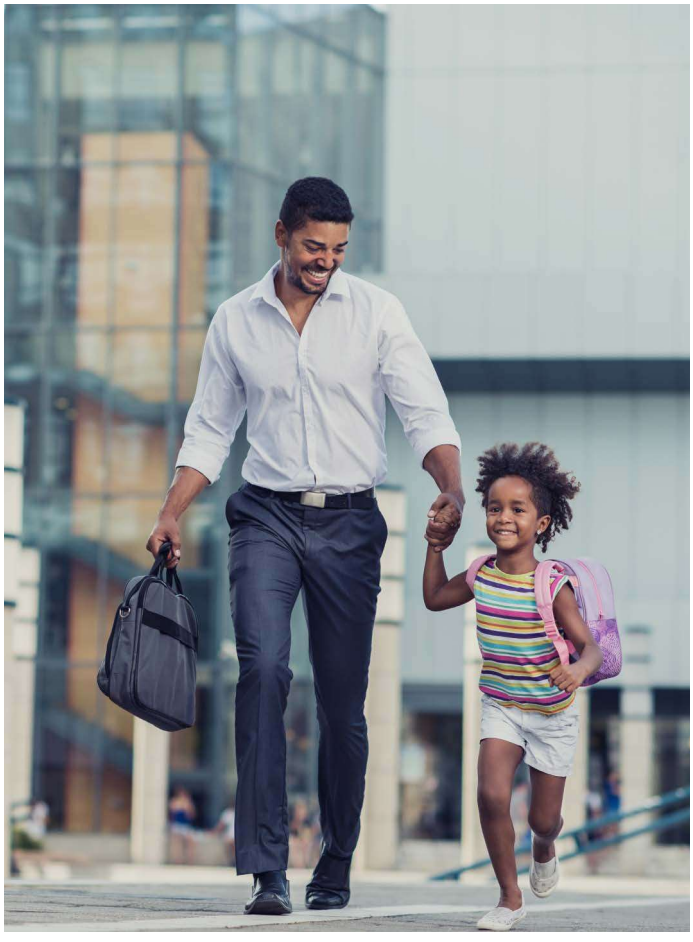
Business Travel

The business travel policy is placed with Chubb under their TravelSmart policy. Comprehensive medical and security advice is available from Travel Guard, both before any travel or during a trip. The Chubb TravelSmart policy provides pre-trip business travel services, including emergency assistance and a range of web and telephone based services which can be used at any time—not just when a claim is being made—including advice and assistance on the following services.

- Business and social customs, and political situations
- Medical issues, medical facilities overseas, and health precautions (including vaccinations)
- Visa and entry permit requirements
- Currency and banking hours, time zones and climate, and driving restrictions
- Security advice covering over 200 countries, updated daily by security analysts, including terrorist, kidnap, and cultural threats; free updates emailed daily to a traveler's inbox
- High-risk travel safety briefings for specific trips to high-risk countries provided within 24 hours by request
- SMS travel alert texts sent directly to a traveler's mobile phone, helping them to stay ahead of changing political situations or severe weather conditions which might disrupt important travel
- Identity theft—guidance on preventive action, credit file monitoring, re-establishment of identity, and repair of the insured person's credit rating standing

CONTACT INFORMATION

This advice is available on the Chubb website—**https://portal.cubbtravelsmart.com/**—by registering using the Intertek policy number UKBBBD41836. A password will then be sent to you. Specific advice is available from their 24-hour hotline number: **+44.207.173.7796**. These services are available to all Intertek employees who travel on Intertek business.



Contact Information

GENERAL ASSISTANCE

Enrollment, changes to benefits, verification of benefits, etc.
Intertek Employee Service Center
866.213.8919

MEDICAL

UnitedHealthcare
866.759.3082
myuhc.com

Surest
866.683.6440
surest.com

RX

CVS/Caremark
888.626.1085
https://www.caremark.com

DENTAL

Delta Dental
Group # 16664
800.521.2651
deltadentalins.com

VISION

VSP
Group # 12088625
800.877.7195
vsp.com

VOLUNTARY CRITICAL ILLNESS AND ACCIDENT INSURANCE COVERAGE

Voya
877.236.7564
https://presents.voya.com/EBRC/Intertek

HSAs AND FSAs

HealthEquity
877.924.3967
https://www.healthequity.com

BENEFIT SERVICE CENTER

For claims regarding UHC medical and CVS Caremark pharmacy
RT Consulting
855.203.0911

STD AND LTD

Lincoln Financial
888.408.7300
https://www.mylincolnportal.com
Company code: Intertek

LIFE AND AD&D INSURANCE

Lincoln Financial
To file a death claim, please email usa.benefits@intertek.com or call 877.694.8543; press prompt 3 and then prompt 2

LEGAL INSURANCE

ARAG
800.247.4184
ARAGlegal.com/myinfo
Access code: 18956int

EAP

Lucet
800.624.5544
eap.lucethealth.com
User Name: Intertek

401(k) RETIREMENT SAVINGS PLAN

Fidelity
800.835.3361
401k.com

TRAVEL ACCIDENT

Chubb
+44.207.173.7796
https://portal.chubbtravelsmart.com/

SECOND OPINION SPECIALIST

2nd.MD
866.269.3534
2nd.MD/intertek

Do not forget to use the Intertek Resource Library to find more information and plan documents for all benefits.
Visit https://my.adp.com, and click on the benefits tab, under the company links, click on the benefits information link.

Health Plan Notices

Table of Contents

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Intertek About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM INTERTEK 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 Intertek and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Intertek has determined that the prescription drug coverage offered by the Intertek Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Intertek Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Intertek Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Intertek Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Intertek prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 713-543-3600. **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 Intertek changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Kim Castillo
Contact—Position/Office:	Employee Service Center
Address:	545 East Algonquin Road Arlington Heights, IL 60005
Phone Number:	713-543-3600

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

INTERTEK
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

INTERTEK USA, INC. HEALTH BENEFIT PLAN & SUMMARY PLAN DESCRIPTION*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Intertek is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not

objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years

prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Kim Castillo
Employee Service Center
713-543-3600

Effective Date
The effective date of this notice is: January 1, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

INTERTEK EMPLOYEE HEALTH CARE PLAN

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact:

Kim Castillo
Employee Service Center
713-543-3600

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

[If the Plan provides retiree health coverage, add the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Intertek and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance

Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Kim Castillo
Employee Service Center
545 East Algonquin Road
Arlington Heights, IL 60005
713-543-3600

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Intertek Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Intertek Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, 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:

Classic	In-Network	Out-of-Network
Individual Deductible	$2,000	$6,000
Family Deductible	$4,000	$12,000
Coinsurance	30%	60%
CDHP	In-Network	Out-of-Network
Individual Deductible	$3,500	$6,000
Family Deductible	$7,000	$12,000
Coinsurance	20%	60%

Surest	In-Network	Out-of-Network
Individual Deductible	$0	$0
Family Deductible	$0	$0
Coinsurance	N/A	N/A

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator at:

Kim Castillo
Employee Service Center
713-543-3600

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 July 31, 2024. 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)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) 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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – 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 July 31, 2024, 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)

INTERTEK BENEFITS

Your blueprint for wellness.

This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.

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