MicroAge®

The Digital Transformation Experts®

associate BENEFITS

BENEFIT PLANS EFFECTIVE NOVEMBER 1, 2022–DECEMBER 31, 2023

IMPORTANT NOTICE

This Benefits Guide 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 Frontier Technology, LLC dba MicroAge About Your Prescription Drug Coverage and Medicare."

benefits BUILT FOR YOU

At MicroAge, we care about you. That's why we offer benefits that support your physical, emotional, and financial health.

Understanding your benefits and knowing how to use them is just as important as having access to them. Review this guide to learn about the benefits available to you for the 2022–2023 plan year (November 1, 2022, through December 31, 2023). Then, choose the options that are best for you and your family.

what's inside

WHO IS ELIGIBLE

If you are scheduled to work at least 30 hours per week, you are eligible for benefits on the first day of the month following 60 days of employment.

Many of the plans allow you to cover your eligible dependents, which include:

- Your legal spouse.
- Your children to age 26, regardless of student, marital, or tax-dependent status (including a stepchild, legally-adopted child, a child placed with you for adoption, or a child for whom you are the legal guardian).
- Your dependent children of any age who are physically or mentally unable to care for themselves.

WHO PAYS

Some benefits are 100% paid by MicroAge, while others require that you contribute.

Benefit	You Pay	MicroAge Pays
Medical Insurance	X	X
Dental Insurance	X	X
Vision Insurance	X	
Health Savings Account	X	X
Basic Life and AD&D Insurance		X
Supplemental Life and AD&D Insurance	X	
Long-Term Disability Insurance		X
Short-Term Disability Insurance	X	
401(k) Retirement Savings Plan	X	
Employee Assistance Programs		X

WHEN TO ENROLL

You can only sign up for benefits or change your benefits at the following times.

Within 45 days of joining MicroAge as a new associate.	During the annual benefits open enrollment period.	Within 30 days of a qualifying life event.
Enroll on ADP	See page 4	Contact human resources

The choices you make at this time will remain in place through December 31, 2023, unless you experience a qualifying life event as described on page 4. If you do not sign up for benefits during your initial eligibility period, you will not be able to elect coverage until the next open enrollment period.

HOW TO ENROLL

To enroll in benefits, log into workforcenow.adp.com and follow these steps:

1. Enter your user ID and password, and then click "Sign In."

   Note: If this is your first time logging in, click the "Create Account" button. If you are unsure of the registration code, please contact Human Resources.

2. Designate a beneficiary through **workforcenow.adp.com**.

3. You will be asked questions regarding you and your family. This includes birthdates, Social Security numbers, and phone numbers.

4. Compare your plan options and choose the best plan for you and your family. You will need to review and confirm your personal and family profile.

CHANGING YOUR BENEFITS

Due to IRS regulations, once you have made your elections for 2022–2023, you cannot change your benefits until the next annual open enrollment period.

The only exception is if you experience a qualifying life event. Election changes must be consistent with your life event.

Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation.
- Birth or adoption of an eligible child.
- Death of your spouse or covered child.
- Change in your spouse's work status that affects his or her benefits.
- Change in your child's eligibility for benefits.
- Qualified Medical Child Support Order.

To request a benefits change, notify Human Resources within 30 days of the qualifying life event. Change requests submitted after 30 days cannot be accepted. You may need to provide proof of the event, such as a marriage license or birth certificate.

HEALTH PLAN RATES

Listed below are the per pay period costs for medical, dental, and vision insurance. The amount you pay for coverage is deducted from your paycheck on a pre-tax basis.

MEDICAL COSTS

Level of Coverage	UHC HDHP 1500 Plan	UHC PPO Base Plan	UHC PPO Buy-Up Plan
Associate Only	$52.50	$52.50	$84.00
Associate + Spouse	$247.50	$282.50	$311.50
Associate + Child(ren)	$232.50	$255.50	$281.50
Associate + Family	$339.00	$403.50	$444.50

DENTAL COSTS

Level of Coverage	MetLife PPO Graduating Maximum Dental Plan
Associate Only	$5.50
Associate + Spouse	$24.00
Associate + Child(ren)	$21.00
Associate + Family	$35.50

VISION COSTS

Level of Coverage	Avesis Vision Plan
Associate Only	$3.60
Associate + Spouse	$6.80
Associate + Child(ren)	$7.31
Associate + Family	$9.53

MEDICAL INSURANCE

MicroAge offers three medical plan options through UnitedHealthcare (UHC).

Before you enroll in medical coverage, take some time to fully understand how each plan works. Refer to page 7 for an overview of the plan benefits.

BEFORE YOU CHOOSE A PLAN, CONSIDER THIS:

Are you able to budget for your deductible by setting aside pre-tax dollars from your paycheck in a health savings account (HSA)?

Consider the UHC HDHP 1500 Plan.

Do you prefer to pay more for medical insurance out of your paycheck, but less when you need care?

Consider the UHC PPO Buy-Up Plan.

What planned medical services do you expect to need in the upcoming year?

Do you or any of your covered family members take any prescription medications on a regular basis?

Consider the UHC PPO plans.

KEY TERMS TO KNOW

Copay

A fixed dollar amount you may pay for certain covered services. Typically, your copay is due at the time of service.

Deductible

The amount you must pay each year for certain covered health services before your insurance plan will begin to pay.

Coinsurance

After you meet your deductible, you may pay coinsurance, which is your share of the costs of a covered service.

Out-of-Pocket Maximum

This includes copays, deductibles, and coinsurance. Once you meet this amount, the plan pays 100% of covered services the rest of the year.

MEDICAL INSURANCE

The table below summarizes the benefits of each medical plan.

The plans offer in- and out-of-network benefits, providing you the freedom to choose any provider. However, you will pay less out of your pocket when you choose a UHC provider. Locate a UHC network provider at **myuhc.com**.

The coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

Summary of Covered Benefits	UHC HDHP 1500 Plan In Network	UHC HDHP 1500 Plan Out of Network	UHC PPO Base Plan In Network	UHC PPO Base Plan Out of Network	UHC PPO Buy-Up Plan In Network	UHC PPO Buy-Up Plan Out of Network
Plan Year Deductible						
Individual/Family	$1,500/$3,000	$10,000/$20,000	$2,000/$4,000	$2,000/$4,000	$1,000/$2,000	$1,000/$2,000
The amount that MicroAge contributes to help you pay for out-of-pocket expenses	Associate-only: $125/quarter ($500 annually) All other coverage levels: $250/ quarter ($1,000 annually)		N/A		N/A	
Out-of-Pocket Max	(Includes deductible, copays, and coinsurance)					
Individual/Family	$4,500/$6,850	$20,000/$40,000	$4,000/$8,000	$8,000/$16,000	$3,000/$6,000	$6,000/$12,000
Preventive Care	Plan pays 100%	50% after ded.	Plan pays 100%	50% after ded.	Plan pays 100%	50% after ded.
Physician Services						
Primary Care Physician	10% after ded.	50% after ded.	$25 copay[1]	50% after ded.	$25 copay[1]	50% after ded.
Specialist	10% after ded.	50% after ded.	$35 copay	50% after ded.	$35 copay	50% after ded.
Virtual Care Services	0% after ded.	50% after ded.	$0 copay	50% after ded.	$0 copay	50% after ded.
Urgent Care	10% after ded.	50% after ded.	$50 copay	50% after ded.	$50 copay	50% after ded.
Lab/X-Ray						
Diagnostic Lab/X-Ray	10% after ded.	$500 copay[2]	$25 copay	$500 copay[2]	$0 copay	$500 copay[2]
High-Tech Services (MRI, CT, PET)	10% after ded.	$500 copay[2]	20% after ded.	$500 copay[2]	20% after ded.	$500 copay[2]
Hospital Services						
Inpatient	10% after ded.	50% after ded.	20% after ded.	50% after ded.	20% after ded.	50% after ded.
Outpatient	10% after ded.	50% after ded.	20% after ded.	50% after ded.	20% after ded.	50% after ded.
Emergency Room	10% after ded.		$150 copay		$150 copay	
Prescription Drugs	Medical ded., then:					
Generic	$10 copay	Copay + balance	$10 copay	Copay + balance	$10 copay	Copay + balance
Preferred Brand	$35 copay	Copay + balance	$45 copay	Copay + balance	$45 copay	Copay + balance
Non-Preferred Brand	$70 copay	Copay + balance	$95 copay	Copay + balance	$95 copay	Copay + balance
Mail Order (Up to a 90-day supply)	2.5x retail copay	Not covered	2.5x retail copay	Not covered	2.5x retail copay	Not covered

(1) The in-network PCP copay is $0 for children under age 19. (2) $500 copay per occurrence applies to out-of-network providers and providers who do not fall under UHC's designated diagnostic provider category

ARE YOU COVERING YOUR SPOUSE AND/OR CHILDREN?

- **HDHP members:** If you elect associate + spouse, associate + child(ren), or family coverage, the individual deductible and out-of-pocket maximum DO NOT apply. The family deductible must be met, either by one individual, or by a combination of family members, before the plan begins to pay. The same rule applies to the out-of-pocket maximum.
- **PPO plan members:** If you elect associate + spouse, associate + child(ren), or family coverage, the individual deductible and out-of-pocket maximum apply to the family deductible and out-of-pocket maximum. An individual will not have to pay more than the individual amount.

MEDICAL INSURANCE

In-network preventive care is free for medical plan members.

The cost of your preventive care is covered 100% by the MicroAge medical plans. This means you won't have to pay anything out of your pocket.

WHAT IS PREVENTIVE CARE?

Preventive health care is meant to **DETECT** issues at an early stage when treatment is likely to work best and **PREVENT** future health problems.

WHY IS PREVENTIVE CARE IMPORTANT?

It is important that you have a preventive health exam each year—even if you feel healthy and are symptom free—in order to **IDENTIFY FUTURE HEALTH RISKS**.

WHAT'S COVERED?

Covered preventive services vary by age and gender. Talk with your provider to determine which **SCREENINGS, TESTS, AND VACCINES** will be covered and that are right for you.

SAVE MONEY ON YOUR HEALTH CARE

Choose an in-network provider.

Choose an in-network provider and you'll pay less out of your pocket. Why? Because in-network doctors and facilities contract with the insurance company and agree to charge a lower price for services.

Request an in-network lab.

When your doctor orders a test, confirm that an in-network lab will be used. If your tests are sent to an out-of-network lab, you may incur additional out-of-pocket expenses.

Check your explanation of benefits.

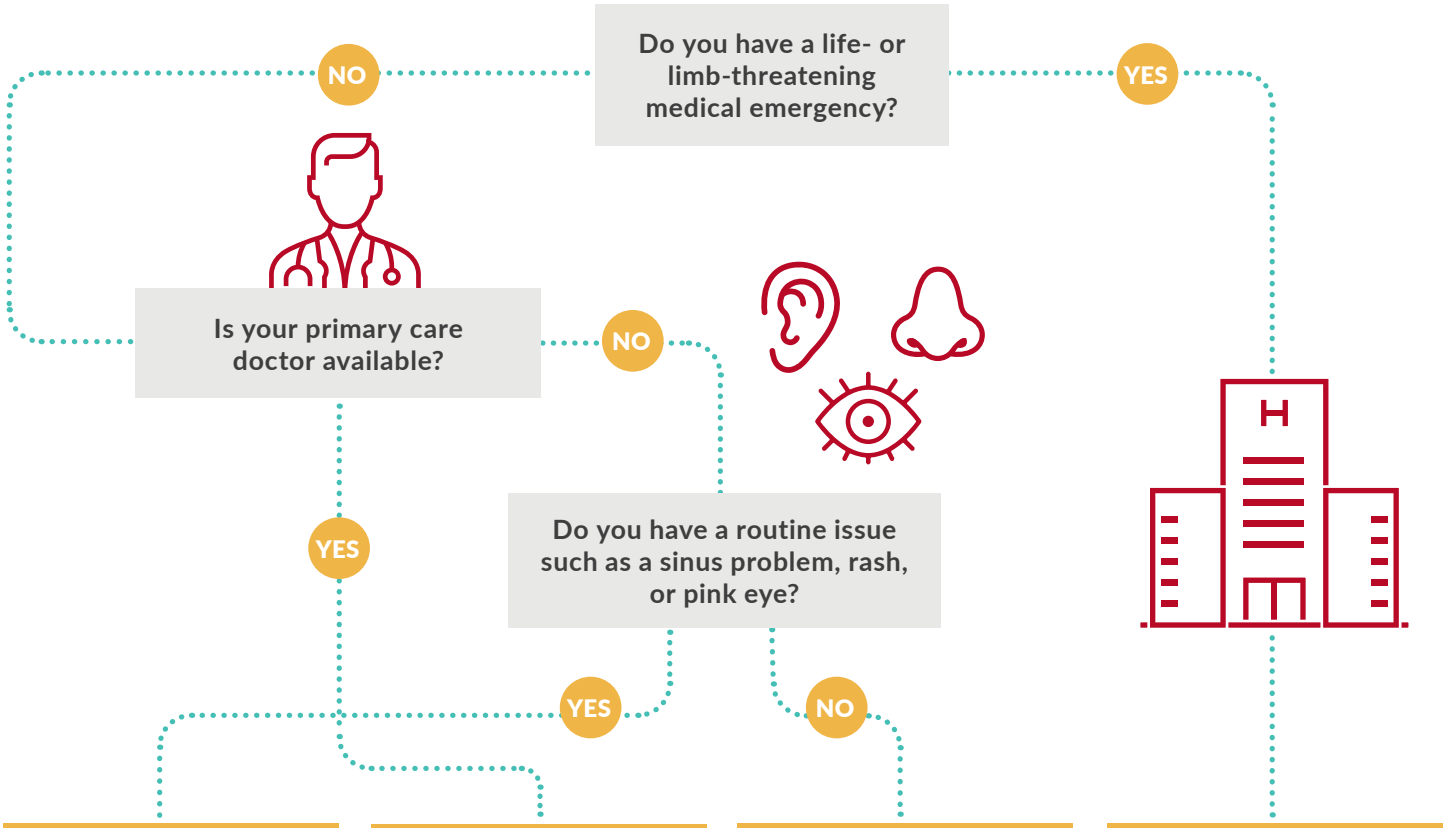
After your appointment, review your explanation of benefits (EOB) and provider bill to confirm you were billed correctly.

Note: Some services are generally not considered preventive if you get them as part of a visit to diagnose, monitor, or treat an illness or injury. Please be aware that you will be responsible for the cost of any non-preventive care services you receive at your preventive care exam based on your plan design. Learn more about preventive care at **myuhc.com**.

MEDICAL INSURANCE

Know where to go for your health care.

Where you go for medical services can make a big difference in how much you pay and how long you wait to see a health care provider. Use the chart below to help you choose where to go for care.



Use UHC Virtual Care Services

Get care without leaving your house. An appointment with a physician is available from your phone or computer.

Find a designated virtual visit network provider by visiting **myuhc.com** or calling the telephone number on the back of your ID card.

$

Go to Your Primary Care Doctor

For care during normal office hours, it's usually best to see your primary care doctor. He or she can provide follow-up care and refer you to a specialist, if needed.

$$

Go to an Urgent Care Center

Urgent care centers typically don't require an appointment and are often open after normal business hours. Plus, in-network urgent care centers provide faster and much less expensive care than the ER.

$$$

Go to the Emergency Room

In the case of a true medical emergency, go to the ER. At the ER, true emergencies are treated first. Other cases must wait—sometimes for hours—and it will cost a lot more to get care at the ER.

$$$$

DENTAL INSURANCE

MicroAge offers a dental insurance plan through MetLife.

The plan offers in- and out-of-network benefits, providing you the freedom to choose any provider. However, you will pay less out of your pocket when you choose a MetLife provider. Locate a MetLife network provider at **metlife.com**.

The table below summarizes key features of the dental plan. The coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

Summary of Covered Benefits	PPO Graduating Maximum Plan	
	In Network	Out of Network
Plan Year Deductible Individual/Family	$50/$150	$50/$150
Plan Year Benefit Maximum	Year 1: $1,750 Year 2: $2,000 Year 3: $2,250	Year 1: $1,250 Year 2: $1,500 Year 3: $1,750
Preventive Care (Oral exams, cleanings, x-rays)	Plan pays 100%	Plan pays 100%
Basic Services (Periodontal services, endodontic services, oral surgery, fillings)	10% after ded.	20% after ded.
Major Services (Bridges, crowns [inlays/onlays], dentures [full/partial])	40% after ded.	50% after ded.
Orthodontia Services (Adult and children)	50%	
Orthodontia Lifetime Maximum	$1,500	

Your dentist can tell a lot about your overall health during your dental visit, including whether or not you may be developing diabetes, heart disease, kidney disease, and even some forms of cancer.

VISION INSURANCE

MicroAge offers a vision insurance plan through Avesis.

You have the freedom to choose any vision provider. However, you will maximize the plan benefits when you choose a network provider. Locate an Avesis network provider at **avesis.com**.

The table below summarizes key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

Summary of Covered Benefits	Avesis Vision Plan	
	In Network	Out of Network
Eye Exam (Every 12 months)	$10 copay	Reimbursement up to $35
Standard Plastic Lenses (Every 12 months)		
Single/Bifocal/Trifocal/Lenticular	$10 copay	Reimbursement up to $25/$40/$50/$80
Progressive	$50 allowance and 20% discount	Reimbursement up to $40
Frames (Every 24 months)	$150 allowance	Reimbursement up to $50
Contact Lenses (Every 12 months in lieu of standard plastic lenses)		
Fitting and Follow up (standard/custom)	$50/$75 copay	N/A
Elective	$150 allowance	Reimbursement up to $128
Medically Necessary	Plan pays 100%	Reimbursement up to $250
Laser Correction Surgery	$150 Allowance	Reimbursement up to $150

Even if you have perfect vision, an annual eye exam is important. Just by examining your eyes, a doctor can find warning signs of high blood pressure, diabetes, and more than 200 other major diseases.

HEALTH SAVINGS ACCOUNT

MAXIMIZE YOUR TAX SAVINGS WITH AN HSA

spend

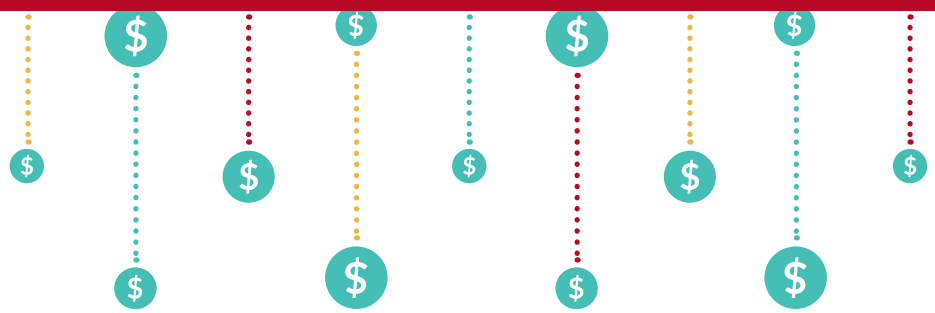
Use your HSA dollars today to pay for eligible health care expenses such as: deductibles, copays, dental expenses, eye exams, and prescriptions.

save

Save your HSA funds for the future. An HSA allows you to save and roll over money year to year. The money in the account is always yours, even if you change health plans or even jobs.

invest

The money in your HSA can be invested and grows tax free—including interest and investment earnings. After you reach age 65, you can spend your HSA dollars penalty free on any expense. Learn more by visiting **optumbank.com** or calling 800-791-9361.



If you enroll in the UHC HDHP 1500 Plan, you may be eligible to open and fund a health savings account (HSA) through Optum Bank.

An HSA is a savings account that you can use to pay out-of-pocket health care expenses with pre-tax dollars.

MICROAGE CONTRIBUTION

If you enroll in the UHC HDHP 1500 Plan, MicroAge will help you save by contributing to your account.

- **Associate-only:** $125 per quarter/$500 per year
- **All other coverage levels:** $250 per quarter/$1,000 per year

2022–2023 IRS HSA CONTRIBUTION MAXIMUMS

Contributions to an HSA cannot exceed the IRS allowed annual maximums (including employer contribution).

- **Individuals:** $3,650 (2022); $3,850 (2023)
- **All other coverage levels:** $7,300 (2022); $7,750 (2023)

If you are age 55+ by December 31, 2023, you may contribute an additional $1,000.

HSA ELIGIBILITY

You are eligible to fund an HSA if:

- You are enrolled in the UHC HDHP 1500 Plan.

You are NOT eligible to fund an HSA if:

- You are covered by a non-HSA eligible medical plan, a PPO plan, health care FSA, or health reimbursement arrangement.
- You are eligible to be claimed as a dependent on someone else's tax return.
- You are enrolled in Medicare, TRICARE, or TRICARE for Life.

Refer to **IRS Publication 969** for additional eligibility details. If you are over age 65, please contact Human Resources.

LIFE AND AD&D INSURANCE

MicroAge provides basic life and AD&D insurance to all benefits-eligible associates AT NO COST. You have the option to purchase supplemental life and AD&D insurance.

BASIC LIFE AND AD&D INSURANCE

MicroAge automatically provides basic life and AD&D insurance through MetLife to all benefits-eligible associates **AT NO COST**. If you die as a result of an accident, your beneficiary would receive both the life benefit and the AD&D benefit. **Please be sure to keep your beneficiary designations up to date.**

- **Associate life benefit:** $25,000
- **Associate AD&D benefit:** $25,000

Depending on your personal situation, basic life and AD&D insurance might not be enough coverage for your needs. To protect those who depend on you for financial security, you may want to purchase supplemental coverage.

Use the calculator at **metlife.com** to find the right amount for you.

LIFE AND AD&D INSURANCE

MicroAge provides you the option to purchase supplemental life and AD&D insurance for yourself, your spouse, and your dependent children through MetLife.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

You must purchase supplemental coverage for yourself in order to purchase coverage for your spouse and/or dependents. Supplemental life rates are age-banded. Benefits will reduce to 65% at age 65 and to 50% at age 70.

- **Associate:** $10,000 increments up to $500,000 or 5x annual salary, whichever is less—guarantee issue: $100,000
- **Spouse:** $5,000 increments up to $100,000—guarantee issue: $25,000
- **Dependent children:** $1,000, $2,000, $4,000, $5,000, or $10,000—guarantee issue: $10,000

ELECT COVERAGE NOW!

If you elect supplemental coverage when you're first eligible to enroll, you may purchase up to the guarantee issue amount(s) without completing a statement of health (evidence of insurability). If you do not enroll when first eligible, and choose to enroll during a subsequent annual open enrollment period, you will be required to submit evidence of insurability (EOI) for any amount of coverage.* Coverage will not take effect until approved by MetLife.

*If you are a currently enrolled associate, you can increase by $10,000 and spouses by $5,000 without EOI.

SUPPLEMENTAL LIFE AND AD&D INSURANCE COSTS

Listed below are the monthly rates for supplemental life and AD&D insurance. The amount you pay for supplemental life and AD&D insurance is deducted from your paycheck on a post-tax basis. Spouse life rates are based on the associate's age.

Associate Age	Associate and Spouse Coverage					
	$1,000	$10,000	$20,000	$40,000	$50,000	$100,000
<30	$0.10	$1.05	$2.10	$4.20	$5.25	$10.50
30–34	$0.14	$1.45	$2.90	$5.80	$7.25	$14.50
35–39	$0.17	$1.75	$3.50	$7.00	$8.75	$17.50
40–44	$0.21	$2.15	$4.30	$8.60	$10.75	$21.50
45–49	$0.33	$3.25	$6.50	$13.00	$16.25	$32.50
50–54	$0.55	$5.45	$10.90	$21.80	$27.25	$54.50
55–59	$0.90	$8.95	$17.90	$35.80	$44.75	$89.50
60–64	$1.32	$13.25	$26.50	$53.00	$66.25	$132.50
65–69	$1.93	$19.25	$38.50	$77.00	$96.25	$192.50
70+	$3.37	$33.65	$67.30	$134.60	$168.25	$336.50

Note: Due to rounding, your actual payroll deduction amount may vary slightly.

	Dependent Child Coverage Monthly Premium
$1,000	$0.26
$2,000	$0.52
$4,000	$1.04
$5,000	$1.30
$10,000	$2.60

DISABILITY INSURANCE

Disability insurance is designed to help you meet your financial needs if you become unable to work due to an illness or injury.

LONG-TERM DISABILITY INSURANCE

MicroAge automatically provides long-term disability (LTD) insurance through MetLife to all benefits-eligible associates **AT NO COST**. LTD insurance is designed to help you meet your financial needs if your disability extends beyond the STD period.

- **Benefit:** 60% of base monthly pay up to $6,000
- **Elimination period:** 90 days
- **Benefit duration:** Social security normal retirement age

SHORT-TERM DISABILITY INSURANCE

MicroAge provides you the option to purchase short-term disability (STD) insurance through MetLife. STD insurance is designed to help you meet your financial needs if you become unable to work due to an illness or injury. Benefits will be reduced by other income, including state-mandated STD plans.

- **Benefit:** 60% of base weekly pay up to $1,000
- **Elimination period:** 7 days
- **Benefit duration:** Up to 12 weeks

SHORT-TERM DISABILITY INSURANCE COSTS

Listed below are the monthly rates for STD insurance. The amount you pay for STD insurance is deducted from your paycheck on a post-tax basis.

Age	Associate Cost Per Payroll Deduction												
	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000	$120,000	$130,000	$140,000	$150,000
Less than 45	$6.92	$9.23	$11.54	$13.85	$16.15	$18.46	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00
45-49	$7.79	$10.38	$12.98	$15.58	$18.17	$20.77	$22.50	$22.50	$22.50	$22.50	$22.50	$22.50	$22.50
50-54	$9.35	$12.46	$15.58	$18.69	$21.81	$24.92	$27.00	$27.00	$27.00	$27.00	$27.00	$27.00	$27.00
55-59	$12.46	$16.62	$20.77	$24.92	$29.08	$33.23	$36.00	$36.00	$36.00	$36.00	$36.00	$36.00	$36.00
60-64	$14.88	$19.85	$24.81	$29.77	$34.73	$39.69	$43.00	$43.00	$43.00	$43.00	$43.00	$43.00	$43.00
65+	$15.92	$21.23	$26.54	$31.85	$37.15	$42.46	$46.00	$46.00	$46.00	$46.00	$46.00	$46.00	$46.00

Note: Due to rounding, your actual payroll deduction amount may vary slightly.

401(k) RETIREMENT SAVINGS PLAN

MicroAge offers a 401(k) retirement savings plan, which is administered by ADP.

New associates will be automatically enrolled for 4% after two months of employment which includes the month you started. If you wish to change or opt out, you must do so by logging in to **mykplan.com**. Adjustments can be made at any time during the year.

& ADDITIONAL BENEFITS

PAID HOLIDAYS

MicroAge provides the following paid holidays to all benefits eligible associates.

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Friday after Thanksgiving Day
- Half day Christmas Eve
- Christmas Day
- Half day New Year's Eve

PAID TIME OFF (PTO)

MicroAge grants associates a set amount of PTO to use as they please for time away from work for personal business, vacation, or illness. With the exception of Account Executives (see below), all associates are eligible to receive PTO benefits outlined in the PTO policy. PTO allotments will be pro-rated for newly hired associates.

UNLIMITED VACATION AND SICK PAY FOR ACCOUNT EXECUTIVES

MicroAge promotes the importance of time away from the office for rest and relaxation, and recognizes Account Executives may, on occasion, work long days and sometimes weekends to meet their responsibilities. In recognition of the particular requirements of this position, MicroAge offers Account Executives the opportunity to take unlimited vacation time effective after 90 days of employment. See vacation policy for more details.

Account Executives accrue four (4) hours of sick pay each pay period, up to 48 hours per year. Sick pay will roll over year over year and caps at 480 hours.

REFERRAL PROGRAM

Earn up to $6,000 for each Account Executive, Account Manager, or Exempt level position referred. Earn $1,000 for any hourly position referred.

EMPLOYEE ASSISTANCE PROGRAMS

Life is full of ups and downs. MicroAge provides two employee assistance programs (EAPs) to help support you and your family.

UNITEDHEALTHCARE EAP (MEDICAL PLAN MEMBERS ONLY)

If you are enrolled in a UHC medical plan, you've got a great source for health information and support with the UHC EAP.

The EAP can assist you with:

- Managing stress, anxiety, and depression.
- Improving relationships at home or work.
- Getting guidance on legal and financial concerns.
- Coping with occupational stress and burnout support.
- Addressing substance use issues.

The EAP provides **three free** counseling sessions per incident, per year. Services are completely confidential and will not be shared with MicroAge. The EAP is available 24 hours a day, seven days a week by calling 888-887-4114 or visiting **myuhc.com**.

METLIFE EAP (ALL ASSOCIATES)

The MetLife program's experienced counselors can talk to you about anything going on in your life, including:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby.
- **Work:** Job relocation, building relationships with coworkers and managers, navigating through reorganization.
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues.
- **Legal services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning.
- **Identity theft recovery:** ID theft prevention tips and help from a financial counselor if you are victimized.
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking.
- **Everyday life:** Moving and adjusting to a new community, grieving over the loss of a loved one, training a new pet.

The EAP includes up to five phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. You can call 888-319-7819 to speak with a counselor or schedule an appointment.

CONTACT INFORMATION

If you have any questions regarding your benefits or the material contained in this guide, please contact the Benefits Concierge Center.

The Benefits Concierge Center is available Monday through Friday from 9 a.m. to 5 p.m. EST. For assistance, please call 833-934-2726.

Provider/Plan	Group Number	Contact Number	Website
Medical—UnitedHealthcare	925480	PPO: 866-633-2446 HSA: 866-314-0335	myuhc.com
Dental—MetLife	05550138	800-438-6388	metlife.com
Vision—Avesis	30781-1155	800-828-9341	avesis.com
Health Savings Account—Optum Bank	N/A	866-234-8913	myuhc.optumbank.com
Life and Disability Insurance—MetLife	05550138	800-438-6388	metlife.com
401(k) Retirement Savings Plan—ADP	251782	800-695-7526	mykplan.com
Employee Assistance Programs— UnitedHealthcare MetLife	 925480 N/A	 888-887-4114 888-319-7819	 myuhc.com metlifeeap.lifeworks.com (username: metlifeeap; password: eap)

This summary of benefits is not intended to be a complete description of the terms and MicroAge insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan. In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although MicroAge maintains its benefit plans on an ongoing basis, MicroAge reserves the right to terminate or amend each plan, in its entirety or in any part at any time.

Frontier Technology, LLC dba MicroAge

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 Frontier Technology, LLC dba MicroAge About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM FRONTIER TECHNOLOGY, LLC DBA MICROAGE 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 Frontier Technology, LLC dba MicroAge 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. Frontier Technology, LLC dba MicroAge has determined that the prescription drug coverage offered by the Frontier Technology, LLC dba MicroAge 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 Frontier Technology, LLC dba MicroAge 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 Frontier Technology, LLC dba MicroAge Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Frontier Technology, LLC dba MicroAge 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 Frontier Technology, LLC dba MicroAge 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 480-366-2031. **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 Frontier Technology, LLC dba MicroAge 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).

IMPORTANT NOTICES

Date:	November 1, 2022
Name of Entity/Sender:	Joelle Fosco
Contact—Position/Office:	Executive Director of Human Resources
Address:	8160 S Hardy Drive Tempe, AZ 85284
Phone Number:	480-366-2031

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

FRONTIER TECHNOLOGY, LLC DBA MICROAGE
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:

Frontier Technology, LLC dba MicroAge Health and Welfare Benefit Plan*

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

The Plan's Duty to Safeguard Your Protected Health Information
Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Frontier Technology, LLC dba MicroAge that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information
The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this

Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Frontier Technology, LLC dba MicroAge) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

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

Joelle Fosco
Executive Director of Human Resources
480-366-2031

Effective Date
The effective date of this notice is: November 1, 2022.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

FRONTIER TECHNOLOGY, LLC DBA MICROAGE 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:

Joelle Fosco
Executive Director of Human Resources
480-366-2031

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

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Frontier Technology, LLC dba MicroAge Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 480-366-2031.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Frontier Technology, LLC dba MicroAge Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Frontier Technology, LLC dba MicroAge Employee Health Care Plan at:

Joelle Fosco
Executive Director of Human Resources
480-366-2031

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Frontier Technology, LLC dba MicroAge 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 Frontier Technology, LLC dba MicroAge 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:

HDHP $1,500 Plan	In-Network	Out-of-Network
Individual Deductible	$1,500	$10,000
Family Deductible	$3,000	$20,000
Coinsurance	80%	50%
Base PPO $2,000 Plan	In-Network	Out-of-Network
Individual Deductible	$2,000	$2,000
Family Deductible	$4,000	$4,000
Coinsurance	80%	50%

Buy-Up PPO $1,000 Plan	In-Network	Out-of-Network
Individual Deductible	$1,000	$1,000
Family Deductible	$2,000	$2,000
Coinsurance	80%	50%

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

Joelle Fosco
Executive Director of Human Resources
480-366-2031

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Joelle Fosco in Human Resources or the carriers directly.

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

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Frontier Technology LLC dba MicroAge	4. Employer Identification Number (EIN) 52-2337159
5. Employer address 15210 S. 50th St., Suite 180	6. Employer phone number 480-336-2031

7. City Phoenix	8. State AZ	9. ZIP code 85044

10. Who can we contact about employee health coverage at this job? Joelle Fosco	
11. Phone number (if different from above)	12. Email address Joelle.Fosco@MicroAge.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All Associates. Eligible Associates are:
  - ☒ Some Associates. Eligible Associates are:
    All full-time Associates working 30 or more hours per week.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Legal spouses and dependents to age 26
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

IMPORTANT NOTICES

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

IMPORTANT NOTICES

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

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 1/31/2023)