2025 BENEFITS ENROLLMENT

Frequently Asked Questions





What's Inside

The benefits described in this document are available to GPC employees and their eligible dependents who meet the eligibility requirements of the corresponding benefit plans. Receipt of this document does not guarantee eligibility or benefits coverage. The plan documents provide a full description of the benefits offered and will always govern if there is a discrepancy between this document and any of the plan documents. To obtain a copy of the Summary Plan Description (SPD) for each plan, contact your Human Resources Department or go to the ***GPC Benefit Plan Services website at gpcbenefitsconnect.ehr.com****.*

Benefits Enrollment

1. WHEN IS BENEFITS ENROLLMENT?

Benefits Enrollment for 2025 GPC benefits coverage begins Friday, November 1, 2024, at 12:01 a.m. ET, and ends on Friday, November 15, 2024, at 11:59 p.m. ET.

2. WHAT BENEFITS MUST I ENROLL IN DURING BENEFITS ENROLLMENT TO HAVE 2025 COVERAGE?

You must choose the Medical, Health Savings Account (HSA), Dental, Vision, Flexible Spending Account (FSA), Accident Insurance, Hospital Indemnity Insurance, Critical Illness Insurance, Legal Services Plan and/or Identity Protection coverage you want for 2025. If you do not enroll, you and your dependent(s) will not have benefits coverage in 2025.

3. HOW DO I ENROLL IN BENEFITS?

You must enroll online through the GPC Benefit Plan Services website at **gpcbenefitsconnect.ehr.com** to receive benefits coverage in 2025. If you are accessing the site for the first time, you will be prompted to create a unique user ID and password when you log in. You can complete your enrollment anywhere you have an Internet connection or through your mobile device.

4. WHO DO I CONTACT IF I HAVE QUESTIONS?

If you have questions, contact **GPC Benefit Plan Services** at **844-305-9663** or your local HR representative.

5. WHERE CAN I FIND MORE INFORMATION?

Visit 2025gpcbenefits.com to learn more about benefits available to you on how to enroll.

6. AM I ALLOWED TO MAKE CHANGES TO MY 2025 BENEFIT ELECTIONS AFTER NOVEMBER 15, 2024?

If you do not enroll by this date, you will not have benefit coverage in 2025, unless you experience certain qualifying events.

Benefit Plan Eligibility

1. WHO IS ELIGIBLE FOR GPC BENEFITS COVERAGE?

You are eligible for the GPC Medical, Dental, Vision, Life and AD&D Insurance and Voluntary Benefit Plans if you're a full-time employee or a part-time employee, provided that you have worked a minimum average of 30 hours per week (1,560 hours annually) during the applicable measurement period. Flexible Spending Account (FSA) coverage is available to full-time employees only.

2. AM I ELIGIBLE TO ENROLL MY DEPENDENT(S) IN GPC BENEFITS COVERAGE?

If you are a full-time employee, you may enroll your eligible dependent(s) in addition to choosing benefits coverage for yourself. Eligible dependents include: your legal spouse and children from birth to age 26 (their 26th birthday) regardless of marital, student or tax-dependent status.

If you are a part-time, benefits-eligible employee, you can enroll child(ren) from birth to age 26 in Medical, Dental, Vision, Optional Life, Optional AD&D, Accident, Critical Illness and/or Hospital Indemnity Insurance coverage.

3. DO I NEED TO PROVIDE PROOF OF ELIGIBILITY TO ENROLL MY DEPENDENT(S) IN BENEFITS COVERAGE?

Yes. GPC requires proof of dependent status to enroll an eligible dependent in GPC's Medical, Dental, and/or Vision Plans. In addition, proof of dependent status may be periodically required.

Failure to provide proof by the required deadline will result in your dependent not being enrolled in benefits coverage for 2025.

4. WHAT DOCUMENTS ARE ACCEPTABLE FOR PROOF OF DEPENDENT ELIGIBILITY FOR GPC BENEFITS COVERAGE?

Acceptable documents include but are not limited to:

For spouse—a copy of both a marriage license/certificate **AND** proof that shows you and your spouse either have the same last name or have had the same address within the last 12 months (e.g., bank statement, mortgage statement or utility bills). If you provide a utility bill(s), you may submit one utility bill displaying your name and your spouse's name or one utility bill in your name and one utility bill in your spouse's name with matching addresses.

For children—a copy of one of the following: birth certificate, legal guardianship or adoption papers, Qualified Medical Child Support Order (QMCSO), baptismal or religious documentation.

For stepchildren—a copy of both a marriage license/certificate of the parent AND the birth certificate of the child.

5. IS MY SAME-SEX SPOUSE ELIGIBLE FOR BENEFITS COVERAGE?

Yes. All legal spouses may be considered eligible dependents for GPC Medical, Dental, Vision, Life and AD&D Insurance and/or Voluntary Benefit Plans.

Medical Plan Carriers

1. WHO ADMINISTERS THE GPD MEDICAL PLAN?

The Medical Plan is administered by Aetna, BlueCross and Blue Shield of Alabama, and UnitedHealthcare.

2. HOW ARE MEDICAL PLAN CARRIERS ASSIGNED?

You are assigned to a Medical Plan carrier based on your home ZIP code. A list of Medical Carrier Assignments by State is available at **2025gpcbenefits.com**.

3. HOW DO I FIND OUT IF MY DOCTOR IS IN MY MEDICAL PLAN CARRIER'S NETWORK?

You can use the provider look-up tool on the Medical Plan carrier's website. You can access the website for Aetna, BlueCross and Blue Shield of Alabama, and UnitedHealth Care on **2025gpcbenefits.com**.

4. WHEN WILL I RECEIVE MY MEDICAL PLAN ID CARD?

You will receive your Medical Plan ID card starting in January 2025.

Medical Plan

1. WHAT ARE THE MEDICAL PLAN OPTIONS GPC OFFERS?

GPC offers the following three medical plan options:

- **The Value Plan** is an account-based health plan that offers the option to contribute to a Health Savings Account (HSA). This plan has the lowest premium and highest deductible of the three plan options.
- **The Savings Plan** is also an account-based health plan that offers the option to contribute to an HSA.
- **The Traditional Plan** has the highest premiums and lowest deductible. Unlike the Value Plan and Savings Plan, under the Traditional Plan you pay copays for office urgent care and emergency care visits, as well as Tier 1 prescription drugs.

2. WHEN I USE AND PAY FOR SERVICES UNDER EITHER GPC MEDICAL PLAN OPTION, WHAT SHOULD I EXPECT TO PAY?

When you receive in-network services through the GPC Medical Plan, you will receive the benefit of your medical plan carrier's negotiated discount with the provider before you are billed for your portion of the cost.

3. HOW ARE X-RAYS AND LAB WORK COVERED?

X-rays and lab work are diagnostic services and are subject to your deductible. Under the Value Plan and Savings Plan, once your deductible is met, you pay 20% coinsurance for these services from an in-network provider. Under the Traditional Plan, you will also pay 20% coinsurance after the deductible is met from an in-network provider. If the X-ray or lab work is considered preventive, it is covered at 100%.

Preventive Care

1. WHAT IS PREVENTIVE CARE?

Preventive care services include screenings, immunizations and other procedures that are designed to detect and treat medical conditions to prevent avoidable illnesses. Preventive care guidelines are based on recommendations by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices.

2. HOW CAN I FIND OUT IF A PARTICULAR PREVENTIVE CARE SERVICE IS COVERED AT 100%?

Contact your medical plan carrier to obtain a complete list of covered preventive care services or to verify the benefits coverage of a specific service. Also, talk to your health care provider; an expense will not be considered preventive care if the provider does not bill it as preventive care.

3. WHAT'S THE DIFFERENCE BETWEEN A PREVENTIVE CARE SERVICE AND A DIAGNOSTIC SERVICE?

Preventive care services that are covered without cost sharing are defined as services performed to prevent disease. Some of these services are only covered for people of a particular age and/or risk status.

Diagnostic services are services related to the diagnosis or testing of a particular condition as prescribed by a doctor. If the service you receive is diagnostic rather than preventive, it will not be covered at 100%. Contact your medical plan carrier to obtain a complete list of covered preventive care services or to verify the benefits coverage of a service.

4. ARE THERE ANY SITUATIONS WHERE I MAY BE CHARGED FOR PREVENTIVE CARE?

Some preventive care services are fully covered only for people of a particular age and/or risk status. If you obtain a service that is not considered preventive, it will not be covered at 100%. In this situation, the service will be considered diagnostic, and you will be responsible for the applicable out-of-pocket expenses before you reach your deductible, an office visit copay or coinsurance.

Contact your Medical Plan carrier to obtain a complete list of covered preventive care services or to verify the benefits coverage of a service.

Tobacco User Surcharge

1. WHAT IS THE TOBACCO USER SURCHARGE?

In addition to Medical Plan premiums, tobacco users will pay $75 more per month for medical coverage. The tobacco user surcharge appears on paychecks separately from the medical coverage premium.

2. WHAT IS THE DEFINITION OF "TOBACCO-FREE"?

Tobacco/smoke-free is defined as someone who has not used a tobacco or smoking product more than two times per month during the last 180 days prior to their benefits eligibility date. A tobacco or smoking product is defined as all tobacco-derived or tobacco containing products, nicotine-based products, and/ or plant-based products including, but not limited to cigarettes (e.g., traditional, clove, bidis, kreteks), cigars and cigarillos, hookah-smoked products, oral tobacco (spit and spit less, smokeless, chew, snuff) and electronic cigarettes.

3. HOW DO I AVOID THE TOBACCO USER SURCHARGE?

In order to avoid the $75 tobacco user surcharge, you and your covered adult dependent(s) (age18 or older) will need to attest that either:

- You and your covered adult dependents have not used tobacco products of any kind more than two times in the last 180 days, or
- You and/or your covered adult dependents are tobacco users but will enroll in and complete the Quit For Life Cessation Program.

This acknowledgement will be part of the online benefits enrollment process.

4. WHAT DO I NEED TO DO TO ENSURE THAT I AND/OR MY COVERED DEPENDENT(S) AGE 18 YEARS OR OLDER ARE NOT ASSESSED THE TOBACCO USER SURCHARGE ON JANUARY 1, 2025?

During Benefits Enrollment, you will need to attest that you and your covered dependent(s) are tobacco-free. This acknowledgment is part of the online enrollment process.

5. DO I NEED TO ATTEST FOR MY DEPENDENT(S) IF THEY ARE NOT COVERED UNDER THE GPC MEDICAL PLAN?

No. You will only be required to attest for those dependent(s) age 18 or older who are enrolled in the GPC Medical Plan.

6. WHAT KINDS OF PRODUCTS ARE CONSIDERED TOBACCO PRODUCTS?

Tobacco products include any cigarettes (traditional and e-cigarettes), pipes, snuff, dipping tobacco, chewing tobacco or other smokeless tobacco products, and all other items developed or processed for the primary purpose of facilitating the use or possession of tobacco or tobacco-related products.

7. DO I HAVE TO PAY THE TOBACCO-USER SURCHARGE IF I USE E-CIGARETTES?

Yes. E-cigarettes are not FDA approved and can often contain varying levels of nicotine and other unknown carcinogens from what is labeled on the packaging.

8. WHAT HAPPENS IF I MISREPRESENT MY TOBACCO USE DURING BENEFITS ENROLLMENT?

Any misrepresentations made about being tobacco-free, when in fact you or your covered dependent(s) are not, could result in penalties, such as requiring you to reimburse the difference of the missed $75 tobacco user surcharge that was not assessed, and other potential disciplinary action up to and including termination.

9. CAN I STILL AVOID THE TOBACCO USER SURCHARGE IF I AND/OR MY COVERED ADULT DEPENDENT(S) ARE TOBACCO USERS?

Yes. If not tobacco-free, you and/or your covered adult dependent(s) have the option to enroll in and complete the Quit For Life® Tobacco Cessation Program. The $75 tobacco user surcharge will no longer be assessed as of June 1, 2025, if all tobacco users complete the Quit For Life® Tobacco Cessation Program by April 30, 2025.

10. WHAT ARE THE TOBACCO-USER REQUIREMENTS TO NO LONGER BE ASSESSED THE TOBACCO USER SURCHARGE?

If you and/or your covered adult dependent(s) use tobacco products of any kind and you no longer want to pay the tobacco user surcharge, you must accomplish all of the following:

Attest during Benefits Enrollment. As part of the enrollment process you must attest that you and/ or your covered adult dependent(s) are tobacco users but will enroll in the Quit For Life Tobacco Cessation Program.

Enroll in the Quit For Life® Tobacco Cessation Program by December 31, 2024. Enroll by calling **866-784-8454** or going online to **www.quitnow.net/gpc**.

Complete the program by April 30, 2025. To satisfy completion of the program, all covered tobacco users must complete four live outreach Quit Coach calls by April 30, 2025.

If all tobacco users successfully complete the program, the tobacco user surcharge will no longer be assessed as of June 1, 2025, and you will be refunded the difference of the previous tobacco user surcharges that you paid from January to May 2025.

11. CAN THE TOBACCO USER SURCHARGE NOT APPLY TO ME IF I AND/OR MY COVERED ADULT DEPENDENT(S) QUIT TOBACCO ON OUR OWN DURING 2025?

No. To not be assessed the Tobacco User Surcharge in 2025, you must attest during Benefits Enrollment that you and your covered dependent(s) who are age 18 years or older as of January 1, 2025, are tobacco-free. The next opportunity to attest and not receive tobacco user surcharge will be during Benefits Annual Enrollment for the 2026 Plan Year.

12. WHAT IS THE QUIT FOR LIFE® TOBACCO CESSATION PROGRAM?

This program is offered at **no cost** to all employees and their adult dependents and is designed to help individuals quit tobacco. It offers confidential, one-on-one coaching from a trained Quit Coach, in addition to many other helpful resources.

13. HOW DO I ENROLL IN THE QUIT FOR LIFE® TOBACCO CESSATION PROGRAM?

You can enroll in the program by calling **866-784-8454** or by going online to **www.quitnow.net/gpc**.

14. ARE THERE ANY COSTS TO PARTICIPATE IN THE QUIT FOR LIFE® TOBACCO CESSATION PROGRAM?

GPC fully covers the cost of the program for all GPC employees and their covered dependent(s) once per calendar year.

15. ARE ANY TOBACCO CESSATION MEDICATIONS COVERED BY THE QUIT FOR LIFE® TOBACCO CESSATION PROGRAM?

Yes. Nicotine gum and nicotine patches are provided at no cost to participants.

16. IF I DECIDE TO USE A TOBACCO CESSATION MEDICATION RECOMMENDED BY THE QUIT FOR LIFE TOBACCO® CESSATION PROGRAM, WILL I NEED PRIOR AUTHORIZATION TO HAVE THEM COVERED UNDER THE GPC PRESCRIPTION DRUG PROGRAM?

Depending on which tobacco cessation medication you choose, there may be a requirement for prior authorization for it to be covered under the GPC prescription drug program. You can discuss how to obtain a prior authorization with your Quit For Life® Quit Coach.

Working Spouse Exclusion

1. WHAT IS THE "WORKING SPOUSE EXCLUSION"?

Spouses who have access to medical coverage through their employers are not eligible for GPC Medical Plan coverage.

2. HOW IS THE WORKING SPOUSE EXCLUSION ENFORCED?

During Benefits Enrollment, you will need to attest that your spouse does or does not have medical coverage available from his/her employer. This acknowledgment is part of the online benefits enrollment process.

3. WHAT IS THE ATTESTATION PROCESS?

Employees will be asked during the online benefits enrollment process to confirm whether or not their spouse has employer- provided coverage available. It is the employee's responsibility to provide accurate and up-to-date information.

4. MY SPOUSE IS UNEMPLOYED. WILL MY SPOUSE BE EXCLUDED FROM THE MEDICAL PLAN?

No. Your spouse will not be excluded from the Medical Plan if your spouse is unemployed.

5. MY SPOUSE AND I BOTH WORK FOR GPC, AND I HAVE MY SPOUSE AS A DEPENDENT ON MY MEDICAL COVERAGE. WILL MY SPOUSE BE EXCLUDED FROM THE MEDICAL PLAN?

No. If you're married to a GPC employee, you can both be covered under the GPC Medical Plan.

6. WHAT IF MY SPOUSE IS COVERED BY HIS/HER EMPLOYER AND LOSES HIS/HER JOB DURING THE YEAR?

If your spouse loses medical coverage because his/her employment ends, that is considered a qualified status change, and your spouse can be enrolled in the GPC Medical Plan.

Contact **GPC Benefit Plan Services** within 31 days of the termination to enroll your spouse in health care coverage through GPC.

7. WHAT IF MY SPOUSE'S EMPLOYER DOESN'T PROVIDE MEDICAL COVERAGE?

You may enroll your spouse in the GPC Medical Plan if he/she does not have access to medical coverage through his/her employer.

8. MY SPOUSE IS SELF-EMPLOYED AND DOES NOT HAVE ACCESS TO GROUP MEDICAL COVERAGE. WOULD MY SPOUSE BE EXCLUDED FROM THE MEDICAL PLAN?

No. If your spouse is self-employed and has no group medical coverage available, your spouse will not be excluded, and you may enroll them in the GPC Medical Plan.

9. IF MY SPOUSE IS ELIGIBLE FOR MEDICARE/MEDICAID, CAN I ENROLL THEM IN THE GPC MEDICAL PLAN?

Yes. Your spouse is eligible to be enrolled in the GPC Medical Plan if they are eligible for Medicare/Medicaid.

10. DOES THE WORKING SPOUSE EXCLUSION APPLY IF MY SPOUSE IS RETIRED AND HAS MEDICAL COVERAGE BASED ON HIS/HER RETIREMENT?

Yes. The working spouse exclusion would apply if your spouse has medical coverage based on his/her retirement.

11. DOES THE WORKING SPOUSE EXCLUSION APPLY IF MY SPOUSE IS COVERED UNDER COBRA CONTINUATION COVERAGE?

Yes. The working spouse exclusion would apply if your spouse is covered under COBRA continuation.

12. DOES THE WORKING SPOUSE EXCLUSION APPLY TO DENTAL OR VISION COVERAGE?

No. The working spouse exclusion does not apply to dental or vision coverage.

13. WHAT HAPPENS IF I MISREPRESENT MY SPOUSE'S ELIGIBILITY FOR OTHER COVERAGE DURING BENEFITS ENROLLMENT?

Any misrepresentations made about your spouse's availability to choose other qualifying group medical coverage could result in penalties, such as retroactive termination of coverage and other potential disciplinary action up to and including termination.

14. IF MY SPOUSE IS GOING TO SCHOOL PART-TIME AND IS COVERED UNDER A HEALTH PLAN THROUGH THE SCHOOL, WILL THE WORKING SPOUSE EXCLUSION APPLY?

No. The working spouse surcharge applies only to spouses who are actively employed and are eligible for coverage from their employer. If your spouse is employed by the school and is eligible for coverage from that employer, then the working spouse exclusion would apply if you add your spouse to the GPC Medical Plan. If your spouse is receiving coverage as a student only, then you can cover him/ her under the GPC Medical Plan.

15. IF MY SPOUSE IS ENROLLED IN MEDICAL COVERAGE THROUGH HIS/HER EMPLOYER, CAN I ENROLL HIM/HER IN THE GPC MEDICAL PLAN AS SECONDARY COVERAGE?

No. You can not enroll your spouse in the GPC Medical Plan for secondary coverage.

Health Savings Account (HSA)

1. WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is a bank account you own that is used to save and pay for qualified health care expenses.

2. WHO CAN OPEN AN HSA?

Employees who enroll in the Value Plan and Savings Plan may choose to open an HSA.

3. HOW DO I OPEN MY HSA?

You can open your HSA through GPC during the online enrollment process. You are required to answer a few eligibility questions to open an account.

4. WHO IS THE TRUSTEE OF MY HSA?

Your HSA trustee is Optum Bank, Member FDIC. Information on your HSA balance, including monthly statements, is available at **www.optumbank.com**.

5. WILL GPC CONTRIBUTE TO MY HSA FOR THE 2025 PLAN YEAR?

Yes. For 2025, GPC contribute $500 for employee-only coverage and $1,000 for employee + dependent(s) coverage.

6. WHEN IS GPC'S CONTRIBUTION MADE TO MY HSA?

GPC will make a full contribution in January 2025.

7. HOW MUCH MAY I CONTRIBUTE TO MY HSA EACH YEAR?

The IRS limits annual contributions to your HSA. For 2025, total contributions are limited to $4,300 for employee-only and $8,550 for employee + dependent(s). This limit includes GPC's contributions as well as your contributions. If you are age 55 or older and are not enrolled in Medicare, you may contribute up to an additional $1,000 in catch-up contributions in 2025.

8. WHAT ARE "CATCH-UP" CONTRIBUTIONS?

Catch-up contributions are additional amounts you may contribute to your HSA each year if you are age 55 or older and are not enrolled in Medicare. For 2025, the catch-up contribution amount is $1,000. If you are enrolled in a high-deductible health plan such as the Value Plan or the Savings Plan for the entire year, you may deposit the entire catch-up amount in the year you reach age 55, and in every year following, until you are enrolled in Medicare.

9. CAN I CONTRIBUTE THE EMPLOYEE+DEPENDENT(S) MAXIMUM IF MY DEPENDENT(S) ARE COVERED UNDER ANOTHER MEDICAL PLAN?

No. If you have employee-only coverage under the GPC Value Plan or Savings Plan, you may only contribute the maximum dollar amount for an individual. This includes the contribution amount made by GPC.

10. AM I REQUIRED TO CONTRIBUTE TO MY HSA?

No. You are not required to contribute to your HSA.

11. HOW DO I CONTRIBUTE TO MY HSA?

There are three ways to contribute to your HSA:

- **Employer contributions**: In 2025, GPC will contribute to the HSA $500 for employee-only coverage or $1,000 for any employee + dependent(s) coverage. GPC's full contribution will be available at the beginning of January 2025.
- **Pre-tax contributions:** As part of Benefits Enrollment, you can choose to contribute to your HSA via pre- tax payroll contributions, you will select an annual amount that will be automatically divided and deducted from each paycheck during the year.
- **After-tax contributions:** You can arrange to make a deposit to your HSA from another bank account. These contributions are made on an after-tax basis, but still decrease your gross taxable income and thus lower your tax liability. You will need to note any after-tax contributions to your HSA when you file your tax return.

12. WHEN ARE MY HSA PAYROLL CONTRIBUTIONS DEPOSITED IN MY HSA?

HSA payroll deductions are deposited into your HSA within 24 to 48 hours after your pay date.

13. WHAT HAPPENS IF I EXCEED THE ANNUAL CONTRIBUTION LIMIT?

Excess contributions are taxable, plus a 6% excise tax penalty. If you request a refund of any amounts paid in excess of the annual contribution limit, there is no penalty as long as the distribution is made before your tax filing deadline (generally, April 15 of the following year). Earnings on the excess amount are taxable, but the 6% excise tax will not apply as long as the excess contributions and any associated earnings (if applicable) are paid out before the tax filing deadline. To request a refund, complete and mail or fax a withdrawal/distribution form, available at **www.optumbank.com**.

14. DO CONTRIBUTIONS TO AN HSA AFFECT MY ABILITY TO CONTRIBUTE TO THE GPC 401(K) SAVINGS PLAN OR AN INDIVIDUAL RETIREMENT ACCOUNT (IRA)?

No. Your HSA contributions do not affect your 401(k) or IRA contribution limits.

15. CAN YOU HAVE MORE THAN ONE HSA ACCOUNT?

Yes. However, the total contributions to all your HSAs cannot exceed the annual maximum contribution limit.

16. HOW DO I DESIGNATE A BENEFICIARY FOR MY HSA?

Complete and submit the beneficiary designation form available at **www.optumbank.com**.

17. WHEN CAN I USE HSA FUNDS?

HSA funds are available for withdrawal as soon as they are deposited. The money is always 100% vested. You have total control over your account; however, withdrawals may not exceed your account balance.

18. DO MY HSA FUNDS ROLL OVER FROM YEAR TO YEAR?

HSA plans are not subject to IRS "use it or lose it" regulations. Funds in the account continue to accumulate over time. Any balance in your HSA as of December 31st of a Plan Year will roll over to the next calendar year and can continue to be used for qualified health care expenses.

19. IS THE TOTAL ANNUAL AMOUNT OF MY HSA CONTRIBUTION AVAILABLE FOR IMMEDIATE USE?

No. An HSA account operates like a regular bank account. You can only access funds that have been deposited in your account.

20. WHAT IF MY HEALTH CARE EXPENSES ARE MORE THAN THE AMOUNT THAT IS IN MY HSA?

If your health care expenses exceed your HSA account balance, you will need to pay the difference between the balance of your HSA and the health care expense out-of-pocket.

21. WHAT EXPENSES CAN BE PAID FROM MY HSA?

Your HSA can be used to pay for most "qualified health care expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services, prescription drugs, LASIK eye surgery and some nursing services. You can request a copy of IRS Publication 502 by calling **800-829-3676** or by visiting the IRS website at www.irs.gov and clicking on "Find forms and Instructions."

22. CAN I USE MY HSA TO PAY FOR BILLS I RECEIVED FOR HEALTH CARE SERVICES THAT WERE RENDERED PRIOR TO MY ACCOUNT BEING OPENED?

No. Expenses incurred before you established your HSA cannot be reimbursed by your HSA.

23. CAN I USE MY HSA TO PAY FOR NON-HEALTH CARE EXPENSES?

Money in your HSA belongs to you; however, if you use your HSA to pay for non-qualified health care or other expenses, the amount is considered taxable income. You will need to pay income tax, and a 20% tax penalty will also apply to money withdrawn or used to pay a non-qualified expense.

24. CAN I USE MY HSA TO PAY FOR QUALIFIED HEALTH CARE SERVICES PROVIDED IN OTHER COUNTRIES?

Yes. You can use your HSA to pay for qualified health care services incurred in other countries.

25. HOW DO I PAY FOR QUALIFIED HEALTH CARE EXPENSES?

You will receive an Optum Bank HSA Debit MasterCard® to access HSA funds for direct payment at a provider's office pharmacy or any health care facility that accepts MasterCard. In most cases, the card can be used to pay a bill received from a provider's office or health care facility.

The HSA debit card can also be used at any ATM displaying the MasterCard brand name. If you go to a provider and pay for your services out-of-pocket, you could withdraw money at the ATM to reimburse yourself. An ATM owner may charge an access fee in addition to Optum Bank's $2.50 ATM withdrawal fee, and you must retain the receipts for the qualified health care expense.

You can also use free online bill pay from your account. Online bill pay allows you to make a one-time payment for health care bills or set up automatic payments for recurring health care bills with set amounts. Another option is to request HSA checks to use when paying your health care bills. There is no fee for checks.

26. CAN I REIMBURSE MYSELF FROM THE HSA FOR OUT-OF-POCKET HEALTH CARE EXPENSES?

Yes. You may reimburse yourself for qualified health care expenses by issuing a check to yourself using online bill pay, by requesting a disbursement from your HSA to another bank account or by making an ATM withdrawal. You must, however, retain all receipts for the qualified health care expenses.

27. IS THERE AN HSA DISBURSEMENT LIMIT?

Yes. Optum Bank limits your ATM withdrawals to $300 within a 24-hour period. There is also a $10,000 limit on disbursements at a point of service, such as a health care facility, in a 24-hour period.

28. DO I NEED TO SAVE MY PURCHASE RECEIPTS OR DOCUMENTATION OF WITHDRAWALS FROM MY HSA?

Yes, you should save all receipts and records for seven years. You—not GPC, your health care provider or Optum Bank—are responsible for maintaining records related to your HSA.

29. ARE THERE FEES AND/OR PENALTIES IF I OVERDRAW ON MY HSA?

Yes. There is a $25 non-sufficient-funds fee if you overdraw your HSA.

30. WHAT HAPPENS IF I WITHDRAW MONEY FROM MY HSA FOR AN EXPENSE THAT I THOUGHT WAS A QUALIFIED HEALTH CARE EXPENSE, BUT LATER I FIND OUT THE EXPENSE IS NOT A QUALIFIED HEALTH CARE EXPENSE?

You can return the money to your HSA if there is evidence that your withdrawal was a mistake of fact. You must repay the amount before April 15th of the following year when you discover the withdrawal was a mistake.

31. IF I ELECT TO OPEN AN HSA IN 2025, WHEN WILL I RECEIVE MY HSA DEBIT CARD?

You will receive your HSA debit card in January 2025, and you may begin using it immediately. Activation instructions will be provided with your card.

32. CAN I INVEST THE BALANCE IN MY HSA?

Yes. Once your account reaches $2,000, known as the investment threshold, you may choose to set up a separate investment account to invest a portion of the balance over $2,000 in mutual funds.

33. ARE THERE ANY FEES FOR HAVING AN HSA?

Yes. Your HSA is subject to a monthly maintenance fee of $1 if your account balance is below $500. If you choose to invest your account, the monthly maintenance fee increases to $3.

34. HOW ARE CONTRIBUTIONS TO THE HSA TAXED?

Contributions to an HSA are tax-free. This reduces your taxable income, and in some cases, tax liability. Withdrawals from your HSA used to pay qualified health care expenses are also tax-free.

35. AM I REQUIRED TO PAY STATE INCOME TAXES ON THE CONTRIBUTIONS THAT I MAKE TO THE HSA?

Not in most states. HSA contributions are taxed by the following states: Alabama, California and New Jersey.

36. DO I NEED TO ITEMIZE MY TAX RETURN IF I PARTICIPATE IN THE HSA? DOES THE IRS REQUIRE ME TO REPORT CONTRIBUTIONS AND WITHDRAWALS ON MY TAXES?

You do not have to itemize your tax return to receive the tax deduction. However, you need to complete IRS Form 8889 with your income tax return. This form shows what your total withdrawals and deposits were from your account during the year for reporting purposes to the IRS. Optum Bank provides Form 1099-SA, which details distributions, and Form 5498-SA, which reports contributions to your HSA account.

37. IS IT POSSIBLE TO CONTRIBUTE TO BOTH THE HSA AND THE GENERAL PURPOSE HEALTH CARE FSA?

No. IRS regulations limit what can be covered under a Health Care FSA when it is offered in the same year with an HSA; however, you may participate in the Limited Purpose Health Care FSA in the same year you have an HSA. The Limited Purpose Health Care FSA is used to pay for eligible dental and vision expenses only.

38. CAN I PAY FOR MY DEPENDENTS' QUALIFIED HEALTH CARE EXPENSES WITH THE HSA IF THEY ARE COVERED UNDER ANOTHER MEDICAL PLAN?

Yes. You may use your HSA to cover qualified health care expenses for you, your spouse and other eligible dependents regardless of their coverage.

39. HOW CAN I CHECK THE BALANCE ON MY HSA?

You can check your balance online at: **www.optumbank.com**.

40. IS MY HSA BALANCE PROTECTED?

Your HSA is insured by the FDIC (Federal Deposit Insurance Corporation) up to $100,000. Note that if you invest in other arrangements such as stocks, bonds and mutual funds, those investments are subject to financial risks typical of those investments.

41. IF I ENROLL IN THE VALUE PLAN OR SAVINGS PLAN AND CHANGE TO A DIFFERENT GPC MEDICAL PLAN OPTION IN A SUBSEQUENT YEAR, WHAT HAPPENS TO MY HSA CONTRIBUTIONS?

Your existing HSA is not affected by the plan that you enroll in; however, you cannot make additional HSA contributions if you are not enrolled in the Value Plan or Savings Plan. Once funds are deposited in the HSA, they belong to you, and you may continue to use HSA dollars to pay for qualified health care expenses.

42. WHAT HAPPENS TO MY HSA IF I STOP PARTICIPATING IN THE VALUE PLAN OR SAVINGS PLAN MID-YEAR?

If you end your coverage under the Value Plan or Savings Plan, you may contribute only a pro-rated amount of the annual maximum to the HSA, based on the number of months you were enrolled in the Value Plan or Savings Plan.

If your contributions exceed that amount, you must apply to have excess contributions returned to you by submitting a withdrawal/distribution form (available at **www.optumbank.com**).

43. WHAT HAPPENS TO MY HSA IF I LEAVE GPC?

All funds contributed to your HSA, including any GPC contributions, belong to you. If you leave GPC, the money can stay in your HSA or transfer to another HSA with a new employer.

44. WHAT HAPPENS TO MY HSA IF I DIE?

Your HSA transfers to your surviving spouse or named beneficiary, tax-free, at your death.

If you are unmarried and do not have a named beneficiary, the money is disbursed to your estate and is subject to any applicable taxes. For more information about designating a beneficiary or to make a designation, visit **www.optumbank.com**.

45. WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT MY HSA?

You can find account information, general information and tools at **www.optumbank.com**. For specific questions about your HSA, you can call Optum Bank at **866-234-8913**.

Transcarent Surgery Care Program

1. WHAT IS TRANSCARENT SURGERY CARE?

The Transcarent Surgery Care Program connects you to high-quality, non-emergency surgical care and personalized care coordination. The Program will also help you manage your healthcare cost by minimizing your out-of-pocket expenses.

2. HOW DOES TRANSCARENT DIFFER FROM TRADITIONAL SURGICAL CARE?

By using Transcarent to connect to top-rated surgery centers, hospitals and doctors, you will receive high-quality care which lowers your risks for complications, infection and readmission. This means you will receive an improved quality of care leading to a faster recovery for you.

3. WHAT IS THE BENEFIT OF UTILIZING THE TRANSCARENT SURGERY CARE PROGRAM?

If you are enrolled in the Traditional Plan, surgery costs are covered at 100%. There is no deductible or coinsurance when you choose to the Program for your surgical care.

If you are enrolled in the Value Plan or Savings Plan, your surgery is covered at 100% after you meet your annual deductible. There is no coinsurance when you choose to connect to a provider through Transcarent for your surgical care.

Covered costs include a preoperative surgical care appointment, surgery (all facility, anesthesia, surgical staff, and surgeon charges), in-patient services, if a hospital stay is required, and a postoperative surgical appointment.

Medical expenses that occur before the preoperative surgical appointment and after your postoperative appointment are covered by the GPC Medical Plan and are subject to Plan guidelines, deductible and coinsurance.

4. WHAT ARE COMMON SURGICAL PROCEDURES COVERED BY THE TRANSCARENT SURGERY CARE PROGRAM?

Covered surgeries through the Transcarent Surgery Care Program include but are not limited to:

- Bariatric: gastric sleeve and gastric bypass
- Cardiac: coronary artery bypass, aortic valve repair and replacements
- General: gallbladder removal, spleen removal, hernia repair
- Orthopedic: ACL repair, Hip and knee replacement, shoulder repair and replacement
- Spine: spinal fusion, artificial disc replacement
- Women's Health: hysterectomy, cyst removal

To confirm if a specific surgical procedure is covered the Program, contact Transcarent at **888-895-3374.**

5. AM I REQUIRED TO USE THE TRANSCARENT SURGERY CARE PROGRAM?

The Transcarent Surgery Care Program is voluntary except for certain bariatric surgical procedures. If you or your covered dependents in the GPC Medical Plan pursue a bariatric surgical procedure, you will first be required to contact Transcarent. Otherwise, the procedure may not be covered under the GPC Medical Plan.

6. ARE THERE ANY SURGICAL PROCEDURES THAT ARE NOT COVERED THROUGH THE TRANSCARENT SURGERY CARE PROGRAM?

Yes. Surgical procedures not available through Transcarent include emergency, pediatric (under age 13), cancer, cosmetic, dental, diagnostic, vision, and transplant procedures.

7. DOES THE TRANSCARENT SURGERY CARE PROGRAM COVER TRAVEL EXPENSES?

Yes. If a local facility and provider is not an option and travel over 100 miles (one way) from your primary residence is required, Transcarent pays travel expenses for you and a companion, including airfare, lodging, and provides a meals and incidental allowance.

To receive the Transcarent travel benefit, airfare and lodging must be arranged by your Transcarent Care Coordinator. Any travel companion must be at least 18 years of age.

8. DO I NEED A REFERRAL TO USE TRANSCARENT SURGICAL CARE?

Yes, you do need a non-emergency surgical recommendation in order to proceed with Surgery Care through Transcarent.

9. WHAT KIND OF PRE-SURGERY SUPPORT DOES THE TRANSCARENT SURGERY CARE PROGRAM OFFER?

Your dedicated Care Coordinator will manage all the administrative work from gathering your health records and needed paperwork to scheduling your appointments and arranging all the details for your surgery. If travel is required, they will also coordinate transportation and lodging for you and a companion.

10. IS MY CARE COORDINATOR A REGISTERED NURSE?

No. While Transcarent Care Coordinators are not registered nurses, they do bring experience from careers such as health insurance customer support or surgery scheduling. Care coordinators do work closely with registered nurses that are part of the Transcarent team to support you and the Care Coordinator as needed.

11. WHAT HAPPENS IF COMPLICATIONS ARISE AFTER SURGERY?

No procedure is 100% risk free, but the chances of having a complication are very low. Because quality standards, surgeries performed with Transcarent are 80% less likely to result in a post-surgical complication compared to other surgeons performing these same surgeries in the US. If you suspect a complication, reach out to your provider immediately as quick assessment and treatment of any post-op complication is critical. While local treatment of a complication would be routed through traditional insurance, a second operation to address the complication could be covered under the Transcarent Surgery Care Program.

12. HOW DO I PAY FOR MY SURGERY?

If you are enrolled in the Savings or Value Plan your surgery cost is covered at 100% after you meet your annual deductible. There is no coinsurance when you choose to connect to a provider through Transcarent for your surgical care. Transcarent will work with you to collect any annual deductible payment that may be due before your surgical procedure.

13. HOW DOES TRANSCARENT VERIFY IF I HAVE MET MY MEDICAL PLAN DEDUCTIBLE?

Transcarent will work with your Medical Plan carrier to obtain your current progress towards your annual deductible. If an annual deductible payment is required, you will be advised of the required payment and a member of the Transcarent billing team will contact you to collect the needed payment. Transcarent will then notify your Medical Plan carrier of your payment so that it is applied to your annual deductible.

14. DOES TRANSCARENT OFFER FINANCING OPTIONS IF I HAVE NOT MET MY DEDUCTIBLE?

No. Transcarent currently does not offer financing options for cost share payments. Cost share payments are due to Transcarent prior to surgery, which unfortunately does not provide sufficient time for a payment plan or financing.

15. HOW SECURE IS MY PERSONAL INFORMATION WITH TRANSCARENT?

Personal information with Transcarent is highly secure. Access to your information is restricted to authorized personnel only, and all access is continuously monitored and alerted for any abnormal activity.

16. WILL MY SURGICAL INFORMATION BE AVAILABLE ON THE TRANSCARENT APP?

Yes, you can track your surgical journey all within the Transcarent app. Track your surgery status through an easy-to-use, dynamic page that updates in real-time so you always know what's next. You can also upload and complete forms, view provider information, and more.

17. CAN I USE MY EXISTING SURGEON WITH TRANSCARENT?

Yes. You may be able to if your existing surgeon coordinates with the Transcarent Surgery Care Program.

18. WHAT IS THE TYPICAL TIMELINE FROM CONSULTATION TO SURGERY?

Since Transcarent collects records and coordinates everything between you and the provider, this process takes an average of 6-10 weeks from initial intake to surgery. Bariatric cases can take about 3-6 months from initial intake to surgery date depending on what steps of the protocol are already completed.

19. HOW DO I CONTACT TRANSCARENT FOR ADDITIONAL SUPPORT OR QUESTIONS?

You can call Transcarent at 888-895-3374 or download the Transcarent app.

Health Management Programs

1. WHAT IS THE LIVONGO HYPERTENSION PROGRAM?

The Livongo Hypertension Program is a voluntary hypertension (high blood pressure) management program for GPC Medical Plan members who are impacted by this condition. Livongo uses a combination of state-of-the-art technology and one-on-one coaching to help individuals better manage high blood pressure.

2. IS THERE A COST TO PARTICIPATE IN THE LIVONGO HYPERTENSION PROGRAM?

No. GPC pays for the full cost of the Livongo Hypertension Program.

3. WHAT IS LIVONGO DIABETES MANAGEMENT?

Livongo Diabetes Management is a voluntary diabetes management program for GPC Medical Plan members who are impacted by this condition. Livongo Diabetes Management uses a combination of state-of-the-art technology and certified diabetes educators to help individuals manage diabetes.

4. IS THERE A COST TO PARTICIPATE IN THE LIVONGO DIABETES MANAGEMENT PROGRAM?

No. GPC pays for the full cost of the Livongo Diabetes Management Program.

5. WHAT IS THE OMADA DIABETES PREVENTION PROGRAM?

Omada is a voluntary program for GPC Medical Plan members who are at risk for developing diabetes. Omada uses a combination of state-of-the-art technology, personalized care plans, one-on-one coaching and nutrition guidance to support individuals along their health improvement journey.

6. IS THERE A COST TO PARTICIPATE IN THE OMADA DIABETES PREVENTION PROGRAM?

No. GPC pays for the full cost of the Omada Diabetes Prevention Program.

7. WHAT IS THE HINGE HEALTH EXERCISE THERAPY PROGRAM?

The Hinge Health Exercise Therapy Program is a free and voluntary, physical program for GPC Medical Plan members who are impacted by musculoskeletal conditions. Hinge Health provides virtual support ranging from information about treatment options to coaching and convenient exercise therapy to help reduce pain and improve mobility.

8. IS THERE A COST TO PARTICIPATE IN THE HINGE HEALTH EXERCISE THERAPY PROGRAM?

No. GPC pays for the full cost of the Hinge Health Exercise Therapy Program.

Dental Plan

1. WHO ADMINSTERS THE DENTAL PLAN?

Delta Dental administers the GPC Dental Plan.

2. WHEN WILL I RECEIVE A DENTAL PLAN ID CARD?

You will receive your Dental Plan ID card starting in January 2025.

3. WHAT DOES THE DENTAL PLAN COVER?

The Dental Plan covers a range of services, including preventive care, minor restorative care, major restorative care, and orthodontia. More detailed information about the Plan is available on GPC Benefit Plan Services

4. DO I HAVE TO ENROLL IN THE GPC MEDICAL PLAN TO ENROLL IN THE DENTAL PLAN?

No. You may enroll in the Dental Plan if you are a benefits eligible employee, regardless of your participation in the GPC Benefit Plan Services

Vision Plan

1. WHO ADMINISTERS THE VISION PLAN?

EyeMed Vision Care administers the GPC Vision Plan,

2. WHAT DOES THE VISION PLAN COVER?

The Vision Plan covers a range of services, including eye exams, eyeglasses and contact lenses. This Plan also offers discounts for other vision services. More detailed information is available on GPC Benefit Plan Services.

3. DO I HAVE TO ENROLL IN THE GPC MEDICAL PLAN TO ENROLL IN THE VISION PLAN?

No. You may enroll in the Vision Plan if you are a benefits eligible employee, regardless of your participation in a GPC Medical Plan.

General Purpose Health Care Flexible Spending Account (FSA)

1. WHAT IS A GENERAL PURPOSE HEALTH CARE FSA?

The General Purpose Health Care FSA allows you the opportunity to pay for qualified health care expenses, such as medical, dental, vision and prescription drugs with pre-tax dollars. You can elect the General Purpose Health Care FSA only if you are a full-time, benefits-eligible employee and you either enroll in the Traditional Plan or waive GPC Medical Plan coverage.

Full-time employees NOT enrolled in the Savings Plan or Value Plan are eligible. Qualified expenses include medical, prescription drug, dental and vision expenses not paid for by a health plan.

2. WHAT IS THE MAXIMUM CONTRIBUTION AMOUNT FOR THE GENERAL PURPOSE HEALTH CARE FSA IN 2025?

The maximum contribution amount for the General Purpose Health Care FSA is $3,200.*

* *Assumption based on 2024 limits. The IRS may increase these limits for 2025, but typically does not announce new limits until late October.*

3. WHO ADMINISTERS THE GENERAL PURPOSE HEALTH CARE FSA?

Via Benefits is the administrator of the General Purpose Health Care FSA.

4. CAN I PAY FOR MY DEPENDENTS' ELIGIBLE HEALTH CARE EXPENSES?

Yes. If you participate in the General Purpose Health Care FSA, you may use the funds to cover eligible health care expenses for you and your eligible dependent(s), regardless of their coverage.

5. HOW DO I PAY FOR QUALIFIED EXPENSES WITH THE GENERAL PURPOSE HEALTH CARE FSA?

After enrolling, you will receive a Spending Account Card in the mail. You may use the Spending Account Card when you receive care. Or, you may pay out-of-pocket at the time you receive care, and then file a claim for reimbursement.

Claim forms for 2025 expenses are available at **viabenefitsaccounts.com**. Or, you can call the Via Benefits Service Center at **800-953-5395** or download the **Via Benefits Accounts mobile app**.

6. DO I NEED TO SAVE MY RECEIPTS FROM PURCHASES MADE WITH THE GENERAL PURPOSE HEALTH CARE FSA?

Yes. You should save all receipts from purchases made with the General Purpose Health Care FSA. You will need to submit copies of receipts if you pay out-of-pocket and file a claim for reimbursement.

7. CAN I CARRY OVER UNUSED GENERAL PURPOSE HEALTH CARE FSA DOLLARS FROM ONE YEAR TO THE NEXT?

Yes, the end of the plan year, you will be able to carry over a **limited amount** of unspent dollars into the following year. The amount you can carry over from 2025 to 2026 will be $640.* You have the entire following year to spend the amount of the Carryover. Carryover amounts do not count toward the next year's contribution limits and do not affect the total you can contribute for the following plan year.

* *Assumption based on 2024 rules. The IRS may increase this amount for 2025, but typically does not announce new carryover limits until late October.*

8. ARE FUNDS SUBJECT TO THE "USE IT OR LOSE IT" RULE?

Yes. Any 2025 funds over the Carryover limit not spent by December 31, 2025, and not claimed by March 31, 2026, will be forfeited.

9. HOW DO I MAKE CONTRIBUTIONS TO THE GENERAL PURPOSE HEALTH CARE FSA?

You choose an amount to contribute each pay period during Benefits Enrollment. Your elected annual amount will be deducted from your pay before taxes each pay period.

10. DOES GPC MAKE CONTRIBUTIONS TO THE GENERAL PURPOSE HEALTH CARE FSA?

No. Only employees contribute to the General Purpose Health Care FSA.

Limited Purpose Health Care Flexible Spending Account (FSA)

1. WHAT IS A LIMITED PURPOSE HEALTH CARE FSA?

The Limited Purpose Health Care FSA allows you the opportunity to pay for eligible dental and vision expenses with pre-tax dollars. You may elect the Limited Purpose Health Care FSA only if you are a full-time, benefits- eligible employee and you enroll in the Value Plan or the Savings Plan.

2. WHY WOULD I WANT TO ENROLL IN THE LIMITED PURPOSE HEALTH CARE FSA IF I CAN USE MY HSA FOR MOST MEDICAL, DENTAL AND VISION EXPENSES?

In general, most people will not see a need to enroll in the Limited Purpose Health Care FSA; however, here are a few reasons you may want to consider enrolling in it:

- Additional tax savings
- Anticipation of a large dental or vision expense during the year
- Preference to use the HSA as a retirement savings

3. WHAT EXPENSES CAN BE PAID WITH THE LIMITED PURPOSE HEALTH CARE FSA?

The Limited Purpose Health Care FSA can be used for eligible dental and vision expenses, which include:

- Dental care and orthodontia—fillings, X-rays, braces, caps, mouth guards, etc.
- Vision care—eyeglasses, contact lenses, solutions and supplies, LASIK eye surgery, etc.

4. WHAT IS THE MAXIMUM CONTRIBUTION AMOUNT FOR THE LIMITED PURPOSE HEALTH CARE FSA IN 2025?

The maximum contribution amount for the Limited Purpose Health Care FSA is $3,200* in 2025.

* *Assumption based on 2024 limits. The IRS may increase these limits for 2025, but typically does not announce new limits until late October.*

5. WHO ADMINISTERS THE LIMITED PURPOSE HEALTH CARE FSA?

Via Benefits is the administrator of the Limited Purpose Health Care FSA.

6. CAN I PAY FOR MY DEPENDENTS' ELIGIBLE DENTAL AND VISION EXPENSES?

Yes. If you participate in the Limited Purpose Health Care FSA, you may use the funds to cover eligible dental and vision expenses for you and your eligible dependent(s), regardless of their coverage.

7. HOW DO I PAY FOR ELIGIBLE EXPENSES WITH THE LIMITED PURPOSE HEALTH CARE FSA?

After enrolling, you will receive a Spending Account Card in the mail. You may use the Spending Account Card when you receive care. Or, you may pay out-of-pocket at the time you receive care, and then file a claim for reimbursement.

Claim forms for 2025 expenses are available at **viabenefitsaccounts.com**. Or, you can call the Via Benefits Service Center at **800-953-5395** or download the **Via Benefits Accounts mobile app**.

8. DO I NEED TO SAVE MY RECEIPTS FROM PURCHASES MADE WITH THE LIMITED PURPOSE HEALTH CARE FSA?

Yes. You should save all receipts from purchases made with the Limited Purpose Health Care FSA. You will need to submit copies of receipts if you pay out-of-pocket and file a claim for reimbursement.

9. CAN I CARRY OVER UNUSED LIMITED PURPOSE HEALTH CARE FSA DOLLARS FROM ONE YEAR TO THE NEXT?

Yes, at the end of the plan year, you will be able to carry over a **limited amount** of unspent dollars into the following year. The amount you can carry over from 2025 to 2026 will be $640.* You have the entire following year to spend the amount of the Carryover. Carryover amounts do not count toward the next year's contribution limits and do not affect the total you can contribute for the following plan year.

* *Assumption based on 2024 rules. The IRS may increase this amount for 2025, but typically does not announce new carryover limits until late October.*

10. ARE LIMITED PURPOSE HEALTH CARE FSA FUNDS SUBJECT TO THE "USE IT OR LOSE IT" IRS RULE?

Yes. Any 2025 funds over the Carryover limit not spent by December 31, 2025, and not claimed by March 31, 2026, will be forfeited.

11. HOW DO I MAKE CONTRIBUTIONS TO THE LIMITED PURPOSE HEALTH CARE FSA?

You choose an amount to contribute each pay period during Benefits Enrollment. Your elected annual amount will be deducted from your pay before taxes each pay period.

12. DOES GPC MAKE CONTRIBUTIONS TO THE LIMITED PURPOSE HEALTH CARE FSA?

No. Only employees contribute to the Limited Purpose Health Care FSA.

Dependent Care Flexible Spending Account (FSA)

1. **WHAT IS A DEPENDENT CARE FSA?**
   A Dependent Care FSA allows you the opportunity to pay for eligible qualified dependent care expenses such as child care or elder care with pre-tax dollars. Eligible dependent(s) include children under age 13 or a physically or mentally disabled parent or child.

2. **WHO CAN PARTICIPATE?**
   All full-time, benefits-eligible employees may choose to participate in the Dependent Care FSA, regardless of the medical plan option elected.

3. **WHAT ARE THE MAXIMUM CONTRIBUTION AMOUNTS FOR THE DEPENDENT CARE FSA IN 2025?**
   You may contribute up to $5,000 pre-tax annually to the Dependent Care FSA.

4. **CAN I CONTRIBUTE TO THE GPC DEPENDENT CARE FSA AND TO A SIMILAR FSA THROUGH MY SPOUSE'S EMPLOYER?**
   Yes, but you cannot contribute more than $5,000 in total to both FSAs in a tax year.

5. **WHO ADMINISTERS THE DEPENDENT CARE FSA?**
   Via Benefits is the administrator of the Dependent Care FSA.

6. **HOW DO I PAY FOR ELIGIBLE EXPENSES WITH THE DEPENDENT CARE FSA?**
   With the Dependent Care FSA, you pay for expenses out-of-pocket at the time of service, and then file a claim for reimbursement. Claim forms for 2025 expenses are available at **viabeneitsaccount.com**. Or, you can call the Via Benefits Service Center at **800-953-5395** or download the **Via Benefits Accounts mobile app**.

7. **ARE FUNDS SUBJECT TO THE "USE IT OR LOSE IT" RULE?**
   Yes. Any unused funds left in your account after December 31,2025 and not claimed by March 31, 2026, will be forfeited. No Dependent Care FSA funds can be carried over to the next year. The Carryover feature of the General Purpose Health Care FSA and the Limited Purpose Health Care FSA does not apply to the Dependent Care FSA.

8. **HOW DO I MAKE CONTRIBUTIONS TO THE DEPENDENT CARE FSA?**
   You choose an amount to contribute each pay period during Benefits Enrollment. Your elected annual amount is deducted from your pay before taxes each pay period.

9. **DOES GPC MAKE CONTRIBUTIONS TO THE DEPENDENT CARE FSA?**
   No. Only employees contribute to the Dependent Care FSA.

10. **DO I NEED TO SAVE MY RECEIPTS FROM PURCHASES MADE WITH THE DEPENDENT CARE FSA?**
    Yes. You should save all receipts for expenses paid with the Dependent Care FSA. You will need to submit copies of receipts when you file a claim for reimbursement.

11. **CAN I CARRY OVER UNUSED DEPENDENT CARE FSA DOLLARS FROM ONE YEAR TO THE NEXT?**
    No. The General Purpose Health Care FSA and the Limited Purpose Health Care FSA have a Carryover feature, but this Carryover feature does not apply to the Dependent Care FSA.

Voluntary Benefits

1. WHAT VOLUNTARY BENEFITS REQUIRE AN ENROLLMENT DECISION BY NOVEMBER 15, 2024?

- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Identity Protection Program
- Legal Services Plan

Accident Insurance

1. CAN I ENROLL IN ACCIDENT INSURANCE AT ANY TIME?

No. You must enroll in Accident Insurance during Benefits Enrollment to have coverage effective January 1, 2025.

2. WHO IS THE PROVIDER FOR ACCIDENT INSURANCE?

Voya Financial is the provider of Accident Insurance.

3. WHAT DOES ACCIDENT INSURANCE COVER?

Accident Insurance pays a cash payment directly to you after a covered accident that results in specific injuries and treatments. These commonly include emergency room treatment, sports injuries, X-rays, stitches, follow-up doctor's treatments and physical therapy.

4. DO I NEED TO ENROLL IN THE GPC MEDICAL PLAN IN ORDER TO ENROLL IN ACCIDENT INSURANCE?

No. You do not need to enroll in the GPC Medical Plan in order to enroll in Accident Insurance.

5. CAN I ENROLL IN ACCIDENT INSURANCE AS MY MAIN FORM OF MEDICAL COVERAGE?

Accident Insurance **is not a substitute** for full medical coverage under a comprehensive medical plan like the GPC Value Plan, Savings Plan or Traditional Plan. Instead, Accident Insurance supplements your regular medical coverage by giving you added protection against unexpected and potentially costly events.

6. HOW DO I PAY FOR THE ACCIDENT INSURANCE PREMIUM?

The Accident Insurance premium is paid through payroll deductions.

7. IS THE DEDUCTION FOR THE ACCIDENT INSURANCE PREMIUM A POST-TAX PAYROLL DEDUCTION?

Yes. The deduction for the Accident Insurance premium is a post-tax deduction.

8. HOW CAN I FIND OUT MORE ABOUT ACCIDENT INSURANCE?

To find out more about Accident Insurance, review the Voya Benefits Summaries on the *Benefits Enrollment page* on GPC Connect for a complete description of benefits, exclusions, limitations and conditions of coverage. If you have questions, call Voya Employee Benefits Customer Service at **877-236-7564**.

Critical Illness Insurance

1. **CAN I ENROLL IN CRITICAL ILLNESS INSURANCE AT ANY TIME?**
   No. You must enroll in Critical Illness Insurance during Benefits Enrollment to have coverage effective January 1, 2025.

2. **WHO IS THE PROVIDER FOR CRITICAL ILLNESS INSURANCE?**
   Voya Financial is the provider of Critical Illness Insurance.

3. **WHAT DOES CRITICAL ILLNESS INSURANCE COVER?**
   Critical Illness Insurance pays a lump-sum cash payment directly to you if you are diagnosed with certain serious illnesses or health conditions, such as Alzheimer's, cancer, heart attack and stroke.

4. **IF I ALREADY HAVE BEEN DIAGNOSED WITH A CRITICAL ILLNESS, CAN I RECEIVE A BENEFIT IF I ENROLL IN CRITICAL ILLNESS INSURANCE?**
   You can only receive benefits for covered health events that are diagnosed after the date your coverage becomes effective. If you enroll during this Benefits Enrollment, this would be January 1, 2025.

5. **WHAT IS THE CRITICAL ILLNESS INSURANCE ANNUAL $50 WELLNESS BENEFIT?**
   This benefit pays you $50 each you if you complete an eligible health screening. Your covered spouse can also earn this benefit. Examples of eligible health screenings include: an annual physical, eye exam or dental exam.

6. **DO I NEED TO ENROLL IN THE GPC MEDICAL PLAN IN ORDER TO ENROLL IN CRITICAL ILLNESS INSURANCE?**
   No. You do not need to enroll in the GPC Medical Plan in order to enroll in Critical Illness Insurance.

7. **CAN I ENROLL IN CRITICAL ILLNESS INSURANCE AS MY MAIN FORM OF MEDICAL COVERAGE?**
   Critical Illness Insurance is **not a substitute** for full medical coverage under a comprehensive medical plan like the GPC Value Plan, Savings Plan or Traditional Plan. Instead, Critical Illness supplements your regular medical coverage by giving you added protection against unexpected and potentially costly events.

8. **HOW DO I PAY FOR THE CRITICAL ILLNESS INSURANCE PREMIUM?**
   The Critical Illness Insurance premium is paid through payroll deductions.

9. **IS THE DEDUCTION FOR THE CRITICAL ILLNESS INSURANCE PREMIUM A POST-TAX PAYROLL DEDUCTION?**
   Yes. The deduction for the Critical Illness Insurance premium is a post-tax deduction.

10. **HOW CAN I FIND OUT MORE ABOUT CRITICAL INSURANCE?**
    To find out more about Critical Insurance, review the Voya Benefits Summaries on the *Benefits Enrollment page* on GPC Connect for a complete description of benefits, exclusions, limitations and conditions of coverage. If you have questions, call Voya Employee Benefits Customer Service at **877-236-7564**.

Hospital Indemnity Insurance

1. **CAN I ENROLL IN HOSPITAL INDEMNITY INSURANCE AT ANY TIME?**
   No. You must enroll in Hospital Indemnity Insurance during Benefits Enrollment to have coverage effective January 1, 2025.

2. **WHO IS THE PROVIDER FOR HOSPITAL INDEMNITY INSURANCE?**
   Voya Financial is the provider for Hospital Indemnity Insurance.

3. **WHAT DOES HOSPITAL INDEMNITY INSURANCE COVER?**
   Hospital Indemnity Insurance provides a fixed daily cash benefit directly to you when you are hospitalized or have a covered stay in an intensive care unit or rehabilitation facility, including stays for childbirth.

4. **DO I NEED TO ENROLL IN THE GPC MEDICAL PLAN IN ORDER TO ENROLL IN HOSPITAL INDEMNITY INSURANCE?**
   No. You do not need to enroll in the GPC Medical Plan in order to enroll in Hospital Indemnity Insurance

5. **CAN I ENROLL IN HOSPITAL INDEMNITY INSURANCE AS MY MAIN FORM OF MEDICAL COVERAGE?**
   Hospital Indemnity Insurance is **not a substitute** for full medical coverage under a comprehensive medical plan like the GPC Value Plan, Savings Plan or Traditional Plan. Instead, Hospital Indemnity supplements your regular medical coverage by giving you added protection against unexpected and potentially costly events. This added protection may allow you to choose a GPC Medical Plan with lower payroll deductions.

6. **HOW DO I PAY FOR THE HOSPITAL INDEMNITY INSURANCE PREMIUM?**
   The Hospital Indemnity Insurance premium is paid through payroll deductions.

7. **IS THE DEDUCTION FOR THE HOSPITAL INDEMNITY INSURANCE PREMIUM A POST-TAX PAYROLL DEDUCTION?**
   Yes. The deduction for the Hospital Indemnity Insurance premium is a post-tax deduction.

8. **HOW CAN I FIND OUT MORE ABOUT HOSPITAL INDEMNITY INSURANCE?**
   To find out more about Hospital Indemnity Insurance, review the Voya Benefits Summaries on the *Benefits Enrollment page* on GPC Connect for a complete description of benefits, exclusions, limitations and conditions of coverage. If you have questions, call Voya Employee Benefits Customer Service at **877-236-7564**.

Legal Services Plan

1. **CAN I ENROLL IN THE LEGAL SERVICES PLAN AT ANY TIME?**
   No. You must enroll in the Legal Services Plan during Benefits Enrollment to have coverage effective January 1, 2025.

2. **WHO IS THE PROVIDER FOR THE LEGAL SERVICES PLAN?**
   The Legal Services Plan will continue to be provided by MetLife.

3. ARE ANY SERVICES EXCLUDED FROM THE LEGAL SERVICES PLAN?

Yes, certain services are excluded from the Legal Services Plan and include:

- Employment-related matters, including GPC or statutory benefits
- Matters involving GPC, plan attorneys, MetLife and affiliates
- Matters in which there is a conflict of interest between the employee and spouse or dependents, in which case services are excluded for the spouse and dependents
- Appeals and class actions

4. ARE CLAIM FORMS REQUIRED WHEN USING THE LEGAL SERVICES PLAN?

Claim forms are not required when you receive service from MetLife network attorneys. Claim forms are necessary only when you receive service from an out-of-network attorney.

5. HOW DO I FIND A METLIFE NETWORK ATTORNEY?

You can access the MetLife member site or call the Client Service Center at **800-821-6400** (8 a.m.-7 p.m. EST/ EDT, Mon.-Fri.) to use the attorney locator. Once selecting the attorney, call to make an appointment or discuss the matter over the phone.

6. HOW MANY ATTORNEYS ARE IN THE METLIFE NETWORK?

The MetLife attorney network has more than 18,000 attorneys operating in all 50 states.

7. CAN LEGAL SERVICES PLAN MEMBERS USE THEIR OWN ATTORNEYS?

Yes, you can use your own attorney anytime. If you wish to use an out-of-network attorney, you can request a copy of the out-of-network fee reimbursement schedule by calling the MetLife Client Service Center at **800-821-6400**. You will pay the attorney, submit a claim form to MetLife and receive reimbursement within 14 days. If the non-participating attorney charges fees in excess of the maximum amount payable, the excess is your responsibility.

8. ARE METLIFE ATTORNEYS RESTRICTED IN THE AMOUNT OF TIME THEY SPEND WITH PARTICIPANTS?

No. There are no hour limits or frequency restrictions on covered attorney network services.

9. HOW DO I PAY FOR THE LEGAL SERVICES PLAN PREMIUM?

The Legal Services Plan premium is paid through payroll deductions.

10. IS THE DEDUCTION FOR THE LEGAL SERVICES PLAN PREMIUM A POST-TAX PAYROLL DEDUCTION?

Yes. The deduction for the Legal Services Plan premium is a post-tax deduction.

11. WILL GPC RECEIVE INFORMATION ABOUT THE SERVICES I RECEIVE THROUGH THE LEGAL SERVICES PLAN?

No. The Legal Services Plan is 100% confidential and GPC will not receive any information on the services you receive through the Plan.

Identity Protection Program

1. WHAT IS THE IDENTITY PROTECTION PROGRAM?

The Identity Protection Program detects different types of identity theft to provide a broad range of protection by monitoring for misuse of credit, and other data sources.

2. WHO IS THE IDENTITY PROTECTION PROGRAM PROVIDER?

The Identity Protection Program provider is Allstate.

3. HOW DOES ALLSTATE PROTECT MY IDENTITY?

Allstate protects your identity by proactively monitoring for fraud from sources such as wireless accounts, automobile and mortgage loans, compromised credentials, high risk transactions (such as unauthorized account access, fund transfers and password resets) and more, to help detect fraud.

4. CAN I ENROLL IN THE IDENTITY PROTECTION PROGRAM AT ANY TIME?

No. You must enroll in the Identity Protection Program during Benefits Enrollment to have coverage effective January 1, 2025.

5. HOW DO I PAY FOR THE IDENTITY PROTECTION PROGRAM PREMIUM?

The Identity Protection Program premium is paid for through payroll deduction.

6. IS THE DEDUCTION FOR THE IDENTITY PROTECTION PROGRAM PREMIUM A POST-TAX PAYROLL DEDUCTION?

Yes. The deduction for the Identity Protection Program premium is a post-tax deduction.