



WE BELIEVE IN PROVIDING
RESOURCES THAT HELP DEVELOP
THE CAREER OF EACH ASSOCIATE
AND ARE COMMITTED TO
SUPPORTING THEM AND THEIR
FAMILIES AS THEY GROW.

JUNE 1, 2025 – MAY 31, 2026

BENEFITS AND ENROLLMENT GUIDE



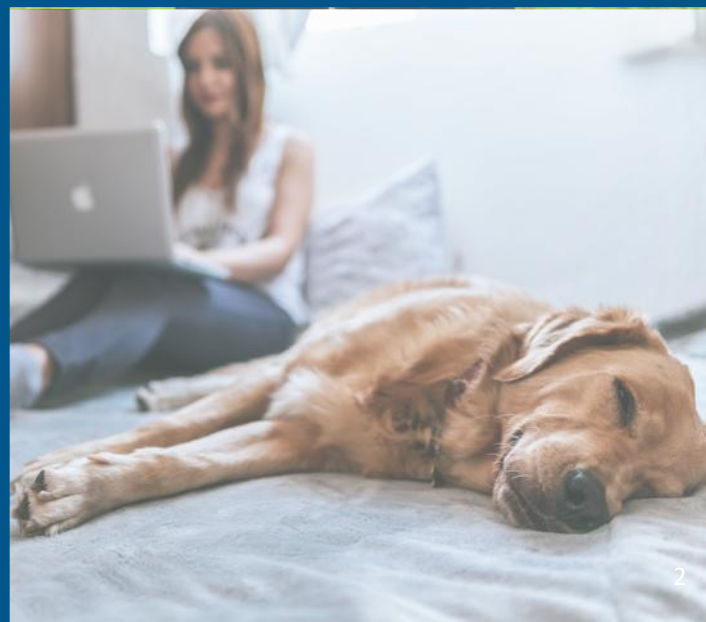
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Enrollment & Eligibility

Haynes Mechanical Systems is proud to offer you and your eligible family members a comprehensive benefits package. Making well-informed decisions about your benefits is an important part of being a consumer within a challenging health care system. It's also increasingly important to select the right benefits to meet your family's needs and effectively manage health care services and costs.

WHO IS ELIGIBLE?

- Employees working 30 or more hours per week for all benefits
- Covered Spouse or Domestic Partner
- Any Natural Child, Step-Child, Foster Child, or Adopted Child (up to age 26)
- Your dependent child over the age of 26 who is physically or mentally unable to care for themselves
- The waiting period to be eligible for benefits is the 1st of the month following 30 days of employment

OPEN ENROLLMENT CHANGES THAT CAN BE MADE EFFECTIVE JUNE 1, 2025

- Cigna for Medical, Dental, and Worksite; VSP for Vision; United Healthcare for Life and Disability
- Enroll, change options or terminate individual and/or dependent coverage

WHERE DO I GO TO ENROLL OR MAKE CHANGES?

Elections will be made online through Paylocity

WHEN WILL I BE ABLE TO MAKE THESE CHANGES?

Open Enrollment Begins **Monday, May 12, 2025**, and ends **Friday, May 23, 2025**.

IF I DO NOT WANT TO MAKE A CHANGE, DO I HAVE TO DO ANYTHING?—YES!

- When logging into the Paylocity system, you will be prompted to complete the open enrollment process
- Reminder—HSA elections must be elected each year as required by IRS guidelines

WHEN CAN I MAKE CHANGES?

Generally, you may change your benefit elections only during the annual open enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including, but not limited to:

- Marriage
- Divorce
- Birth, adoption or placement of adoption of your child
- Death of your spouse or dependent child
- Spouse's open enrollment
- Change in employment status of employee, spouse or dependent child that causes a change in eligibility for other coverage
- Qualified medical support order mandating coverage as part of a child support order
- Gain in eligibility in Medicare or Medicaid

YOU MUST NOTIFY HR WITHIN 30 DAYS OF A QUALIFIED LIFE EVENT.

If you do not complete your enrollment within 30 days of the qualified event, you may be required to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

PLEASE NOTE: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. *Please see page 44 for more details.*

Notice: This guide is for illustrative purposes only and is not considered a binding document. While every effort has been made to ensure the information included is accurate, should there be any discrepancy between this guide and individual plan documents, the policy plan documents are contractual and binding.

2025 Premiums

Your share of the medical, dental and vision premiums will be deducted from your pay pre-tax. If you fail to elect coverage within the annual open enrollment or new hire eligibility period, you will be deemed to have voluntarily waived eligibility for the respective coverage for the entire year. Once made, pre-tax benefit elections are irrevocable and remain in effect for the plan year unless you have a “Qualified Life Event.”

The premiums illustrated below reflect the monthly cost.

CIGNA | MEDICAL

\$2,000 HSA Plan	 Associate Only	 Associate + Spouse	 Associate + Children	 Family
Employee Contribution	\$134.70	\$465.22	\$375.65	\$598.17
Employer Contribution	\$521.10	\$1,056.42	\$896.97	\$1,421.81

CIGNA | DENTAL

Employee Contribution	 Associate Only	 Associate + Spouse	 Associate + Children	 Family
DPPO	\$10.29	\$25.72	\$20.58	\$30.87

VSP | VISION

Employee Contribution	 Associate Only	 Associate + Spouse	 Associate + Children	 Family
VSP Choice	\$5.39	\$9.31	\$9.31	\$15.68



Medical



Medical benefits are offered through **Cigna Healthcare**. Maximum benefits are available when services are received from **Cigna Healthcare** providers. Your financial responsibility is based on the provider network you select. The benefits illustrated below reflect in-network costs/allowances. Benefits are effective **June 1, 2025—May 31, 2026**. For more easy-to-understand details on the plan(s) offered through Cigna, check out your benefits education open enrollment website at www.benefitseducationcigna.com/782d42bb5a9f12c9b5ed15ae0120389d.



Member Responsibility

MEMBER PAYS	In-Network	Out-of-Network
Member Deductible - Plan Year Period	\$2,000 Individual \$4,000 Family	\$4,000 Individual \$8,000 Family
Member Coinsurance Plan Year Period	20%	50%
Annual Out-of-pocket Maximum (includes copays, deductible and coinsurance)	\$6,000 Individual \$6,850 Family	\$8,000 Individual \$16,000 Family
	If the annual out-of-pocket maximum is reached within a benefit period, eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period.	



Medical Service Coverages

MEMBER PAYS	In-Network	Out-of-Network
Office Visits: PCP Specialist	20% coinsurance after ded. 20% coinsurance after ded.	50% coinsurance after ded. 50% coinsurance after ded.
Preventive care as defined by the Affordable Care Act	Paid at 100% of the allowable charge. Some of the services include: Routine screenings, Preventive immunizations, Well-women visits/screenings, and Contraceptive methods.	
Emergency Room	20% coinsurance after ded.	20% coinsurance after ded.
Urgent Care	20% coinsurance after ded.	50% coinsurance after ded.
Telehealth and Virtual	20% coinsurance after ded.	50% coinsurance after ded.



MEMBER PAYS	In-Network	Out-of-Network
Emergency medical transportation (Ambulance)	20% coinsurance after ded.	20% coinsurance after ded.
Inpatient surgery physician/surgical	20% coinsurance after ded.	50% coinsurance after ded.
Inpatient facility fee	20% coinsurance after ded.	50% coinsurance after ded.
Outpatient surgery physician/surgical	20% coinsurance after ded.	50% coinsurance after ded.
Outpatient lab and radiology	20% coinsurance after ded.	50% coinsurance after ded.
Advance Imaging	20% coinsurance after ded.	50% coinsurance after ded.
Outpatient rehabilitation	20% coinsurance after ded.	50% coinsurance after ded.
Hospice	20% coinsurance after ded.	50% coinsurance after ded.
Home health care	20% coinsurance after ded.	50% coinsurance after ded.



Behavioral/Mental Health Coverages

MEMBER PAYS	In-Network	Out-of-Network
Mental/behavioral health Inpatient services	20% coinsurance after ded.	50% coinsurance after ded.
Outpatient Services	20% coinsurance after ded.	50% coinsurance after ded.

FIND A PROVIDER



You have the option to seek care in or out-of-network. However, you will experience a higher level of benefits and your out-of-pocket costs will be substantially lower if you stay within the network. Cigna Open Access Plus is the name of the provider network. Using network providers saves you and the plan money! Visit www.cigna.com/hcpdirectory/ to find a provider near you. Or download myCigna app through the Apple Store or Google Play.

Download the myCigna® app

With easy one-touch secure sign on, you can access your digital ID cards, manage your health information, update your profile, and more.



Pharmacy and Prescription



Prescription Costs

MEMBER PAYS	In-Network	Out-of-Network
Retail: 30-day supply Tier 1 / 2 / 3	\$10 / \$35 / \$70	Not covered
Mail Order: 90-day supply Tier 1 / 2 / 3	\$25 / \$88 / \$175	Not covered

Copays are after deductible has been met.

PRESCRIPTION DRUG INFORMATION

Whether you're taking medications now or in the future, it's important to know which medications your plan covers. Cigna makes it easy by providing up-to-date drug lists online. Follow these simple steps to find out how your plan covers your medication(s).

1. Go to www.Cigna.com/PDL.
2. Scroll down until you see a pdf of the Cigna Advantage 3-Tier Prescription Drug.
3. Then look for your medication name. Medications are listed by the condition they treat, then listed alphabetically within tiers (or cost-share levels).

Under your plan, both your covered medical and prescription medication costs count towards your plan's deductible and out-of-pocket maximum.

How your pharmacy benefits work.

When you fill a prescription at an in-network pharmacy, what you pay depends on your cost-share for the medication and your annual deductible (the amount you pay out of your own pocket for covered services before your plan starts covering part of the costs).

Once you meet your deductible, for the rest of the plan year, you'll pay a copay or coinsurance for covered services, while your plan pays the rest. Review your plan materials for more information.

Save money by choosing a generic.

When it comes to prescription medications, you and your doctor usually have a choice between a brand name medication and its generic equivalent.

Generics offer the same strength and active ingredients as the brand name medication but often cost much less – in some cases, up to 85% less.

Questions?

Call the number on your Cigna ID card.

You can also chat with us online on the **www.myCigna.com** website, Monday–Friday, 9:00 am–8:00 pm EST.



Visit Cigna.com/PDL from any computer or mobile device. Try it today!



Important Pharmacy and Member ID Updates

PHARMACY

Cigna Pharmacy has introduced a new Member Choice network solution which generates two complete networks, both of which include 30-day and 90-day pharmacies. Member Choice offers associates a choice of which major retail pharmacy chain (CVS or Walgreens) is suitable for their personalized care. CVS or Walgreens will become what Cigna calls an “anchor chain selection.” The anchor network has been set at the group level to **CVS, effective 6/1/2024**. However, there will be a choice at the individual associate level if they would like CVS or Walgreens to be their anchor network.

The choice between CVS or Walgreens as an associate’s anchor pharmacy is at the individual associate level, meaning each person covered in the household can choose the network that is right for them!

To start, the associate is defaulted to their anchor chain selection based on utilization. Where no utilization is present within the past 180 days, associates will be defaulted to the client anchor chain (**CVS in this case**).

Whichever anchor chain selection is chosen is where an associate will be able to fill 30- and 90-day prescriptions (in addition to other in-network pharmacies for 30-day prescriptions, just like today). However, the change will be that the associate will no longer be able to fill scripts at the opposite anchor pharmacy. Meaning if an associate chooses CVS as their anchor network, they will no longer be able to fill prescriptions at Walgreens (30 or 90 day).

Associates do have the option to change their anchor pharmacy once per year (in addition surrounding an QLE, like a change in address for example). They can change their network through myCigna.com or by calling customer service. Their choice will be displayed on MyCigna.com. If an associate has changed their anchor network selection once already in a year, then they will need to call customer service in order to change it again.

Associates will still be able to utilize their in-network pharmacies outside of CVS or Walgreens, such as Walmart, local independent pharmacies, Costco, or CostPlusDrugs.com – any non-pharmacy chain. This change applies to associates who utilize CVS or Walgreens.

DIGITAL ID CARDS

Effective 7/1/2023, Cigna transitioned to Digital ID cards, which will replace physical ID cards. Please note, if there are associates that would still like a physical ID card, associates can request physical medical ID cards through myCigna.com; or by calling Cigna Customer Service and following the prompts to request an ID card.

To access your digital ID card:

1. Log in to myCigna.com or the myCigna App
2. Click or tap “ID Cards”
3. View your card(s), as well as any dependents’ cards
4. Email cards directly to doctors
5. Save your digital ID cards in your Apple Wallet

Not yet registered on myCigna yet? Visit myCigna.com or scan the QR code to download the myCigna App and register now.



Apple App Store



Google Play Store

Medical Insurance

In-network preventive care is free for medical plan members

The Cigna medical plan pays 100% of the cost of preventive care when received from a network provider. This means you won't have to pay anything out of your pocket.



WHAT IS PREVENTIVE CARE?

The focus of preventive health care is to **PREVENT** illnesses, disease, and other health problems, and to **DETECT** issues at an early stage when treatment is likely to work best.



WHY IS PREVENTIVE CARE IMPORTANT?

It's important that you have a preventive 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 when and how often you should get them.

TAKE CHARGE OF YOUR HEALTH CARE EXPENSES



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.

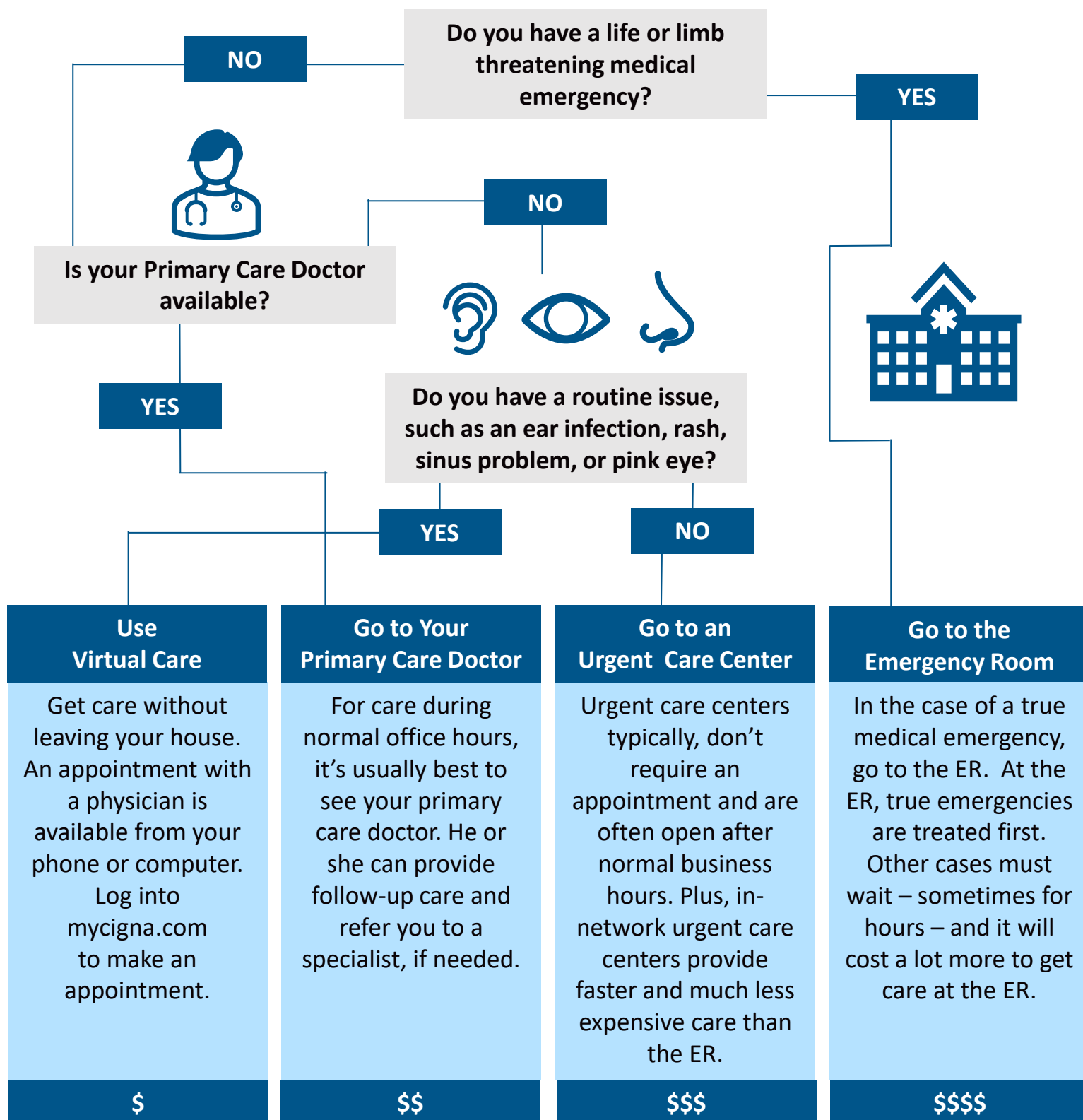
After your appointment, review your explanation of benefits (EOB) and provider bill to confirm you were billed correctly.

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-preventative care services you receive at your preventive care exam based on your plan design. Learn more about preventive care at <https://www.healthcare.gov/coverage/preventive-care-benefits/>.



Where Do You Go For 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.



Health Savings Account



USE

Use your HSA dollars today to pay for eligible health care expenses such as: deductibles, doctor's office visits, dental expenses, eye exams, and prescriptions.



SAVE

Use your HSA to prepare for the unexpected. 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 jobs.



INVEST

The money in your HSA can be invested and grows tax-free – including interest and investment earnings. After you reach age 65, your HSA dollars can be spent without penalty on any expense.

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

2025 IRS HSA CONTRIBUTION MAXIMUMS

Contributions made to an HSA cannot exceed the IRS allowed annual maximums, regardless of whether they are made by an individual or an employer.

- **Individuals:** \$4,300
- **All other coverage levels:** \$8,550

If you are age 55 or older by December 31, 2025, you may contribute an additional \$1,000.

WHO IS ELIGIBLE FOR AN HSA?

- You are covered by a High Deductible Health Plan (HDHP)
- You are not covered under another medical plan that is not an HDHP
- You are not enrolled in Medicare benefits
- You cannot be claimed on another person's tax return
- You have not received VA benefits in the last three months
- You are not participating in a healthcare FSA (i.e. spouse's healthcare FSA)

HOW DO I CONTRIBUTE TO AN HSA?

1. Open an HSA through Optum Bank
2. Choose your annual election amount

Health Savings Account

A Health Savings Account (HSA) is a plan designed to help you manage rising healthcare costs by setting aside money to pay for out-of-pocket medical expenses and to save for retirement. You can think of it as a personal savings account for medical expenses. HSAs are employee-owned, meaning you take the HSA with you if you change employers. Unused funds will earn interest and can be invested until they are withdrawn for eligible expenses or at retirement. You set aside money on a pre-tax basis—this means as long as you use the money for eligible expenses, you won’t pay income taxes on it. Haynes will help you fund your HSA! You must be enrolled in the Haynes medical plan with Cigna. The amount Haynes will contribute varies based on whether you and your spouse, if also enrolled in the Haynes medical plan, completes an annual preventive exam. Contact HR for details.

2025 Annual IRS HSA Contribution Limits	Associate Only	Family
Maximum Contribution Amount	\$4,300	\$8,550
Employee Catch-Up Contribution (over age 55)	\$1,000	\$1,000
Coverage Tier	2025 – 2026 Haynes HSA Contribution	
Associate Only w/ Age Qualifying Preventative Exam	Up to \$1,250 per year (Prorated at \$104.16/month)	
Associate + Spouse Both w/ Age Qualifying Preventative Exam	Up to \$2,500 per year (Prorated at \$208.33/month)	

WHO IS ELIGIBLE FOR AN HSA?

- You are covered by a High Deductible Health Plan (HDHP)
- You are not covered under another medical plan that is not an HDHP
- You are not enrolled in Medicare benefits
- You cannot be claimed on another person’s tax return
- You have not received VA benefits in the last three months
- You are not participating in a healthcare FSA (i.e., spouse’s healthcare FSA)

HOW DO I CONTRIBUTE TO AN HSA?

1. Open an HSA through Optum Bank
2. Choose your annual election amount

Once you’ve enrolled and set your annual election amount, that amount will be payroll deducted pre-tax in equal increments throughout the year. You can change your annual election amount within the IRS limits anytime throughout the year **without** a qualifying event. Post-tax contributions can also be made as long as it does not surpass the annual IRS limits for that year. Any unused funds in your HSA will roll over at the end of the year and will continue to earn interest and can be invested until they are withdrawn for medical expenses or until you turn 65 years old, when you can withdraw funds for any reason without incurring penalties.

WHEN DO I USE MY HSA?

Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles, coinsurance, copays) billed by the physician, facility or pharmacy, or you can choose to save your HSA dollars for a future medical expense. You can use your HSA debit card or pay out of pocket and file a claim for reimbursement.

TAX ADVANTAGES OF AN HSA

- Contributions are 100% tax-deductible up to a legally mandated maximum amount
- Tax-free interest earnings, if money is spent on health care costs
- Tax deferred interest earnings



Dental



COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Policy Year Deductible (individual/family)	\$50 / \$150	\$50 / \$150
Policy Year Maximum (per covered person)	\$1,500	\$1,500
Diagnostic & Preventive Care • Oral evaluations - twice per policy year • Bitewing x-rays - twice per policy year • Full mouth or panoramic x-rays - once each per 36 consecutive months • Cleanings - twice per policy year • Topical fluoride - once per policy year for dependents under age 19 • Space Maintainers - for dependents under age 19 for premature loss of primary molars	Associate pays \$0	Associate pays \$0
Orthodontics (subject to deductible) • Coverage for eligible children, up to age 19 • Lifetime max. of \$1,000	Associate pays 50%	Associate pays 50%
Basic Services • Ancillary - 1 emergency exam per plan year for relief of pain • Oral surgery - extractions, oral surgery, and pre/post operative care • Regular Restorative - fillings • Periodontics - treatment of diseases of the tissues supporting the teeth • Endodontics - root canal treatments and root canal fillings	Associate pays 20% after deductible	Associate pays 20% after deductible
Major Services • Special Restorative - individual crowns • Prosthodontics - bridges, partial and complete dentures • Implants	Associate pays 50% after deductible	Associate pays 50% after deductible



Dental benefits are offered through **Cigna Healthcare**. When you receive services from a Cigna PPO provider, you receive discounts on your dental care, meaning you save money on your portion of the cost of services, and your annual maximum goes further. To locate a dentist in-network, visit www.mycigna.com or download the myCigna mobile app (available on Apple or Android).

MANAGING MY BENEFITS

At myCigna.com, you can log in to your member account to:

- Access digital ID cards
- Check your eligibility and benefit information
- Check your claim status
- Search for in-network providers, procedures, cost estimates
- And more!

THROUGH CIGNA'S MOBILE APP, YOU CAN:

- Easy one-touch secure sign on
- Use your mobile ID card
- Manage your health information
- Update your profile
- And more!

IMPORTANT DISCLAIMER

Benefits for dental care services started prior to the Effective Date of your coverage under the plan are not covered.



HEALTHY MOUTH. HEALTHY BODY. HAPPY FACE.

Get to know the Cigna Dental PPO (DPPO) plan.



The power of preventive dental care

When you enroll in the Cigna Dental PPO (DPPO) plan, certain preventive dental care services like cleanings, oral exams and routine x-rays are **covered at no additional cost** when you use a network dentist.¹ And those visits are about more than brightening your smile — they're important for maintaining your overall health, too.

1.5x

People who do not get preventive care are 1.5 times more likely to develop gum disease, which can cause complications, especially for people with underlying medical conditions.²

22%

People who get regular preventive care are **22 percent less likely to need care at an emergency room or urgent care center.**²

Your plan includes other features and benefits to help make getting dental care simple and affordable, including:



Enhanced flexibility

The Cigna DPPO plan allows you to choose any licensed dentist for care. However, you'll save more by using a dentist in the Total DPPO network. The Total DPPO network offers convenient access to highly rated dentists all across the country and savings on covered dental services.³



Savings and convenience

Network dentists have agreed to reduce their fees for Cigna customers. They will also file claims for you and they cannot "balance bill" you for the difference between their regular fees and the reduced fees they have agreed to accept from Cigna.



Preventive care at no additional cost

Your plan covers certain preventive care services like cleanings, oral exams and routine x-rays at **no additional cost** when you use a network dentist.¹



What is balance billing?

Balance billing happens when a dentist who isn't in your plan's network charges more than your plan pays. Balance billing is a risk when you get services from an out-of-network dentist, so it helps to understand the difference between in-network and out-of-network dentists.

Together, all the way.®



Find dentists in the Total DPPO network.

You can search for network dentists before your benefits become active by visiting Cigna.com.

- Select “Find a Doctor, Dentist or Facility”
- Follow prompts to search by type of dentist or by dentist name.
- When prompted to select a plan, choose “DPPO/EPO > Total Cigna DPPO”

Once your benefits become active, you can use your myCigna.com account to access enhanced search tools including verified patient reviews, Brighter Scores and a treatment cost estimator that shows costs specific to your plan.



No ID card needed!

You don't need an ID card to receive care from network dentists. Simply make your appointment and provide identification to the office staff. They can verify your coverage with Cigna. You can also access a digital ID card after your benefits are effective and you have activated your myCigna.com account.



Dental coverage that keeps you smiling and helps you stay healthy.



Questions?

We're here to help 24/7, with live customer support in over 150 languages. Call 1.800.Cigna24

Together, all the way.®



1. Not all preventive services are covered, including athletic mouth guards. Refer to the policy for a complete list of covered and non-covered preventive services. Frequency limitations apply.
2. “Preventive Dental Treatment Associated with Lower Medical Utilization and Costs.” National study of Cigna customers with dental and medical coverage, updated December 2020.

The dentists who participate in the Cigna network are independent contractors solely responsible for the treatment provided to their patients. They are not agents of Cigna. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Vision

Vision coverage is administered by **VSP**. Locate a provider at www.vsp.com. Please note that you may only use the contact lens allowance or the frame allowance, but not both within the same benefit period. Service frequencies are computed by date of service, NOT calendar year.

PLAN FEATURES	IN-NETWORK COPAYS	FREQUENCY
Eye Exam	\$20 Copay	Every 12 months
Lens	\$20 copay	Every 12 months
Frames	\$20 copay	Every 24 months
VSP Lightcare	\$20 copay	Every 24 months
Contact Lens		
Fitting & Evaluation	\$60 copay	Every 12 months
Necessary Lenses	\$20 copay	Every 12 months
PLAN FEATURES	IN-NETWORK COST	OUT-OF-NETWORK ALLOWANCE
Frames	\$130 allowance, then 20% off	Up to \$70
Lightcare (Ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses)	\$130 allowance	See Contract
Contact Lens Allowances		
Elective	\$130 allowance	Up to \$105
Necessary	Covered in full after copay	Not covered
Standard Lenses (per pair)		
Single Visions	Covered in full after copay	Up to \$30
Bifocal	Covered in full after copay	Up to \$50
Trifocal	Covered in full after copay	Up to \$65

LENS ENHANCEMENTS	OUT-OF-POCKET COSTS
Scratch Coat	\$17
Ultraviolet Coat	\$16
Tints-Solids	\$0
Anti-Reflective Coat	\$41
Polycarbonate (Adult)	\$31 to \$35
Premium Progressive Lenses	\$95 - \$105
Custom Progressive Lenses	\$150 - \$175
Photochromics	\$75

DISCOUNT FEATURES	
Additional Pairs of Glasses	20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses
VSP Lightcare	Non-prescription blue light filtering glasses or sunglasses, covered in full after copay, up to frame allowance
Lasik	Average savings of 15-20% off retail price or 5% off promotional price



Disability

Haynes Mechanical Systems provides eligible employees with short-term and long-term disability income benefits through United Healthcare and pays 100% of the premiums. In the event you become disabled from a non-work-related injury or sickness, disability income protection benefits are provided as a source of income. You are not eligible to receive disability benefits if you are receiving workers' compensation benefits. Disability benefits protects your paycheck and replaces a portion of your income if an injury or illness forces you out of work for an extended period of time.

DISABILITY INSURANCE WILL BE EFFECTIVE:

- Full-time employees— first of the month following 30 days of full-time continuous employment

PLAN FEATURES	SHORT-TERM DISABILITY	LONG-TERM DISABILITY
Benefits Begin	15 th day illness/accident	91 st day illness/accident
Maximum Benefit Period	Up to 11 weeks	Social Security Normal Retirement Age
Percentage of Income Replaced	60%	
Maximum Benefit	\$1,000 weekly	\$6,000 monthly

PRE-EXISTING CONDITION EXCLUSION

The Long- and Short-Term Disability policy through United Healthcare includes a pre-existing condition exclusion. You have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.



Life Insurance

EMPLOYER PAID LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

Haynes Mechanical Systems provides eligible employees with a basic life and accidental death and dismemberment (AD&D) insurance policy through United Healthcare—at **no cost to you**. Please update your beneficiary information in Paylocity. Effective first of the month following 30 days of full-time continuous employment.

BASIC LIFE AND AD&D BENEFIT AMOUNTS

Employee Basic Life & AD&D	1x annual earnings* to a maximum of \$100,000
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**Benefits reduce to 67% at age 65; 45% at age 70*

VOLUNTARY LIFE INSURANCE

Haynes Mechanical Systems offers voluntary life insurance administered through United Healthcare. This benefit provides a lump-sum cash payment to a beneficiary upon the death of the insured. **Employees must be enrolled in order to elect coverage for dependents.** Coverage is effective first of the month following 30 days of full-time continuous employment.

PLAN FEATURES	EMPLOYEE	SPOUSE	CHILD(REN)
Maximum Life Amount	5x annual earnings to a max of \$500,000	\$250,000, not to exceed 50% of employee elected amount	Live Birth to 14 days: \$0 14 days and over: \$10,000
Purchase Increments	\$10,000	\$5,000	\$10,000
Guarantee Issue Amount	\$100,000	\$30,000	\$10,000
AD&D Benefit	The AD&D is not a stand-alone election. Amounts available are the same as a Voluntary Life.		



GUARANTEE ISSUE

Guarantee Issue is the opportunity to purchase life insurance with no medical questions asked and is offered at your initial opportunity only. If you wish to enroll at a later date, you will need to complete Evidence of Insurability (EOI). If you are currently enrolled and want to increase your coverage above the Guarantee Issue amount, you will need to complete EOI. Additional amounts approved through the EOI underwriting process, as well as any new premiums, will begin on the date of approval.

If at your initial opportunity, you elect the minimum \$10,000 life insurance coverage, you will be able to purchase up to the guaranteed issue at future annual enrollments with medical questions.

VOLUNTARY AD&D INSURANCE

AD&D insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident - up to a maximum of 5x your annual earnings or \$500,000, whichever is less. AD&D coverage can be purchased according to the same increments and spouse and dependent parameters as set above in the Voluntary Life Coverage summary.

AD&D coverage is not a **stand-alone election** and **has** to be combined with the purchase of life insurance. **Employee must be enrolled in order to elect for dependents.** AD&D coverage is guarantee issue at all benefit levels. Benefits are paid according to the schedule below:

- Full benefit amount paid

 - Life
 - Both hands or both feet
 - Sight of both eyes
 - One hand and sight of one eye
 - One foot and sight of one eye
 - Quadriplegia
- One half the full benefit amount paid

 - One hand or one foot
 - Sight of one eye
 - Paraplegia
 - Hemiplegia

EMPLOYEE & SPOUSE VOLUNTARY LIFE AND AD&D MONTHLY RATES													
Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	AD&D
EE \$1,000	\$0.068	\$0.091	\$0.114	\$0.137	\$0.205	\$0.319	\$0.569	\$1.070	\$1.594	\$2.595	\$4.849	\$15.777	\$0.03
SP \$1,000	\$0.068	\$0.091	\$0.114	\$0.137	\$0.205	\$0.319	\$0.569	\$1.070	\$1.594	\$2.595	\$4.849	\$15.777	\$0.03

Age-based reductions apply 65+ (Ask HR for details). Spouse rate is based on employee age.

Premium _____ / \$1,000 times _____ = \$ _____

Calculation (Life Amount Election) (Age Rate from Above) (Monthly Premium)

DEPENDENT CHILD(REN) VOLUNTARY LIFE & AD&D MONTHLY RATES	
Per \$1,000 (One premium all eligible children) \$0.200	AD&D (One premium all eligible children) \$0.030



Worksite Benefits

Accident, Hospital Indemnity and Critical Illness through Cigna Voluntary Benefits: Employee Paid

Accident

Accidental Injury insurance can provide you and your family with the additional financial protection you may need for expenses associated with an unexpected covered accident. The plan pays benefits directly to you. What you do with the money is up to you. This benefit will pay a lump sum in the event of a covered accident.

Examples include:

- Fractures
- Dislocation
- Surgery
- Concussion
- Coma

ACCIDENT MONTHLY RATES	
Employee	\$7.88
Employee + Spouse	\$14.02
Employee + Child(ren)	\$18.65
Family	\$24.79

Hospital Indemnity

Hospital Indemnity provides payment directly to you if you need to be unexpectedly hospitalized, which helps you from dipping into savings to pay for additional medical expenses that your health plan doesn't cover.

Benefits include:

- Hospital Admission - \$1,000 / day, one benefit every 365 days
- Hospital Chronic Condition Admission - \$50 / day, one benefit every 90 days
- Hospital Stay - \$100 / day, limited to 30 days, one benefit every 90 days
- Hospital Intensive Care Unit Stay - \$200 / day, limited to 30 days, one benefit every 90 days
- Hospital Observation Stay - \$100 / day, 24-hour elimination period, limited to 72 hours
- Newborn Nursery Care Stay - \$200 / day, limited to 30 days, one benefit per newborn child. Payable to the associate even if child coverage is not elected

HOSPITAL INDEMNITY MONTHLY RATES				
Age	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
0-49	\$10.12	\$25.09	\$20.79	\$35.76
50-59	\$14.74	\$29.24	\$25.42	\$39.92
60-69	\$23.32	\$46.15	\$33.99	\$56.82
70+	\$60.84	\$120.92	\$71.51	\$131.59



Critical Illness

When an unexpected critical illness occurs, Critical Illness insurance offers you and your family financial protection for unexpected costs. The plan pays you directly for expenses associated with an unexpected critical illness, and how you use the money is up to you.

This benefit pays all or a percentage of the selected Guaranteed Issue Amount upon diagnosis or recurrence of a schedule of specific covered illness such as cancer, heart attack, or Alzheimer's.

Employee: \$10,000 or \$20,000

Spouse: 50% of issued employee benefit

Children: 25% of issued employee benefit

\$10,000 Guaranteed Issue Amount				
Age	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
0-24	\$2.64	\$4.28	\$3.82	\$5.46
25-29	\$3.09	\$4.99	\$4.27	\$6.17
30-34	\$4.30	\$6.91	\$5.49	\$8.10
35-39	\$6.40	\$10.23	\$7.58	\$11.41
40-44	\$8.52	\$13.60	\$9.70	\$14.78
45-49	\$12.65	\$20.15	\$13.84	\$21.34
50-54	\$18.22	\$28.97	\$19.40	\$30.15
55-59	\$25.44	\$40.42	\$26.62	\$41.60
60-64	\$32.09	\$51.01	\$33.27	\$52.19
65-69	\$38.61	\$61.42	\$39.80	\$62.61
70-74	\$53.07	\$84.29	\$54.26	\$85.48
75-79	\$69.23	\$109.82	\$70.41	\$111.00
80-84	\$85.17	\$134.96	\$86.35	\$136.14
85+	\$116.26	\$183.91	\$117.44	\$185.09

Rates continued on the following page



Critical Illness - Continued

\$20,000 Guaranteed Issue Amount				
Age	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
0-24	\$5.29	\$8.57	\$7.65	\$10.93
25-29	\$6.17	\$9.98	\$8.54	\$12.35
30-34	\$8.60	\$13.82	\$10.98	\$16.20
35-39	\$12.80	\$20.46	\$15.16	\$22.82
40-44	\$17.03	\$27.19	\$19.41	\$29.57
45-49	\$25.30	\$40.29	\$27.68	\$42.67
50-54	\$36.44	\$57.94	\$38.80	\$60.30
55-59	\$50.88	\$80.85	\$53.24	\$83.21
60-64	\$64.18	\$102.02	\$66.54	\$104.38
65-69	\$77.22	\$122.84	\$79.60	\$125.22
70-74	\$106.14	\$168.59	\$108.52	\$170.97
75-79	\$138.46	\$219.65	\$140.82	\$222.01
80-84	\$170.33	\$269.93	\$172.70	\$272.30
85+	\$232.52	\$367.82	\$234.89	\$370.19



401(K)



Haynes provides a 401(k)-retirement savings plan through Principal Financial Group to help you save for retirement. You are able to participate in the 401(k) plan upon hire if you are at least **18** years of age. You may enter the plan on the first day of the month on or after you meet the eligibility requirements.

Haynes automatically enrolls all eligible associates with a 3% contribution, unless you choose a different percentage. You may elect to contribute 1% to 25% of your pay into the plan. You can stop making contributions to the plan at any time. By contributing to the plan, you may reduce your taxable income. The maximum salary deferral for 2025 is \$23,500. If you are age 50+, you can contribute an extra \$7,500/year. There is also a special catch-up provision for those who are between the ages of 60-63. You will be able to contribute up to 150% of the regular catch-up amount for a total of \$11,250.

Haynes matches 100% on the first 3%, **PLUS** 50% on the next 2% that you contribute for a **total of 4% match when you contribute 5%**. You are 100% vested in your contributions into the plan. You are vested in Haynes contributions based on the below vesting schedule:

Years of Service	Vesting Percentage	Your 401(k) Contribution	Haynes' Match to You
Up to 1	0%	1%	1%
Up to 2	25%	2%	2%
Up to 3	50%	3%	3%
Up to 4	75%	4%	3.5%
4 or more	100%	5%+	4%

Plan members may also defer after-tax dollars into a Roth 401(k) account. Your Roth after-tax contributions and your pre-tax contributions both count towards the annual maximum deferral limit.

The plan allows rollovers into the plan from other retirement funds you may have outside of this plan. To learn more about making a rollover into your Principal 401(k) account, visit www.principal.com or call (800) 547-7754. You are able to direct your own investments in your Principal 401(k) account by choosing among several fund options. In order for you to make informed investment decisions, it's important that you review the investment materials and prospectuses. You can obtain this information by calling the Client Contact Center at Principal at (800) 547-7754 or online at www.principal.com. Contributions will be automatically directed to the plan's investment default if you do not choose any investment options. You may change your investment options at any time. Please note that when transferring existing balances from one investment option to another, redemption fees or restrictions on transfer frequency may apply. See your plan document or contact Principal for full details.

Benefits will be payable to you at retirement (generally, age 62), at age 59 ½ if you are still working, death, disability, or termination of employment. Be sure to update at least annually your 401(k)-account beneficiary information. If you experience a financial hardship, you may withdraw all or part of the vested amount.



A Guide to Your Employee Assistance Program

YOUR COUNSELING SERVICES

As a Haynes Mechanical Systems employee, you and your household members are entitled up to 5 counseling sessions per issue*, per contract year, free of charge. When you call in for a referral, you can choose to be scheduled for a face-to-face appointment in an area of your choosing (near your office, near your home, etc.) or you may choose to access your sessions telephonically. The use of your Employee Assistance Program is strictly confidential and available 24/7. We are here to help with the everyday issues that come up in your life, including:

- Stress
- Career
- Family Issues
- Death and Grief
- Anxiety
- Financial Problems
- Drug/Alcohol Abuse
- Eating Disorders
- Depression
- Legal Referrals
- Relationships
- Work-Related Issues

YOUR ONLINE BENEFITS

Your online Personal Advantage page contains thousands of resource articles, self-search locators, interactive online training, wellness self-assessments, and videos. You will also find a wealth of online resources under categories ranging from grief and loss to managing your 401(k).

Visit: MINESandAssociates.com / Username: Haynes / Password: employee

YOUR FINANCIAL/LEGAL BENEFITS

Each employee, and their household members, is entitled to one initial 30-minute office or telephone consult per separate legal matter at no cost with a network attorney. You also have financial counselors to advise you via telephonic consultations that are limited between thirty and sixty minutes per issue. Other tools under the MINES financial/legal benefit include meditation, tax consultation and preparation, and “Do-it-Yourself” legal forms and document preparation.

YOUR WORK/LIFE REFERRAL SERVICES

Finding the right dependent care provider can be a time-consuming and exhausting endeavor. You and your household members have access to unlimited specialized work/life services that provide information, research, and referrals for childcare, eldercare, and convenience services. This can include:

- Assisted Living Facilities
- Caregiver Support
- Community Services
- Medicare/Medicaid
- Childcare Centers
- Adoption Services
- New Parents/Pregnancy
- Special Needs
- Fitness Classes
- Home-based Services
- Pet Care
- Repair Services

YOUR WELLNESS COACHING

Each employee and their household members can utilize up to 4 sessions per year to access free and confidential 20 to 30-minute telephonic coaching sessions to help reach individual wellness goals. Each certified wellness coach can help assess current wellness needs around a variety of topics, help you set specific wellness goals, and do regular progress checks to help answer questions along the way to help you reach your wellness objectives. Topics include weight loss, fitness, nutrition, healthy habits, stress, health concerns, caffeine reduction, injury recovery, physical training, relationship development, sleep issues, smoking cessation, and more.

*Per Issue: Separate and distinct situations. A MINES case manager will review requests for additional sets of sessions. This guide is for informational purposes only. Call MINES for specific information about benefits, limitations, and exclusions.



Additional Benefits for Eligible Employees

RTD FlexPass Benefit	Haynes Mechanical will reimburse you for 75% of the retail cost of your monthly FlexPass when purchased online. Contact Human Resources for details.		
Legal Shield	Legal assistance and identity theft protection are available through our vendor, Legal Shield. There is a monthly charge for the service.		
Health & Fitness Reimbursement	To encourage associates to maintain an active and healthy lifestyle, Haynes will reimburse 45% of your monthly cost (not to exceed \$70) for a family or individual health club membership, or for a regularly attended fitness activity. You must provide a copy of your contract or participation agreement which states the monthly cost of the membership or activity along with a copy of your receipt showing payment of the charges.		
Tobacco Cessation Benefit	Haynes encourages its associates to maintain a healthy lifestyle and offers a one-time incentive of \$250 when you quit using tobacco products (tobacco free for at least 6 months).		
Paid Time Off (PTO)	PTO is available to regular full-time associates on a calendar year basis for the purpose of rest, relaxation and personal needs. PTO may be used for vacation, personal illness, illness of spouse or dependents, celebration of holidays that are not designated company holidays, children's school events or other personal business. Please contact Human Resources for more details.		
Paid Holidays	New Years Day Memorial Day	Independence Day Labor Day	Thanksgiving (and Friday after) Christmas Day



FINDING A DOCTOR IN OUR DIRECTORY IS EASY



Is your doctor or hospital in your plan's Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

SEARCH YOUR PLAN'S NETWORK IN FOUR SIMPLE STEPS



Step 1

Go to **Cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

(If you're already a Cigna customer, log in to **myCigna.com** or the myCigna® app to search your current plan's network. To search other networks, use the **Cigna.com** directory.)



Step 2

Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.



Step 3

Answer any clarifying questions, and then verify where you live (as that will determine the networks available).



Step 4

Optional: Select one of the plans offered by your employer during open enrollment.

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

Search first. Then choose Cigna.

There are so many things to love about Cigna. Our directory search is just the beginning.

After you enroll, you'll have access to **myCigna.com** – your one-stop source for managing your health plan, anytime, just about anyplace. On **myCigna.com**, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

Questions? Call the number on the back of your ID card.

Together, all the way.®



Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

Providers and facilities that participate in the Cigna network are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, see your plan documents.

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PREVENTIVE HEALTH CARE

Understanding what's covered.



What is preventive care?

Preventive care is a specific group of services recommended when you don't have any symptoms and haven't been diagnosed with a related health issue. It includes your periodic wellness exam (check-up) and specific tests, certain health screenings, and most immunizations. Most of these services typically can take place during the same visit. You and your health care provider will decide what preventive services are right for you, based on your:

- › Age
- › Gender
- › Personal health history
- › Current health

Why do I need preventive care?

Preventive care can help you detect problems at early stages, when they may be easier to treat. It can also help you prevent certain illnesses and health conditions from happening. Even though you may feel fine, getting your preventive care at the right time can help you take control of your health.

Make a plan for preventive care.

Use this space to write down the details for your next periodic wellness exam.

Date: _____

Time: _____

Questions for my provider: _____

Together, all the way.®

What's not considered preventive care?

Once you have a symptom or your health care provider diagnoses a health issue, additional tests are not considered preventive care. Also, you may receive other medically appropriate services during a periodic wellness exam that are not considered preventive. These services may be covered under your plan's medical benefits, not your preventive care benefits. This means you may be responsible for paying a share or all of the cost depending on your plan, including deductible, copay or coinsurance amounts.

Which preventive services are covered?

Many plans cover preventive care at no additional cost to you when you use a health care provider in your plan's network. Use the provider directory on **myCigna.com** for a list of in-network health care providers and facilities.

See the following pages for the services and supplies considered preventive care under most health plans. Coverage for services recommended specifically for "men" or "women" is provided based on the anatomical characteristics of the individual and not necessarily the gender of the individual as indicated on the claim and/or an enrollment form.



Questions?

Check your plan materials, talk with your health care provider or call the number on the back of your Cigna ID card.



Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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Wellness exams

SERVICE	GROUP	AGE, FREQUENCY
Well-baby/well-child/well-person exams, including annual well-woman exam (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	  	- Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months - Additional visit at 2–4 days for infants discharged less than 48 hours after delivery - Ages 3 to 21, once a year - Ages 22 and older, periodic visits as doctor advises

Routine immunizations covered under preventive care

SERVICE	SERVICE
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP, Tdap, Td)	Meningococcal (meningitis)
Haemophilus influenzae type b conjugate (Hib)	Pneumococcal (pneumonia)
Hepatitis A (Hep A)	Poliovirus (IPV)
Hepatitis B (Hep B)	Rotavirus (RV)
Human papillomavirus (HPV)	Varicella (chickenpox)
Influenza vaccine	Zoster (shingles)
Measles, mumps and rubella (MMR)	

You may view the immunization schedules on the CDC website: cdc.gov/vaccines/schedules/.

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Abnormal blood glucose and type 2 diabetes screening/counseling	 	Adults ages 40–70 who are overweight or obese; women with a history of gestational diabetes mellitus
Anxiety screening		Adult and adolescent women including pregnant and postpartum women
Aspirin to prevent cardiovascular disease and colorectal cancer; or to reduce risk for preeclampsia ¹	 	Adults ages 50–59 with risk factors; Pregnant women at risk for preeclampsia
Autism screening		18, 24 months
Bacteriuria screening		Pregnant women
Bilirubin screening		Newborns before discharge from hospital
Breast cancer screening (mammogram)		Women ages 40 and older, every 1–2 years
Breast cancer-discussion of benefits/risks of preventive medication		Women at risk
Breast-feeding support/counseling, supplies ²		During pregnancy and after birth
Cervical cancer screening (Pap test) HPV DNA test alone or with Pap test		Women ages 21–65, every 3 years Women ages 30–65, every 3 years
Chlamydia screening		Sexually active women ages 24 and under and older women at risk
Cholesterol/lipid disorders screening ¹	  	- Screening of children and adolescents ages 9–11 years and 17–21 years; children and adolescents with risk factors ages 2–8 and 12–16 years - All adults ages 40–75
Colon cancer screening ¹	 	The following tests will be covered for colorectal cancer screening, ages 45 and older: - Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually - Flexible sigmoidoscopy every 5 years - Flexible sigmoidoscopy every ten years + annual FIT - Double-contrast barium enema (DCBE) every 5 years - Colonoscopy every 10 years - Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - Requires prior authorization - Stool-based deoxyribonucleic acid (DNA) test (i.e., Cologuard) every 1–3 years

 = Men  = Women  = Children/adolescents

Health screenings and interventions *(continued)*

SERVICE	GROUP	AGE, FREQUENCY
Congenital hypothyroidism screening	●	Newborns
Critical congenital heart disease screening	●	Newborns before discharge from hospital
Contraception counseling/education (including fertility awareness-based methods); contraceptive products and services ^{1,3,4}	●	Women with reproductive capacity
Dental application of fluoride varnish to primary teeth at time of eruption (in primary care setting)	●	Children to age 6 years
Dental caries prevention Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride ¹	●	Children older than 6 months
Depression screening/Maternal depression screening	● ● ●	Ages 12–21, All adults, including pregnant and postpartum women
Developmental screening	●	9, 18, 30 months
Developmental surveillance	●	Newborn, 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
Fall prevention in older adults (physical therapy)	● ●	Community-dwelling adults ages 65 and older with risk factors
Folic acid supplementation ¹	●	Women planning or capable of pregnancy
Genetic counseling/evaluation and BRCA1/BRCA2 testing	●	Women at risk • Genetic counseling must be provided by an independent board-certified genetic specialist prior to BRCA1/BRCA2 genetic testing • BRCA1/BRCA2 testing requires precertification
Gestational diabetes screening	●	Pregnant women
Gonorrhea screening	●	Sexually active women age 24 years and younger and older women at risk
Healthy diet and physical activity counseling	● ● ●	Ages 6 and older – to promote improvement in weight status; Overweight or obese adults with risk factors for cardiovascular disease
Hearing screening (not complete hearing examination)	●	All newborns by 2 months. Ages 4, 5, 6, 8, 10. Adolescents once between ages 11–14, 15–17 and 18–21
Hemoglobin or hematocrit	●	12 months
Hepatitis B screening	● ● ●	Pregnant women; adolescents and adults at risk
Hepatitis C screening	● ●	Adults ages 18–79
High blood pressure screening (outside clinical setting) ²	● ●	Adults ages 18 and older without known high blood pressure
HIV Preexposure Prophylaxis (PrEP) for prevention of HIV infection ¹ HIV PrEP related services (HIV screening, kidney function testing, hepatitis B & C screening, pregnancy testing, sexually transmitted infection screening / behavioral counseling, adherence counseling)	● ● ●	Individuals at risk
HIV screening and counseling	● ● ●	Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women (adolescent/adult), annually
Intimate partner/interpersonal violence screening	●	All women (adolescent/adult)
Lead screening	●	12, 24 months
Lung cancer screening (low-dose computed tomography)	● ●	Adults ages 50 to 80 with 20 pack year smoking history, and currently smoke, or have quit within the past 15 years. Computed tomography requires precertification
Metabolic/hemoglobinopathies (according to state law)	●	Newborns
Obesity screening/counseling	● ● ●	Ages 6 and older, all adults
Ocular (eye) medication to prevent blindness	●	Newborns
Oral health evaluation/assess for dental referral	●	6, 9 months. Ages 12 months, 18 months–6 years for children at risk

● = Men ● = Women ● = Children/adolescents

Health screenings and interventions *(continued)*

SERVICE	GROUP	AGE, FREQUENCY
Osteoporosis screening	●	Age 65 or older (or under age 65 for women with fracture risk as determined by a Clinical Risk Assessment Tool). Computed tomographic bone density study requires precertification
PKU screening	●	Newborns
Perinatal depression preventive counseling	●	Pregnant and postpartum women with risk factors
Preeclampsia screening (blood pressure measurement)	●	Pregnant women
Prostate cancer screening (PSA)	●	Men ages 45 and older or age 40 with risk factors
Rh incompatibility test	●	Pregnant women
Sexually transmitted infections (STI) counseling	● ● ●	Sexually active women, annually; sexually active adolescents; and men at increased risk
Sexually transmitted infections (STI) screening	●	Adolescents ages 11–21
Sickle cell disease screening	●	Newborns
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation	● ● ●	Ages 6 months – 24 years
Syphilis screening	● ● ●	Individuals at risk; pregnant women
Tobacco use cessation: counseling/interventions ¹	● ●	All adults ¹ ; pregnant women
Tobacco use prevention (counseling to prevent initiation)	●	School-age children and adolescents
Tuberculosis screening	● ● ●	Children, adolescents and adults at risk
Ultrasound aortic abdominal aneurysm screening	●	Men ages 65–75 who have ever smoked
Unhealthy alcohol use and substance abuse screening	● ● ●	All adults; adolescents age 11–21
Unhealthy drug use screening	● ●	All Adults
Urinary incontinence screening	●	Women
Vision screening (not complete eye examination)	●	Ages 3, 4, 5, 6, 8, 10, 12, and 15 or as doctor advises

● = Men ● = Women ● = Children/adolescents

WELCOME TO CIGNA

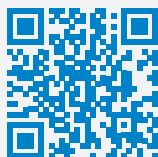
Simple ways to make the most of your plan

Cigna resources are designed to help you make smarter choices to improve your whole health and health plan spending.



First, register on myCigna.com^{®1} to access your digital ID cards and activate all available programs

When your plan year begins, register on **myCigna.com**. That way you're ready to go whenever you need to find in-network health care providers, estimate costs or use My Health Assistant.



Register now



Access virtual care

Conveniently connect with board-certified doctors, therapists, psychiatrists and dermatologists via video or phone.²



Connect with Cigna One Guide[®]

Our friendly guides have forward-thinking technology to answer questions on your plan, offer personalized advice and connect you to the right care. They can also proactively reach out.³



Ensure in-network care

myCigna and Cigna One Guide can help you stay in-network, maximize savings and avoid any surprises.



Get preventive care

Preventive care, such as check-ups, biometric screenings and wellness screenings, is available at no additional cost to you.⁴ It's even available virtually for maximum convenience.



Prioritize behavioral support

229K+ behavioral health and substance use providers⁵ can help, either in person or virtually. We also have 24/7 therapy, including Talkspace and Ginger for Cigna, and digital tools, such as iPrevail and Happify^{™,6}



Call our 24/7 Health Information Line

Talk with a clinician who can help you choose the right care, whenever you need it – late nights, holidays and more.



Simplify with mail-order medications

Express Scripts[®] is one of the largest pharmacies in the United States and offers convenience, savings and stress-free prescription management.



Identity Theft protection

At no additional cost.



Bounce back with RecoveryOne[™] for Cigna[®]

Virtual physical therapy from the comfort of home is convenient and available at no additional cost to you.



Utilize case management programs

Complex medical conditions can be overwhelming. Our trained teams can help you coordinate care, understand benefits and reach goals through online coaching.





Make sure to get approval from your plan before getting care (known as prior authorization) for routine hospital stays or outpatient procedures.

Learn more at **myCigna.com** or by calling the number on your ID card.



First, register on myCigna.com or the myCigna® App⁷

Once you've registered, you can:

- › Access your digital ID cards for yourself and any dependents. You can download the card images to save, share, print or email directly to your dependents and to your providers.
- › Understand what's covered in your plan
- › Find in-network doctors, hospitals and facilities and sort them by location, reviews and Cigna's quality rating
- › Get cost estimates for appointments, procedures and medications
- › Compare costs for 30- and 90-day medications and see if lower-cost alternatives are available
- › Find retail pharmacies that offer a 90-day supply
- › Manage and track claims
- › Get alerts when new plan documents are available
- › Access a variety of health and wellness resources, including an online health assessment, health tracking tools and My Health Assistant digital coaching



Virtual care²

Virtual care can be a convenient and affordable option for a wide range of care. For appointments, you can work with an in-network provider or connect with an MDLIVE^{®2} provider at **myCigna.com**.

Right from your phone, tablet or computer, you can:

- › Access board-certified doctors, psychiatrists, dermatologists and licensed therapists
- › Get virtual urgent care 24/7/365 – even on weekends and holidays with MDLIVE
- › Access virtual primary care for preventive care, routine care and specialist referrals
- › Access dermatologists⁸ for fast, customized care for skin, hair and nail conditions – no appointment required
- › Schedule an online virtual behavioral health appointment in minutes through MDLIVE
- › Have a prescription sent directly to your local pharmacy if appropriate

Virtual primary care

- › Preventive care check-ups/wellness screenings are available at no additional cost⁹ and can help identify conditions early
- › Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions

- › Access MDLIVE by logging in to **myCigna.com** and clicking on “Talk to a doctor.” You can also call MDLIVE at **888.726.3171**.
- › Select the type of care you need: Medical care or counseling. The cost will be displayed on both **myCigna.com** and MDLIVE.
- › Appointments are available via video or phone, whenever it's most convenient for you. No appointments are required for dermatology care.



Cigna One Guide

Combining digital technology with our personalized customer service, over the phone or on the myCigna App,⁷ the Cigna One Guide support tool can help you:

- › Resolve health care issues
- › Save time and money
- › Get the most out of your plan
- › Find the right hospitals, dentists and other health care providers in your plan's network
- › Get cost estimates
- › Understand your bills
- › Navigate the health care system



In-network care

Save money when you use doctors, hospitals and health facilities that are part of your plan's network. Chances are there's a network doctor or facility right in your neighborhood. It's easy to find quality, cost-effective care at **myCigna.com**.



Preventive care

It's important to catch any issues while they're still small. That's why we cover eligible preventive care services at no extra cost, including:⁴

- › Screenings for blood pressure, cholesterol and diabetes
 - › Testing for colon cancer
 - › Clinical breast exams and mammograms
 - › Pap tests
 - › Additional covered procedures listed on **myCigna.com**
- Since your physical and emotional health are connected, make sure to talk about how you're feeling at your annual check-up.



Behavioral care

You have access to 229K+ behavioral health and substance use providers,⁵ and 75K+ of those are virtual.⁵ Whether you're dealing with a behavioral health condition, going through a rough time or looking for substance use support, you can find the one that fits your needs, either in person or virtually. To find a virtual provider:

- › Go to **myCigna.com** > Find Care & Cost
- › Search for "Behavioral Health Counselor" under "Doctor by Type"
- › Call to make an appointment with your selected provider

Online visits with our behavioral health network providers cost the same as in-office visits. Costs vary by plan.



24/7 Health Information Line

At no extra cost, you can speak to a clinician to make more-informed decisions about your care. Whether it's reviewing home treatment options, following up on a doctor's appointment or finding the nearest urgent care center in your plan's network, you can call the number on your Cigna ID card, day or night.



Specialty medications

We can help you understand, manage and treat complex conditions that require a specialty medication. Our therapy management teams, made up of health advocates with nursing backgrounds as well as pharmacists, are specially trained to help with your specific needs.¹⁰

- › Personalized, 24/7 support
- › Condition-specific education on medication therapy and side effects
- › Help with the medication approval process
- › Financial assistance programs if needed

For more information, call **800.351.3606**.



Identity Theft Protection

- › We're committed to the physical, emotional and financial well-being of those we serve. That's why Cigna teamed up with IdentityForce, a top-rated provider of identity theft protection.¹¹

- › We'll help protect you and your children against identity theft and help fix any identity theft compromises – at no additional cost for all medical subscribers.
- › Three ways to register:
 - Visit **<https://cigna.identityforce.com/starthere>**
 - Call 833.580.2523
 - If you are new to a Cigna Medical plan and you provide your email address on **myCigna.com**, you may also receive emails from IdentityForce that will provide you links to register for services.

Once registered, you and your children can access IdentityForce directly through the IdentityForce app or website.



RecoveryOne for Cigna includes:⁶

- › Virtual physical therapy at no additional cost¹²
- › A private video consult with a virtual physical therapist
- › Customized plans to meet your needs – from the comfort and convenience of wherever you are
- › A multimedia app that guides you through your personalized exercises
- › Video, voice and chat conversations with your support team
- › Motion-tracking technology



Case management programs

Take advantage of our personal services to help you with your personal health needs. A Cigna case manager, trained as a nurse, can work closely with you and your doctor to check on your progress. You can get help with conditions and illnesses, such as cancer and end-stage renal disease, as well as with neonatal care and pain management.

You also have access to My Health Assistant on **myCigna.com** to help you:

- › Control stress
- › Lose weight and eat better
- › Enjoy exercise
- › Quit tobacco
- › Manage diabetes, chronic obstructive pulmonary disease, asthma and other conditions

Enroll online today. Go to **myCigna.com** > Wellness > Health Assistant.

TIPS TO HELP YOU SAVE MONEY



Find where to get prescription drugs

- Find the complete list of covered medications on **myCigna.com**
- Use cost-comparison tools on myCigna to compare prices and purchase mail-order prescriptions¹³
- Use generics when possible
- Know what brand-name drugs are covered in your plan
- Ask your doctor about a 90-day supply for your maintenance medication(s) through our home delivery pharmacy service



Know where to go for care

- Use an emergency room for true emergencies
- Don't wait: Locate an in-network convenience care clinic, sometimes found within a grocery store, or urgent care center near you, before you need it
- For minor medical conditions, connect with a board-certified doctor via video or phone when, where and how it works best for you. Visit **myCigna.com**, or call MDLIVE at 888.726.3171 to talk with a doctor 24/7²
- Don't be fooled: Some emergency rooms look like urgent care centers, so know what type of facilities are in your area



Choose the right provider

- Know which providers are in your network by going to **myCigna.com** > Find Care & Costs
- Choose providers who have received the Cigna Care Designation – high-performance recognition given to physicians in certain specialties who meet Cigna quality and medical cost-efficiency standards¹⁴
- Opt to connect with a board-certified doctor, therapist or psychiatrist via video or phone²
- Use in-network national labs to help save money



Be proactive about your health

- Get information on the cost of medications and treatments to avoid surprises
- Use your preventive care benefits, learn your core health numbers (blood pressure, cholesterol and blood glucose), and make use of the health improvement tools at **myCigna.com**

Find your way to better health.

Get more information on all the programs that are available to you.



When your plan year begins, register on **myCigna.com**.



Call the 24/7 customer service number on your ID card.



Download the **myCigna App**.⁷



1. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com. 2. Cigna provides access to virtual care through participating in-network providers. Not all providers have virtual capabilities. Cigna also provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. All health care providers are solely responsible for the treatment provided to their patients; providers are not agents of Cigna. Refer to plan documents for complete description of virtual care services and costs. 3. Not available with all plans. 4. Not all preventive care services are covered, and different plans may cover different things. For example, immunizations for travel are usually not covered. See your plan materials for a complete list of covered preventive care services. 5. Internal unique provider data as of December 2021. Subject to change. 6. The program and services are provided by an independent company and not by Cigna. Program and services are subject to all applicable program terms and conditions. Program availability is subject to change. 7. The downloading and use of any mobile App is subject to the terms and conditions of the App and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply. 8. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days but usually within 24 hours. 9. For legacy clients that have a non-zero preventive care benefit, customers' preventive benefit will be applied when receiving a virtual wellness screening. 10. Not all plans offer all of these programs and services. Please log in to the myCigna App or website, or check your plan materials, to learn more about what your plan offers. The providers in Cigna's pharmacy network don't work for Cigna and are solely responsible for any treatment they provide. 11. White, A. "Best identity theft protection services of September 2021." CNBC.com. August 27, 2021. <https://www.cnbc.com/select/best-identity-theft-protection-services/>. Frankel, RS. "Best Identity Theft Protection Services Of 2021." Forbes Advisor. June 10, 2021. <https://www.forbes.com/advisor/personal-finance/best-identity-theft-protection-services/>. The program and services are provided by Sontiq, Inc. and not by Cigna Corporation or its operating subsidiaries. Program and services are subject to all applicable program terms and conditions. Program availability is subject to change. References to third-party organizations or companies, and/or their products, processes or services, do not constitute an endorsement or warranty thereof. Your use of such products, processes or services is at your sole risk. Product may be updated or modified prior to availability. 12. Cost and usage of this program is covered by your plan administrator; no additional out-of-pocket expense applies for you or your covered dependents (ages 18+). 13. Prices shown on myCigna are not a guarantee. Coverage falls under your plan terms and conditions. Visit myCigna for more information. 14. Patient experience, quality designations, cost-efficiency and other ratings found in Cigna's online provider directories are a partial assessment of quality and should not be the only basis for decision-making (as such measures have a risk of error). They are not a guarantee of the quality of care that will be provided to individual patients. Individuals are encouraged to consider all relevant factors and talk with their physician about selecting a health care facility. Providers are solely responsible for any treatment provided and are not agents of Cigna.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, contact a Cigna representative.

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HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care¹ from MDLIVE.®



It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE®

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost² to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities³

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology⁴

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours



3 easy steps to connect to care

Virtual care visits are convenient and easy.
To schedule an appointment:



Access MDLIVE by logging into myCigna.com and clicking on “Talk to a doctor.” You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)



Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE



Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.



Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®



1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost \$0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

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EXPRESS SCRIPTS® PHARMACY

Our home delivery pharmacy

Express Scripts® Pharmacy, our home delivery pharmacy, is a convenient option if you're taking a medication on a regular basis to treat an ongoing health condition. Express Scripts® Pharmacy, which is a Cigna company, is one of the country's largest home delivery pharmacies.

What are the benefits of using Express Scripts® Pharmacy?

Express Scripts® Pharmacy helps make it easy for you to get your medication. With just a few simple clicks of your mobile phone, tablet or computer, your important medications will be on their way to your door (or location of your choice).

- Easily order, manage, track and pay for your medications **on your phone or online**
- Standard shipping **at no extra cost**¹
- **Fill up to a 90-day supply** at one time
- Helpful pharmacists **available 24/7**
- **Automatic refills**² and **refill reminders** so you don't miss a dose
- **Flexible** payment options

Three easy ways to switch to home delivery

1. **Log in to the myCigna® App or myCigna.com to move your prescription electronically.** Click on the Prescriptions tab and select My Medications from the dropdown menu. Then simply click the button next to your medication name to move your prescription(s).
2. **Call your doctor's office.** Ask them to send a 90-day prescription (with refills)³ electronically to Express Scripts Home Delivery. Or,
3. **Call Express Scripts® Pharmacy at 800.835.3784.** They'll contact your doctor's office to help transfer your prescription. Have your Cigna ID card, doctor's contact information and medication name(s) ready when you call.



Got a new prescription?

Ask your doctor to send it to Express Scripts® Pharmacy using one of these methods:

1. **Electronically:** For fastest service, they can send your prescription electronically to Express Scripts Home Delivery, NCPDP 2623735.
2. **By fax:** They can call 888.327.9791 to get a Fax Order Form.

Together, all the way.®



Offered by: Cigna Health and Life Insurance Company or its affiliates.

Use the myCigna® App or website. It's your "go-to" for everything you need to know about your plan's coverage.

➤ **Easily manage all of your prescriptions on the My Medications page.** Click on the Prescriptions tab and select My Medications from the dropdown menu.

- View all of the prescriptions you've filled within the last 18 months.
- Use the **myCigna** App to review your medications with your doctor during an office visit.
- Move your prescription from a retail pharmacy to home delivery with the click of a button.
- For home delivery fills: Refill your prescriptions, get real-time order status and tracking, sign up for automatic refills, pay your bill online, sign up for a payment plan, and more.
- For retail pharmacy fills: View where and when you last filled your medications.
- For specialty medications: Easily connect to your online Accredo account to manage orders.⁴

➤ **See which medications your plan covers.** You have hundreds of generic, preferred brand, and non-preferred brand medications to choose from.

➤ **Use the Price a Medication tool to see how much your medication costs.** You can also see if there are lower-cost alternatives available.⁵

➤ **View your plan information.** See your pharmacy claim history, coverage details, and account balances.

Call 800.835.3784



**Place
an order**



**Talk to customer
service about
an order**



**Talk to a
pharmacist about
your medication**



1. Standard shipping costs are included as part of your prescription plan.

2. Express Scripts® Pharmacy can automatically refill certain medications. Log in to the myCigna App or website or call 800.835.3784 to sign up.

3. Certain medications may only be packaged in less than a 90-day supply. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.

4. Not all plans offer Accredo as a covered pharmacy option. Please log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network.

5. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.

Para obtener ayuda en español llame al número en su tarjeta de Cigna.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

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Contacts & Resources

Carrier Contacts	Website/Email	Phone Number
Cigna <i>Medical & RX</i>	www.myCigna.com	1 (800) 244-6224
Cigna <i>Telemedicine Services</i>	www.myCigna.com	1 (888) 726-3171
Cigna <i>Dental</i>	www.myCigna.com	1 (800) 244-6224
VSP <i>Vision</i>	www.vsp.com	1 (800) 877-7195
United Healthcare <i>Life & Disability Insurance</i>	www.myuhc.com	1 (888) 299-2070
Cigna <i>Worksite Benefits</i>	www.myCigna.com	1 (800) 997-1654
Mines and Associates <i>Employee Assistance Program</i>	www.minesandassociates.com	1 (800) 873-7138
Principal Financial Group <i>401(k)</i>	www.principal.com	1 (800) 547-7754

Employer Contact	Email	Phone Number
Debbie Finn <i>HR Manager</i>	dfinn@haynesmechanical.com	(720) 829-7559



Model (For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA ****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

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

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

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

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

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

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Debbie Finn, HR Manager

dfinn@haynesmechanical.com

(720) 829-7559



Important Notice from Haynes Mechanical Systems, Inc. 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 Haynes Mechanical Systems, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Haynes Mechanical Systems, Inc. has determined that the prescription drug coverage offered by the Cigna Healthcare plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan and drop your current Haynes Mechanical Systems, Inc. coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.



When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Haynes Mechanical Systems, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Haynes Mechanical Systems, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	6/1/2025
Name of Entity/Sender:	Haynes Mechanical Systems, Inc.
Contact--Position/Office:	Debbie Finn, HR Manager
Address:	5700 S Quebec Street, Ste 210, Greenwood Village, CO 80111
Phone Number:	(303) 779-0787

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly

- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact you may contact Cigna at www.cigna.com/contact-us/ or by calling 1-800-997-1654.

Visit www.healthcare.gov for more information about your rights under federal law.

PATIENT PROTECTION DISCLOSURE

Cigna 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 Cigna at www.cigna.com/hcpdirectory/.

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



NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: \$2,000 individual deductible and 20% coinsurance. If you would like more information on WHCRA benefits, call your plan administrator at 1-800-997-1654.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 1-800-997-1654 for more information.



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations
- We are not required to agree to your request, and we may say "no" if it would affect your care



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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety*

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

- Help manage the health care treatment you receive
- We can use your health information and share it with professionals who are treating you
- Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services

Run our organization

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

Pay for your health services

- We can use and disclose your health information as we pay for your health services
- Example: We share information about you with your dental plan to coordinate payment for your dental work



Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

- We can use or share your information for health research

Comply with the law

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

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

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

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

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

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena

Our Responsibilities

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

Changes to the Terms of this Notice

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



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

Beginning in 2014, there is 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.

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. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 (adjusted to 9.02% for 2025), 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?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 Haynes Mechanical Systems, Inc.		4. Employer Identification Number (EIN) 84-1318272	
5. Employer address 5700 S Quebec Street, Ste 210		6. Employer phone number (303) 779-0787	
7. City Greenwood Village	8. State CO	9. ZIP code 80111	
10. Who can we contact about employee health coverage at this job? Debbie Finn			
11. Phone number (if different from above) (720) 829-7559		12. Email address dfinn@haynesmechanical.com	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time or part-time employees working 30 or more hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Covered spouse or domestic partner, any natural child, step-child, foster child, or adopted child (up to age 26), or dependent child over the age of 26 who is physically or mentally unable to care for themselves.

☐ 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2025. Contact your State for more information on eligibility.

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

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

To see if any other states have added a premium assistance program since January 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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



Glossary

Allowed Amount	Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference.
Balance Billing	When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you for covered services.
Coinsurance	Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is \$100 and you’ve met your deductible, your coinsurance payment of 20% would be \$20. The insurance or plan pays the rest of the allowed amount.
Copayment (Copay)	A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Deductible	The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won’t pay anything until you’ve met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.
Emergency Medical Condition	An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.
Explanation of Benefits (EOB)	A statement that gives all of the details about what the health insurance plan covers, what the plan does not cover, how much money needs to be paid, and more.
Network	The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.
Out-of-Pocket Limit	The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance plan doesn’t cover. Some health insurance or plans don’t count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.
Out-of-Pocket Maximum	The most money you have to pay for covered expenses in a plan year.
Primary Care Physician (PCP)	A physician (M.D.—Medical Doctor or D.O.—Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.
Specialist	A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.
Urgent Care	Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

QUESTIONS?

Have Questions? We've Got You.

If you need help navigating your benefits or have any questions along the way, reach out to Debbie Finn or Danielle Tyner in HR — they're here to support you.

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