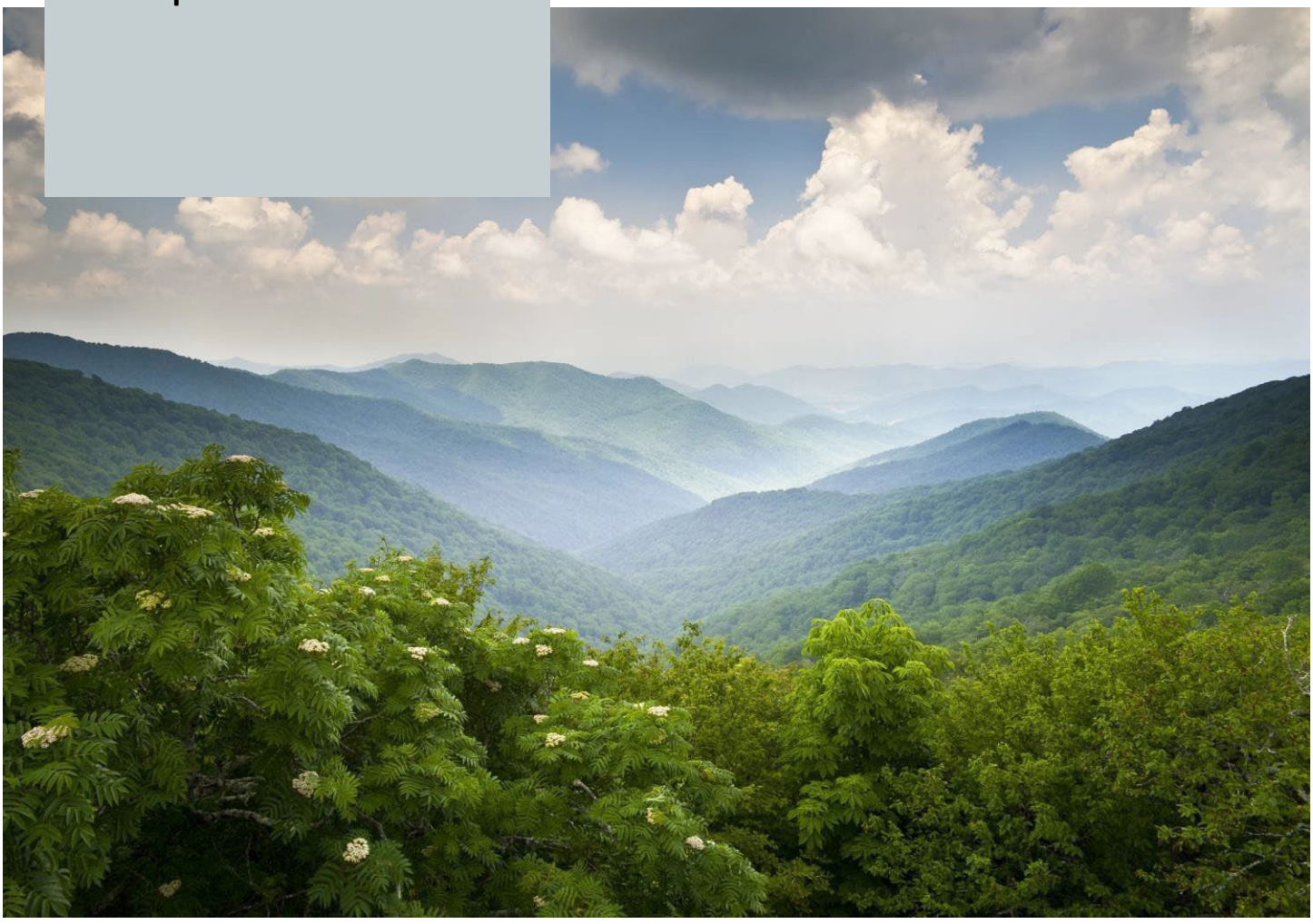
Benefits Enrollment Guide

2025

CapinCrouse



Annual Enrollment Checklist

Use this checklist to help you through the enrollment process. CapinCrouse's annual enrollment period takes place in December for an effective date of January 1st.

Before Enrollment:

Before enrollment begins, take the time to educate yourself on all of the benefit options that are available to you. CapinCrouse provides a variety of resources to help you make your benefit decisions. These tools can be accessed online within the Paycor Benefits Portal, as well as on CapinConnect.

- ☐ Review this Benefits Enrollment Guide carefully as you consider your plan choices.
- ☐ Attend a Benefits Enrollment Meeting, if available, to hear benefits staff explain the details of each plan and give you an overview of all benefit programs.

During Enrollment:

- ☐ Actively enroll each December. Every eligible employee must complete enrollment, even if they do not want to make changes.
- ☐ Select your beneficiary(ies). If you already have a beneficiary(ies) listed, please be sure they are up-to-date.
- ☐ Once you have completed your enrollment online, save or print a copy of your confirmation, review it for accuracy, and retain it for your records. The Benefits Department will not mail confirmations to your home address.

After Enrollment:

- ☐ Verify your benefit elections after your effective date or when any changes are made by regularly reviewing your paystubs. If you notice any errors, notify the Benefits Department immediately at **1-505-50-CAPIN**. Most elections cannot be changed after the effective date except within 30 days of a qualifying life event.

New Hire Enrollment Information

Before Enrollment:

- Before enrolling, take the time to educate yourself on all of the benefit options that are available to you, as well as meet with an HR team member to discuss details about the benefit offerings. Review this Benefits Enrollment Guide carefully as you consider your plan choices.
- If you are electing to cover your dependents on any plans, proof of dependent eligibility may be required.

During Enrollment:

- Be sure to make your elections within 30 days after your eligibility date. If you do not make elections, then you may not be able to enroll until the next open enrollment period.

After Enrollment:

- Medical coverage: If you elect coverage, you will receive an ID card in the mail that you should use for all medical and prescription services. Your ID card contains important information about you, your employer group and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card. Additionally, if you elected a plan that includes the secondary/gap coverage, you will also receive an ID card for that plan as well, which you should present to all medical providers (with the exception of pharmacies).
- Dental coverage: If you elect coverage, you may receive an ID card. For dental services, coverage will be tied to the employee's social security number. Be sure to give this to your provider at time of service.
- Vision coverage: For vision services, coverage will be tied to the employee's social security number. Be sure to give this to your provider at the time of service.

General:

- The new 2025 plan year is from January 1, 2025 - December 31, 2025.
- Your medical, dental and vision plan premiums are pre-tax, which means you save money, and you can only make future changes to your elections during Open Enrollment or if you have a qualifying life event. Choose your new hire elections carefully.
- As long as you enroll within 30 days of your eligibility date, new hires are not required to provide proof of good health to enroll in voluntary life or disability insurance, if available.

Eligibility & Enrollment

CapinCrouse is proud to offer a comprehensive program of benefits to service the diverse needs of our workforce, and we are committed to continually enhancing and expanding our offerings. The information in this document is meant to familiarize you with the benefits and programs currently in place. Please remember that this guide is not intended to cover all provisions of all plans, but rather is a quick reference to help answer most of your questions. Please see each benefit's Summary Plan Description for complete details of the benefits.

Am I Eligible?

Eligibility and required contributions for these benefits and programs depend on both your employee classification and whether you elect to extend coverage to your dependents.

Dependents eligible for coverage under the plans include:

- Your legal spouse
- Your dependent child(ren) up to age 26, regardless of full-time student status or marital status
- Your unmarried children of any age who are incapable of self-support due to mental or physical disability and who are totally dependent on you

Change In Status

Once you have made your benefit elections and your enrollment is closed, you cannot make changes until the next open enrollment period unless you experience a qualified change in status, such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

You have 30 days from the date of the qualifying event to notify Human Resources and provide appropriate documentation to change your benefits. Requests received after 30 days will not be accepted.

Please note: Not every change in status permits a change in benefit plan elections. A change in election is permitted only when it is determined that the change in status affects eligibility for coverage of the employee, a spouse or a dependent under a benefit plan.

Plan	Employment Status	New Hire Waiting Period
Medical & Prescription	Full-time, actively at work and scheduled to work 30+ hours per week on a non-seasonal basis	Benefits are effective the first day of employment or the first day in which an employee transitions to an eligible class
Dental		
Vision		
Health Savings Account		
Flexible Spending Accounts*		
Basic & Voluntary Life		
Employer-Paid Short- and Long-Term Disability		
401(k) Plan*		
Employee Assistance Program		

**Non-seasonal employees scheduled to work 10+ hours per week are eligible to participate in the Flexible Spending Accounts. All non-seasonal employees are eligible for participation in the 401(k) plan immediately upon hire.*

Medical Insurance – High Deductible Health Plan (HDHP)

CapinCrouse's medical and prescription drug insurance is provided through Aetna. Below is a brief summary of the HDHP plan. If you elect this plan option, you may also participate and contribute to a Health Savings Account (HSA). CapinCrouse will contribute $500 for Employee Only and $1,000 for Employee/Spouse, Employee Child(ren) and Family annually towards your HSA, with contributions being prorated and deposited with each regular pay period. This medical plan utilizes Aetna's Open Access Managed Choice POS – Indiana network. In order to make the best use of your benefits and out-of-pocket expenses, we strongly encourage the use of in-network providers, Tier 1 drugs whenever possible, and Urgent Care facilities instead of Emergency Room visits.

Aetna HDHP with HSA Plan		
Services	**In-Network**	**Out-of-Network**
Annual Deductible Individual / Family	$5,000 / $10,000	$10,000 / $20,000
Annual Out-of-Pocket Maximum Individual / Family	$7,000 / $14,000 (includes deductible)	$14,000 / $28,000 (includes deductible)
Coinsurance	20% after deductible	40% after deductible
Preventive Care Services *	100% covered, no charge	40% after deductible
Primary Care Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Virtual Visit	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room	20% after deductible	
Inpatient Services	20% after deductible	40% after deductible
Prescription Drugs - Tier 1 - Tier 2 - Tier 3 - Tier 4	$10 copay after deductible $45 copay after deductible $70 copay after deductible 30% with a minimum of $250 after deductible	40% of submitted cost; after applicable in-network cost share

*You can find a list of preventive services at https://uspreventiveservicestaskforce.org/uspstf/

Medical Insurance – PPO Base Plan

CapinCrouse's medical and prescription drug insurance is provided through Aetna. Below is a brief summary of the PPO Base Plan. This plan utilizes Aetna's Open Access Managed Choice POS – Indiana network. In order to make the best use of your benefits and out-of-pocket expenses, we strongly encourage the use of in-network providers, Tier 1 drugs whenever possible, and Urgent Care facilities instead of Emergency Room visits.

(The firm also provides a medical bridge plan, which is designed to coordinate with this PPO plan, significantly reducing and often eliminating the deductible and coinsurance on this option. Anyone enrolling in this PPO plan is automatically enrolled in the secondary (gap) coverage. Additional information on this benefit is provided in this guide.)

Aetna Healthcare PPO Base Plan		
Services	**In-Network**	**Out-of-Network**
Annual Deductible Individual / Family	$5,000/ $12,500	$10,000 / $25,000
Annual Out-of-Pocket Maximum Individual / Family	$7,000 / $14,000 (includes deductible)	$18,000 / $45,000 (includes deductible)
Coinsurance	30% after deductible	50% after deductible
Preventive Care Services	100% covered, no charge	50% after deductible
Primary Care Office Visit	$30 copay	50% after deductible
Specialist Office Visit	$60 copay	50% after deductible
Virtual Visit	$30 copay	50% after deductible
Urgent Care Facility	$75 copay	50% after deductible
Emergency Room	$500 copay	
Inpatient Services	30% after deductible	50% after deductible
Prescription Drugs - Tier 1 - Tier 2 - Tier 3 - Tier 4	 $10 copay $45 copay $70 copay 30% up to the maximum of $250	50% of submitted cost; after applicable in-network cost share

*You can find a list of preventive services at https://uspreventiveservicestaskforce.org/uspstf/

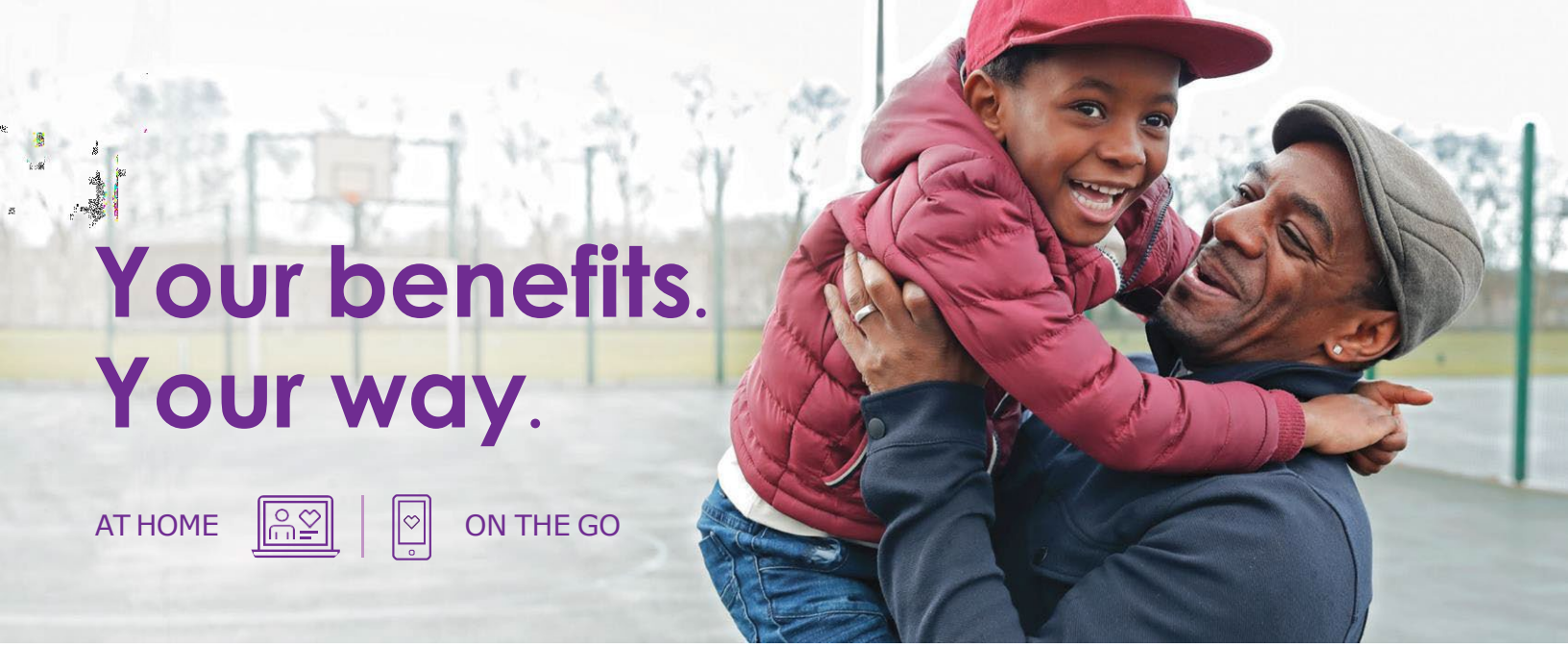
Medical Insurance – PPO Buy-Up Plan

CapinCrouse's medical and prescription drug insurance is provided through **Aetna**. Below is a brief summary of the PPO Buy-Up Plan. This plan utilizes Aetna's Open Access Managed Choice POS – Indiana network. In order to make the best use of your benefits and out- of- pocket expenses, we strongly encourage the use of in-network providers, Tier 1 drugs whenever possible, and Urgent Care facilities instead of Emergency Room visits.

(The firm also provides a medical bridge plan, which is designed to coordinate with this PPO plan, significantly reducing and often eliminating the deductible and coinsurance on this option. Anyone enrolling in this PPO plan is automatically enrolled in the secondary (gap) coverage. Additional information on this benefit is provided in this guide.)

Aetna Healthcare PPO Buy-Up Plan		
Services	**In-Network**	**Out-of-Network**
Annual Deductible Individual / Family	$5,000/ $10,000	$15,000 / $30,000
Annual Out-of-Pocket Maximum Individual / Family	$7,000 / $14,000 (includes deductible)	$21,000 / $42,000 (includes deductible)
Coinsurance	0% after deductible	25% after deductible
Preventive Care Services	100% covered, no charge	25% after deductible
Primary Care Office Visit	$30 copay	25% after deductible
Specialist Office Visit	$60 copay	25% after deductible
Virtual Visit	$30 copay	25% after deductible
Urgent Care Facility	$50 copay	25% after deductible
Emergency Room	$500 copay	
Inpatient Services	0% after deductible	25% after deductible
Prescription Drugs - Tier 1 - Tier 2 - Tier 3 - Tier 4	$10 copay $45 copay $70 copay 30% up to the maximum of $250	20% of submitted cost; after applicable in-network cost share

*You can find a list of preventive services at https://uspreventiveservicestaskforce.org/uspstf/



Your benefits. Your way.

AT HOME | ON THE GO

Stay on top of your health care, when and where it works for you.

Understand and manage your benefits

- Review benefits and coverage details specific to your plan.
- See what your health care costs, how much is covered by your plan and where you are with your deductible and out-of-pocket maximum.
- View and pay claims for your whole family.
- Access your ID card whenever you need it.

Connect to care and stay healthy

- Find in-network providers, including those offering telemedicine services, as well as walk-in clinics and urgent cares near you.
- Get cost estimates before you get care.
- View ratings and reviews of providers.
- Talk with a doctor anytime by phone or video chat.
- Receive personalized reminders to help you improve your health.

Register now to get started

Visit myaetnawebsite.com to register for your member website.

Get the **Aetna Health℠ app** by texting "**AETNA**" to **90156** to receive a download link. Message and data rates may apply.*

Aetna.com

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aetna®

Loomis Company (Gap) Secondary Plan Summary

The firm provides a medical bridge plan (administered by **The Loomis Company**) which is designed to coordinate with the primary PPO plans, significantly reducing and often eliminating the deductible and coinsurance on those options. *(The Loomis Company is a new administrator for this plan in 2025.)* While plan copays still apply for things like doctor's office visits and prescriptions, the plan provides secondary comprehensive coverage for nearly all other plan expenses, essentially doing away with the in-network deductible in many cases, which members would otherwise incur. **Anyone enrolling in one of the PPO plans is automatically enrolled in the secondary (gap) coverage.**

Inpatient/Outpatient Services	
Benefit Year Maximum Per Covered Person/Family	$6,000 / $12,000
Examples of Covered Inpatient Services	Hospital room and board Inpatient surgery Radiological imaging Professional fees (i.e. surgeon)
Examples of Non-Covered Inpatient Services	Drug/alcohol treatment Nursing home Skilled nursing facility Hospice care facility
Examples of Covered Outpatient Services	Physical therapy expenses Independent laboratory services (i.e. Quest, LabCorp) Treatment in a hospital ER Surgery in an outpatient facility Radiological diagnostic testing in hospital or MRI facility Cancer outpatient treatment Ambulance expenses Treatments in physician office applied to deductible including: X-rays and other imaging Chiropractic services In-office laboratory expenses Office charges applied to deductible Durable medical equipment (DME)
Examples of Non-Covered Outpatient Services	Physician office visits and services covered under a copay Substance abuse treatment Prescription drugs

Loomis Company (Gap)

INNOVATIVE WORKPLACE BENEFITS
Innovative Solutions For Today's Workforce

How do I file a claim for my GAP plan?

Insured Instructions

You have two options for filing a GAP plan claim!

Present Your ID Card to the Provider

At the time of service, be sure to hand the provider both your medical ID card (primary) ***and*** your GAP plan ID card (secondary).

This will allow the provider to file the claim for you by following the instructions on the ID card and accepting the assignment of benefits, the same way they would with any "secondary" insurance coverage.

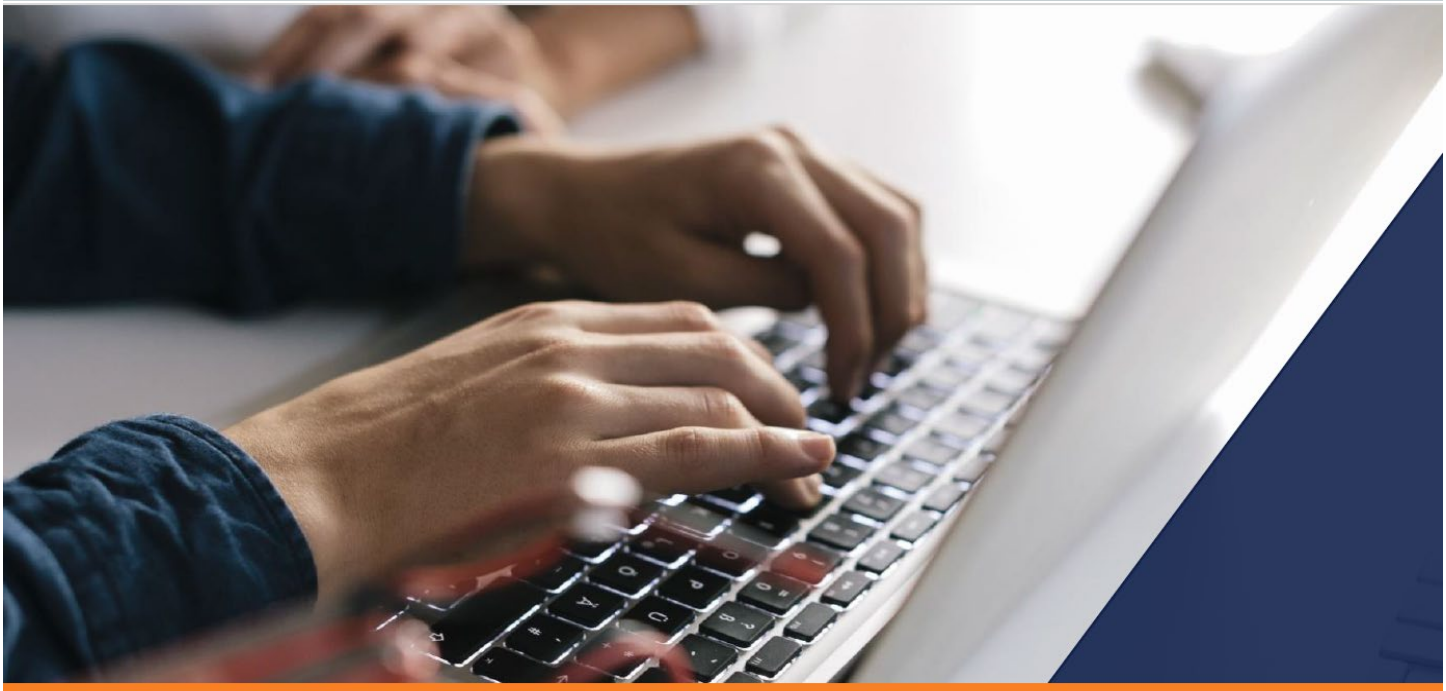
Submit a Claim Directly to the GAP Administrator

If for any reason the provider cannot submit the claim for you, you have the option of submitting a claim directly to the GAP plan administrator.

You will generally need certain information and documents from your provider, such as an explanation of benefits (EOB) or an itemized bill, to complete the claim submission.

For additional information or to check the status of a claim, visit: www.loomisco.com
Need further assistance? Call 866-340-7184 to speak with a Customer Service representative.

Loomis Company (Gap)



Detailed Instructions from Your Administrator

The Loomis Company

A member can file a GAP claim (in the event the provider cannot or will not file a claim) by sending Loomis the primary Explanation of Benefits (EOB), the Itemized Bill and any additional major medical claim information. If the documents being submitted do not include the provider's address and contact information, a member should include that information in their submission to help expedite the claims processing. A claim form is not required.

Members can either mail in a claim or submit it through Loomis's Employee Portal.

Mail Your Claims to:
The Loomis Company
PO Box 7011
Reading, PA 19612-3668

Submit via Loomis Portal:
Visit www.loomisco.com to Log In
Click "Submit a Claim" Under Quick Links
Attach Items/Info Listed Above

Once this information is received, Loomis will process the claim to determine benefits to be paid. You may be contacted if additional information is required. And a final GAP Explanation of Benefits will be sent to you.

For Benefits and Eligibility, the member or providers can contact Loomis Customer Service at 866-340-7184.

For additional information or to check the status of a claim, visit: www.loomisco.com
Need further assistance? Call 866-340-7184 to speak with a Customer Service representative.

Health Savings Account (HSA)

If you enroll in a High Deductible Health Plan (HDHP), you should consider contributing to the Health Savings Account administered by **Associated Bank**. CapinCrouse will contribute $500 for Employee Only and $1,000 for Employee/Spouse, Employee Child(ren) and Family annually towards your HSA. (The firm's contributions to the HSA will be prorated and deposited with each regular pay period.) With an HSA, you can gain more control over your health care expenses because contributions, interest and withdrawals for qualified health care expenses are all tax-advantaged. This plan is not available for those enrolled in a PPO Plan.

Why have an HSA?

- Contributions are tax deductible
- Withdrawals to pay for eligible expenses are never taxed
- Accumulated interest earnings are tax deferred, and if used to pay eligible expenses, are tax free
- Money not used at year end 'rollsover' for use the next year
- The balance in your HSA account can be invested

Eligibility Requirements:

- Must be enrolled in a Qualified High Deductible Health Plan (HDHP)
- Must not be enrolled in Medicare
- Must not be covered by other medical insurance(s) such as a Health Care FSA, HRA and other 'first dollar' coverage
- Must not have received VA medical benefits at any time in the past three months
- May not be claimed as a dependent on another individual's tax return
- Spouse not contributing to/participating in a Health Care FSA through his/her employer

Health Savings Account (HSA)			
Coverage Level	**2025 IRS Contribution Limits**	**Employer 2025 Contribution**	**Employee 2025 Maximum Contribution**
Employee Only	$4,300	$500	$3,800
Employee + Spouse	$8,550	$1,000	$7,550
Employee + Child(ren)	$8,550	$1,000	$7,550
Family Coverage	$8,550	$1,000	$7,550

All HSA participants will receive an HSA debit card from Associated Bank. Your HSA card can be used to pay for qualified medical expenses billed from an insurance company, a physician's office and pharmacies. Transactions with your HSA debit card are secure and may only be used to purchase eligible and authorized items.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.

Flexible Spending Accounts (FSAs)

CapinCrouse continues to offer Health Care and Dependent Care Flexible Spending Accounts (FSAs), administered by **Associated Bank**. FSAs allow you to pay for eligible health care and dependent care expenses with pre-tax dollars, which can increase your take-home pay. The Dependent Care FSA is offered to all eligible employees, no matter what medical plan you may be covered under, through CapinCrouse or elsewhere.

Health Care FSAs may be used to pay for eligible medical, prescription, dental and vision expenses not fully covered by your insurance plans for you and your tax eligible dependents. If you are enrolled in the HDHP Plan, you are not eligible to participate in the Health Care FSA.

Dependent Care FSAs may be used to pay for eligible expenses related to the care and supervision of your child (to age 13) or adult dependent on your tax return. Eligible expenses include child or adult daycare, after school care, nursery school, nanny or babysitter. You must accumulate the funds in your Dependent Care FSA before you can be reimbursed.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.

	Our Plan Maximums
Health Care FSA	$3,300
Dependent Care FSA	$5,000 (or $2,500 if married and filing separately)

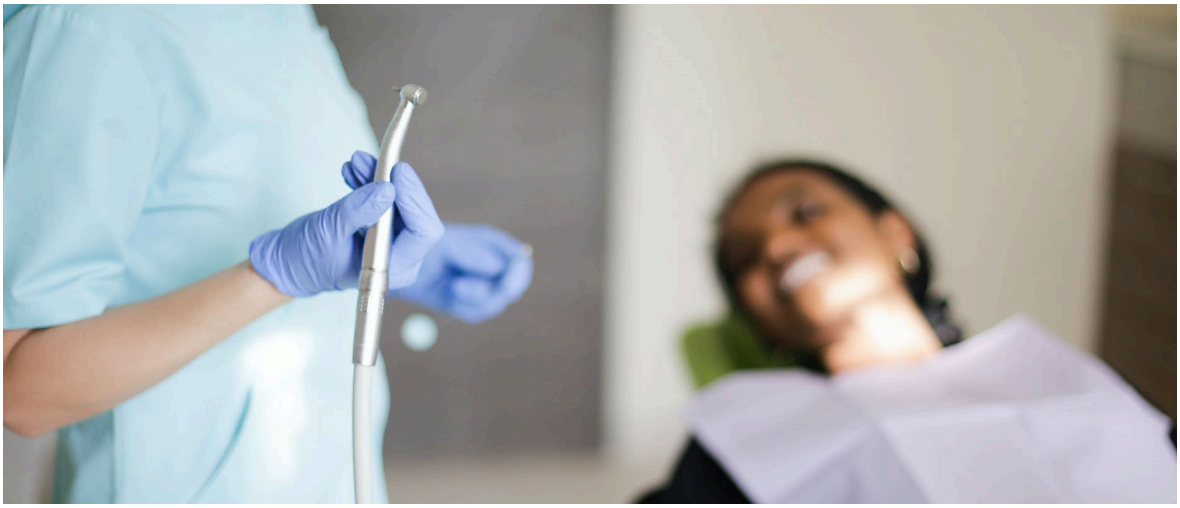
FSA	Expense Incurred	Submit Expense for Reimbursement
Health Care FSA	January 1, 2025—March 15, 2026	January 1, 2025—May 15, 2026
Dependent Care FSA	January 1, 2025—March 15, 2026	January 1, 2025—May 15, 2026

Dental Insurance

CapinCrouse's administrator for the dental plan is **Aetna**. Your dental network is the Preferred Provider Organization (PPO) MAX. You may continue to seek treatment from the dentist of your choice, but you will always realize your biggest savings by visiting in-network providers whenever possible. In-network providers have contracted rates with the carrier, giving you the best available price for services. Out-of-network providers do not have contracts, so they are free to charge the usual and customary cost of the service rather than only the negotiated discounted rate throughthe carrier. The chart below provides a summary of your dental benefits.

Aetna Dental Plan		
Services	**In-Network**	**Out-of-Network***
Annual Deductible Individual / Family	$50 / $150	$50 / $150
Calendar Year Maximum	$2,000	$2,000
Preventive Services (Covered services include oral exams, brush biopsies, cleanings and x-rays)	100%, not subject to deductible	100%, not subject to deductible
Basic Services	20% after deductible	20% after deductible
Major Services	50% after deductible	50% after deductible
Child Orthodontia up to age 19	50% with a lifetime maximum of $1,000	50% with a lifetime maximum of $1,000

*Non-Participating coverage is limited to a maximum allowable charge (MAX) of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.



Vision Insurance

CapinCrouse's administrator for the vision plan is **Unum**, utilizing the EyeMed network. You may seek treatment from the eye doctor of your choice, but you will realize your biggest savings by visiting in-network providers whenever possible. Please see the summary below for an outlineof covered services.

Unum Vision Plan		
Services	**In-Network**	**Out-of-Network***
Eye Exam	$10 copay	Up to $40
Lenses - Single - Bifocal - Trifocal - Lenticular	 $10 copay $10 copay $10 copay $10 copay	 Up to $30 Up to $50 Up to $70 Up to $70
Frames	$150 allowance	Up to $150
Contact Lenses (in lieu of frames) - Conventional - Medically Necessary	 $150 allowance Covered at 100%	 Up to $150 Up to $210
Frequency - Exam - Lenses or Contact Lenses - Frames	Based on Date of Service 12 months 12 months 24 months	

*Out-of-network amounts are reimbursed to member.

Cost of Coverage

Aetna Medical – HDHP Plan	Semi-Monthly Deduction
Employee Only	$0.00
Employee + Spouse	$217.45
Employee + Child(ren)	$170.96
Family	$279.55

Aetna Medical – PPO Base Plan *(Gap Plan Premiums Included in Cost)*	Semi-Monthly Deduction
Employee Only	$20.37
Employee + Spouse	$276.12
Employee + Child(ren)	$223.58
Family	$361.33

Aetna Medical – PPO Buy-Up Plan *(Gap Plan Premiums Included in Cost)*	Semi-Monthly Deduction
Employee Only	$62.00
Employee + Spouse	$432.39
Employee + Child(ren)	$298.13
Family	$659.97

Aetna Dental Plan	Semi-Monthly Deduction
Employee Only	$0.00
Employee + Spouse	$15.95
Employee + Child(ren)	$16.80
Family	$36.47

Unum Vision Plan	Semi-Monthly Deduction
Employee Only	$3.38
Employee + Spouse	$5.68
Employee + Child(ren)	$5.79
Family	$9.16

Life and AD&D Insurance

Basic Life Insurance

CapinCrouse provides eligible employees with Basic Term Life and Accidental Death and Dismemberment (AD&D) coverage through Unum. Please remember to review and update your beneficiary designation annually.

Benefit	Basic Life and AD&D Insurance
Employee Life	1X annual earnings to a maximum of $150,000
Basic AD&D Amount	Matches Employee Life amount
Reduction	65% at age 65 40% at age 70 25% at age 75

Voluntary Life and AD&D Insurance

CapinCrouse is offering employees who would like to supplement their Basic Term Life and AD&D insurance benefits the opportunity to purchase additional coverage through Unum. You may purchase coverage for yourself, your spouse and your dependents in the amounts shown in the table below. Please note you must elect Voluntary Life for yourself in order to enroll your spouse and/or eligible dependents.

Benefit	Voluntary Life Insurance
Employee	$10,000 increments up 5X annual earnings to a maximum of $300,000
Employee Guarantee Issue Amount	5X annual salary, up to $100,000
Spouse	$5,000 increments, 100% of employee's benefit up to $150,000
Spouse Guarantee Issue Amount	$30,000
Dependent Child	Live birth to 14 Days - $1,000 14 Day to 6 Months Old - $1,000 $2,000 increments, up to $10,000
Reduction	65% at age 65 40% at age 70 25% at age 75

Voluntary Life Insurance	
Employee/Spouse Age	**Monthly Premiums (per $1,000)**
< 25	$0.05
25-29	$0.05
30-34	$0.05
35-39	$0.08
40-44	$0.14
45-49	$0.21
50-54	$0.42
55-59	$0.65
60-64	$0.70
65-69	$1.24
70-74	$3.23
75+	$12.98
Supplemental AD&D Rate Per $1,000	Emp.: $0.03 / Spouse: $0.03 /Child(ren): $0.04
Child(ren) Life Rate per $1,000	$0.16

Short-Term Disability (Employer-Paid)

Short-Term Disability

CapinCrouse is proud to provide all eligible employees with Employer-Paid Short-Term Disability benefits, administered through Unum. There is no cost to you for this valuable coverage and eligible employees are automatically enrolled. Disability benefits protect a portion of your income in the event of any injury, accident or illness that keeps you from working.

Benefits are provided in the event you become disabled for more than 7 days due to a non work-related accident or illness. The plan pays 60% of an eligible employee's pre-disability base weekly earnings, to a maximum of $1,500 per week for a qualified disability.

Benefit Detail	Short-Term Disability
Waiting Period	Benefits begin on 8th day due to accident or illness
Benefits Duration	12 weeks
Benefit Percentage	60% of weekly income
Maximum Benefit	$1,500 per week

Long-Term Disability

Long-Term Disability

CapinCrouse is proud to provide all eligible employees with Employer-Paid Long-Term Disability benefits, administered through Unum. There is no cost to you for this valuable coverage and eligible employees are automatically enrolled. In the event you become disabled due to a non-work related injury or illness, disability income benefits are there to help provide a source of income.

Benefit Detail	Long-Term Disability
Waiting Period	90 days
Benefits Duration	Benefits are paid to the later of either age 65 or Social Security Normal Retirement Age (SSNRA)
Benefit Percentage	60% of monthly income
Maximum Benefit	$10,000 per month
Pre-Existing Conditions*	Pre-existing conditions may not be covered by this plan

401(k) Retirement Savings Plan

CapinCrouse's 401(k) Plan through **EMPOWER Retirement Services** is a valuable benefit program offered to you as an employee. It can help you put money aside for a financially secure retirement. Through the plan, you can save for retirement now so that you will have the income you'll need after you stop working.

Participation is easy. You can contribute a portion of your pay to your 401(k) account through convenient payroll deductions. These contributions are then invested in the Plan's investment options you select.

IRS Contribution Limits	2025
Pre-Tax or Roth (After-Tax) Contributions	$23,000
Catch-Up (Age 50+)	$7,500

	401(k) Retirement Savings Plan
Eligibility	All non-seasonal employees are eligible to participate in the plan immediately upon hire
Contributions	Up to 100% of annual salary (up to IRS maximums)
Company Safe Harbor Contribution	3%, vested immediately

Employee Assistance Program (EAP)

unum
Better benefits at work.

Help, when you need it most

With your Employee Assistance Program and Work/Life Balance services, confidential assistance is as close as your phone or computer.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver™ — helps you save on medical bills

Who is covered?

Unum's EAP services are available to all eligible employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Employee Assistance Program — Work/Life Balance

Toll-free 24/7 access:

- 1-800-854-1446 (multi-lingual)
- www.unum.com/lifebalance

Turn to us, when you don't know where to turn.

Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Family and parenting problems
- Anger, grief and loss
- And more

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

Ask our Work/Life Specialists about:

- Child care
- Elder care
- Legal questions
- Identity theft
- Financial services, debt management, credit report issues
- Even reducing your medical/dental bills!
- And more

Help is easy to access:

- **Online/phone support:** Unlimited, confidential, 24/7.
- **In-person:** You can get up to 3 visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

* The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

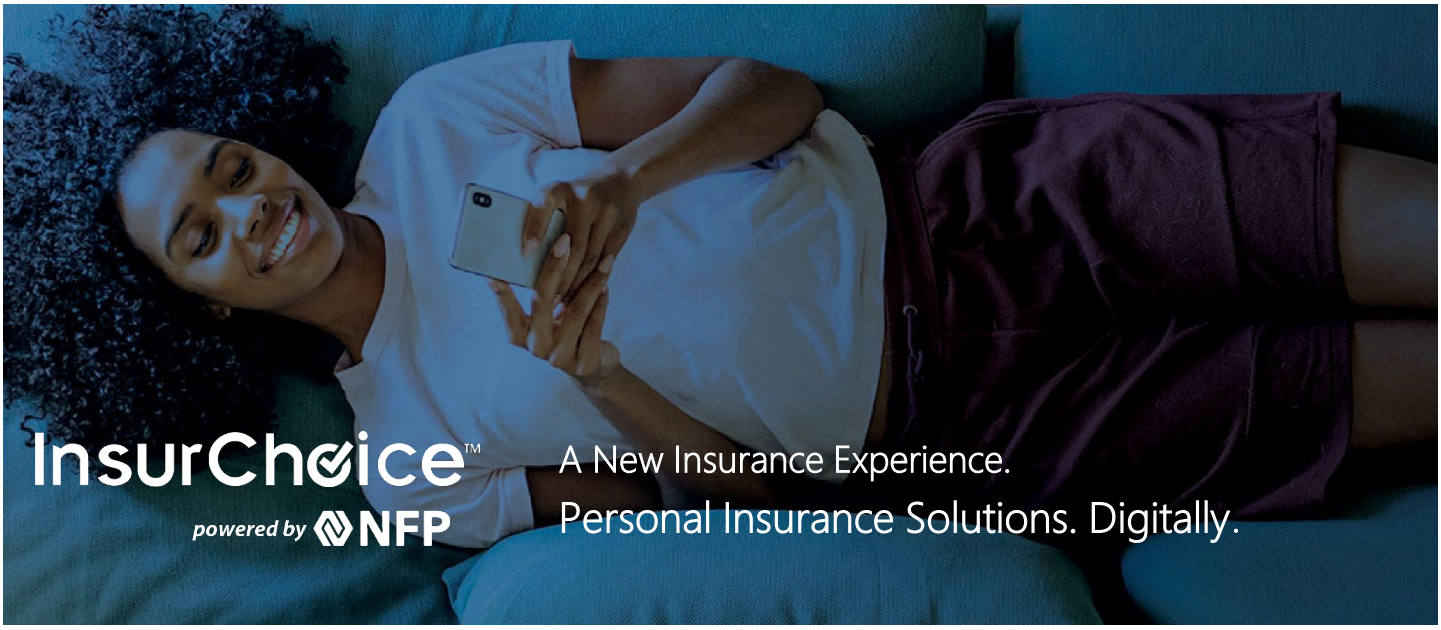
Unum's Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Insurance products are underwritten by the subsidiaries of Unum Group.

unum.com

EN-2058 (4-18) FOR EMPLOYEES

Additional Benefits - InsurChoice



All-around protection for what matters most to you — spanning the entire breadth of NFP's focused expertise.

Key benefits include:

- **Competitive pricing:** One size doesn't fit all, so you can match yourself with the best rates and coverages from multiple insurance companies.
- **Custom-tailored coverage:** Select the products that meet YOUR needs & YOUR schedule.
- **Stability:** We have relationships with key national carriers who have a proven track record of rate and coverage stability.
- **Innovation:** With our innovative digital product platform we are constantly striving to add more benefits and improve your experience.

For more information, visit

https://digital.nfp.com/pc/CCBDO_IC_MP

Or email us at InsurChoice@nfp.com

Your Personalized Solutions are a scan away!

Scan Here to start $aving Today!

Additional Benefits – InsurChoice Cont'd

A New Insurance Experience
InsurChoice™
Personal Insurance Solutions. Digitally.

Your Menu

Pick and choose the products that fit your needs for a custom experience.


Auto Insurance


Home Insurance


Renters Insurance


Pet Insurance


Medicare Advantage


Travel Protection


Discount Program


Mental Wellness


Home Warranty

InsurChoice™ powered by NFP

Required Annual Notices

Notices not described below, including rights under the Uniform Services Employment and Reemployment Rights Act (USERRA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Employee Retirement Income Security Act (ERISA) can be found in the Summary Plan Descriptions (SPDs) or by calling Human Resourcesat **1-505-50-CAPIN.**

Special Enrollment Notices

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources representative.

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 reconstructionof the breast on which the mastectomy was performed;
- surgery and reconstructionof the other breast to producea symmetrical appearance;
- prostheses; and
- treatment of physicalcomplications 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 the plans offered. If you would like more information on WHCRA benefits, call your Plan Administrator at **1-505-50-CAPIN.**

Women's Health and Cancer Rights Act 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 **1-505-50-CAPIN.** for more information.

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospitallength 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).

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

If you or your children are eligible for Medicaidor 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.

Required Annual Notices

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 employerplan, 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 followinglist of states is current as of July 31, 2019. Contact your State for more informationon eligibility.

State	Program	Website	Phone Number
Alabama	Medicaid	http://myalhipp.com/	1-855-692-5441
Alaska	Medicaid	The AK Health Insurance Premium Payment Program: http://myakhipp.com/ CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861
Arkansas	Medicaid	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
Colorado	Medicaid	https://www.healthfirstcolorado.com/ https://www.colorado.gov/pacific/hcpf/child-health-plan-plus	1-800-221-3943 1-800-359-1991/ State Relay 711
Florida	Medicaid	http://flmedicaidtplrecovery.com/hipp/	1-877-357-3268
Georgia	Medicaid	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	678-564-1162ext 2131
Indiana	Medicaid	http://www.in.gov/fssa/hip/ http://www.indianamedicaid.com	1-877-438-4479 1-800-403-0864
Iowa	Medicaid	http://dhs.iowa.gov/Hawki	1-800-257-8563
Kansas	Medicaid	http://www.kdheks.gov/hcf/	1-785-296-3512
Kentucky	Medicaid	https://chfs.ky.gov	1-800-635-2570
Louisiana	Medicaid	http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	1-888-695-2447
Maine	Medicaid	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-442-6003 TTY: Maine relay 711
Massachusetts	Medicaid and CHIP	http://www.mass.gov/eohhs/gov/departments/masshealth/	1-800-862-4840
Minnesota	Medicaid	https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/ programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri	Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084

Required Annual Notices

State	Program	Website	Phone Number
Nebraska	Medicaid	http://www.ACCESSNebraska.ne.gov	Phone: (855)632-7633 Lincoln: (402)473-7000 Omaha: (402)595-1178
Nevada	Medicaid	https://dhcfp.nv.gov	1-800-992-0900
New Hampshire	Medicaid	https://www.dhhs.nh.gov/oii/hipp.htm	603-271-5218
New Jersey	Medicaid CHIP	hhttp://www.state.nj.us/humanservices/dmahs/clients/medicaid/ http://www.njfamilycare.org/index.html	609-631-2392 1-800-701-0710
New York	Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	Medicaid	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota	Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma	Medicaid and CHIP	http://www.insureoklahoma.org	1-888-365-3742
Pennsylvania	Medicaid	http://www.dhs.pa.gov/provider/medicalassistance/ healthinsurancepremiumpaymenthippprogram/index.htm	1-800-692-7462
Rhode Island	Medicaid	http://www.eohhs.ri.gov/	855-697-4347,or 401-462-0311
South Carolina	Medicaid	https://www.scdhhs.gov	1-888-549-0820
South Dakota	Medicaid	http://dss.sd.gov	1-888-828-0059
Texas	Medicaid	http://gethipptexas.com/	1-800-440-0493
Utah	Medicaid and CHIP	https://medicaid.utah.gov/http://health.utah.gov/chip	1-877-543-7669
Vermont	Medicaid	http://www.greenmountaincare.org/	1-800-250-8427
Virginia	Medicaid CHIP	http://www.coverva.org/programs_premium_assistance.cfm	1-800-432-5924 1-855-242-8282
Washington	Medicaid	https://www.hca.wa.gov/	1-800-562-3022 ext. 15473
West Virginia	Medicaid	http://mywvhipp.com/	1-855-MyWVHIPP (1-855-699-8447)
Wisconsin	Medicaid CHIP	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	1-800-362-3002
Wyoming	Medicaid	https://wyequalitycare.acs-inc.com/	307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, 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) or 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.

Required Annual Notices

Medicare Part D – Notice of Credible Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with UnitedHealthcare 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. CapinCrouse has determined that the prescription drug coverage offered by the company is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special EnrollmentPeriod (SEP) to join a Medicaredrug plan.

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

If you decide to join a Medicare drug plan, your current CapinCrouse coverage will not be affected. Please see your current plan design(s) for a description of current coverage. Your current coverage pays for other medical expenses, in addition to prescription drugs. You will still b e eligible to receive all of your current medical and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. However, your prescription benefits will not coordinate with the Medicare prescription drug plan. If you decide to join a Medicare drug plan and drop your current CapinCrouse coverage, be aware that you and any covered dependents will not be able to get this medical/prescription coverage back until the next annual open enrollment period for the following January effective date of coverage, and/or if a qualifying event or HIPAA specialenrollmentevent occurs.

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 CapinCrouse 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) a s 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 Health Plan administrator for further information. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

Required Annual Notices

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 prescriptiondrug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbookfor their telephonenumber) 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).

RIGHTS TO CONTINUE GROUP COVERAGE

Dear Employee and Covered Dependents:
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, your spouse 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 shouldreview the Plan's Summary Plan Description (SPD) 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.

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

Required Annual Notices

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

Spouses. 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 followingqualifying events:

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

Dependent Children. 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'shoursof 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 eligiblefor 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 notifythe Plan Administrator of the following qualifying events:

- The end of employment or reductionof hoursof employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employees becoming entitled to Medicarebenefits (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 providethis notice by calling Human Resources at **505-50-CAPIN** and providing the required supporting documentation.

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 duringthe initial period of coverage, may permit a beneficiaryto 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:

Required Annual Notices

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, Medicaid, 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 optionsat www.healthcare.gov.

If you have questions concerning your Plan or your COBRA continuation coverage rights, those 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.

Required Annual Notices

Notice of Extended Coverage to Participants Covered Under a Group Health Plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year. The CapinCrouse plan currently permits an employee to continue a child's coverage through age 18, or through age 22, if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status. There are two definitions that are important for purposes of determiningwhether the Michelle's Law extension of eligibility applies to a particular child:

- Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medicallynecessary leave of absence.
- Medically necessary leave of absence means a leave of absence or any other change in enrollment of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury; which is medically necessary; and which causes the dependent child to lose student status under the terms of the plan.

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility). If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligiblefor coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than the failure to be a full-time student).

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under this Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependentchild to the same extent as it applies to other dependent childrencovered under the Plan.

Terminology Tip Sheet

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance forms.

Annual Maximum: Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.

Out-of-Pocket Maximum: The maximum amount of coinsurance a Plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Deductibles and copays apply to the annual out-of -pocket maximum.

Coinsurance: A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible.

Copayment: A set dollar amount you pay for network doctors' office visits, emergency room services and prescription drugs.

Deductible: Total dollar amount, based on the allowed amount, you must pay out of pocket for covered medical expenses each calendar year before the plan pays for most services. The deductible does not apply to network preventive care if any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services.

Brand Formulary Drugs: The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Generic Drugs: These drugs are usually the most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non-formulary brand name drugs.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Non-Formulary Drugs: These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of-pocket cost.

Specialty Drugs: Prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions.

Portability: An employee carries or 'ports' his/her current Group Life coverage after employment ends, without having to answer any medical questions. Portability is for an employee who is leaving his/her job and still wants to maintain the protection that life insurance provides.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Network: A group of health care providers, including dentists, physicians, hospitals and other health care providers that agree to accept pre-determined rates when servicing members.

Qualifying Event: An occurrence that qualifies the subscriber to make an insurance coverage change outside of Open Enrollment.

Contact Information

Human Resources Contacts

Christina Bishop Senior
Senior HR Generalist
505-50-CAPIN ext. 1110

Shelby Bright
HR Assistant
505-50-CAPIN ext. 1136

Kim ter Horst
Director of Talent Management
505-50-CAPIN ext. 2026

Provider Contacts

For questions regarding your **Medical** or **Dental** benefits, call **Aetna** at 888-266-5519 (Medical), 877-238-6200 (Dental) or visit www.myaetnawebsite.com.

For questions regarding your **HSA**, call **Associated Bank** at 800-270-7719 or visit https://participantbenefits.associatedbank.com/Login.

For questions regarding your **FSA**, call **Associated Bank** at 800-270-7719 or visit https://participantbenefits.associatedbank.com/Login.

For questions regarding your **Vision, Life** or **Disability** coverage**,** call **800-Ask-Unum** www.unum.com.

For questions regarding your **401(k)**, call **EMPOWER Retirement Services** at 1-855-756-4738 or visit https://participant.empower-retirement.com/participant/#/login.

The information in this Enrollment Guide is presented for illustrative purposes and was taken from various summary plan descriptions and benefit information. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any ques ons about your Enrollment Guide, contact Human Resources.

Notes

Notes


CAPINCROUSE LLP