2025 Employee Benefit Guide
(Non-Union Employees)
Plan Year: Jan 1-Dec 31, 2025

Medical | Dental | Vision | Life & AD&D | Voluntary Life | Disability | Health Savings Account | Paid Time Off | Employee Assistance Program | Retirement | Additional Benefits

Welcome!

At Micro-Lite, we are committed to supporting the well-being of our employees and their families through a comprehensive benefits program. This guide is designed to help you make informed decisions about the benefits available to you, ensuring you and your family have the coverage and resources needed for your health, financial security, and peace of mind. We encourage you to explore all your options and take full advantage of the benefits Micro-Lite offers.

For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the Summary Plan Descriptions and official plan documents. If any discrepancy exists between this Guide and the official documents, the official documents will prevail.

Benefit Guide Contents

Important Contact Information

FOR QUESTIONS ABOUT	CARRIER CONTACT	GROUP #	PHONE #	WEBSITE
Medical Insurance	BCBS of Kansas City	43684000	816-395-3558 888-989-8842	MyBlueKC.com
Pharmacy Coverage	BCBS of Kansas City	43684000	800-228-1436	MyBlueKC.com
Telemedicine / Virtual Care	BCBS of Kansas City	43684000	Available through MyBlueKC App	
Health Savings Account	Empower/Optum	E22076	800-331-5455	Empowermyretirement.com
Dental Insurance	Principal	1103065	800-247-4695	Principal.com
Vision Insurance	Carrier: Principal Network: VSP	1103065	800-247-4695 800-877-7195	Principal.com VSP.com
Life, AD&D, and Disability Insurance	Principal	1103065	800-245-1522	Principal.com
Employee Assistance Program (EAP)	Lucet	Company Code: Clarkson	800-624-5544	Eap.lucethealth.com
Retirement 401(k)	Empower	530842-01	800-338-4015	Empowermyretirement.com

If you have questions, concerns, or need support, please don't hesitate to reach out to Human Resources.

Eligibility and Enrollment

Eligibility and Enrollment

Unless otherwise noted, all regular, full-time, non-union employees are eligible for the benefits described in this guide and coverage is effective on your first day of employment. New hires make benefit elections during the onboarding process. For all other employees, the annual open enrollment period is during the month of November for a January 1 effective date.

All benefit elections are made in the web version of your UKG portal.

Eligible Dependents

Your dependents are eligible for some of these benefits as well, where indicated. "Dependent" means:

- Your legally recognized spouse.
- Your dependent child under age 26. Dependent children can include your natural born child, step-child, legally adopted child, or child placed for adoption.

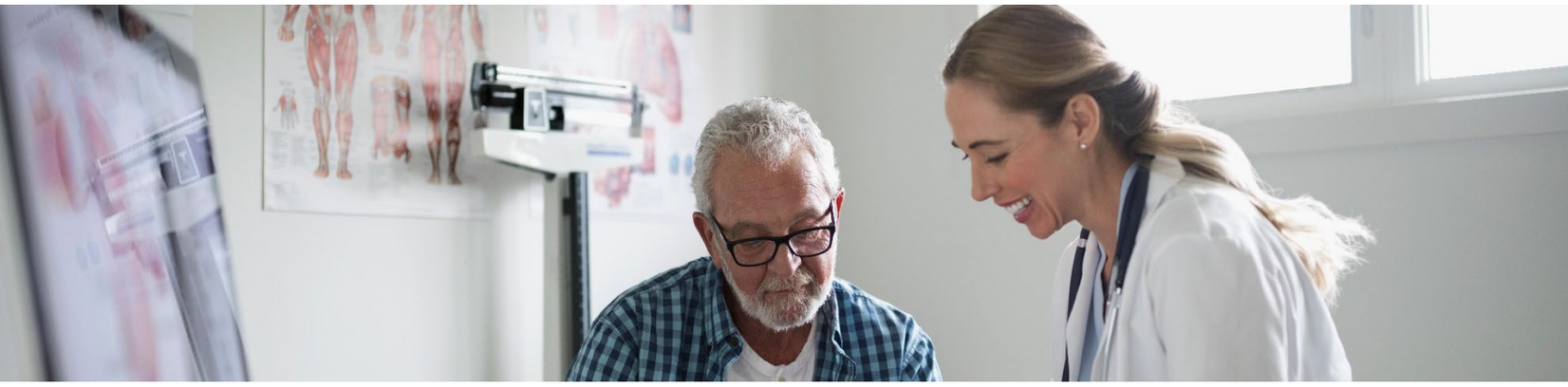
There may be other circumstances in which an individual would be considered a dependent. More information about this can be obtained from Human Resources. Coverage for eligible dependents begins on the same day your coverage is effective.

Making Changes to Your Benefit Elections

The benefits you elect at your time of hire (or open enrollment for existing employees) will be effective until the end of the current plan year. Once you have made your elections, you will not be able to make changes until the next open enrollment period, unless you experience a qualifying event status change. Qualifying events include, but may not be limited to:

- Changes in your legal marital status including marriage, death of your spouse, divorce, legal separation or annulment.
- Birth or adoption of a child.
- Your dependent satisfying or no longer satisfying the eligibility requirements due to age, or other circumstances.
- Loss of other coverage due to termination of employment, reduction in hours, exhaustion of COBRA or state continuation, or death.
- Becoming Medicare eligible.

You must notify Human Resources within 30 days from the date of any qualifying event status change in order to change your benefit elections!



Medical Benefits

Medical coverage helps keep you healthy and provides important financial protection if a medical need or condition occurs. Micro-Lite has partnered with Blue Cross Blue Shield of Kansas City (BCBSKC) for the care you need at a reasonable cost to help protect you against the catastrophic costs of major illness or injury.

You have up to two medical plan options; a High Deductible Health Plan with an HSA and a traditional PPO plan. Important details of each plan are below.

In every option it is best to in-network providers, who have pre-negotiated service fees, and to compare healthcare prices prior to receiving services. A complete listing of providers is available on MyBlueKC.com.

OPTION 1: Qualified High Deductible Health Plan (QHDHP) & Health Savings Account (HSA)

QHDHPs are flexible PPOs that can pair with a tax-favored Health Savings Account (HSA), offering freedom to see any provider, though out-of-network care costs more. HSA plans don't require a primary care physician or referrals. Preventive care is fully covered, but all other healthcare, including prescriptions, is paid by you until the deductible is met.

HSA Benefits:

- Contributions, interest, and withdrawals for qualified health expenses are tax-free
- Any unused money stays in your account each year and is always yours, regardless of employment status
- At age 65, HSA funds can be used penalty-free for any purpose (though non-medical uses are taxed) and can be used for Medicare premiums (Parts A, B, and D).

To participate in an HSA, you must:

- Be enrolled in a QHDHP
- Not be claimed as a dependent on another's tax return
- Have no other non-QHDHP coverage (e.g., Medicare, Medicaid, Tricare)
- Not be covered by an FSA, including a spouse's

For more information about HSA-eligible expenses, visit **irs.gov**. Common HSA-eligible expenses include:

- Uncovered medical expenses such as deductibles and coinsurance
- Dental, vision, and hearing services
- Prescription drugs and many over-the-counter (OTC) products
- Certain medical equipment, therapies, and treatments

2025 HSA Contribution Limits

The IRS sets annual HSA contribution limits. Exceeding the limit incurs a 6% excise tax unless the excess is withdrawn by the tax deadline. ***The limits below include any Company contribution to your account***.

- Under 55: $4,300 (individual), $8,550 (family)
- Age 55+ at any point in 2025: Additional $1,000 catch-up contribution allowed

For married couples with family coverage, the $8,300 limit is shared. If both are 55+, each must have a separate HSA to make the $1,000 catch-up contribution. If only one is 55+, the older spouse must open a separate account for the catch-up if the younger spouse contributes the full family limit.

2025 Micro-Lite Contribution to Your HSA

To help cover potential out-of-pocket expenses, the Company makes weekly HSA contributions for employees who contribute to their HSA at any level. Weekly Company contributions are outlined below:

- Employee coverage only: $10 per week ($520 annual equivalent),
- Employee with dependents coverage: $20 per week ($1,040 annual equivalent).

Starting January 2025, our HSA provider will switch to Empower/Optum, offering new tools to help you manage and maximize your funds. Separate instructions will be provided for transferring your HSA funds, if applicable to you.

OPTION 2: Preferred Provider Organization (PPO)

A PPO offers you the freedom to receive care from any provider, in or out of your network. This means you can see any doctor or specialist, or use any hospital, though you will be charged significantly more out of network. In addition, PPO plans do not require you to choose a primary care physician and do not require referrals.

With a lower deductible than the HSA option, this plan option has the highest premiums and annual out-of-pocket maximum for employees.

Medical Plans Comparison

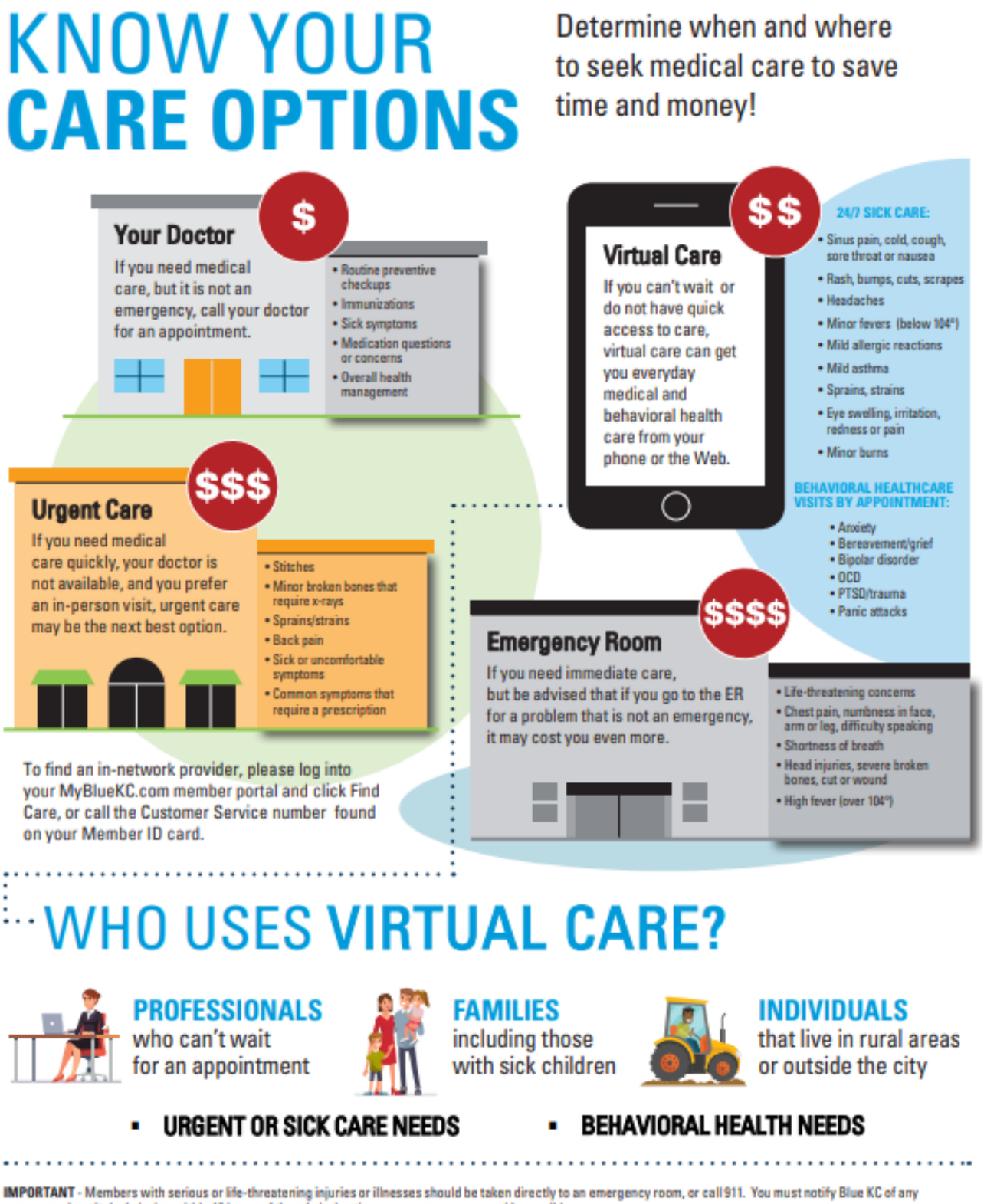
Plan Provision	$3,300 Deductible HSA		$1,000 Traditional PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
***Deductible** Individual/Family	$3,300 / $6,600		$1,000 / $3,000	
Coinsurance	0%	20%	20%	50%
***Maximum Out of Pocket** Individual/Family (Includes all Copays, Deductible & Coinsurance)	$3,300 / $6,600	$6,400 / $12,800	$4,000 / $8,000	$8,000 / $16,000
Preventive Care	No Cost	Deductible + 20%	No Cost	Deductible + 50%
Office Visit: Primary or Specialist	Deductible	Deductible + 20%	$30 Copay	Deductible + 50%
Urgent Care	Deductible	Deductible + 20%	$30 Copay	Deductible + 50%
Blue KC Virtual Care	No Cost	Not Covered	No Cost	Not Covered
Hospital: Inpatient or Outpatient	Deductible	Deductible + 20%	Deductible + 20%	Deductible + 50%
Emergency Room	Deductible		$100 Copay + Deductible + 20%	
Retail Prescription Tiers 1 / 2 / 3 / 4	Deductible	Deductible + 50%	$15 / $70 / $110 / $200	Copay + 50%
Mail Order Prescription Tier 1 / 2 / 3	Deductible	Deductible + 50%	$37.50 / $175 / $275	Copay + 50%

*Using In-Network providers and facilities saves you significant out-of-pocket expenses. Finding in-network providers and facilities is fast and simple. See the contacts page of this Guide for carrier contacts.

Getting Care When you Need It

With various options for quick care, it can be challenging to know where to go and what costs to expect. Visit MyBlueKC.com, select FIND CARE, then FIND A DOCTOR OR HOSPITAL to find providers, estimate medical costs, and explore savings options.

Search for hospitals, pharmacies, walk-in clinics and urgent care centers at **mybluekc.com**. You may also contact Blue KC customer Service by calling the phone number printed on your Member ID Card.



Virtual Care

Virtual care provides access to licensed doctors and behavioral health providers online anytime for common medical issues and mental health support. Consider a virtual visit for convenient consultations from home or on the go, and support during evenings, weekends, or when your doctor isn't available.

Common Conditions Treated:
- Common Medical Issues: COVID-19, pink eye, minor fevers, colds, sore throat, sinus pain, asthma, rashes, nausea, minor burns, and sprains
- Behavioral health: anxiety, depression, PTSD, panic attacks, OCD, Bipolar disorder, grief, and more

How to Start:
- Download the MyBlueKC app or visit MyBlueKC.com.
- Choose a doctor from available options.
- Create an account with your Blue KC member ID.

Prescriptions Savings with Rx Savings Solutions

Rx Savings Solutions (RxSS) is a free tool for members and dependents to find prescription savings. RxSS pharmacists work with your doctor or pharmacist to reduce costs safely. For support, call 1-800-268-4476.

How RxSS Helps You Save

- **Explore Options:** Compare treatment options and costs.
- **Transparent Pricing:** See medication costs, coverage, and deductible impact.
- **Easy Access:** Request lower-cost prescriptions anytime, even at the doctor's office.
- **Expert Assistance:** RxSS staff coordinate with your doctor for safe savings.

Start Saving with Rx Savings Solutions

- Log in at MyBlueKC.com.
- Go to Plan Benefits > Pharmacy.
- Select "Shop & Save with Rx Savings Solutions" or visit MyRxSS.com/BlueKC.

Save & Earn with SmartShopper

Medical costs vary widely by facility. Blue KC's SmartShopper helps you find in-network providers and healthcare services with lower-cost options and earn cash rewards for choosing cost-effective care.

Accessible on MyBlueKC.com, SmartShopper lets you view a range of in-network providers and facilities and compare prices side by side. This program supports Blue KC's commitment to cost transparency and savings by passing a portion of the savings back to you in the form of cash rewards.

How to Use SmartShopper

- Log into MyBlueKC.com and go to Find Care > Find Doctors, Specialists & Hospitals.
- Click the SmartShopper rewards tile to compare costs for your procedure.
- Choose a reward-eligible provider and receive care. Once your claim is paid, you'll receive a reward check.
- For support, call Blue KC Customer Service at the number on your member ID card.

Dental Insurance

Regular dental visits protect both your smile and health. Gum disease links to other health issues, and dentists can spot signs of diseases like cancer, diabetes, and heart disease. Micro-Lite offers two dental plans through Principal. Find in-network dentists at principal.com/dentist.

Base Plan	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$50 / covered person $150 / family	
Annual Plan Maximum	$1,000 / covered person	
Diagnostic and Preventive (exams, cleanings, x-rays, sealants, etc.)	100%	100%
Basic Services (such as fillings, emergency exams, etc.)	80%	80%
Major Services	50%	50%
Orthodontia	Not Covered	Not Covered
Rollover Benefit	Provided. Allows for a portion of unused dollars to roll over to next year's maximum benefit. To qualify, must have had dental service in the calendar year and use less than $1,000.	
Buy-Up Plan	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$50 / covered person $150 / family	
Annual Plan Maximum	$1,500 / covered person	
Diagnostic and Preventive (exams, cleanings, x-rays, sealants, etc.)	100%	100%
Basic Services (such as fillings, emergency exams, etc.)	80%	80%
Major Services	50%	50%
Orthodontic Services	50% up to a $1,500 Lifetime Maximum per eligible dependent	50% up to a $1,500 Lifetime Maximum per eligible dependent
Rollover Benefit	Provided. Allows for a portion of unused dollars to roll over to next year's maximum benefit. To qualify, must have had dental service in the calendar year and use less than $1,000.	

***Out-of-Network Providers & Balance Billing** - Please note that providers that do not participate with your insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.

Vision Insurance

Regular eye exams can help detect health issues like diabetes, cancer, and glaucoma. Our voluntary vision plan, provided by Principal, has no employer contribution. Using in-network providers offers the best coverage and lowest out-of-pocket costs. Visit principal.com and click "Locate a Provider" to find one near you.

Benefit	In-Network	**Out-of-Network Allowance**
Eye Exam		
Copay	$10 Copay	N/A
Frequency	Every 12 Months	Every 12 Months
Allowance	100%	Up to $45
Prescription Glasses		
Copay	$25 Copay	N/A
Frequency	Every 12 Months	Every 12 Months
Single Allowance	100%	Up to $30
Bifocal Allowance	100%	Up to $50
Trifocal Allowance	100%	Up to $65
Lenticular	100%	Up to $100
Frames		
Frequency	Every 12 Months	Every 12 Months
Allowance	$130 + 20% off remaining amount	Up to $70
Contact Lenses		
Lens Fitting Copay	Up to $60 Copay	N/A
Elective	$130 Allowance	Up to $105
Medically Necessary	Covered in Full after $25 Copay	Up to $210

Laser Vision Correction

Employees, spouses, and dependents can save $800 with LASIK providers (LASIKPlus, TLC Laser Eye Centers, or The LASIK Vision Institute) or receive 15% off standard or 5% off promotional pricing through the National LASIK Network, administered by LCA Vision.

Visit Principal.com to access vision benefits, find providers, view eligibility, download forms, and more. Register online to get started!

Basic Life and AD&D

If loved ones depend on your income, life and AD&D insurance can provide financial security and help pay for large expenses like housing, education, and daily needs. Micro-Lite offers these benefits, at no cost to you, through Principal.

Basic Life Insurance

Provides a lump sum to your beneficiary equal to one time (1x) your annual salary (rounded to the next $1,000) with a maximum of $200,000 if you pass away. Coverage reduces by 35% at age 65 and by 50% at age 70.

Accidental Death & Dismemberment (AD&D)

AD&D provides another layer of benefit to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The amount is equal to your basic life benefit.

Voluntary and Dependent Life and AD&D

Voluntary life and AD&D is additional coverage you can purchase for yourself, spouse, or children. To cover a spouse or child, employee voluntary life coverage is required.

Spouse rates vary based on age, while child rates remain the same regardless of the number covered. Coverage reduces by 35% at age 70 and by 55% at age 75. If you request more than the guaranteed issue amount, increase coverage, or add coverage outside the initial offering, a health questionnaire will be required for provider approval.

Voluntary Life Coverage Level Options	
Employee Voluntary Life / AD&D	$10,000 increments up to $500,000 Guaranteed Issue is $100,000 (under age 70)
Spouse Voluntary Life / AD&D	$5,000 increments up to $150,000 Guaranteed Issue is $30,000 (under age 70)
Child(ren) Voluntary Life / AD&D	$2,000, $4,000, or $10,000 $100 under six months of age Birth to six months max benefit $1,000

Monthly Rates for Voluntary Life / AD&D By Age Band										
Adult Age Bands	0-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Adult Rate (per $1,000)	$0.131	$0.140	$0.184	$0.266	$0.383	$0.592	$0.900	$1.229	$2.226	$3.622
Dependent Child(ren)	$2,000 benefit $0.40/month - $4,000 benefit $0.80/month - $10,000 benefit $2.00/month									

_____ / $1,000 X _____ = Premium Per Month

Amount of coverage
(for employee, increments of $10,000 up to $500,000)

Age Rate
(ex: 36-year-old pays $0.184)

Short-Term Disability

If you are unable to work due to a qualified short-term disability, including maternity leave, Micro-Lite provides a short-term disability ("STD") plan through Principal. This plan offers income replacement for up to 11 weeks if you are unable to work due to a non-work-related injury or illness, at no cost to you.

Approved STD claims provide 70% of regular salary (excluding bonuses/commissions) up to $2,500 per week, after a 14-day elimination period (waiting period after the disability starts but before the benefit is paid). During this period, employees can use vacation or sick time to cover lost earnings.

Work-related illness, injury, or other disability are not covered under STD, as it falls under worker's compensation insurance.

Long-Term Disability

A Long-Term Disability (LTD) can have a major financial impact. To support employees during an LTD, Micro-Lite provides LTD coverage through Principal at no cost to you. This benefit covers 66.67% of an employee's regular salary, up to $7,500 per month (excluding bonuses and commissions), with payments beginning after a 90-day elimination period (waiting period after the disability starts but before the benefit is paid).

For the first two years of your disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education. The benefit duration for LTD is until Social Security Normal Retirement Age for individuals under age 65. Individuals age 65 or over have a limited benefit duration as follows:

- Age 65-67 – 24 months
- Age 68-69 – 18 months
- Age 70-71 – 15 months
- Age 72 and over – 12 months

HOW TO FILE A SHORT-TERM OR LONG-TERM DISABILITY CLAIM:

Disability claims must be completed online or on paper. If you need assistance filing a disability claim, please see Human Resources or call the Principal Claims Hotline at (800) 245-1522, weekdays, 7:00am to 5:00pm, CST for assistance. Refer to your member ID (social security number) and your plan number: 1103065

Employee Assistance Program (EAP)

Lucet | Employee Assistance Program

Personalized care and resources, *when you need them.*

Whether its planning for your financial future or beginning to seek mental health resources, your Employee Assistance Program (EAP) is here to help. Available to you and your household members, Lucet's EAP is your first step to resources, counseling and so much more to support your wellbeing.

We're here to help

Stress, relationships, work and money. These are the most common reasons people reach out to EAP every year. No matter what issues you're facing, the resources you access are confidential so feel safe knowing you can begin addressing any of your personal challenges today.

EAP Services & Resources

Help for every day life

Counseling
Call us or go online to access no-cost sessions with a provider.

Legal & Financial
Navigating finances and the legal system with a no-cost 30-minute telephonic consultation per issue.

Work/Life
Referrals and resources for family, career, caregiving, health and wellness needs.

Coaching
Sessions with a life coach designed to promote self-awareness and clarify goals.

Your well-being is our priority.

Lucet EAP provides confidential support, counseling services and resources to help you overcome life challenges and live a happy, balanced life.

Call 800-624-5544 | Visit eap.lucethealth.com

Your company code: **Clarkson**

6 counseling/coaching sessions, per topic, per year.

Scan to learn more at eap.lucethealth.com

LC-1001 26-2024(1)01

Effective January 1, 2025, our EAP provider has rebranded to Lucet (formerly New Directions).

Retirement / 401(k)

Micro-Lite offers a 401(k) plan to support your retirement savings. This guide provides a summary only and does not cover all details; please refer to the Empower official plan documents for comprehensive information, as they govern the plan provisions.

Eligibility

New hires with regular employment status become eligible to participate on the first day of the month following 2 months of employment. You must be 21 years of age or older to participate.

Plan Options and Company Match

You may contribute pre-tax to lower your taxable income, or choose the Roth option to make after-tax contributions, allowing for tax-free growth and withdrawals (if conditions are met). You may also use both the pre-tax and Roth options together. You can contribute as much as you wish, in whole percentages to be deducted from your check, and within the annual IRS limits. Micro-Lite provides a matching contribution of 50% of the first 6% you contribute each pay period, which is vested over a three-year period.

2025 401(k) Contribution Limits

Contributions limits are set by the IRS annually and generally announced in late October or early November for the following calendar year. For 2025, the 401(k) contribution limits are:

- Individuals under 50 years old: **$23,500**
- Individuals 50+: additional $7,500 catch-up contribution allowed (total limit **$31,000**)
- Individuals 60-63: additional $11,250 catch-up contribution allowed (total limit **$34,750**)

Automatic Enrollment and Contribution Increases

Your plan makes it easier to save for your future by automatically enrolling you. Unless you elect otherwise, you will be automatically enrolled in the pre-tax 401(k) plan with a 6% contribution.

Auto-enrolled participants will have annual automatic increases of 1% each Jan 1, up to a maximum of 15%. You can opt out of auto increases at any time.

You can change your contributions at any time on the Empower website, empowermyretirement.com, or by calling 800-338-4015.

Starting January 1, 2025, a new catch-up age category has been added to allow even greater savings for individuals 60-63. Catch-up age ranges refer to anyone who is, ***or becomes,*** that age at any point during the plan year; you do not have to be the catch-up age at the beginning of the plan year to qualify.

Paid Time Off (PTO)

Regular employees on active status accrue paid time off ("PTO") based upon their years of active service. Active service commences with an employee's first day of work and continues thereafter unless broken by a leave of absence, or termination of employment. Temporary and part-time employees, and employees on any leave of absence including but not limited to FMLA, Short-Term Disability or Long-Term Disability, do not accrue PTO.

Employees begin to accrue PTO upon date of hire and may use PTO for any reason, as work schedules permit and subject to supervisor/manager approval. For scheduling purposes, we ask that all PTO requests are submitted to supervisors/managers with as much notice as possible. For operational purposes, supervisors/managers reserve the right to decline a PTO request.

PTO rolls over from year to year and can accrue up to a maximum balance equivalent to the employee's total annual accrued hours + 40 hours. Once this maximum balance is reached, the employee will not accrue PTO until some PTO is used allowing for additional accrual up to the maximum.

Except where otherwise stated, employees are required to use available PTO before taking an unpaid leave or having unpaid absences of any kind including, but not limited to, FMLA, Short-Term Disability or Long-Term Disability. Employees may use up to one week (40 hours) of PTO that has not yet accrued. In other words, an employee's PTO balance can be negative by up to 40 hours.

For non-exempt, hourly paid employees, PTO hours do not count the same as regular worked hours (will not be included) for weekly overtime calculations. PTO accrues on the following basis:

Years of Active Service	PTO Hours Accrued / Pay Period	PTO Hours Accrued / Year	PTO Days Accrued / Year	PTO Hours Maximum Balance
Hire Date – Year 5	2.308	120	15	160
Beginning of 6th Year – Year 10	3.077	160	20	200
Beginning of 11th Year +	3.847	200	25	240

Employees who terminate employment for any reason will be paid for accrued, unused PTO.

Paid Holidays & Leaves

Paid Holidays

Micro-Lite provides one work-day / 8 hours of holiday paid for the following observed holidays:

- New Year's Day (January 1st)
- Memorial Day (Last Monday in May)
- Independence Day (July 4th)
- Labor Day (First Monday in September)
- Thanksgiving Day (4th Thursday in November)
- Day after Thanksgiving
- Christmas Eve (Dec. 24th)
- Christmas Day (Dec. 25th)
- New Year's Eve (Dec 31st)

Holidays that fall on a Saturday or Sunday are usually observed on the preceding Friday or the following Monday. However, Micro-Lite may grant another day off in lieu of closing. Holiday observance will be announced in advance.

Employees are eligible for holiday pay immediately upon hire. Hourly-paid employees who are required to work on a paid scheduled holiday will receive their regular pay in addition to holiday pay. Hours paid as holiday pay do not count the same as regular worked hours (will not be included) for weekly overtime calculations. Part-time employees working a minimum of 20 hours per week receive 4 hours of holiday pay per holiday.

Paid Jury Duty Leave

We encourage employees to serve on jury duty when called. Employees will receive full pay while serving up to 40 hours / 5 business days of jury duty. You should notify your supervisor or manager of the need for time off for jury duty as soon as a notice or summons from the court is received, as well as provide a copy of the court summons. You may be requested to provide written verification from the court clerk of performance of jury service. If work time remains after any day of jury selection or jury duty, you will be expected to return to work for the remainder of your work schedule.

Paid Parental Leave

Employees requiring parental leave for the birth or adoption of their own child will be paid 100% of normal hourly wage or salary up to 40 hours / 5 days. Pregnancy disability leave / maternity leave and related pay is covered under the provisions of the FMLA and Short-Term Disability policies. Parental leaves may run concurrently with FMLA, if applicable.

Paid Bereavement Leave

We understand that a death in your family is devasting. To give employees necessary paid time to attend to family matters, Micro-Lite grants paid bereavement leave to employees who experience a death in the family as follows:

- 80 hours / 10 work days for death of employee's spouse or children
- 40 hours / 5 work days for death of employee's mother, father, siblings
- 24 hours / 3 work days for employee's mother-in-law, father-in-law, siblings-in-law, grandparents, or grandchild.

Paid bereavement leave must be approved by the Company. Supervisors and managers may approve additional unpaid bereavement leave to allow an employee more time during their time of need.

Additional Benefits

Notary Services

Micro-Lite is fortunate to have a notary public available to notarize your documents at no charge. If you have a need for notary services, please see Ron May for more information.

Principal Hearing Aid Program

Protect your hearing health to improve your quality of life. You, your spouse, children, parents and grandparents can get exclusive discounts up to 48% off on hearing aids, including rechargeable and Bluetooth options, with a 60-day trail to ensure your full satisfaction. You can also receive a free hearing consultation at any of their 3,000+ locations nationwide.

Visit principal.com/hearingbenefits/ahb or call 877-890-4694 to learn more!

Benefit Rates (Your Costs)

With the exception of voluntary life insurances, which are after-tax deductions, your contributions to your elected plans are deducted pre-tax each pay-check date.

Blue Cross Blue Shield of Kansas City Medical Insurance		
$3,300 HSA Base Plan	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$27.52	$119.25
Employee + Spouse	$69.33	$300.43
Employee + Child(ren)	$62.50	$270.82
Family	$106.51	$461.54
$1,000 PPO Buy-Up Plan	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$58.72	$254.47
Employee + Spouse	$126.85	$549.68
Employee + Child(ren)	$113.38	$491.30
Family	$177.55	$769.40
Principal Dental Plans		
Base Plan	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$1.18	$5.12
Employee + Spouse	$7.81	$33.84
Employee + Child(ren)	$14.93	$64.69
Family	$23.19	$100.50
Buy-Up Plan	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$3.77	$16.32
Employee + Spouse	$12.28	$53.21
Employee + Child(ren)	$18.05	$78.22
Family	$28.27	$122.51
Principal Vision Plan		
Employee Only	$1.64	$7.09
Employee + Spouse	$3.27	$14.18
Employee + Child(ren)	$3.30	$14.32
Family	$5.21	$22.59
Principal Basic Life & AD&D		
Paid 100% by Micro-Lite.		
Principal Short-Term and Long-Term Disability Insurance		
Paid 100% by Micro-Lite.		
Lucet Employee Assistance Program (EAP)		
Paid 100% by Micro-Lite.		
Principal Voluntary Life & AD&D Insurance		
Rates vary by age and amount you elect. Please see detail page.		

Annual Notices

Important Notice from Micro-Lite About Your Prescription Drug Coverage and Medicare

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This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by Micro-Lite AND (2) eligible for 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 Micro-Lite 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 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. Micro-Lite has determined that the prescription drug coverage offered by **2025 Medical Plan Offerings** 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.

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 Micro-Lite coverage will not be affected.

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If you do decide to join Medicare drug plan and drop your **current Micro-Lite** coverage, be aware that you and your dependents will not be able to get this coverage back.

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 **Micro-Lite** 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 **Micro-Lite** changes. You may also 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 more 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)

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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:	January 1, 2025
Name of Entity:	**Micro-Lite**
Contact:	Tara McKinney
Address:	1737 McGee Street Kansas City, MO 64108
Phone Number:	(913) 433-3199

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Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, if you request enrollment within 30 days after your other coverage ends. 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 if you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non- election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

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Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator. Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives' conflict, the Plan document will control.

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Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit:

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in The Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by The Company, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in The Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 800-318-2596.

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PATIENT PROTECTIONS AGAINST SURPRISE MEDICAL

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 balanced 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 balanced billed for these post-stabilization services.

There are some states that have surprise bill or balance billing laws. These laws apply to fully insured plans and may impact self-funded plans, including state or municipal government plans and church group plans. Please check with your plan administrator and/or insurance certificate/booklet to see if state law applies to your coverage.

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.

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

There are some states that have surprise bill or balance billing laws. These laws apply to fully insured plans and may impact self-funded plans, including state or municipal government plans and church group plans. Please check with your plan administrator and/or insurance certificate/booklet to see if state law applies to your coverage.

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:

- The US Department of Health and Human Services at:

  Phone: 800-985-3059
  Website: https://www.cms.gov/nosurprises/consumers

- Your state agency, which can be found at:
  https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants

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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.

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General Notice of COBRA Continuation Coverage Rights

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 are an employee, you will 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 are the spouse of an employee, you will 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.

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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.

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:
Tara McKinney / VP of HR / 1737 McGee St., Kansas City, MO 64108 / (913) 433-3199

Annual Notices continued...

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)**.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
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
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322 / Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
http://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website:
http://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
http://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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or, www.lahipp.gov/lahipp
Phone: 1-888-342-6207 (Medicaid Hotline) or, 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003, TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740, TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https: www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – 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

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
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
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

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/Services/Assistance/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: http://www.coverva.org/en/famis-select
http://www.coverva.org/en/hipp
Medicaid and CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
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
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

If you live in one of the above states, you may be eligible for assistance paying your employer health plan premiums. The above list of states is current as of July 31, 2022. Contact your state for more information on eligibility. To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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