2025

keys energy services

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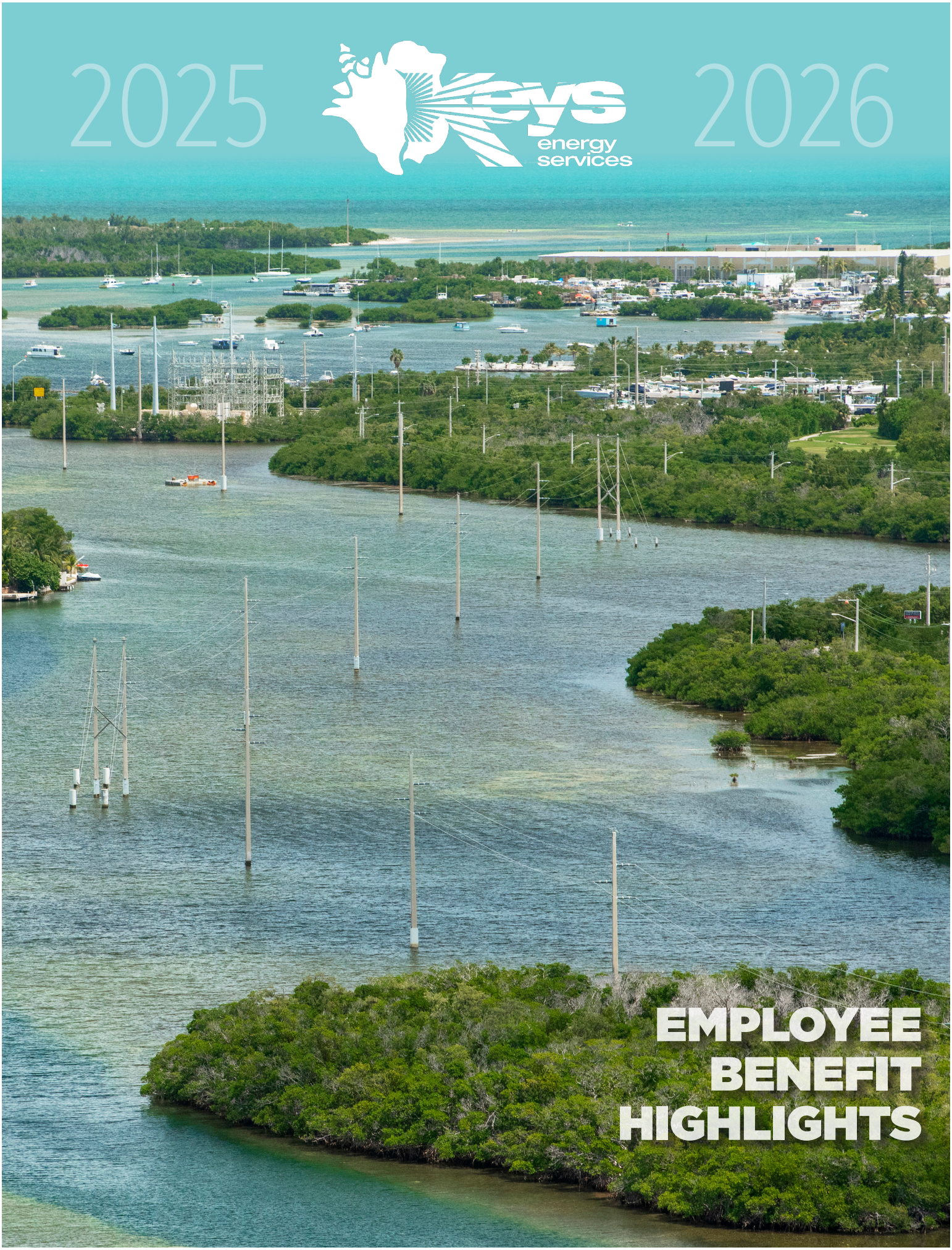

EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

	Human Resources	Director of HR - Communications	Phone: (305) 295-1023
		Human Resources Supervisor	Phone: (305) 295-1068
		Human Resources Coordinator	Phone: (305) 295-1067
	Online Enrollment	Bentek	Customer Service: (888) 5-Bentek (523-6835) Email: support@mybentek.com app.mybentek.com/keysenergy
	Medical Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Prescription Drug Coverage **Mail-Order Program**	Express Scripts Pharmacy through Cigna Healthcare	Customer Service: (800) 835-3784 www.mycigna.com
HSA	**Health Savings Account**	Cigna	Customer Service: (800) 244-6224 www.mycigna.com
	Telehealth	MDLIVE through Cigna Healthcare	Customer Service: (888) 726-3171 www.mycigna.com
	Dental Insurance	Cigna Healthcare	Customer Service: (800) 244-6224 www.mycigna.com
	Vision Insurance	Cigna Healthcare Vision	Customer Service: (877) 478-7557 www.mycigna.com
FSA	**Flexible Spending Account**	UpSwing	Customer Service: (866) 676-3665 upswing.wealthcareportal.com
	Employee Assistance Program	Cigna	Customer Service: (877) 622-4327 www.mycigna.com
	Basic Life, AD&D, and **Voluntary Life Insurance**	The Standard	Customer Service: (800) 368-1135 www.standard.com
	Long Term Disability Insurance	The Standard	Customer Service: (800) 368-1135 www.standard.com
	Deferred Compensation	Nationwide Retirement Solutions	Customer Service: (877) 677-3678 www.nrsforu.com
	Supplemental Benefits	Aflac	Customer Service: (800) 992-3522 www.aflac.com Agent: Jean Smith | Phone: (561) 289-1360 Email: Jean_smith@us.aflac.com

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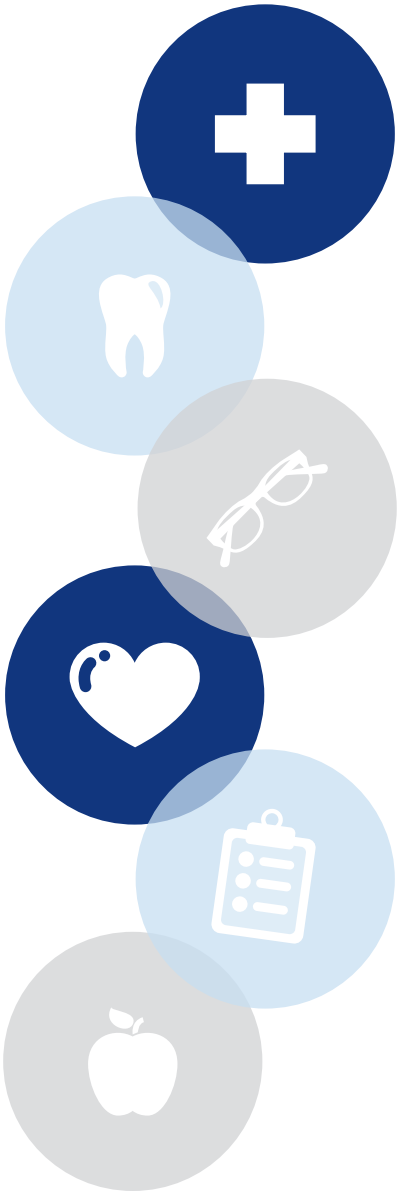


This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. KEYS reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

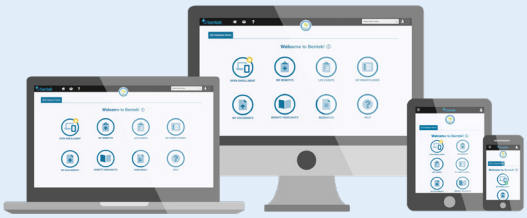
Introduction

KEYS provides group insurance benefits to eligible employees. This Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to the KEYS' Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources for further information.

Online Benefit Enrollment

KEYS provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Life Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report qualifying life events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to **app.mybentek.com/keysenergy**

  Please Note: *Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.*
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com, Monday through Friday during regular business hours 8:30am - 5:00pm.

To access Bentek using a mobile device, scan code.

Group Insurance Eligibility

The KEYS group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the KEYS' insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the first of the month following 31 days of employment. For example, if an employee is hired on April 11, then the effective date of coverage will be June 1.

Separation of Employment

If employee separates employment from KEYS, insurance will cease the date in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

Retiree Eligibility

Employees hired before June 10, 1999, who attain retirement eligibility, will receive employer paid health insurance in retirement. Employees hired after June 10, 1999, who attain retirement eligibility, have the opportunity to purchase health insurance through KEYS' insurance provider at the same rate as KEYS pays for its active employees, to the extent it does not conflict with any applicable laws.

Dependent Eligibility

A dependent is defined as the legal spouse or domestic partner and/or dependent child(ren) of the participant or spouse or domestic partner. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to the age of 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse or domestic partner

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group medical plan; and
- The dependent has been continuously insured

Proof of disability will be required upon request. Please contact Human Resources if further clarification is needed.

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent (taxable dependent) may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Dental Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 30.

Vision Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 30.

Please see Taxable Dependents if covering eligible over-age dependents.

Taxable Dependents

Employee covering adult child(ren) under employee's medical, dental and vision insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent child reaches age 26. Beginning January 1 of the calendar year in which dependent child reaches age 27 through the end of the calendar year in which the dependent child reaches age 30, imputed income must be reported on the employee's W-2 for that entire tax year and will be subject to all applicable Federal, Social Security and Medicare taxes. Imputed income is the dollar value of insurance coverage attributable to covering each adult dependent child. Contact Human Resources for further details if covering an adult dependent child who will turn age 27 any time during the upcoming calendar year or for more information.

Please Note: There is no imputed income if adult dependent child is eligible to be claimed as a dependent for Federal income tax purposes on the employee's tax return.

Group Insurance Eligibility *(Continued)*

Domestic Partner Coverage

Domestic partners may be eligible to participate in KEYS' group insurance plans if the partner is officially registered as a domestic partner with KEYS. The IRS guidelines state that employee may not receive a tax advantage on any portion of premiums paid related to domestic partner coverage. Employees insuring domestic partners and/or child dependent(s) of a domestic partner are required to pay imputed income tax on subsidy amounts and should consult a tax advisor. Please contact Human Resources for more information. Qualifying Events and Section 125.

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, vision insurance, contributions to Flexible Spending Accounts (FSA), and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Please Note: *This is not a KEYS policy, but is governed by the IRS Code, Section 125.*

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

IMPORTANT NOTES

If employee experiences a Qualifying Event, **Human Resources must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes may be effective the date of the Qualifying Event or the first of the month following the Qualifying Event. Newborns are effective on the date of birth. Qualifying Events will be processed in accordance with employer and carrier eligibility policy. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements.

Medical Plan Resources

Cigna offers all enrolled employees and dependent(s) additional services and discounts through value added programs. For more details regarding other available plan resources, please contact Cigna's customer service at (800) 244-6224, or visit www.mycigna.com.

Mobile App

Mobile app provides on-the-go access to the medical benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Health Information Line

The 24-Hour Health Information Line (HIL) assists individuals in understanding the right level of treatment at the right time. Trained nurses are available 24 hours a day, seven (7) days a week, 365 days a year to provide health and medical information and assistance on available resources. For more information call (800) 244-6224.

Healthy Rewards

Cigna's Healthy Rewards is provided automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members may log on to www.mycigna.com and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- ✓ Vision Care
- ✓ LASIK Vision Correction Services
- ✓ Fitness Club Discounts
- ✓ Nutrition Discounts
- ✓ Hearing Care
- ✓ Tobacco Cessation

Cigna Healthcare
Customer Service: (800) 244-6224 | www.mycigna.com

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is provided as a supplement to this booklet being distributed to new hires and existing employees during the Open Enrollment period. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From:	Human Resources
Address:	1001 James St. Key West, FL 33040
Website URL:	app.mybentek.com/keysenergy

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting Human Resources.

If there are any questions about the plan offerings or coverage options, please contact Human Resources.

Telehealth

Cigna provides access to telehealth services as part of the medical plan. MDLIVE is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is suggested and should be completed prior to using services. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telehealth, such as:

- ✓ Sore Throat
- ✓ Fever
- ✓ Rash
- ✓ Headache
- ✓ Cold And Flu
- ✓ Acne
- ✓ Stomachache
- ✓ Allergies
- ✓ UTIs And More

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact MDLIVE through Cigna Healthcare.

Cigna Healthcare
MDLIVE | Customer Service: (888) 726-3171 | www.mycigna.com

Medical Insurance

KEYS offers medical insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium tables below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plan, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Cigna's customer service.

Medical Insurance – Cigna Open Access Plus Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Monthly Cost	Employee Cost Per Pay
Employee Only	$1,669.42	$0.00
Employee + Spouse	$2,743.24	$536.91
Employee + Child(ren)	$2,474.15	$402.37
Employee + Family	$3,569.73	$950.16

Medical Insurance – Cigna HDHP Open Access Plus Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Monthly Cost	Employee Cost Per Pay
Employee Only	$1,434.11	$0.00
Employee + Spouse	$2,387.81	$476.85
Employee + Child(ren)	$2,153.58	$359.73
Employee + Family	$3,107.22	$836.55

Cigna Healthcare | Customer Service: (800) 244-6224 | www.mycigna.com

Cigna Open Access Plus Plan At-A-Glance

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$1,500	$3,000
Family	$4,500	$9,000
Coinsurance		
Member Responsibility	30%	50%
Calendar Year Out-of-Pocket Limit		
Single	$5,000	$10,000
Family	$10,000	$20,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$30 Copay	50% After CYD
Specialist Office Visit	$45 Copay	50% After CYD
Chiropractor Office Visit *(60 visit max combined with other Therapy Visits)*	$25 Copay	50% After CYD
Telehealth Services	No Charge	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	30% After CYD	50% After CYD
X-rays	30% After CYD	50% After CYD
Advanced Imaging *(MRI, PET, CT)* - Per Scan	30% After CYD	50% After CYD
Outpatient Surgery at Surgical Center	30% After CYD	50% After CYD
Physician Services at Surgical Center	30% After CYD	50% After CYD
Urgent Care *(Per Visit)*	$50 Copay	$50 Copay
Hospital Services		
Inpatient Hospital *(Per Admission)*	30% After CYD	50% After CYD
Outpatient Hospital *(Per Visit)*	30% After CYD	50% After CYD
Physician Services at Hospital	30% After CYD	50% After CYD
Emergency Room *(Per Visit; Waived if Admitted)*	$100 Copay	$100 Copay
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	30% After CYD	50% After CYD
Outpatient Services *(Per Visit)*	30% After CYD	50% After CYD
Outpatient Office Visit	$45 Copay	50% After CYD
Prescription Drugs *(Rx)*		
Generic	$15 Copay	50% Coinsurance
Preferred Brand Name	$50 Copay	50% Coinsurance
Non-Preferred Brand Name	$80 Copay	50% Coinsurance
Self-Administered Injectables	20% Coinsurance *(Not to exceed $200)*	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	2x Retail Copay	Not Covered
Mail Order Self-Administered Injectables	20% Coinsurance *(Not to exceed $400)*	Not Covered

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select **Open Access Plus** network.

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage.*

***LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.*

Cigna HDHP Open Access Plus Plan At-A-Glance

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select Open Access Plus network.

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.*

***LabCorp or Quest Diagnostics are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus network prior to receiving services.*

Network	Open Access Plus	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$2,500	$5,000
Family	$5,000	$10,000
Coinsurance		
Member Responsibility	30%	50%
Calendar Year Out-of-Pocket Limit		
Single	$5,000	$10,000
Family	$9,100	$20,000
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	30% After CYD	50% After CYD
Specialist Office Visit	30% After CYD	50% After CYD
Telehealth Services	30% After CYD	Not Covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)***	30% After CYD	50% After CYD
X-rays	30% After CYD	50% After CYD
Advanced Imaging *(MRI, PET, CT)*	30% After CYD	50% After CYD
Outpatient Surgery at Surgical Center	30% After CYD	50% After CYD
Physician Services at Surgical Center	30% After CYD	50% After CYD
Urgent Care *(Per Visit)*	30% After CYD	50% After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	30% After CYD	50% After CYD
Outpatient Hospital *(Per Visit)*	30% After CYD	50% After CYD
Physician Services at Hospital	30% After CYD	50% After CYD
Emergency Room *(Per Visit)*	30% After CYD	30% After CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	30% After CYD	50% After CYD
Outpatient Services *(Per Visit)*	30% After CYD	50% After CYD
Outpatient Office Visit	30% After CYD	50% After CYD
Prescription Drugs *(Rx)*		
Generic	30% After CYD	50% After CYD
Preferred Brand Name	30% After CYD	50% After CYD
Non-Preferred Brand Name	30% After CYD	50% After CYD
Self-Administered Injectables	30% After CYD	50% After CYD
Mail Order Drug *(90-Day Supply)*	30% After CYD	50% After CYD
Mail Order Self-Administered Injectables	30% After CYD	50% After CYD

Health Savings Account

The Cigna High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies enrollee to open a Health Savings Account (HSA). An HSA is an interest-bearing account where funds may be used to help pay employee and dependent(s) deductible, coinsurance and any qualified health care expenses not covered by the plan.

Plan Year Funding*

KEYS contribution to the HSA account will be:

- Employee Only: $2,823.84
- Employee + Family: $2,823.84

Employee may opt to fund an HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction. Employee contributions to an HSA may also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free.)

- 2025 IRS Contributions Limitations: $4,300 (individual coverage) $8,550 (family coverage)
- Individuals age 55 and older can also make additional "catch-up" contributions up to $1,000 annually

This maximum HSA amount would include any employer and employee contributions (pre-tax or post-tax). If employee is receiving an employer contribution, employee will want to account for this towards the annual IRS total maximum so employee does not over-contribute for the tax year. Guidelines regarding the HSAs are established by the IRS.

**Please contact Human Resources for further information regarding funding variations towards employer HSA contributions.*

What to Know About an HSA

- Employee owns the HSA funds from day one and decides how and when to spend the money.
- No use-it or lose-it rules; funds are in the account when needed, now or in the future. Participant cannot fund a traditional Health Care FSA, however, participant may fund a Limited Purpose FSA for dental and vision expenses only.
- HSA funds may earn interest.
- The HSA will be funded with employer contributions. If employee desires to fund the remaining IRS HSA Combined Contribution Limit balance, they may do so with pre-tax payroll deductions.
- HSA dollars may be used tax-free for all eligible health care expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employee plan for retirement.
- An account holder may write a check or withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.
- Account holder can access HSA statement at any time to track account balance and activity online at www.mycigna.com.
- To be eligible to open an HSA, employee must be covered by a qualified high deductible health plan. Employee may not be covered under another medical plan that is not a qualified high deductible health plan including a plan the employee's spouse may have selected where he/she has family coverage. Please Note: Eligibility status to qualify for an HSA is specifically driven by employee and NOT dependents.
- HSA funds can be used for dependent(s) even if dependent is not enrolled in the employee's group insurance benefits as long as the dependent is a qualified tax dependent.
- Over-age dependent is not able to use HSA funds for qualified expenses, even if dependent is covered under the medical plan as Federal law does not recognize them as a qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits KEYS from contributing HSA funds into the account. If employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the maximum contribution amounts of tier enrolled.
- Active employee NOT on Medicare but with a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare is eligible to enroll and contribute into the HSA up to the maximum contribution amounts of tier enrolled. These funds can be utilized for the active employee and spouse expenses.
- Active employee ON Medicare and with a spouse NOT enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse may not contribute or receive HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.

Cigna Healthcare | Customer Service: (800) 244-6224 | www.mycigna.com

Dental Insurance

Cigna Dental PPO Plan

KEYS offers dental insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Cigna's customer service.

Dental Insurance – Cigna Dental PPO Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Monthly Cost	Employee Cost Per Pay
Employee Only	$47.32	$23.66
Employee + Family	$111.82	$55.91

In-Network Benefits

The Dental PPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Cigna Total DPPO Network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Please Note: *Total DPPO dental members have the option to utilize a dentist that participates in either Cigna's Advantage Network or DPPO Network. However, members who use the Cigna Advantage Network will see additional cost savings from the added discount allowed for using an Advantage network provider. Members are responsible for verifying whether the treating dentist is an Advantage Dentist or a DPPO Dentist.*

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Cigna Total DPPO provider. Cigna reimburses out-of-network services based on what it determines as the Maximum Reimbursable Charge (MRC). The MRC is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between Cigna's MRC and the amount charged by the out-of-network dentist. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The Dental PPO plan requires a $50 individual or a $100 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the Dental PPO plan will pay for each covered member is $2,000 for in-network and out-of-network services combined. Preventive services accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next calendar year.

Mobile App

Mobile app provides on-the-go access to the dental benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Cigna Healthcare
Customer Service: (800) 244-6224 | www.mycigna.com

Cigna Total Dental PPO Plan At-A-Glance

Network	Total DPPO	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network**
Per Member	$50	
Per Family	$100	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$2,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(2 Per Year)*	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(2 Per Year)*		
Complete X-rays *(1 Set Per 3 Years)*		
Bitewing X-rays *(2 Films Per Year)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam or Composite)*	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Deep Cleaning		
Endodontics *(Root Canal Therapy)*		
Periodontal Services		
Anesthesia		
Simple Extractions		
Oral Surgery		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 60% After CYD	Plan Pays: 60% After CYD *(Subject to Balance Billing)*
Dentures		
Bridges		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,500	
Benefit *(Dependent Children Up To Age 19)*	Plan Pays: 50% Deductible Waived	Plan Pays: 50% Deductible Waived *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select **DPPO** network.

Plan References

***Out-Of-Network Balance Billing:** *For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the previous page.*

Important Notes

- *Each covered family member may receive up to two (2) routine cleanings per calendar year covered under the preventive benefit.*
- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

Vision Insurance

Cigna Vision Plan

KEYS offers vision insurance through Cigna Healthcare to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the carrier's benefit summary plan document or contact Cigna's customer service.

Vision Insurance Premiums – Cigna Vision Plan

24 Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Monthly Cost	Employee Cost Per Pay
Employee Only	$6.18	$3.09
Employee + Spouse	$12.38	$6.19
Employee + Child(ren)	$12.51	$6.26
Employee + Family	$19.71	$9.86

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, employee and covered dependent(s) may select any network provider who participates in the Cigna Vision network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may choose to receive services from vision providers who do not participate in the Cigna Vision Plan network. When going out of network, the provider will require payment at the time of appointment. Cigna will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Calendar Year Deductible

There is no calendar year deductible.

Calendar Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

Mobile App

Mobile app provides on-the-go access to the vision benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Claims Mailing Address
Cigna Vision, Claims Department
P.O. Box 385018, Birmingham, AL 35238-5018

Cigna Healthcare Vision
Customer Service: (877) 478-7557 | www.mycigna.com

Cigna Vision Plan At-A-Glance

Network	Cigna Vision	
Services	**In-Network**	**Out-of-Network**
Eye Exam	$10 Copay	Up to $45 Reimbursement
Materials	$25 Copay	Plan Reimbursement is Based on Type of Service
Frequency of Services Per Calendar Year		
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses		
Single	No Charge After $25 Materials Copay	Up to $32 Reimbursement
Bifocal		Up to $55 Reimbursement
Trifocal		Up to $65 Reimbursement
Frames		
Allowance	Up to $150 Allowance *(After $25 Materials Copay)*	Up to $83 Reimbursement
Contact Lenses*		
Non-Elective *(Medically Necessary)*	No Charge	Up to $210 Reimbursement
Elective *(Fitting, Follow-up & Lenses)*	Up to $130 Allowance	Up to $105 Reimbursement

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.mycigna.com. When completing the necessary search criteria, select **Cigna Vision** network.

Plan References

**Contact lenses are in lieu of spectacle lenses.*

Important Notes

- *The Frequency Period is based on a calendar year basis (January 1).*
- *Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.*

Flexible Spending Accounts

KEYS offers Flexible Spending Accounts (FSA) administered through UpSwing. The FSA plan year is from October 1 through September 30.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employees to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year. There are three (3) types of FSAs:

- **Health Care FSA:** Available to eligible employee **not** enrolled in the Cigna HDHP Open Access Plus Plan with an HSA. Covers medical, dental, and vision expenses that are not paid by insurance.
- **Limited Purpose FSA:** Available to eligible employee enrolled in the Cigna HDHP Open Access Plus Plan with an HSA. A Limited Purpose Health Care FSA may be used for qualified dental and vision expenses.
- **Dependent Care FSA:** Covers day care expenses for qualified dependents necessary for employee and legal spouse, if married, to work.

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,300. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note, if family income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household.

Please Note: Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from participant's paycheck for the Dependent Care FSA.

A sample list of qualified Health Care expenses eligible for reimbursement include, but not limited to, the following:

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees*
- ✓ Diagnostic Tests/Health Screenings*
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses*
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery*
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees*
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

**These items are eligible expenses under the Limited Purpose FSA.*

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- The Health Care FSA allows a grace period at the end of the plan year (90 days). The grace period allows additional time to incur claims and use any unused funds on eligible expenses after the plan year ends. Once the grace period ends, any unused funds still remaining in the account will be forfeited.
- The Health Care FSA has a run out period at the end of the grace period (until March 31) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year and/or grace period.
- When a plan year ends and all claims have been filed, all unused funds will be forfeited and not returned.
- Employee can enroll in an FSA only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility period.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted online through the member portal, by email or via mail . The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

Health care FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. UpSwing may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to KEYS. This card will not expire at the end of the benefit year. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $50,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $41.66 based on a 24 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$50,000	$50,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$49,000	$50,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $9,628	- $9,825
After Tax Expenses	- $0	- $1,000
Spendable Income	$39,372	$39,175
Tax Savings	**$197**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year.* ***This rule is known as "use-it or lose-it."***

Claims Submission
Member Portal: upswing.wealthcareportal.com
Mailing Address: UpSwing Compliance & Technology Solutions
2630 W Broward Blvd, Suite 203-675,
Ft Lauderdale, FL 33312
Email: upswing_receipts@alegeus.com

UpSwing
Customer Service: (866) 676-3665 | upswing.wealthcareportal.com

Basic Life and AD&D Insurance

Basic Term Life Insurance

KEYS provides Basic Term Life insurance for all eligible employees at no cost, through The Standard. Eligible employees are covered for a benefit amount of one (1) times employee's base annual salary, rounded to the next higher multiple of $1,000, with a maximum benefit of $200,000.

Life Insurance Imputed Income

The IRS requires that the imputed cost of employer paid Employee Life insurance benefits in excess of $50,000 must be included in income and is subject to Social Security and Medicare taxes.

Accidental Death & Dismemberment Insurance

Also, at no cost to employee, KEYS provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit, partial benefits may also be payable.

Always remember to keep employee beneficiary forms updated. Employees may update beneficiary information at anytime through Bentek.

The Standard | Customer Service: (800) 368-1135 | www.standard.com

Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

Eligible employee may elect to purchase additional Life and AD&D insurance on a voluntary basis through The Standard. This coverage may be purchased in addition to the Basic Term Life and AD&D coverage. Voluntary Life and AD&D insurance offers coverage for employee, spouse and/or child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $150,000.**

- Units can be purchased on employee equal to three (3) times employee's annual salary rounded to the next higher multiple of $1,000, up to a maximum of $200,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 65
  - Reduces to 50% of the benefit amount at age 70
  - Reduces to 35% of the benefit amount at age 75
- Accidental Death & Dismemberment (AD&D) insurance is included.
- Premium Calculation:
  - Elected coverage ÷ $1,000 x Employee Rate (see rate table on the next page) = Monthly Premium

Voluntary Spouse Life and AD&D Insurance

New Hires may purchase Voluntary Spouse Life insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $20,000.**

- Employee must participate in the Voluntary Employee Life plan for spouse to participate.
- Units can be purchased in increments of $10,000 to a maximum of $100,000, not to exceed 50% of the employee's combined Basic and Voluntary Life coverage amount.
- Spouse Life insurance coverage is subject to the same age reduction schedule as the employee.
- Accidental Death & Dismemberment (AD&D) insurance is included.
- Premium Calculation:
  - Elected coverage ÷ $1,000 x Spouse Rate (see rate table on the next page) = Monthly Premium

Voluntary Life Insurance *(Continued)*

Dependent Child(ren) Life Insurance

- Employee must participate in the Voluntary Employee Life plan for dependent child(ren) to participate.
- Coverage may be purchased in the amount of $5,000.
- Coverage may be purchased for employee's unmarried dependent child(ren) from birth through age 20, (or through age 24 if a registered full-time student). Coverage will end on the date of dependent child's 21st (or 25th) birthday.
- Dependent Child(ren) Life rate is $1.10 per month, regardless of the number of covered dependents.

Voluntary Life and AD&D Insurance Rate Table

Monthly Premium

Age Bracket *(Based On Employee Age)*	Employee/Spouse *(Rate Per $1,000 of Benefit)*
< 30	$0.12
30-34	$0.13
35-39	$0.17
40-44	$0.25
45-49	$0.44
50-54	$0.72
55-59	$1.13
60-64	$1.76
65-69	$3.16
70-74	$5.07
75+	$8.00

The Standard | Customer Service: (800) 368-1135 | www.standard.com

Long Term Disability

KEYS provides Long Term Disability (LTD) at no cost to all full-time employees through The Standard. The LTD pays employee a percentage of monthly earnings if employee becomes disabled due to an illness or injury.

Long Term Disability (LTD) Benefits

- LTD provides a benefit up to 50% of employee's monthly earnings up to a benefit maximum of $3,000 per month.
- Employee must be disabled for 60 consecutive days prior to becoming eligible for benefits (known as the elimination period).
- Benefits will begin on the 61st day of disability.
- Employee will not earn vacation or sick leave while on disability.
- The benefit elimination period (60) days includes all accumulated sick leave (including leave from the Employee Sick Leave Bank) and vacation leave. Employee should apply for LTD during this period, but the benefit will not be paid until all leave has been exhausted and employee has reached the 61st day of disability.
- The maximum benefit period is determined based on age at the time of disability.
- Employee returning to work after a disability period will be required to present a physician's statement certifying ability to resume normal duties and may, at KEYS' discretion, be sent for a Fitness For Duty medical evaluation.
- LTD benefits will be reduced by other benefits employee may receive, such as disability benefits paid by Social Security. Additionally, if there are any discrepancies between a policy and a plan document, the plan document prevails.

The Standard | Customer Service: (800) 368-1135 | www.standard.com

Employee Assistance Program

KEYS cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Cigna. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members/domestic partners' free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes six (6) face-to-face, visits with a specialist, per person, per issue, per year, telephonic consultation, online material/tools and webinars. EAP offers counseling services on issues such as:

- ✓ Child Care Resources
- ✓ Legal Resources
- ✓ Grief and Bereavement
- ✓ Stress Management
- ✓ Depression and Anxiety
- ✓ Work Related Issues
- ✓ Adult & Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor/manager, we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor/manager will not receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

To Access Services

Employee and family member(s) must register and create a user ID on www.mycigna.com to access EAP services.

Please Note: *This program is strictly confidential. There is no information shared with the employer.*

Cigna | Customer Service: (877) 622-4327
www.mycigna.com | Employee ID: keysenergy

Deferred Compensation

KEYS offers voluntary Deferred Compensation Retirement Plan options.

Employees may choose from a wide selection of investment options and the money contributed, including earnings, accumulate on a tax-deferred basis.

To learn more about this option or to schedule a personal appointment with a representative, contact Human Resources.

Supplemental Benefits

KEYS offers employees the opportunity to purchase voluntary products with premiums paid by payroll deduction. In the case of an accident or illness, Aflac pays cash benefits directly to the employee, regardless of what other insurance plans an employee might have. Aflac plans are affordable, portable at the same rate, and many claims can be paid in one business day.

Available Aflac Plans Include:

- ✓ Hospital Choice - This plan eases the financial burden of hospital stays by helping with out of pocket expenses due to a hospitalization or ER visit.
- ✓ Accident Advantage - This plan helps provide a financial cushion in the event an unexpected injury occurs.
- ✓ Cancer Assurance - This plan helps offset cancer related expenses with a lump sum benefit paid upon diagnosis, daily hospital confinement, surgical benefit, radiation and chemotherapy benefit, and mileage. These are just a few benefits covered though this plan.
- ✓ Critical Care Protection - This plan helps with the cost of treatment if you experience a covered health event, such as a heart attack, stroke, or paralysis. A lump sum is paid upon diagnosis with addition benefits paid for things like hospital stays and continuing care.

To learn more about these Aflac plans and/or schedule a personal appointment, contact KEYS' Aflac Agent, Jean Smith, at (561) 289-1360.

Aflac | Customer Service: (800) 992-3522 | www.aflac.com
Agent: Jean Smith | Phone: (561) 289-1360
Email: Jean_smith@us.aflac.com

Vacation Day Trade Credits

Once a year, during Open Enrollment, KEYS employees may trade-in up to 80 vacation hours for monetary credits towards benefits. For each hour the employee trades, employee receives the equivalent monetary amount credited to biweekly pay, across 24 pay periods, to offset the expense of benefits, or for a one-time, lump-sum credit into employee's deferred compensation account.

In order to participate in the vacation day trade credit program, the employee must complete an Employee Leave Request indicating the number of hours employee is trading, and provide to Human Resources during the annual Open Enrollment meeting. Human Resources will calculate the total value of the hours being traded (based on the employee's current hourly rate), then calculate for credit and distribution across 24 pay periods, beginning October through September of the current benefit year.

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctors' names and addresses or prescription medications.

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RISK strategies | GEHRING GROUP
A RISK STRATEGIES COMPANY

3500 Kyoto Gardens Drive, Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696 | Fax: (561) 626-6970 | www.gehringgroup.com

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