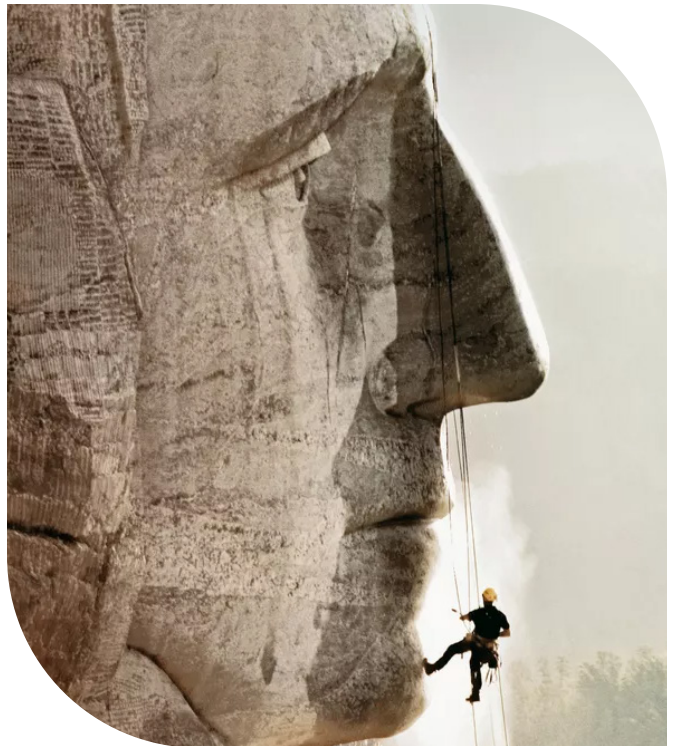


KÄRCHER



2026 TOTAL REWARDS GUIDE

Open Enrollment: March 23 - April 3, 2026



AT KÄRCHER, WE ARE DEDICATED TO SUPPORTING ALL ASPECTS OF YOUR WELL-BEING—BOTH AT WORK AND AT HOME—AND YOUR BENEFITS ARE A BIG PART OF THAT.

We're committed to creating a culture that prioritizes the well-being of our employees and their families by providing a comprehensive and competitive benefits package.

We encourage you to prioritize your well-being by focusing on preventive care and the tools and resources available to help you live your best life.

Before you make your benefit elections, take the time to review this guide so you can make an informed decision on which plans are the right fit for you and your family. Remember to choose wisely; the choices you make during Open Enrollment cannot be changed until the following year unless you have a Qualifying Life Event.



WELCOME TO YOUR 2026 BENEFITS GUIDE

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 39 for more details.

Disclaimer: This guide provides a summary of plan highlights. This is not a binding contract. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this guide. Please consult the Summary Plan Description for information on covered charges, limitations, and exclusions.

OPEN ENROLLMENT

March 23 - April 3, 2026

If you do not take action during Open Enrollment, most of your 2025 benefits will carry over to 2026. FSA and HSA contributions require an active election every year, so be sure to make that election if applicable.

You will not be able to enroll or make changes to your elections until the next Open Enrollment, unless you experience a Qualifying Life Event (QLE).



NEW EMPLOYEE ENROLLMENT

As a new employee, you have 30 days from your date of hire to elect coverage. Failure to enroll in benefits during your initial eligibility period will result in no coverage for medical, dental, or vision. In addition, your dependents will not be covered.

In this case, you will receive only Kärcher-provided Basic Life Insurance, Short-Term Disability, Long-Term Disability, and Employee Assistance Program (EAP) benefits.

ELIGIBILITY

All permanent, full-time employees who work a minimum of 30 hours per week are eligible to participate in the Kärcher benefit plans beginning on the first day of the month following their hire date. For the purpose of these benefits, eligible dependents include:

- Your lawful spouse or domestic partner
- Your dependent children, under age 26
- Your unmarried children, age 26 and older, who are mentally or physically disabled and unable to support themselves



QUALIFYING LIFE EVENTS

Your benefit elections made during Open Enrollment will be effective May 1, 2026. You may not make changes to your elections unless you experience a Qualifying Life Event, including

- Marriage, divorce, legal separation, or new domestic partnership
- Birth, adoption, placement, guardianship, or court-ordered coverage of a dependent child
- Death of your spouse or dependent
- Eligibility for Medicare
- Covered dependent is no longer eligible
- Covered spouse or dependent gains or loses coverage due to a job change or their employer's open enrollment



IMPORTANT

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation **WITHIN 30 DAYS** of the Qualified Life Event.

Log in to ADP to initiate a Qualifying Life Event.

HOW TO ENROLL

Enrollment in benefits can be completed online at ADP WorkforceNow. This is the same portal where you view and print your bi-weekly pay statements: <https://workforcenow.adp.com>.

ONLINE

Visit <https://workforcenow.adp.com>

1. Select the User Login (not the Admin Login)
2. Enter you ADP User ID
3. Enter your password
4. First time user? Click on the “Register Here” button
5. Use the passcode: KÄRCHERNA-1234.

Take time to review the information in this guide to ensure the elections you make meet the needs of you and your family. Be sure to make an election for each specific benefit option (e.g. medical, dental, vision, etc.). If you choose not to enroll in a specific plan, select “decline” in the appropriate box.

If you have any questions regarding the enrollment process or your benefits in general, please reach out to your local Human Resources team for assistance.

DO I HAVE TO DO ANYTHING?

Most benefits will automatically roll over to 2026-2027 plan year. You must enroll if you want to:

- Contribute to a Health Savings Account (HSA)
- Contribute to a Flexible Spending Account (FSA)
- Make changes to your coverage
- Change your beneficiaries

WHAT DO I NEED TO THINK ABOUT?

- Which family members do I want to cover?
- Which medical plan option works best for me and my family?
- Does my family need dental or vision coverage?
- What type of coverage do we need to provide financial protection in case of serious illness, injury, or death?
- Do I want to participate in the HSA or FSAs (depends on medical plan enrollment) to help pay for healthcare expenses by taking advantage of pre-tax money?



ADDING A DEPENDENT?

If you are electing to cover dependents, you must verify their eligibility during Open Enrollment. Your newly added dependents will not be added to your coverage until the dependent eligibility verification process is complete. If you are not able to provide the required documentation within 30 days of enrollment, please contact Human Resources to discuss your options.

Change in marital status

- Copy of marriage certificate
- Copy of divorce decree
- Copy of death certificate

Change in employment

- Notification of increase or reduction of hours that changes coverage status
- Notification of spouse's employment status that results in a loss or gain of coverage

Change in number of dependents

- Copy of birth certificate or copy of legal adoption papers
- Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
- Copy of death certificate



TERMS TO KNOW

Benefits can be confusing! Here's a quick reference to help you navigate commonly used terms:

- **Copay:** A flat dollar amount you pay the provider when you receive a service.
- **Deductible:** The amount you pay for services before the plan begins paying some of the cost. The deductible may not apply to all services, including preventive care.
- **Coinsurance:** The portion of covered expenses you and the plan share after you meet the deductible (listed as a percentage).
- **Out-Of-Pocket Maximum (OOP Max):** The maximum amount you pay out of your pocket for covered expenses in a year. Once you reach the out-of-pocket maximum, the medical plan pays for all covered services for the rest of the year.
- **Embedded Deductible or OOP Max:** A single family member does not need to meet the family deductible or OOP max before the benefit begins to pay for healthcare services.
- **Non-Embedded Deductible or OOP Max:** The total family deductible or OOP max must be met before health insurance starts paying for the healthcare services for any single family member.



MEDICAL BENEFITS

When it comes to your health, it's important to care for your body and mind. Kärcher offers a variety of benefits to help you focus on your whole well-being.

MEDICAL BENEFITS

It's important to have choices when it comes to healthcare. That's why Kärcher offers three medical plan options—a High-Deductible Health Plan (HDHP) with a Health Savings Account (HSA), a PPO, and the Colorado Doctors Plan (CDP)—designed to give you choice in cost, control, and coverage level. All plans are offered by United Healthcare.



CONSIDER YOUR COVERAGE

When choosing between the HDHP, PPO, and CDP, the main differences are flexibility, network rules, and how you pay for care.

- If you prefer to pay less out of your paycheck and are okay with higher out-of-pocket costs and a higher deductible when you need care, then the HDHP might be the right fit. The HDHP is compatible with a Health Savings Account (HSA). The company will contribute to the account to help pay for your qualifying medical, dental, and vision expenses.
- If you prefer to pay more out of your paycheck and have a lower out-of-pocket expense and deductible when you need care, you might prefer the PPO.
- If you choose the Colorado Doctors Plan, you'll pay lower out-of-pocket costs when you need care, but you must stay within the Colorado-only network. *Please note, the Colorado Doctors Plan only has coverage for in-network providers except in emergency situations. If you have dependents outside of the Colorado Doctors Plan area, benefits would be paid according to the Choice Plus PPO plan.*

See the Funding Accounts page for more information on how you can plan to cover your cost of care.

No matter which option you choose, all plans:

- Provide preventive care at 100%
- Provide prescription drug coverage
- Use the same nationwide network of doctors and pharmacies except the CDP, which includes a narrow network within the State of Colorado.
- Provide access to virtual care, mental health services, and additional care resources



PREVENTIVE CARE

Identifying potential problems before they become major issues is key to your physical health.

All medical plans include free in-network preventive care that includes annual physicals, mammograms, well child visits, immunizations, and more. So, stay on top of your wellness and schedule your in-network preventive visit today.

MEDICAL PLANS AT A GLANCE

	HDHP CHOICE PLUS	PPO CHOICE PLUS	COLORADO DOCTORS PLAN
PLAN FEATURE			
Deductible	\$3,400 individual \$6,800 family	\$1,000 individual \$3,000 family	\$500 individual \$1,500 family
Out-of-Pocket Maximum	\$5,200 individual \$10,400 family	\$3,000 individual \$6,000 family	\$1,500 individual \$4,500 family
Coinsurance	10%	10%	10%
YOU PAY			
Preventive Care	No charge	No charge	No charge
Office Visits	Deductible & 10% Coinsurance	\$20 Copay	Covered 100%
Specialist Visits	Deductible & 10% Coinsurance	\$40 Copay	\$75 Copay
Virtual Care	Covered 100%	Covered 100%	Covered 100%
Urgent Care	Deductible & 10% Coinsurance	\$45 Copay	Covered 100%
Emergency Room	Deductible & 10% Coinsurance	\$250 Copay	Deductible & 10% Coinsurance
X-Rays and Labs (Diagnostics)	Deductible & 10% Coinsurance	Covered 100%	Deductible & 10% Coinsurance
Complex Imaging	Deductible & 10% Coinsurance	Deductible & 10% Coinsurance	Deductible & 10% Coinsurance
Inpatient & Outpatient Services	Deductible & 10% Coinsurance	Deductible & 10% Coinsurance	Deductible & 10% Coinsurance



SAVE MONEY USING IN-NETWORK PROVIDERS

Choosing an in-network provider maximizes your savings, as these providers have agreed to reduced fees for covered services, lowering your out-of-pocket costs.

To find a provider, please visit member.uhc.com/myuhc and search by your zip code and the network you are enrolled in.

VIRTUAL HEALTH CARE

VIRTUAL VISITS

UNITED HEALTHCARE

Connect with a provider by phone, tablet, or computer — **at no cost for employees and covered dependents.**

1. 24/7 Virtual Visits: Receive care for non-emergencies — and get a prescription, if needed, for:

- Coughs, colds and flu
- Headaches
- Pinkeye
- Rashes
- Stomach pain
- Urinary tract infections (UTIs)

2. Virtual Primary Care: Connect with a primary care provider (PCP) for everything from checkups to help with complex conditions, including:

- Acute and chronic care
- Annual wellness visits
- Lab orders
- Non-urgent needs
- Prescription refills
- Specialist referrals

3. Virtual Specialty Care: Get ongoing care from specialists for a variety of needs, such as

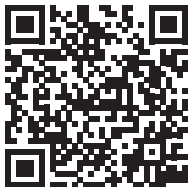
- Cardiac rehabilitation
- Dermatology
- Gastroenterology
- Migraines
- Sleep apnea
- Speech therapy
- Women's health issues

FEATURES:

- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.
- Avoid costly copays and deductibles of the ER and urgent care clinic.
- See a board-certified, licensed doctor on your schedule with on-demand virtual visits 24/7.
- Get treated for more than 80 common conditions including colds, flu, allergies, and more.

GET STARTED

1. Download the “United Healthcare” app using the QR code or visit www.uhc.com/member-resources/telehealth-virtual-care.
2. Create an account or sign in.
3. Schedule your appointment.



MATERNITY CARE

MAVEN MATERNITY

Maven offers 24/7 virtual support for pregnancy, postpartum, and early parenting — **at no cost.**

Get the app for support with:

- Creating your birth plan
- Breastfeeding and bottle-feeding
- Navigating infant sleep
- Returning to work
- Managing your mental health

FEATURES:

- Book virtual visits with maternity, postpartum, and pediatric specialists.
- Message providers anytime for quick guidance between appointments.
- Access on-demand classes, videos, and clinically vetted articles.
- Join supportive community groups for every stage of the family-building journey.
- Receive personalized care plans tailored to your needs during pregnancy and postpartum.

GET STARTED

1. Visit mavenclinic.com/join/getstarted or download the Maven Clinic app.
2. Create an account and enter the information requested to verify eligibility.
3. Start booking appointments or accessing resources immediately.





KNOW BEFORE YOU GO

Staying in-network is the best way to keep your medical costs low. But did you also know that deciding where to go for care based on the type of treatment you need and how quickly you need it can also save you money?

If you're enrolled in one of the medical plans, the chart below can help you decide where to go for care based on the type of treatment you need, how much you can expect to spend, and how quickly you need it.



TYPE OF SYMPTOMS	BEST PATH FOR CARE	YOUR VISIT COST*	AVERAGE WAIT TIME	HOURS OF OPERATION
Common cold, flu, sinus or ear infections, mild Covid-19, allergies, UTI	Virtual Visits	\$0 or \$	A few minutes	24/7
Anxiety, depression, mood disorders, PTSD, other mental health challenges	Virtual Visits	\$0 or \$	A few minutes	24/7
Basic health problems, chronic conditions, persistent joint pain	Primary Care Physician (PCP)	\$	Wait times vary	Traditional office hours (appointment often required)
Minor cuts, burns, or sprains, ear or sinus pain, minor allergic reactions, animal bites, broken bones	Urgent Care Clinic	\$\$	About an hour	Extended hours (includes evenings, weekends, and holidays)
Sudden numbness, uncontrolled bleeding, difficulty breathing, seizure or loss of consciousness, chest pain or pressure	Emergency Room	\$\$\$	A few hours	24/7

PRESCRIPTIONS

OPTUM RX

All medical plans include prescription drug coverage. Optum Rx's network of pharmacies includes hundreds of retail locations. You will also have access to convenient home delivery through Optum Rx Mail Order.

Under the HDHP, you pay the full cost of all non-preventive prescriptions until you meet your deductible, then the plan begins paying a portion of the costs.

Under the PPO and CO Doctors Plan, the plan pays a portion of your prescription drug costs whether you've met the medical deductible or not.

YOU PAY	HDHP CHOICE PLUS	PPO CHOICE PLUS	CO DOCTORS PLAN
IN-NETWORK RETAIL PHARMACIES (UP TO A 30-DAY SUPPLY)			
Generic	Deductible & 10% Coinsurance	\$20	\$20
Preferred		\$40	\$40
Non-Preferred		\$60	\$60
HOME DELIVERY MAIL ORDER (90-DAY SUPPLY)			
Generic	Deductible & 10% Coinsurance	\$40	\$40
Preferred		\$80	\$80
Non-Preferred		\$120	\$120



DIABETES CARE

- **Free Meter Program:** Get an approved blood sugar meter at no cost through Optum Rx. Contact Optum customer service for a list of covered meters.
- **Critical Drug Affordability Program:** Many diabetes medications are covered, often at little or no cost. Optum customer service can provide the full list of eligible medications.



MAIL ORDER PRESCRIPTIONS

Home delivery is a convenient, cost-effective, and safe option for medications you take regularly. Make sure you have your ID card ready.

1. Sign in or register for a new account with [Optum Home Delivery](#).
2. Transfer your prescription or have your prescriber send a new one.
3. Once your prescription is processed, your delivery should arrive in 3-5 business days.

DENTAL PLAN

DELTA DENTAL



In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings, and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Kärcher offers you two (2) dental insurance options through Delta Dental of Colorado. Under these plans, you may visit the dentist of your choice, however, you will receive the best benefit by choosing an in-network dentist.

Find a provider:

www.deltadentalco.com/dentist-search.html



RIGHT START 4 KIDS

- Covers children up to age 13 at 100% (no deductible) for services covered under the plan, up to the annual maximum.
- Must use a Delta Dental PPO or Premier provider to receive the full 100% coverage.
- Out-of-network visits are covered at the adult coinsurance level.
- Orthodontics are not covered at 100%—they follow the plan's standard coinsurance.

PLAN FEATURES	LOW PLAN	HIGH PLAN
Annual Deductible: Applies to Basic & Major	\$50 Individual \$150 Family	\$50 Individual \$150 Family
Annual Maximum	\$1,000/person	\$2,500/person
Preventive Care	Covered at 100%	Covered at 100%
Basic Services: Fillings, oral surgery, endodontics, periodontics	50% after deductible	20% after deductible
Major Services: Crowns, implants, dentures	80% after deductible	50% after deductible
Lifetime Orthodontia Maximum: Adult & Child	50% to \$1,000	50% to \$2,000

VISION PLAN

VSP

Kärcher's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

If you enroll in vision coverage, you can go to any eye care provider you chose for care. However, if you choose providers who are part of the VSP network, you will receive a discount on services.



VSP PROVIDERS

You can use any eye doctor you choose, but using VSP in-network providers will save you money. Use the Find a Provider tool at www.vsp.com to locate an in-network eye doctor.

	VSP NETWORK	
BENEFIT FREQUENCY		
Contact Lenses or Lens	Once every calendar year	
Exam	Once every calendar year	
Frame	Once every two calendar years	
VISION CARE SERVICE	IN-NETWORK	OUT-OF-NETWORK
EXAM		
Exam	\$10 Copay	Up to \$45
LENS		
Materials Copay	\$25 Copay	N/A
Single Vision	Covered in Materials Copay	Up to \$30
Lined Bifocals	Covered in Materials Copay	Up to \$50
Lined Trifocals	Covered in Materials Copay	Up to \$65
Lenticular	Covered in Materials Copay	Up to \$100
FRAME		
Frame	\$200 Allowance, 20% Discount	Up to \$70
CONTACTS		
Contacts – In lieu of glasses	\$180 Allowance	Up to \$105
Medically Necessary Contacts	Covered in Full	Up to \$210
PROTEC SAFETY		
Frame	Covered in Full	\$65 Allowance, 20% Discount
Lenses: Prescription single vision, lined bifocal, and lined trifocal	Combined with Frame	

PAYCHECK DEDUCTIONS

The following chart contain the monthly paycheck deductions for benefits beginning May 1, 2026. For the insurance programs listed below, deductions are made on a pre-tax basis.

MEDICAL

COVERAGE LEVEL	HDHP	CHOICE PLUS PPO	COLORADO DOCTORS PLAN
Employee Only	\$134.92	\$147.19	\$106.10
Employee + Spouse	\$289.47	\$461.18	\$234.27
Employee + Child(ren)	\$222.62	\$365.39	\$188.75
Employee + Family	\$377.50	\$663.04	\$296.42

DENTAL

COVERAGE LEVEL	LOW PLAN	HIGH PLAN
Employee Only	\$7.20	\$35.45
Employee + Spouse	\$20.49	\$82.49
Employee + Child(ren)	\$22.71	\$78.65
Employee + Family	\$38.22	\$137.36

VISION

COVERAGE LEVEL	RATE
Employee Only	\$2.14
Employee + Spouse	\$6.43
Employee + Child(ren)	\$5.36
Employee + Family	\$8.58

PAYING FOR COVERAGE

You and Kärcher share the cost of your benefits, with Kärcher paying most of the premium.

Your share of medical, dental, and vision coverage is deducted from your paycheck on a pre-tax basis. Any contributions you make to a Flexible Spending Account (FSA) or Health Savings Account (HSA) are also taken out pre-tax. This means the amount you elect is removed from your pay before federal taxes, state taxes, and Social Security are calculated—reducing your taxable income and increasing your take-home pay.

Premiums for other optional benefits—such as Optional Life Insurance or Accidental Death & Dismemberment (AD&D)—are deducted on an after-tax basis.

How much you pay for medical coverage depends on the plan you choose and the number of family members you cover.

DEDUCTION SCHEDULE

Your benefit premiums are deducted from the first two paychecks each month (24 deductions per year).

If a month has a third paycheck, no benefit deductions are taken from that paycheck.

FSA (Healthcare and Dependent Care) contributions are deducted from all 26 pay periods.

BENEFIT PLAN YEAR

Kärcher's benefit plans follow a May 1 – April 30 plan year.

Some benefits may follow a calendar year. Any exceptions will be noted throughout this guide.

MENTAL HEALTH RESOURCES

UNITED HEALTHCARE

Kärcher offers several mental health and emotional wellbeing resources at no additional cost through UnitedHealthcare. Each program provides a different type of support so you can choose what fits your needs best.

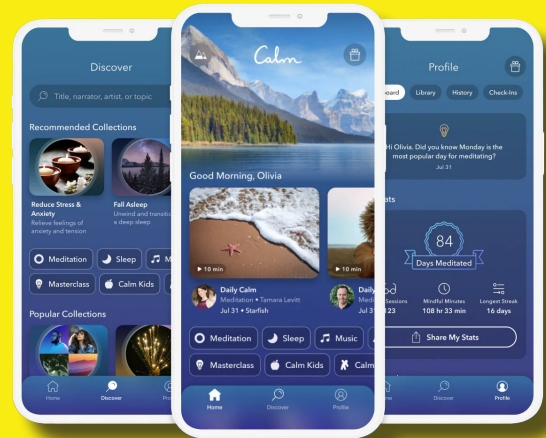


1. VIRTUAL THERAPY

Virtual therapy is designed to help treat conditions like anxiety, depression, stress, substance use, and other mental health concerns

- **Private video sessions:** 1-on-1 virtual visits with licensed therapists- for yourself and your dependents including children and teens
- **Help with coping:** Your licensed therapist may provide a diagnosis, treatment, and medication if needed
- **Similar standards of care as in-person visits:** You can see the same therapist with each appointment and establish an ongoing relationship

To get started, sign in or register on myuhc.com. Then, go to Find Care & Costs > Virtual Care > Behavioral Health Care > Get Started



2. CALM: MENTAL WELLBEING APP

Self-paced programs and tools to support mental well-being. Start with a brief mental health screening. Then, Calm Health will suggest programs based on where you are in your wellbeing journey.

- **Library of support:** Mindfulness content and programs created by psychologists for a variety of health experiences and life stages
- **Learn techniques to improve wellbeing:** Find tools, music and sounds to help you meditate, improve focus, move mindfully and feel calm
- **Work towards goals:** Join self-guided self-care programs, and track your progress along the way
- **Support your body and mind:** Access mental health information and support to help you strengthen the mind-body connection



To get started, scan this code or visit uhc.app/calm. You'll first need to sign in to your account on myuhc.com or the United Healthcare app. If you don't have an account, select Register to create one.

Employee Assistance Program (EAP)

Lincoln Financial

Available to all employees and provided by Lincoln Financial's Employee Connect service, the Employee Assistance Program (EAP) is a free and completely confidential counseling program offering unlimited telephone consultation for everyday concerns, such as parenting, care giving, pet care, and college, as well as marital and family concerns, depression, substance abuse, grief, loss, financial entanglements, and other personal stressors.

MENTAL WELL-BEING

You can receive up to four counseling sessions per issue per year. The sessions are a free and confidential service and are available face to face, online with televideo, or by phone.

Licensed counselors can help with issues such as:



Mental health concerns



Emotional difficulties



Domestic abuse



Substance abuse



Financial worries



Grief and loss



Relationship support



Self-esteem and personal development



Stress management



Work-life balance

When you need in-the-moment emotional well-being support, counselors are here to help 24/7. You can call **888-628-4824**.

WORK-LIFE ASSISTANCE

Resources for living also provides a wide variety of work-life support, with some services at no cost. A few of the services include:



Daily life assistance: Resources for child, elder, or pet care, and household services



Legal support: Wills and estate planning, family, civil, criminal, and real estate



Financial services: Budgeting, mortgages, college funding, and issues



Identity theft services: Fraud resolution and credit restoration coaching



CALL (888) 628-4824 FOR 24/7 COUNSELOR SUPPORT

FOR MORE INFORMATION AND RESOURCES

Visit www.GuidanceResources.com (username: LFGsupport; password: LFGsupport1)

WELLNESS PROGRAMS

United Healthcare

1. REAL APPEAL

Real Appeal® on Rally Coach™ is an online weight-management program designed to help you create sustainable, healthy habits. The program is available to you and your eligible family members at no additional cost as part of your Kärcher benefits.

WHAT YOU'LL GET

- Personalized goals for nutrition, exercise, and weight management.
- Easy tracking tools right from your daily dashboard.
- Supportive coaching, including online group sessions led by trained coaches.
- A motivating community of members working toward similar goals.

SUCCESS KIT DELIVERED TO YOUR HOME

After attending your first live group session, you'll receive a Success Kit with helpful tools like:

- Weight and food scales
- A portion plate
- Additional resources to support your journey



GET STARTED

Enroll at enroll.realappeal.com and begin building healthier habits today.

2. ONE PASS SELECT

One Pass Select gives you flexible, affordable access to fitness options at home, at the gym, and even in your kitchen. You and your eligible family members (18+) can choose the membership tier that works best for your lifestyle.

WAYS TO USE ONE PASS SELECT



At the gym

- Access thousands of nationwide gyms and local fitness studios.
- Use any location in your tier—mix and match to build your ideal routine.



At home

- Stream live or on-demand fitness classes.
- Use the workout builder to create personalized routines based on your fitness level and interests.



In the kitchen

- Enjoy grocery and household essentials delivered to your home.
- Make nutritious meal planning easier and more convenient.

HOW TO ENROLL

1. Visit member.uhc.com/coverage/additional
2. Sign in or create an account
3. Select the One Pass Select tile

MEMBERSHIP TIERS

- Classic – \$34/month: 12,000+ gym locations
- Standard – \$69/month: 14,000+ gym + premium locations
- Premium – \$109/month: 16,000+ gym + premium locations
- Elite – \$159/month: 20,000+ gym + premium locations
- Digital-only plan – \$10/month

TIME AWAY

Balancing work and life is important to your health. That's why Kärcher provides programs to help you take time away from work to recharge and revitalize your well-being.

PAID TIME OFF PROGRAMS

VACATION: HOURLY EMPLOYEES

Hourly employees accrue vacation biweekly beginning on their first day of employment.

- Accrued balances appear in ADP.
- Accrual stops once you reach the annual maximum and resumes after you use time.
- Up to 24 hours of unaccrued time may be borrowed with HR approval.
- Unused earned vacation is paid out at termination.
- Part-time employees accrue prorated vacation.

Full-time non-exempt employees are provided Vacation as described below:

YEARS OF SERVICE	VACATION MAXIMUM ANNUAL ALLOTMENT
Up to 5 Years	80 Hours
5 Years up to 10 Years	120 Hours
10 Years up to 20 Years	160 Hours
20+ Years	200 Hours

USING VACATION

Submit requests to your supervisor as early as possible. Approvals are based on staffing, scheduling needs, and business demands.

PAID TIME OFF: SALARIED EMPLOYEES

Salaried employees do not accrue a set number of hours. PTO is discretionary and based on:

- Your ability to meet performance expectations
- Manager approval
- Proper entry of time off in the timekeeping system

Use PTO for vacation, personal time, or occasional illness.

PAID SICK TIME

Available to hourly employees (salaried employees use PTO when sick). Sick time accrues biweekly based on hours worked, including overtime.

Accrual & Carryover: Accrual amounts and carryover rules vary by location according to state/local laws.

LOCATION	SICK TIME ACCRUAL RATES	ANNUAL MAXIMUM	CARRY OVER OF UNUSED SICK TIME
State of Washington	1 Hour of Sick Time for every 40 Hours Worked	No Annual Cap	Up to 40 Hours of Unused Sick Time
State of Colorado	1 Hour of Sick Time for every 30 Hours Worked	48 Hours Annual Cap	Up to 48 Hours of Unused Sick Time
Westchester County, New York	1 Hour of Sick Time for every 30 Hours Worked	56 Hours Annual Cap	All Unused Sick Time
All Other Locations	1 Hour of Sick Time for every 30 Hours Worked	40 Hours Annual Cap	Up to 40 Hours of Unused Sick Time

You may use sick time for:

- Your own illness, injury, or preventive care
- Caring for a covered family member
- Domestic/sexual violence–related needs
- School meetings or health-related child appointments
- Public health closures (e.g., school or workplace)

REPORTING SICK TIME

Notify your supervisor as soon as possible, preferably before your shift. Documentation may be required for absences of three or more consecutive days.

VOLUNTEER TIME OFF

Full-time employees receive up to 8 hours of paid volunteer time each year to support any 501(c)(3) charity. Time can be used in 4- or 8-hour increments, and team volunteer projects with your manager or coworkers are encouraged. To use VTO, notify your supervisor two weeks in advance and submit the Volunteer Form with proof of hours.

LEAVES OF ABSENCE

MEDICAL LEAVE (NON-FMLA)

For employees who need time off for their own serious health condition but are not yet eligible for FMLA.

- Available in 30-day increments; max 60 days per year
- Unpaid unless you use accrued Sick, Vacation (hourly), or PTO (salaried)

FAMILY AND MEDICAL LEAVE (FMLA)

Provides job-protected unpaid leave for serious health conditions affecting you or an immediate family member.

Eligibility

- 12 months of employment and
- 1,250 hours worked in the past 12 months

Employees may choose—or be required—to use available paid leave during FMLA.

MILITARY LEAVE

- Up to 10 paid days per year for eligible employees (1+ year of service) to cover the difference between regular pay and military pay
- Additional military service is unpaid, but accrued Vacation may be used
- Employees with less than one year of service receive unpaid Military Leave

OTHER PAID TIME OFF

PAID HOLIDAYS

Kärcher observes 11 paid holidays annually.

Employees on nonstandard schedules receive up to 8 hours of holiday pay for holidays falling on scheduled workdays.

JURY DUTY

- Up to 5 paid days for jury service or subpoenaed witness duty
- Provide summons and court verification to receive jury pay
- Must report to work when not required in court

BEREAVEMENT LEAVE

Up to 5 paid days following the loss of an immediate family member (including spouses, parents, children, siblings, in-law equivalents, grandparents, and step-relations). Additional time may be taken using available Vacation or PTO.

PARENTAL LEAVE

Up to 4 weeks of paid leave to bond with a newborn or newly adopted/placed child. Runs concurrently with FMLA, when applicable.

STATE DISABILITY & PAID FAMILY LEAVE

Some states offer additional disability or family leave benefits (e.g., CA, CO, CT, NJ, NY, MA, OR, WA, DC). Employees in these states may qualify for state-funded wage replacement. Contact HR for details.



FUNDING ACCOUNTS

HEALTH SAVINGS ACCOUNT (HSA)

WEX

WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account (HSA) is a way for you to save pre-tax dollars that can be used to pay for qualified healthcare expenses like deductibles, copays, co-insurance, prescriptions, vision, and dental expenses.

Your HSA offers triple tax savings, allowing you to save on taxes in three ways.

- **Before-tax contributions:** Any money you contribute lowers your federal taxable income.
- **Tax-free growth:** The money in your account earns interest, and the investment earnings are tax-free, too.
- **Tax-free withdrawals:** HSA money you use to pay for eligible expenses is withdrawn tax-free.

WHO IS ELIGIBLE FOR AN HSA?

- Must be enrolled in a high deductible health plan.
- Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP.
- Cannot be enrolled in a traditional health care FSA in 2026.
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid or Tricare.
- Cannot be claimed as a dependent on another person's tax return.
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months.

HOW MUCH CAN I CONTRIBUTE TO AN HSA?

- Employee only coverage: \$4,400 per calendar year.
- Employee plus dependents coverage: \$8,750.
- If you are 55 or older, you can make an additional annual catch-up contribution of \$1,000.

If you are eligible for a health savings account and enroll in the HDHP, Kärcher will provide a contribution to your Health Savings Account. To be eligible you must open a Health Savings Account with WEX.

	IRS LIMIT	KÄRCHER CONTRIBUTION	YOUR CONTRIBUTION LIMIT
Employee Only	\$4,400	\$500	\$3,900
All Other Coverage	\$8,750	\$1,000	\$7,750

HSA's AND YOUR TAXES

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.



FLEXIBLE SPENDING ACCOUNT (FSA)

WEX



Flexible Spending Accounts (FSAs) let you set aside pre-tax dollars to pay for eligible health care, dependent care, transit, and parking expenses—helping you lower your taxable income and save money throughout the year. Kärcher offers four tax-advantaged FSA options through WEX: Healthcare FSA, Dependent Care FSA, Transit FSA, and Parking FSA. Enrollment is optional, and you can choose any accounts for which you're eligible.



HEALTH CARE FSA

- Use pre-tax dollars to pay for eligible health care expenses such as deductibles, copays, and coinsurance.
- Contribute up to \$3,400 in 2026. Your full annual election is available on day one.
- Once elected, contributions cannot be changed unless you experience a Qualifying Life Event.

WHO CAN PARTICIPATE?

You can participate in the Healthcare FSA if you are not enrolled in a High-Deductible Health Plan (HDHP), whether through Kärcher or another source. You do not need to be enrolled in a Kärcher medical plan to participate.

WHAT HAPPENS AT THE END OF THE YEAR?

Healthcare FSAs are “Use It or Lose It.” Any funds not spent by the deadline are forfeited.

- Expenses must be incurred in the same plan year.
- Only expenses incurred on or after your effective date are eligible.
- All claims must be submitted by July 15 following the end of the plan year.

HOW DO I ACCESS MY FUNDS?

If you enroll, you will receive a debit card in the mail. You can use your debit card to pay for eligible expenses up front and submit your receipts as substantiation. Please remember that the IRS does require you to save all receipts to substantiate the tax deduction on your income tax return.



DEPENDENT CARE FSA

- Use pre-tax dollars to pay for eligible childcare or eldercare expenses.
- Contribute up to \$7,500 in 2026 (or \$3,750 if filing separately). Funds are available as they are deposited.
- Once elected, contributions cannot be changed unless you experience a Qualifying Life Event.

WHO CAN PARTICIPATE?

Any employee.

WHAT ARE THE CONTRIBUTION LIMITS?

Employees can contribute up to \$7,500 annually per family or \$3,750 if filing separately.

WHAT HAPPENS AT THE END OF THE YEAR?

Dependent Care FSA funds can only be used for expenses incurred during the plan year (5/1/2026 - 4/30/2027).

- Unlike the Healthcare FSA, Dependent Care funds are not available in full on day one—you can only be reimbursed up to the amount contributed at that point in time.
- Unused funds expire at the end of the plan year.
- Claims must be submitted by the plan's deadline for reimbursement.



COMMUTER FSA:

- 1. TRANSIT FSA:** Covers eligible mass transit costs, including bus, rail, ferry fares, passes, and vouchers.
- 2. PARKING FSA:** Covers work-related parking expenses at or near your workplace or a transit location. (Home parking is not eligible.)

Contribute up to \$340 per month for transit and/or parking. You may start, stop, or adjust contributions at any time.

FSA COMPARISON

	HEALTHCARE FSA	COMMUTER FSA: TRANSIT AND PARKING	DEPENDENT CARE FSA
Eligibility	Any benefits-eligible employee	Any benefits-eligible employee	Any benefits-eligible employee
Contribution Limits*	\$3,400	\$4,080 (\$340/month)	\$7,500 (\$3,750 if married and filing taxes separately)
Minimum Annual Election	\$100	N/A	\$100
Fund Availability	Full annual amount available immediately	Funds available as deposited	Funds available as deposited
Eligible Use	Qualified medical, prescription, dental, and vision expenses including: <ul style="list-style-type: none"> • Copays • Deductibles • Hearing aids and batteries • Ambulance services • Contact Lenses and cleaning solution • Prescription eyeglasses • Laser/Lasik Eye Surgery 	Work-related parking or mass transit expenses such as <ul style="list-style-type: none"> • Transit passes • Tokens • Fare cards • Vouchers • Parking fees for parking meters garages, etc. 	<ul style="list-style-type: none"> • Daycare, preschool, and before/after-school care for children under age 13 (kindergarten is not eligible). • Care for a disabled dependent of any age, including a spouse or parent. • Nanny, babysitter, or au pair costs when the care allows you to work (non-work-related babysitting is not eligible). Summer day camps (not overnight camps). • Care must be provided by someone you do not claim as a tax dependent.



NEED HELP?

Contact WEX Benefits at (866) 451-3399 or visit www.wexinc.com to view balances, submit claims, and manage your account.

For a full list of eligible expenses, please visit www.wexinc.com.

INCOME PROTECTION

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

LINCOLN FINANCIAL

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment, or paralysis. This benefit is sponsored by Kärcher, so you will automatically be enrolled at no cost to you.



EMPLOYEE BASIC LIFE AND AD&D

Basic Life: Employees

NOTE: Benefits reduce by 50% at age 70. Benefits terminate at retirement.

Coverage Level	1x Basic Annual Earnings, rounded up to the next highest \$1,000
Minimum Benefit	\$25,000
Maximum Benefit	\$250,000

Basic AD&D: Employees

Accidental Death	Equal to Life Benefit
Dismemberment	Please see Plan Benefit Booklet for Dismemberment Benefit Schedule

DEPENDENT BASIC LIFE AND AD&D

Basic Life: Dependents

NOTE: Benefits terminate for a spouse at age 70.

Spouse	\$2,000
Child (Birth to age 26)	\$2,000

Basic AD&D: Dependents

Accidental Death	Not Available
Dismemberment	Not Available

BASIC LIFE INSURANCE TAXABILITY

While there is no cost to you for Basic Life Insurance, it is important to note that you are responsible for paying the taxes associated with the premium for this coverage for any amounts over \$50,000. Why? If you were to pass away, the Basic Life Insurance benefit is payable to our beneficiary. By paying the taxes on the premium for this plan, it ensures that your beneficiaries who receive this life insurance do not pay income taxes on the life insurance they receive. This is a significant tax savings to your beneficiary.

Please ensure your beneficiary remains up-to-date within ADP.

VOLUNTARY LIFE AND AD&D

LINCOLN FINANCIAL

While Kärcher offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

NEW EMPLOYEE: GUARANTEE ISSUE FOR VOLUNTARY LIFE INSURANCE

As a new employee, you and your dependents may purchase additional life insurance coverage up to a specific amount without providing personal health information. This is called the “Guarantee Issue” limit. The guaranteed-issue purchase options are a one-time opportunity for employees when they are newly hired with Kärcher. Should you decline Voluntary Life coverage upon hire and elect to participate at a later date, any coverage elections in the future will require that you apply for – and be approved for – the coverage prior to it taking effect.

EXISTING EMPLOYEE: VOLUNTARY LIFE INSURANCE

If you have never enrolled in Voluntary Life or AD&D coverage, any election for coverage requires you to complete an Evidence of Insurability (EOI) application during the annual Open Enrollment process. Once your application is approved, your coverage will then go into effect, and you will begin premium contributions through payroll deduction.

BENEFIT	EMPLOYEE	SPOUSE*	DEPENDENT*
Benefit Increments	May purchase coverage in \$10,000 increments	May purchase coverage in \$5,000 increments	Age 1 Day to age 26: \$2,000 increments
Minimum Amount	\$10,000	\$5,000	\$2,000
Maximum Amount	5 times your annual salary up to \$500,000 (\$50,000 for employees 70 and older)	50% of employee election amount, to a maximum of \$250,000	\$10,000
Guarantee Issue for Newly Eligible Employees	\$200,000	\$30,000	N/A
Current Eligible Employees	You or your spouse may elect or increase your voluntary life insurance amount up to two benefit levels on a guaranteed-acceptance basis during Kärcher’s Open Enrollment period, provided that you or your spouse has not been previously declined, withdrawn, or pending for coverage		

*Employee must elect coverage for spouse or dependent coverage to be elected.

MONTHLY COST FOR EVERY \$1,000 OF EMPLOYEE AND SPOUSE LIFE INSURANCE COVERAGE

Spouse Voluntary Life Insurance premiums are based on the employee’s age

Age	<24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +
Employee	\$.058	\$.070	\$.093	\$.104	\$.116	\$.174	\$.267	\$.498	\$.765	\$1.472	\$2.387
Spouse	\$.058	\$.070	\$.093	\$.104	\$.116	\$.174	\$.267	\$.498	\$.765	\$1.472	N/A
AD&D	\$.033 per \$1,000 of coverage										
Dependent Children	\$.123 per \$1,000 of coverage										

VOLUNTARY AD&D

Should you wish to purchase additional Accidental Death and Dismemberment (AD&D) coverage, the following plan provisions apply:

- AD&D coverage must be equal to the Voluntary Life coverage you’ve purchased
- Benefits will reduce by 50% at age 70 for both employees and spouses
- For spouses, benefits terminate when the employee reaches age 70 or retirement, whichever comes first.
- Additional benefits include Accelerated Death Benefit and Portability or Conversion.

LIFE INSURANCE – ADD-ON BENEFITS

You are entitled to participate in the LifeKeys and TravelConnect programs at no additional cost. From estate planning to identity theft resources, these programs can provide invaluable support to you; whether in a time of need, or while planning for your future.



LIFEKEYS SERVICES:

LifeKeys offers emotional, legal, and financial support to help you navigate life's challenges—whether you're planning for the future or managing unexpected events.

Services include:

- **Discounts on shopping and entertainment.** Save up to 60% on products and services including electronics, health, fitness, Broadway shows, and more. Discounts are available in the GuidanceNow mobile app.
- **Help with important life matters.** Support tools and advice on a wide range of topics including legal, financial, family, and career. Visit GuidanceResources Online.
- **Identity theft protection:** Online resources to help you recognize and prevent identity theft and restore your identity if it has been compromised.
- **Online will preparation:** EstateGuidance offers a secure, efficient way to create and execute a will.
- **Guidance and support for beneficiaries:** LifeKeys offers resources to help your loved ones address common concerns after experiencing a loss. Services include grief counseling, financial and legal advice, and additional support.

How to access:

Call 1 (855) 891-3684

Visit [GuidanceResources.com](https://www.guidanceresources.com)

(First-time user Web ID: LifeKeys)



TRAVELCONNECT® SERVICES

TravelConnect provides access to medical, safety, and travel assistance whenever you're more than 100 miles from home—whether traveling for work or personal reasons. These services are offered in partnership with On Call International.

Services include:

- **Emergency travel assistance:** Arrange emergency travel if you're injured and need medical evacuation, coordinate travel for a companion or dependent (including transportation and escort services), plan and pay for evacuation due to natural disasters or political/security threats, arrange transportation following a medical emergency, and coordinate secure pet or vehicle return.
- **Help managing medical needs while traveling:** Assistance obtaining medical records, arranging medication or vaccine delivery, and providing medical, dental, and pharmacy referrals. Support is also available for replacing corrective lenses or critical medical devices so you can continue your trip safely.
- **Legal, document, and identity support:** Access to legal consultation, help recovering lost or stolen documents or luggage, and ID recovery services if your personal information is compromised while traveling.
- **Additional travel support services:** Access language translation assistance and destination information to help you prepare before and during your trip, ensuring you have reliable support wherever you go

How to access:

Visit [MyOnCallPortal.com](https://www.myoncallportal.com)

Enter Group ID: LFGTravel123



WHOLE LIFE INSURANCE

VOYA

Whole Life Insurance provides long-term, portable protection with guaranteed premiums and guaranteed cash value. It can complement your existing term life insurance to help ensure your family has lasting financial security.

If you already have term life insurance, adding whole life insurance can help ensure you have enough long-term coverage to meet your family's needs.

TERM **VS** WHOLE LIFE INSURANCE

<p>Term Life Insurance</p> <ul style="list-style-type: none"> • Coverage provides protection for a specific period of time. • Costs increase as you get older. • Does not build cash value. 	<p>Whole Life Insurance</p> <ul style="list-style-type: none"> • Provides lifetime coverage as long as premiums are paid. You can keep your coverage even if you leave Kärcher—through retirement and beyond. • Premiums never increase, helping with long-term budgeting. • Builds guaranteed cash value that can be accessed through policy loans.
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BENEFIT	EMPLOYEE	SPOUSE*
Issue Age	15 Years through 70 years	15 Years through 70 years
Election Increments	\$10,000	\$5,000
Coverage Amount	\$10,000 up to \$250,000	\$5,000 up to \$50,000 (not to exceed 50% of the employee benefit)
Guarantee Issue for Newly Eligible Employees	\$100,000	\$50,000

*Employee must elect coverage for spouse coverage to be elected.



OPTIONAL RIDERS

Available riders may vary by state.

Long-Term Care Benefit: Access a portion of your death benefit early if you require qualified care such as home health care, adult day care, or long-term care facility services. May be taxable or impact eligibility for government programs.

Accelerated Death Benefit: Provides early access to your death benefit if you're diagnosed with a terminal or serious illness/injury. May be taxable or affect eligibility for certain benefits.

Accidental Death Benefit: Pays an additional benefit equal to your base policy amount (up to \$150,000) if death results from a covered accident. Available through age 60; ends at the policy anniversary following age 65.

Children's Term Insurance Benefit: Offers \$5,000 or \$10,000 in guaranteed-issue term life coverage for eligible unmarried dependent children ages 15 days–24 years. One premium covers all eligible children.



DISABILITY

LINCOLN FINANCIAL

Kärcher provides full-time employees with short- and long-term disability income benefits **at no additional cost**. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, though, you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.



	SHORT-TERM DISABILITY	LONG-TERM DISABILITY
Benefits Begin	8th Day for Injury and Illness	90th Day for Injury and Illness
Benefits Payable	Up to 13 Weeks	Up to SSNRA (Social Security Normal Retirement Age)
Percentage of Income Replaced	60% of your pre-disability weekly earnings	60% of your pre-disability monthly earnings
Maximum Benefit	\$2,000	\$10,000




PERKY

Get Ready for your parental leave! Navigate every step with the PERKY Leave digital tool. As you look forward to welcoming a new child into your family, we want you to be prepared for your parental leave.

This self-service tool helps you proactively plan and navigate your leave. It's easy to use and provides a clearer picture of your options, even before you need to contact your Human Resources team.

A STEP-BY-STEP ACTION PLAN

PERKY Leave's custom action plan helps you understand and prepare for your next steps:

- 
Estimate how much time you can take off work: an interactive calendar helps you keep track of the multiple leave benefits available to you during your parental and bonding leaves, including federal and state family leaves.
- 
Estimate changes to your income while you're on leave: Make sure you're fully informed about how your leave may affect your financial picture.
- 
Receive regular reminders: Reminders help you keep track of information you need to provide your employer.



LOG IN TO PERKY TODAY!

Visit <https://leave.perky.co/karcher-na>

ACCIDENT, CRITICAL ILLNESS, AND HOSPITAL INDEMNITY INSURANCE

LINCOLN FINANCIAL

These benefits offer an extra layer of protection for you and your family. The payment these benefits provide is in addition to any other insurance you may have and is yours to spend as you wish—to help cover bills or for everyday living expenses. These plans do not provide health insurance coverage and do not replace the medical plans.

ACCIDENT COVERAGE

Accident insurance pays a cash benefit directly to you when you are injured and require medical services due to a covered accident that occurs on or after your coverage date. The benefit amount depends on the type of injury and care received. If you elect coverage for yourself, you may also purchase coverage for your spouse and/or children equal to your own coverage.

BENEFIT	REIMBURSEMENT AMOUNT
Emergency care/treatment	\$200
Fracture: Based upon bone fractured	\$125-\$2,500
Laceration: Based upon need/length of sutures	\$75-\$750
Physician follow-up visits (up to 6 visits)	\$125
Physical, occupational, and chiropractic therapy (up to 10 sessions)	\$50

CRITICAL ILLNESS

Critical illness insurance pays a lump-sum cash benefit directly to you if you are diagnosed with a covered illness or condition on or after your coverage effective date.

- Employees and spouses can elect either \$10,000, \$20,000 or \$30,000 of coverage.
- You can elect either \$5,000, \$7,500, or \$15,000 of coverage for your dependent children.

Please note, to enroll your dependents in coverage, you as the employee must elect coverage. Rates for the Critical Illness coverage is based on your age and amount of coverage elected and can be found during your enrollment process in ADP.

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance pays a daily benefit if you have a covered stay in a hospital, critical care unit, or rehabilitation facility that occurs on or after your coverage date. The benefit amount is determined based on the type of facility and the number of days you stay. If you elect coverage for yourself, you may also purchase coverage for your spouse and/or children equal to your own coverage.

TYPE OF STAY	COVERAGE
Hospital Admission	\$500
Hospital Confinement	\$100 per day up to 30 days
Hospital ICU	\$200 per day up to 30 days
Hospital ICU Admission	\$1,000

*Initial Confinement benefit is paid for the first day of confinement, once per calendar year.





FINANCIAL

Your well-being extends beyond the physical and emotional—it applies to your financial health too. Kärcher offers a variety of benefits designed to help you save and grow your money.

401(K) PLAN

T. ROWE PRICE

To help plan for your future, Kärcher sponsors a 401(k) plan. The 401(k) plan is a great way to plan for your future, as you control how much you save and how you invest your funds.

ELIGIBILITY

If you are an employee, you are eligible to join on the first of the month following date of hire.

YOUR CONTRIBUTIONS

Newly hired employees will be automatically enrolled at a 3% salary deferral rate. You can change your deferral percentage at any time by contacting Principal. You may contribute 1% to 75% of your eligible base pay up to the IRS limits.

IRS CONTRIBUTION LIMITS	
Salary Deferral	\$24,500
Catch-Up Contribution (age 50-59 or 64 and older)	\$8,000
Catch-Up Contribution (age 60-63)	\$11,250

YOU CAN MAKE CONTRIBUTIONS IN TWO WAYS:

- 1. Before-Tax:** Pretax contributions allow you to reduce your current taxable income. In addition, any earnings on your contributions are tax-deferred. Any contributions and earnings are fully taxable as ordinary income when you withdraw them.
- 2. Roth:** You make Roth 401(k) contributions with after-tax money, so you see no immediate tax benefit. Any earnings from those contributions are tax-free when you take a qualified distribution.

COMPANY MATCH

Kärcher matches your retirement savings dollar-for-dollar, up to 4% of your pay. If you contribute to both the pre-tax and the post-tax Roth plan, the match is made up to the first 4% of your contributions. All employer match funding is made on a pre-tax basis.

VESTING

You are immediately vested (the money is yours to keep) in your own contributions as well as Kärcher match contributions as soon as they are deposited.

LOANS

- You may borrow up to 50% of your vested account balance, up to a maximum of \$50,000.
- Loan payments are made through payroll deduction, with a repayment period of up to 5 years (or 10 years if the loan is used to purchase your primary residence).
- Only one loan may be outstanding at a time.
- If you leave Kärcher with an active loan, you may continue making payments directly to T. Rowe Price—you do not need to pay off the loan immediately.

AGE 59^{1/2}

When you reach age 59 ½ or your Normal Retirement Age, you may withdraw money from your pre-tax account without being subject to the 10% Early Withdrawal Penalty. Regular taxes still apply.

HARDSHIP WITHDRAWAL

After exhausting all available loan options, a participant may withdraw money from his or her pre-tax account in the event of certain financial hardships:

- Cost related to the purchasing a primary residence
- Medical expenses
- Tuition related expenses
- Amounts needed to prevent foreclosure or eviction
- Funeral or burial expenses
- Expenses related to damage on your primary residence (provided the damage qualifies under the casualty loss deduction)

After taking a hardship distribution, you may not contribute to the plan for six (6) months.

ENROLL AND MANAGE YOUR 401(K)

Enrolling in the 401(k) is a separate process and is not part of the annual benefits enrollment. Enroll or make changes at any time by logging in to www.troweprice.com/workplace/en/login.html or calling (800) 922-9945

MEDICARE TRANSITION SUPPORT HTA INSURANCE SERVICES

Employees approaching Medicare eligibility have access to personalized guidance to help navigate the Medicare enrollment process with clarity and confidence. This resource provides education, plan comparisons, and ongoing support as your coverage needs change.



EDUCATIONAL SUPPORT

- Clear explanations of Medicare Parts A & B, Medicare Supplement Insurance, Medicare Advantage, Prescription Drug Plans, and supplemental options such as dental, vision, hearing, and travel coverage.
- Access to Medicare educational webinars and materials to help you understand your options.

PERSONALIZED ASSISTANCE

- One-on-one consultations to review your situation and compare plan options based on your coverage needs.
- Guidance tailored to different life events: turning 65, retiring after age 65, transitioning from employer coverage, or helping a family member.

PLAN COMPARISONS

- Side-by-side comparisons of available Medicare plans to help you make informed decisions about cost and coverage.

ONGOING SUPPORT

- Continued assistance after enrollment, including help reviewing or adjusting your plan during future enrollment periods.

TAKE THE FIRST STEP TOWARD MEDICARE CONFIDENCE

Schedule a Free Consultation

Call: (610) 430-6650

Visit: www.HTA-insurance.com

Email: Medicare@HTA-insurance.com

COLLEGEINVEST 529 SAVINGS PLAN

A 529 savings plan is a tax-advantaged way to save for future education expenses. The CollegeInvest 529 Savings Plan allows you to set aside money for a beneficiary—such as a child, grandchild, or other family member—to help cover qualified education costs at many types of schools nationwide.

TAX ADVANTAGES

- Colorado state income tax deduction for contributions.
- Tax-free growth—earnings are exempt from federal and state taxes when used for qualified education expenses.
- Potential gift and estate tax benefits.

HIGH SAVINGS CAPACITY

- Plans allow a high account-balance limit of \$400,000 per beneficiary.

FLEXIBLE USE OF FUNDS

- Funds can be used at public or private colleges, universities, community colleges, or vocational schools nationwide.
- Beneficiaries can be changed at any time.
- No restrictions on who can contribute or how many accounts you can hold.

GETTING STARTED

More information, tools, and enrollment resources are available at:

www.collegeinvest.org

Phone support is available at (800) 448-2424.

TUITION REIMBURSEMENT PROGRAM

The Tuition Reimbursement Program supports employees pursuing education that builds skills relevant to current roles or future opportunities within the company. Eligible coursework includes degree programs, professional certifications, and other approved training.

ELIGIBILITY: Employees are eligible if they:

- Are regular full-time or part-time employees
- Have completed six (6) months of service before the course begins
- Enroll in coursework directly related to their current job or another role, skill, or area of knowledge within the company
- Maintain a standard work schedule and performance at expected levels
- Have a minimum performance rating of “meets expectations/fully competent” or receive manager approval

REIMBURSEMENT GUIDELINES

- Reimbursement may be up to 100% of eligible expenses (e.g., tuition, books, lab fees, registration fees), up to the IRS annual maximum of \$5,250.
- Part-time employees are reimbursed proportionally based on hours worked.
- Proof of payment is required.
- Employees must earn a grade of “C” or “Pass” or higher to qualify.
- If outside funding (e.g., scholarships, VA benefits, grants) applies, reimbursement covers only the portion not paid by those sources

REPAYMENT REQUIREMENTS: Employees must remain employed for 24 months after completing a course. If employment ends earlier:

- Tuition reimbursed in the prior 12 months must be repaid.
- Reimbursement is not provided for any unpaid expenses at the time of termination.
- If separation is due to a reduction in force, previously approved tuition is still reimbursed.



HOW TO GET STARTED

- Obtain supervisor approval before enrolling.
- Complete and submit the Tuition Reimbursement Approval Form.
- Once approved, enroll in the course and begin your studies.

REIMBURSEMENT PROCESS: To request a reimbursement of your tuition expenses, please submit the following documentation with your completed Application for Tuition Reimbursement Form:

- Proof of payment
- Grade report
- Accounting report showing the total amount due for your course
- Report any grants or scholarships that may have offset your obligation for payment

Once you have the attached information, please return the Application for Tuition Reimbursement to your supervisor for final approval. Please keep a copy of your paperwork and submit the original documents to Human Resources for recording and reimbursement.

OTHER INFORMATION

PET INSURANCE SPOT

Spot plans help ensure your pet is covered from head-to-tail for unexpected accidents and injuries. Employees can use the link or QR code below to enroll in a discounted pet insurance policy through Spot Insurance. Employees will receive a 10% discount for using Kärcher's specific links. You can also receive an additional 10% discount for enrolling multiple pets in the insurance.



SPOT PLANS HELP COVER VET BILLS FOR:

- Vet exam fees
- Behavioral issues
- Dental illnesses
- Surgery
- Microchip implantation
- Unexpected emergencies
- Hereditary conditions
- Prescriptions
- Diagnostics
- X-Rays & tests
- Cancer & growths
- Flexible plans for any budget
- And much more...



SIMPLE & EASY CLAIMS PROCESS

1. Visit any vet in the U.S. or Canada
2. Submit your claim online
3. Get cash back for covered vet bills!



24/7 PET TELEHEALTH HELPLINE

Get unlimited virtual pet care from vet experts for your pet.



GET YOUR QUOTE TODAY:

1. Visit spotpet.link/Kärcher
2. Call (800) 905-1595
When calling, use code: EB_KÄRCHER



EXCLUSIVE EMPLOYEE DISCOUNTS

TicketsatWork provides employees with access to exclusive discounts on everyday purchases, entertainment, travel, and special events. It's an easy way to save on the products, services, and experiences you enjoy throughout the year.



Earn points on eligible purchases such as theme parks, attractions, hotels, and more.



Redeem points toward future purchases, including shows, getaways, and other activities.



Access extra employee-only savings on select deals.

READY TO GET STARTED?

1. Visit TicketsatWork.com
2. Select Become a Member
3. Enter your company code: Karcher or use your work email to create an account

Enjoy discounts, rewards and perks on thousands of the brands you love in a variety of categories:

- Electronics & appliances
- Apparel
- Fitness memberships
- Gift cards & groceries
- Flowers & gifts
- Hotels & rental cars
- Movie tickets & special events
- Flights, cruises & theme parks
- Subscriptions and more

EMPLOYEE PURCHASE PROGRAM

Eligible employees can purchase Kärcher products for personal or family use at discounted employee pricing. All purchases are subject to applicable state and local taxes.

ELIGIBILITY: Full-time and part-time employees with at least 90 days of employment are eligible.

PROGRAM GUIDELINES

- **Payroll deduction required:** Purchases are paid through payroll deduction with a minimum of \$50 per pay period, or the full cost of the product if the price is lower. Purchases must be fully paid within 90 days of the first deduction.
- **Personal use only:** Products may not be purchased for resale or commercial use.
- **Annual limits:** Employees may purchase up to two (2) pieces of the same type of equipment per calendar year. Parts and accessories do not count toward this limit. Certain products may be excluded from the program at the company's discretion.
- **Pricing:** Employee pricing for equipment and parts is outlined in program materials and may be updated or discontinued by the company at any time.
- **Pick-up and shipping:** Purchases should be picked up at company facilities. Employees are responsible for freight charges if shipping is requested.

If Employment End: Any outstanding balance at the time employment ends will be deducted from the final paycheck, as permitted by applicable law.



CONTACTS

PLAN	CARRIER	WEBSITE	PHONE
Medical	UnitedHealthcare	http://www.myuhc.com/	1 (866) 801-4409
Prescription	Optum Rx	www.OptumRx.com	1 (800) 765-6830 Specialty: 1 (877)-656-9604
Dental	Delta Dental of Colorado	https://www.deltadentalco.com/delta-dental-co.html	(800) 610-0201
Vision	Vision Service Plan (VSP)	www.vsp.com	(800) 877-7195
Health Savings Account (HSA)	WEX	www.wexinc.com	(866) 451-3399
Flexible Spending Accounts (FSAs)	WEX	www.wexinc.com	(866) 451-3399
Employee Assistance Program (EAP)	Lincoln Financial – EmployeeConnect	www.guidanceresources.com	(888) 628-4824
Life and Disability	Lincoln Financial	www.lincolnfinancial.com	(800) 423-2765
Accident, Critical Illness, and Hospital Indemnity Insurance	Lincoln Financial	www.lincolnfinancial.com	(800) 423-2765
Retirement Savings Plan	T. Rowe Price	www.troweprice.com	(888) 285-2612
Whole Life	Voya Financial	www.voya.com	(800) 755-7736
Pet Insurance	Spot Insurance	https://spotpet/link/Karcher	(800) 905-1595

REQUIRED NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.^{1 2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit healthcare.gov/medicaid-chip/getting-medicaid-chip for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: Human Resources.

Your Information. Your Rights. Our Responsibilities

This notice describes:

HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH HUMAN RESOURCES AT 303-738-2400 IF YOU HAVE ANY QUESTIONS.

Please review it carefully.

YOUR RIGHTS

You have the right to:

Consent to most uses and disclosures of your health information

Get a copy of your health and claims records

Correct your health and claims records

Request confidential communication

Ask us to limit the information we share

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

Get a list of health care providers who have received your information through certain third parties

Get a copy of this privacy notice

Choose in advance whether to receive fundraising communications

Discuss this notice with someone in our program

Choose someone to act for you

File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

With your consent, we can use and share your information as we:

Treat you

Run our organization

Bill for our services

Fulfill your requests to share information with your consent

Prevent multiple program enrollments

Report about court-referred treatment

Report to prescription drug monitoring programs

OUR USES AND DISCLOSURES

We may use and share your information without your consent as we:

Help manage the health care treatment you receive

Run our organization

Pay for your health services

Administer your health plan

Help with public health and safety issues

For your medical emergencies

Do research

Comply with the law

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

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

Respond to lawsuits and legal actions

Assist with cause of death inquiries

Communicate within our program and with contractors

Respond to management and financial audits and program evaluation

Prevent or reduce crime in our program

In these circumstances, we must protect your information and limit how we use and share it

YOUR RIGHTS

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

Get a copy of health and claims records

You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Provide consent when we use or share your information for most purposes

You may provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes. We are not required to agree to your request, and we may say “no” if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

We are not required to agree to your request, and we may say “no” if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our health care operations with your health insurer. We will say “yes” unless a law requires us to share that information

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

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, costbased fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose in advance about fundraising

You have the right to a clear and obvious notice in advance of, and a choice about whether to receive, fundraising communications for our program.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

With your consent, we may also use and share your information in the following ways:

- To whomever you name in a consent to share your information
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs
- To report participation in treatment required by the criminal justice system
- To report prescribed substance use disorder treatment medications to a state prescription drug monitoring program when required by law

File a complaint if you feel your rights are violated

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

YOUR CHOICES

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

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES**How do we typically use or share your health information?**

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

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

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

Example: We use health information about you to develop better services for you.

Example 2: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications

Bill and Pay for your health services

We can use and disclose your health information as we bill or pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

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

Help with public health and safety issues

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

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence, only as required by applicable law
- Preventing or reducing a serious threat to anyone’s health or safety

For your medical emergencies

We can share your information during a bona fide medical emergency with the personnel and health care providers responding to your emergency, even when you are unable to consent because of the emergency

Do research

We can use or share your information for health research. Researchers cannot include any patient identifying information in their reports about the research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Legal Proceedings and Court Orders

We must follow certain procedures before using or sharing your information for investigations and legal proceedings.

- We will not use or share your information or provide testimony about your information in any civil, administrative, criminal, or legislative proceedings against you without your written consent or a court order.
- We will only respond to a court order to use or share your health information if it is accompanied by a subpoena or other similar legal mandate requiring us to comply.
- We will only use or share your information in proceedings against you based on a court order after we have received notice and an opportunity to be heard or you tell us that you have received notice.
- We may use or share your information to respond to legal proceedings against our program based on a court order and you may not be notified in advance. You have the right to seek to overturn or change the court order after you learn about it.

Assist with cause of death inquiries

We can share patient identifying information about a deceased patient as required or allowed by laws that collect information relating to cause of death.

Communicate within our program and with contractors

We can share your information within our program, with an organization that has administrative control over our program, and with contractors who help us run our program.

Respond to management and financial audits and program evaluation

We can use or share your information to improve the quality of our services, obtain needed credentials, and cooperate with oversight agencies for activities authorized by law, as long as those who view or receive the information agree to destroy or return the information when they are finished and agree not to use it against you.

Prevent or reduce crime in our program

We may report to law enforcement when a patient commits or threatens to commit a crime within our program or against our staff

Re-disclosure According to HIPAA

When you consent to uses and disclosures for all future treatment and payment purposes and to run our business, we may share your information with other substance use disorder treatment programs, doctors' offices, and health care businesses for those activities. If the person who receives it is subject to HIPAA, then they are allowed to use and share your information again without your consent for the purposes that HIPAA allows. Your information still cannot be used in legal proceedings against you unless (1) you consent or (2) based on a Part 2 court order and a subpoena (or similar legal requirement).

OUR RESPONSIBILITIES

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

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

Important Notice from Karcher North America About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Karcher North America and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. If you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will 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 Karcher North America 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 Karcher North America changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-3250778).

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: 05/01/2006

Name of Entity/Sender: Karcher North America

Contact--Position/Office: Human Resources

Address: 6398 Karcher Way, Aurora, CO 80019

Phone Number: 303-738-2400

Continuation Coverage Rights Under COBRA

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

Disability Extension of 18-month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

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

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

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

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

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

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

Human Resources

Kärcher North America, Inc.

6398 N. Kärcher Way

Aurora, CO 80019

303-738-2400

1. <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: HDHP Choice Plus (\$3,400 single and \$6,800 family deductibles and \$5,200 single and \$10,400 family out-of-pocket maximums); PPO Choice Plus (\$1,000 single and \$3,000 family deductibles and \$3,000 single and \$6,000 family out-of-pocket maximums); Colorado Doctors Plan (\$500 single and \$1,500 family deductibles and \$1,500 single and \$4,500 family out-of-pocket maximums). If you would like more information on WHCRA benefits, call your plan administrator at 303-738-2400.

ANNUAL NOTICE

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 303-738-2400 for more information.

Newborns’ and Mothers’ Health Protection Act

The Newborns’ and Mothers’ Health Protection Act (the Newborns’ Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns’ Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns’ Act only applies to certain coverage. Specifically, it depends on whether coverage is “insured” by an insurance company or HMO or “self-insured” by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is “insured” or “self-insured.”)

The Newborns’ Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns’ Act depends on state law. Many states have enacted their own version of the Newborns’ Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the [Frequently Asked Questions \(FAQs\)](#) About the Newborns’ and Mothers’ Health Protection Act.

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

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

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

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

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

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact United Healthcare.

Visit myuhc.com for more information about your rights under federal law.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska	Premium Payment Program: myakhipp.com	8662514861

STATE	WEBSITE/EMAIL	PHONE
Medicaid	Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	
Arkansas Medicaid	http://myarhipp.com/	855MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	9164458322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	8002213943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/healthinsurancepremiumpayment-programhipp CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	8004030864 800-457-4584
Iowa Medicaid and CHIP (Hawki)	Medicaid: hhs.iowa.gov/programs/welcomeiowamedicaid Hawki: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	8003388366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	8007924884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KIHIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KI-HIPP.PROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KIHIPP: 8554596328 KCHIP: 877-524-4718
Louisiana Medicaid	Medicaid: ldh.la.gov/healthylouisiana or email: healthy@la.gov LaHIPP: www.ldh.la.gov/lahipp or email: La.HIPP@la.gov	Medicaid: 8883426207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/of/applications-forms	Enroll: 8004426003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	8008624840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	8556327633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcnp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programsservices/medicaid/healthinsurancepremiumprogram Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	6032715218 or 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 8003561561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100

STATE	WEBSITE/EMAIL	PHONE
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/applyformedicaidhealthinsurancepremiumpayment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 8006927462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	cohhs.ri.gov	8556974347 or 401-462-0311 (Direct RIte Share Line)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premiumassistance/famiselect coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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



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A thick, solid yellow horizontal bar is positioned directly below the Kärcher logo text.