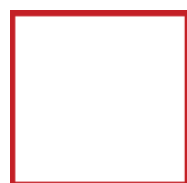
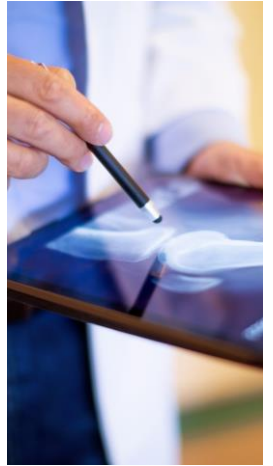


2026 Benefits Guide



Mechdyne

Important Contacts

Coverage	Contact	Phone	Website
Medical	Wellmark	(800) 524-9242	www.Wellmark.com
Health Savings Account	HSA Bank	(800) 357-6246	www.hsabank.com
Flexible Spending Account	iSolved	(515) 224-9400	www.isolvedbenefitservices.com
Dental	Delta Dental	(877) 423-3582	www.deltadentalia.com
Vision	Delta Vision	(888) 899-3747	www.deltadentalia.com/deltavision
Life and AD&D/Disability	Reliance Standard	(800) 351-7500	www.reliancestandard.com
Employee Assistance Program	Bree Health	(800) 327-2255	www.login.breehealth.com
Voluntary Products Accident, Critical Illness, Universal Life	Trustmark	Billing Questions: (800) 514-3446 Policy Questions: (800) 918-8877 Claims Questions: (877) 201-9373	www.trustmarksolutions.com

Helpful resources regarding Mechdyne Corporation's benefits:

- [Mechdyne Corporation - Benefit Overview Site](#)
- [Benefit Enrollment Site](#)

Welcome to Your Benefits!

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement. This brochure was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this brochure to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

This brochure highlights the main features of our employee benefits program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. The Company reserves the right to change or discontinue its employee benefits plans at any time.

How To Enroll

All employees will need to log into the Avant/Trustmark website to make benefit elections or changes for the 2026 plan year. Be sure to review your current benefit elections, verify your personal information and make changes if necessary.

1. Login to <https://trustmark.benselect.com>
2. Login using your Social Security Number
3. Your PIN is the last 4 digits of your Social Security number followed by the last 2 digits of your birth year (no spaces)

If you need assistance, you can call the enrollment counselors at 844-346-2790. You can also visit <https://flimp.live/MechdyneCorporationOverview> to get more detailed information on the benefits available to you.

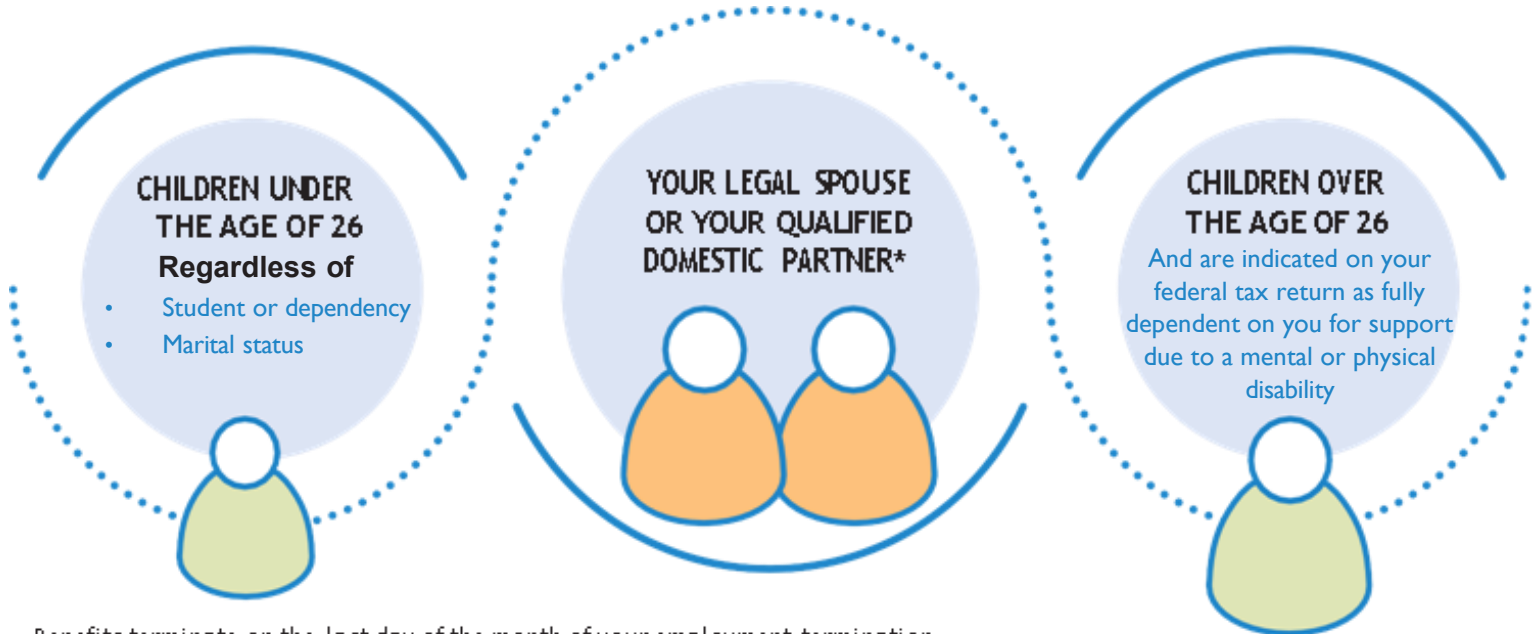
The benefits you elect during open enrollment will be effective from January 1, 2026 through December 31, 2026.

This benefit summary describes the benefit plans available to you as an employee of Mechdyne Corporation. The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contracts. This summary is meant only to cover the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of Mechdyne Corporation.

Eligibility

If you are a full-time employee (working 30 or more hours per week), you are eligible to enroll in the benefits described in this guide. New hire waiting period is first of the month coinciding with or following 30 days of employment. You may also enroll your eligible dependents for coverage. Please note: the eligible dependent chart below refers to medical, dental and vision, other benefits may vary. Eligible dependents could be:



Benefits terminate on the last day of the month of your employment termination.

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a qualified life event. If you do not make changes to your benefits within 30 days of the qualified life event, you will have to wait until the next annual open enrollment period to make changes (unless you experience another qualified life event).

Qualified Life Event	Documentation Needed
Change in Marital Status	Marriage Copy of marriage certificate
	Divorce/legal separation Copy of divorce decree
	Death Copy of death certificate
Change in Number of Dependents	Birth or adoption Copy of birth certificate or copy of legal adoption papers
	Stepchild Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death Copy of death certificate
Change in Employment	Change in your eligibility status (i.e., full time to part time) Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status Notification of spouse's employment status that results in a loss or gain of coverage
Loss of dependent Coverage status	Turning age 26 and aging out of parent's coverage Date of Birth

Employee Contributions

The amounts listed below are the monthly rates for each plan.

Basic Coverages	Monthly Premium	Employee Pays	Employer Pays
Medical			
Traditional Plan			
Single:	\$710.73	\$282.16	\$428.57
Employee/Spouse:	\$1,425.19	\$846.26	\$578.93
Employee/Children:	\$1,319.51	\$717.81	\$601.70
Family:	\$2,121.23	\$1,299.91	\$821.32
High Deductible Health Plan			
Single:	\$619.16	\$34.67	\$584.49
Employee/Spouse:	\$1,237.65	\$498.03	\$739.62
Employee/Children:	\$1,146.17	\$342.70	\$803.47
Family:	\$1,840.20	\$760.93	\$1,079.27
Dental			
Single:	N/A	\$2.94	Actual Claims
Employee/Spouse:	N/A	\$17.26	Actual Claims
Employee/Child(ren):	N/A	\$19.92	Actual Claims
Family:	N/A	\$42.35	Actual Claims
Life and AD&D (Employee only)	N/A	\$0	100%
LTD	N/A	\$0	100%
Flexible Spending Accounts (Admin Fees)	N/A	\$0	100%
Health Savings Account (Admin Fees)	N/A	\$0	100%
Employer HSA Contributions (Annual Amount)	N/A	N/A	\$500.00
Voluntary Products	Monthly Premium	Employee Pays	Employer Pays
Vision:			
Single:	\$8.44	100%	0%
Employee/Spouse:	\$16.06	100%	0%
Employee/Child(ren):	\$18.12	100%	0%
Family:	\$23.94	100%	0%
Voluntary Life:	Varies	100%	0%
Accident Insurance:	Varies	100%	0%
Critical Illness Insurance:	Varies	100%	0%
Universal Life Insurance:	Varies	100%	0%

Voluntary Life and AD&D

Monthly Cost for Each \$10,000 of Employee Life Insurance Coverage

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Life/AD&D	\$0.80	\$1.00	\$1.10	\$1.60	\$2.50	\$4.10	\$6.50	\$8.70	\$13.50	\$23.30	\$40.20

Monthly Cost for Each \$5,000 of Spouse Life Insurance Coverage

Spouse Life/AD&D	\$0.30	\$0.40	\$0.45	\$0.70	\$1.15	\$1.95	\$3.15	\$4.25	\$6.65	\$11.55	\$20.00
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Monthly Cost for Each \$10,000 of Children Life Insurance Coverage

Child(ren)	\$0.60
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MEDICAL PLAN



Mechdyne Corporation's medical options all provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

When it comes to medical coverage, Mechdyne offers you these choices:

- Alliance Select \$2,500 PPO Plan
- Alliance Select \$4,000 High Deductible Health Plan (HDHP)

These plans are administered through Wellmark and utilize the Alliance Select PPO network. [Find a provider](#): 'browse list of plans' select Wellmark Blue PPO. The drug formulary is [Blue Rx Value Plus](#).

Preferred Provider Organization (PPO) – National Network

The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

Qualified High Deductible Health Plan (QHDHP)

A QHDHP protects you from catastrophic medical bills. This plan contains a deductible which must be met before the health plan provides coverage – this typically means that 100% of the charges you and your family members incur for health and prescription services are subject to the deductible – this plan has no copays for office visits, prescription, etc. Please review all your medical plan information carefully, before enrolling in this plan.

Being enrolled in a QHDHP allows you to contribute to a Health Savings Account (HSA). See the HSA page in this summary for additional information.

REGISTER ONLINE

Your connection to great healthcare is only a click away.

Register for an online account at [Wellmark.com](#) so you can access time- saving tools, tips for healthy living, view lab results, choose a doctor, manage your EOBs, and more!



DOWNLOAD THE MOBILE APP

With the Wellmark mobile app, you've got the tools you need to manage your healthcare all from your smartphone. The mobile app is available in the Apple and Google Play store.



Medical

Wellmark Blue Cross & Blue Shield

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted rates instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

	\$2,500 PPO		\$4,000 HDHP (Embedded)	
Calendar Year Deductible	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Individual	\$2,500	\$5,000	\$4,000	\$8,000
Family	\$5,000	\$10,000	\$8,000	\$16,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible)				
Individual	\$5,000	\$10,000	\$4,000	\$10,000
Family	\$10,000	\$20,000	\$8,000	\$20,000
Coinsurance / Copays				
Preventive Care	Covered at 100%	Deductible, 40% Coinsurance	Covered at 100%	Deductible, 40% Coinsurance
Primary Care Physician	\$25 Copayment	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance
Specialist	\$50 Copayment	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance
Eye Exam (Adult and Child)	Covered at 100%	Deductible, 40% Coinsurance	Covered at 100%	Deductible, 40% Coinsurance
Doctor On Demand	Covered at 100%	Not Covered	Deductible	Not covered
Urgent Care	\$25 Copayment	\$25 Copayment	Deductible	Deductible
Emergency Room	\$250 Copayment	\$250 Copayment	Deductible	Deductible
Inpatient Facility Services	Deductible, 30% Coinsurance	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance
Outpatient Facility Services	Deductible, 30% Coinsurance	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance
Pharmacy				
Retail Rx (up to 31-day supply)				
Tier 1/Tier 2/Tier 3	\$8 Tier 1 / \$40 Tier 2 / \$60 Tier 3 / PrudentRx Eligible ⁽¹⁾ : \$0 All Other Specialty: \$100		Deductible	
Mail Order Rx (Up to 93-day supply)				
Tier 1/ Tier 2/ Tier 3	3 Copayments		Deductible, 40% Coinsurance	

⁽¹⁾ Eligible specialty medications not purchased through PrudentRx will be subject to 30% coinsurance. PrudentRx Drug List can be found here [Wellmark Drug List](#).

Member Services: Wellmark

myWellmark

Get the most from your health insurance benefits.

- Estimate your cost of care for your procedures and services
- Detailed claims information
- Track and organize your medical expenses
- Receive electronic versions of your Explanation of Benefits (EOB)
- Find a provider in your plan's network
- See the following page for how to register

Doctor On Demand

Visit a doctor on your smartphone, tablet or computer from virtually anywhere.

- Download the Doctor on Demand app or visit [Wellmark - Doctor on Demand](#)
- Have your Wellmark member ID card ready
- Create an account or sign in

Wellmark Mobile App

Access your favorite myWellmark tools on your smartphone: View benefit information, claims, flex, mobile ID card, wellness services and customer service

- Download the Wellmark mobile app from any of the app stores or visit [myWellmark](#)
- Open the app and select myWellmark
- Log in using your myWellmark user ID and password. If you are not registered for myWellmark, create an account using your Wellmark member ID, found on your ID card.

Blue365

Exclusive discounts on wellness products and services.

- Go to [Wellmark.com/Blue365](#)
- Have your email address and the first three characters of your Wellmark ID number ready

IDXIdentity

Free access to identity protection services.

- Log in to your [myWellmark.com](#) account and have your Wellmark insurance card handy
- Click on Identity Protection in the lower left corner of the page
- Write down the enrollment code shown on your screen and then click the Enroll/Login button
- Enter the Group ID and Subscriber ID from your Wellmark card, register your email and a password
- Enter the enrollment code and follow directions to complete enrollment
- To activate credit monitoring, enter your date of birth, Social Security number, and answer authentication questions





Health insurance made easy

Your personal health care information is at your fingertips with myWellmark® — no matter your location — with tools, resources and insights to help you manage health care spending and live a healthier life.



Get more from your health plan by registering at [myWellmark.com](https://mywellmark.com).



Get easy, on-the-go access to tools and resources that help you manage health care spending.

Use myWellmark to better understand and get the most from your health insurance benefits.

With myWellmark, you can:

- Estimate your cost of care for procedures and services before you go.
- View detailed claims information, including a cost breakdown and status tracker.
- Visit the usage page to see how you are using your benefits.
- Receive electronic versions of your Explanation of Benefits (EOB).
- Find mental health resources.
- Search providers in your plan's network.
- See relevant information related to your specific coverage.

myWellmark streamlines your health insurance information and makes it easier to find what you need, when you need it, on any device.

Get the information you need

Using your specific health plan benefits and a powerful suite of tools, myWellmark helps you:

- Find an in-network provider for physical and mental health care.
- Estimate what your visits will cost before you go.
- Discover virtual care benefits if covered under your plan.

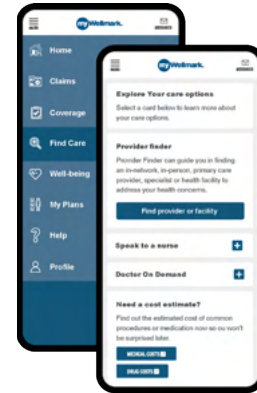
Keep tabs on claims and spending

On your personalized myWellmark, you'll see an at-a-glance overview of recent claims activity and whether a claim is paid, pending or denied (and why). Need more details, including your share of the cost? Just click on any claim.

Know your benefits inside and out

When it comes to your coverage and benefits, myWellmark has you covered. You're able to:

- Keep track of services you've used.
- Determine potential copay or coinsurance costs for in-and out-of-network services.
- See how close you are to meeting your deductible and out-of-pocket maximums.
- Choose how you would like to receive communications and important documents related to your benefits.
- Visit the usage page to understand how you are using your benefits.



Your health care — at your fingertips.

Get easy, on-the-go access to tools, resources and insights that help you keep track of care costs and stay healthy. It's all available in the myWellmark mobile app. The best part? **IT'S FREE.**

With the mobile app, you can:

- **Log in securely** using fingerprint or facial recognition technology.*
- **View in-network providers** and hospitals.
- **Get health answers** over the phone with one tap of a finger.
- **Find the closest provider** or facility and get driving directions.
- **View and email** your mobile ID card for easy, on-the-go access.

*If supported by your mobile device.



Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

Blue Cross®, Blue Shield® and the Cross® and Shield® symbols are registered marks of the Blue Cross and Blue Shield Association, an Association of independent Blue Cross and Blue Shield Plans. Wellmark® and myWellmark® are registered marks of Wellmark, Inc.



Say goodbye to the **stress** of **scheduling**

Doctor On Demand® virtual mental health care is available on your schedule, when and where you need it, with a provider who fits your needs.

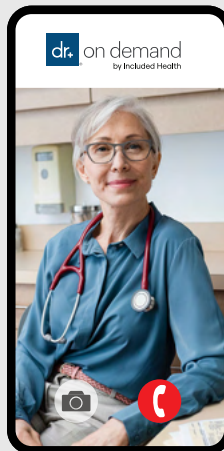
How can we help?

Some examples of how our providers and therapists can help:

- Anxiety
- Depression
- Stress and burnout
- Isolation
- Grief and loss
- Relationship issues
- PTSD
- Difficulty sleeping

What it costs

Doctor On Demand virtual visits are a covered benefit and the copay is often much less than an in-office visit. The cost of your visit is provided up front, so you won't have any surprises after your visit. There are no setup or monthly fees.



Visit a therapist on your smartphone, tablet or computer from virtually anywhere.

Getting started is easy.



1. Scan the QR code to visit [DoctorOnDemand.com/Wellmark](https://www.DoctorOnDemand.com/Wellmark) and download the Doctor On Demand app.
2. Have your Wellmark Blue Cross and Blue Shield member ID card ready.
3. Create an account or sign in to begin your visit.
4. Pick your provider. Select the next available appointment or find the time best for your schedule.



FOR MORE INFORMATION VISIT:

[DoctorOnDemand.com/Wellmark](https://www.DoctorOnDemand.com/Wellmark)

HSA

HSABank

A Health Savings Account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP Medical plan.

How a Health Savings Account Works



Eligibility

You must be enrolled in the High Deductible Health Plan.

Contributions

Mechdyne Contributes: \$500 Annually

You contribute on a pretax basis and can change how much you contribute from each paycheck up to the IRS maximum of \$4,400 if you enroll only yourself, or \$8,750 if you enroll in family coverage. You can make an additional catch-up contribution if you are age 55 or older.



Eligible Expenses

You may use your HSA funds to cover medical, dental, vision and prescription drug expenses incurred by you and your eligible family members.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future health care expenses.



Your HSA is Always Yours — No Matter What.

One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the Company or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.



HSA Eligibility

To be eligible for an HSA, you must be enrolled in a qualified High Deductible Health Plan. In addition:

- You cannot be covered under a health plan (as a spouse or dependent) that is not an HDHP
- You cannot be claimed as a dependent on someone else's tax return
- You cannot be enrolled in Medicare
- If you are also covered by a medical flexible spending account (FSA) or health reimbursement arrangement (HRA), it must be a limited FSA or HRA

Eligible Expenses

You choose what to do with the money in your HSA

- Use it to pay medical expenses for yourself, spouse and dependents. Your family members do not need to be enrolled in Mechdyne's health plan. You can keep your children on your health plan until they turn 26, but you can only use your HSA to pay for their eligible medical expenses while they are your tax dependents
- Use it to pay other qualified expenses such as dental, orthodontia and vision expenses
- Save the money in your account for future health care expenses

Tax Advantages

- Contributions you make to your HSA reduce the amount of taxes you pay
- Health care expenses you pay from your HSA are paid with tax-free dollars
- Any interest or investment earnings your account earns grow tax-free

Medicare and HDHP/Health Savings Accounts(HSA)

- Turning age 65 soon and on a HDHP with HSA? We have some important reminders/things to consider!
 - If you enroll in Medicare Part A and or B, you can no longer contribute pre-tax dollars to your HSA.
 - When you enroll in Medicare, it does not offer an HSA qualifying option.
 - Many people turning 65 who continue to work enroll in Medicare Part A since it is premium free, however once you enroll in Part A, you can't make any more pre-tax contributions to your HSA.
 - **If you defer/delay** enrollment in Medicare until after age 65, once you do enroll in Medicare Part A, the coverage is retroactive for up to 6 months, but no earlier than your eligibility date. Because of this, you need to plan to **STOP** your HSA contributions at least 6 months **BEFORE** enrolling in Medicare.
 - You can contribute to your HSA for the months that you were eligible for Medicare and were not yet enrolled.
 - There is some good news! Even after you enroll in Medicare and stop your HSA contributions, you are still able to withdraw your funds tax-free for your qualified medical, dental and vision expenses, among others.

Please consider your options carefully if you are in this situation. We recommend employees to reach out and speak with a Medicare Expert at least 6 months prior to turning 65 to be certain what the employee decides on the HSA has been discussed with a licensed professional. *Once you are enrolled in Medicare, you are no longer able to keep contributing to your HSA.* You are still able to use the HSA funds for qualified medical, dental and vision expenses, among others, please check with HSABank on the full list. Knowing this, it's important to think carefully about your Medicare enrollment decisions once you become eligible.



Designating a beneficiary for your HSA

Protect your assets. Protect your loved ones.

What is a beneficiary?

A beneficiary is a person or legal entity that has been designated to receive the proceeds from your Health Savings Account (HSA) in the event of your death. A beneficiary can be one or more individuals (i.e., spouse, children, relatives, or friends) or organizations, such as a trust or charity. You can designate two types of beneficiaries:

1

Primary beneficiaries are first to receive the designated asset upon your death. If you name more than one primary beneficiary, each will share the benefit equally, unless you indicate specific percentages totaling 100% are to be paid.

2

Secondary (contingent) beneficiaries receive the asset if there are no surviving primary beneficiaries upon your death. Multiple contingent beneficiaries will share the benefit equally, unless you indicate specific percentages totaling 100 percent are to be paid.

You may designate a beneficiary to receive your HSA assets in the event of your death. If you name your spouse as beneficiary, your spouse can elect to treat the HSA as their own. In this case, your spouse will not owe taxes or penalties when they use the HSA for IRS-qualified healthcare expenses. If you designate a non-spouse beneficiary, they must take a distribution of the funds. A non-spouse beneficiary will have to pay income tax on the amount received, but will not have to pay a penalty tax. Beneficiary designations can generally be made through your online account. However, if you're married, live in a community property state and designate a non-spouse primary beneficiary, you must submit a beneficiary form with the notarized consent of your spouse.

Why it's important to designate a beneficiary

One of the most neglected areas of retirement planning is beneficiary designation. By having a designated beneficiary in place at the time of your death, the assets of your HSA can be distributed according to the designation. If you die without having a valid beneficiary designation, your HSA will be distributed to your estate.¹

Review your beneficiary designations

By periodically reviewing your beneficiary designations for your HSA, you can rest assured that your assets will be distributed according to your wishes. It's also recommended to keep up-to-date copies of your beneficiary designation forms.

Circumstances for which a review is recommended

1. You experience a major life event such as a birth, marriage, dissolution of marriage or domestic partnership, or death in the family.
2. You update your estate plan. Consult with your legal advisor when you update your estate plan to determine whether your HSA beneficiary designations also need to be updated.
3. You receive a beneficiary verification notice.

Designate a beneficiary with HSA Bank¹

Designate a beneficiary or update your current beneficiary through your [online account](#). You'll be asked to provide information about your chosen beneficiary, including their Social Security number and birthdate.

¹ You may designate one or more persons or entities as the beneficiary(ies) of your HSA. This designation can only be made in a manner or form prescribed by us and will only be effective when filed with us during your lifetime. Except when adding beneficiaries, each beneficiary designation you file with us will cancel all previous designations. Unless otherwise provided under applicable state law, you may alter or revoke a beneficiary designation without the consent of any beneficiary previously named. You may designate one or more primary beneficiaries and one or more contingent beneficiaries. Your benefit will be paid in equal shares to your primary beneficiary(ies) who survive you unless your beneficiary designation provides otherwise. If a primary beneficiary does not survive you, his or her interest will lapse and the interest of any remaining primary beneficiaries shall be increased on a pro rata basis unless your beneficiary designation provides otherwise. Contingent beneficiaries shall be treated as primary beneficiaries only if all primary beneficiaries die before you. If you do not file a beneficiary designation form with us, if you file an incomplete or invalid form, or if no designated beneficiary survives you, your beneficiary shall be your estate. We will determine who the beneficiaries are in each case, consistent with your designation and this Agreement, and our determination will be final and binding on all parties in interest. We will not be liable to any beneficiary for paying your surviving spouse any amount that may be required to satisfy state marital or community property laws, and we may delay all or a portion of any payment while we make this determination. For more information regarding non-spousal beneficiaries, or beneficiaries under the age of 18, including disbursement procedures, please contact HSA Bank.



Visit hsabank.com or call the number on the back of your debit card for more information.





Invest your HSA today to benefit tomorrow

Health Savings Accounts (HSAs) are often thought of just for healthcare savings. But they can also be a powerful addition to your investment portfolio. Investing your HSA funds can help you grow your account to save for future healthcare expenses or your retirement nest egg.

Investing your HSA: A healthy boost for your future

1

The only way to get three tax perks:

You don't pay federal taxes on contributions, distributions for qualified healthcare expenses, or investment earnings.

3

The money is yours — for life:

HSA funds carry over every year, even if you change jobs or retire.

2

Build long-term retirement savings: Investments cover future healthcare costs and build your retirement savings.

4

Access funds as needed:

You can liquidate investment funds at any time to pay for IRS-qualified healthcare expenses from your HSA cash balance.

The HSA Invest program

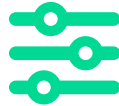
HSA Invest offers you a seamless experience to manage your saving, spending and investing on one website and one app. Three investment options — Choice, Select and Managed — give you thoughtfully chosen securities that are aligned to your HSA and relevant to your financial objectives. And you're able to enroll in more than one option.

Your investment options



Choice

This option offers a simplified brokerage experience with a large range of stocks, mutual funds, exchange-traded funds (ETFs) and more. This option is ideal if you're an experienced investor who may not need guidance from a professional.



Select

Get a recommended list of mutual funds, specific to your unique risk tolerance and investment objectives. All funds are selected by an SEC-registered investment advisor (RIA), organized by asset class and aligned to your investment profile. This option gives you guidance and the opportunity to make the final decision about your investments and allocations.



Managed

Get an even higher level of personalization, where the RIA actively manages the investments on your behalf. This option lets you go beyond the tailored guidance in the Select option and have your investments completely managed by an RIA.

You may have one or all of the investment options based on your employer program. Your option(s) will show in your online account.

Simplified and efficient investment management

- Enrollment before you meet the investment balance threshold.
- Same-day enrollment and funding.
- Real-time and fractional share trading (during market hours).
- Funds remain in your HSA cash balance until invested so you can use them for qualified medical expenses.
- Auto-funding so new funds go directly to the investments you've chosen.
- Dividends and interest are automatically reinvested.
- Online access to your account history, balance information, trades and more on the Member Website and app.

Fees

Annual asset-based fees may be applied on a quarterly basis and deducted from the investment balance. Fees are waived when a minimum is maintained in your HSA cash balance. View exact fees in your online account.

SECURITIES AND INVESTMENTS

Not Insured by FDIC or Any Other Government Agency	Not Bank Guaranteed	Not Bank Deposits or Obligations	May Lose Value
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You may be required to keep a minimum in your HSA cash balance to invest funds in the HSA Invest program.

The HSA Invest program is administered by DriveWealth, LLC, a FINRA registered broker dealer. LeafHouse Financial Advisors, LLC is a registered investment advisor with the U.S. Securities and Exchange Commission that selects and manages the investments. Registration does not imply a certain level of skill or training. More information about LeafHouse Financial Advisors, LLC, including investment strategies, fees and objectives, can be found in the ADV Part 2A, which is available on the Member Website.

HSA Bank, DriveWealth, LLC and LeafHouse Financial Advisors, LLC are not affiliated and not responsible for the products and services provided by the other. Neither HSA Bank nor DriveWealth can provide investment advice to investors. Past performance is not indicative of future results. All investments involve risk, including loss of principal, and there is no guarantee that investment objectives will be met. The ability to replace investment losses may be limited by the annual HSA contribution limits.



Visit hsabank.com or call the number on the back of your debit card for more information.





Health savings in the palm of your hand

Manage your accounts with the HSA Bank app

Get the tools to take control of and better manage your health accounts with the HSA Bank app. Safe and secure, the app offers instant access for all your account needs, 24/7. It's simple, intuitive and convenient.

The faster, easier way to manage your HSA Bank accounts

- Simple and secure login.
- Check account balances and view activity.
- Enter and track expenses.
- Make a payment from your account.
- Search for eligible expenses.
- Schedule HSA contributions.
- File a claim.

Download the app

Download the app on [Google Play](#) or the [App Store](#).

Apple and the Apple logo are trademarks of Apple Inc. App Store is a service mark of Apple Inc. Google Play and the Google Play logo are trademarks of Google LLC.



Visit hsabank.com or call the number on the back of your debit card for more information.

 **hsabank**[™]

FSA

iSolved

Mechdyne Corporation offers Flexible Spending Accounts (FSAs), which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by iSolved. Mechdyne's plan has a 90 day run out period at the end of the 12 month flex plan year (December 31, 2026) in which you may continue to submit claims for 2026 expenses. Participants are allowed to roll over up to \$680 of unused FSA dollars into the 2026 plan year. These funds will roll over into the new plan year once the current plan year's 90 day runout period has ended.

How FSAs Work

Three Types of FSAs are available to you:

- Health Care FSA
- Limited Purpose FSA
- Dependent Care FSA

If you elect to contribute to any of the FSAs, you choose an annual amount to be taken from each of your paychecks pre-tax and deposited into your account throughout the year. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year. The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other.



Health Care FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by dental plan

For a complete list of eligible expenses and resources, visit [iSolved FSA Resource Center](#).

Limited Purpose FSA

If you are contributing to an HSA, you are eligible to use the Health Care FSA for vision and dental expenses only. You can contribute up to the annual maximum below.

Annual Contribution Amount

You can contribute up to a maximum of **\$3,400** this year to the Health Care FSA.

Check out the websites below for eligible FSA items

[Amazon FSA](#)

[FSA Store](#)

Health Care FSA Debit Card

If you enroll in the Health Care FSA, you will receive one debit card in the mail. To request additional debit cards for your family members, please contact iSolved.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. If you use your debit card at a health care provider's office or at a vendor that has the software in place to track eligible FSA expenses, you will not be required to submit a receipt. However, for most debit card transactions, you will need to submit your receipts as substantiation of your expense, so it's important to keep them.

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled and unable to provide care for himself or herself.

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care for:

- Your children under age 13 whom you claim as a dependent for tax purposes.
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:

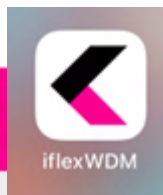
- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

Annual Contribution Amount

You can contribute up to a maximum of \$7,500 per year to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is \$3,750. It's important to keep copies of all your receipts—even if you are not required to submit them as proof of your expense. That way, if the IRS asks for substantiation of your expenses, you will have the receipts.

isolved Benefit Services

iFlexWDM MOBILE APP



Check account balances, submit claims, and review resources for your Flexible Spending Account (FSA)

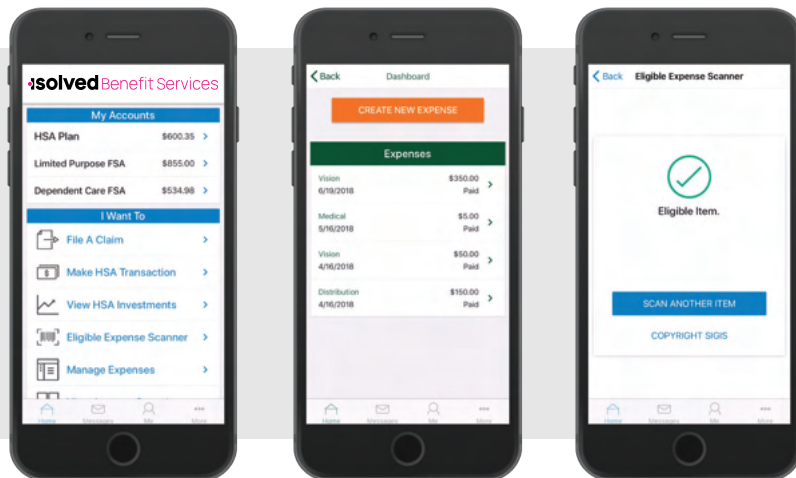
When you enroll in the company-sponsored Flexible Spending Account (FSA), you have a variety of tools and resources available at your fingertips. One of these offerings is the **iFlexWDM** mobile app, which allows you to use your mobile device to check health benefit account balances from anywhere at any time.

Search for **isolved Benefit Services WDM** as soon as you enroll in the FSA and start using your smartphone or tablet to access your account balance. It's easy to see exactly how much money you have available to spend on qualified health or dependent care expenses at the time of purchase. You can also submit claims for reimbursement and upload receipts using the camera on your mobile device.

There is also an option to set up text message alerts for balance updates and other configurable data.

iFlexWDM gives you access from anywhere, simplifying the process of making the most out of your FSA funds.

No sensitive account information is ever stored on your mobile device.



The iFlexWDM mobile app is available for free on Google Play and the App Store.

As soon as you enroll in the company-sponsored FSA, search for **iSolved Benefit Services WDM** in the app store to start enjoying instant access to your FSA account information, along with a variety of resources, from your mobile device.

www.isolvedbenefitservices.com/wdm

For help, contact Flex Team at (515) 224-9400, toll free (800) 300-9691 or flexteamkb@isolvedhcm.com
Website: <https://kabelparticipant.lh1ondemand.com>

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isolved Benefit Services

Dental

Delta Dental

With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures.

	Delta Dental of Iowa	
	PPO	Premier/Non Par
Calendar Year Plan Maximum		
Benefit Period Maximum Per Individual	\$2,000	\$2,000
Orthodontic Lifetime Maximum Per Dependent (up to age 19)	\$1,500	\$1,500
Calendar Year Deductible		
Individual	\$25	\$50
Family	\$75	\$150
Preventive Care		
Exams, Cleanings, X-rays	0%	10%
Basic Services		
Fillings, Sealants, Extractions, Emergency Exams	30%	30%
Major Procedures		
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50%	50%
Orthodontia (dependents up to age 19)	50%	50%

Vision

Delta Vision

Healthy eyes and clear vision are an important part of your overall health and quality of life.

The table at right summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	Delta Vision Plan	
	IN-NETWORK	OUT-OF-NETWORK
	You Pay	Reimbursement
Exam	\$10 Copay	Up to \$35
Single Vision Lenses	\$10 Copay	Up to \$25
Bifocal Lenses	\$10 Copay	Up to \$40
Trifocal Lenses	\$10 Copay	Up to \$55
Lenticular Lenses	\$10 Copay	Up to \$55
Standard Progressive Lens	\$75	Up to \$40
Premium Progressive Lens (See full Vision plan summary for additional lens option cost)	Tier 1 - \$95 Tier 2 - \$105 Tier 3 - \$120 Tier 4 – 80% of charge less \$120, plus \$75 Copay	Up to \$40
Frames	80% of Balance over \$130	Up to \$65
Medically Necessary Contacts	\$0	Up to \$200
Elective Contacts	85% of Balance over \$130	Up to \$104
LASIK	85% of Retail Price or 95% of Promotional Price	N/A
Benefit Frequency		
Exams	Once every calendar year	
Lens or Contact Lenses	Once every calendar year	
Frames	Once every two calendar years	

Listen Up

Your ears could be telling you something



Do you often find yourself asking others to repeat themselves? Is there a constant ringing in your ears? If so, your ears could be trying to tell you something.

What causes hearing loss?

Hearing loss is caused by temporary obstructions in the outer or middle ear or permanent damage to the tiny hairs in the inner ear. Common causes of damage include exposure to noise, aging, other health conditions, and certain medications.

When should I get my hearing checked?

Hearing loss can come gradually. You may not even notice it's happening. If your hearing test reports your hearing is okay, stick to once every three to five years. You should test your hearing more often if you are 55 or older or are experiencing any of the following:

- **Consistent exposure** to loud noises
- **Ringing** in your ears
- **Difficulty understanding** in noisy environments or in groups
- **Hearing mumbling** or feeling as though people are not speaking clearly



1 in 9

Americans have hearing loss. By 2030, that number is expected to double.¹

Delta Dental of Iowa now offers hearing discount benefits.

[See back for benefit information >>](#)

FOR MORE INFORMATION

Call [866-925-1698](tel:866-925-1698)

or visit deltadentalia.com/hearing

¹ <https://www.asha.org/articles/untreated-hearing-loss-in-adults/>

Worried about your hearing? We have you covered.

If you think you may have hearing loss, don't worry. Delta Dental of Iowa has teamed up with Amplifon to offer you quality hearing care.

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Hearing Aid Features	Standard features	Additional, easy-to-use functions	Designed for work and play	Enhanced to keep you on the go	Leading technology keeps you connected
One Simple Price	\$995/ear	\$1,295/ear	\$1,495/ear	\$1,895/ear	\$2,195/ear

Complimentary Aftercare*

- Risk-free trial** - find your right fit by trying your hearing aids for 60 days
- Follow-up care** - ensures a smooth transition to your new hearing aids
- Battery support** - battery supply or charging station to keep you powered
- Warranty** - 3 year coverage for loss, repairs, or damage

*Risk-free trial - 100% money back guarantee if not completely satisfied, no return or restocking fees. Follow-up care - for one year following purchase. Batteries - two year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. Warranty - Exclusions and limitations may apply. Contact Client Services (1-844-267-5436) for details.

Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Delta Dental of Iowa and Amplifon are independent, unaffiliated companies. The Amplifon Hearing Health Care discount program is not approved for use with any 3rd party payor program, including government and private third-party payor programs. Hearing services are administered by Amplifon Hearing Health Care, Corp.

Take advantage of these benefits and start hearing better today!

FOR MORE INFORMATION

Call 866-925-1698

or visit deltadentalia.com/hearing



GREAT SAVINGS BROUGHT TO YOU BY DELTA DENTAL!

Regular eye exams not only correct vision problems, they also can reveal early warning signs of more serious health conditions such as hypertension, cardiovascular disease and diabetes. So, schedule eye exams annually and you'll be set on a path to better health.

Find an eye doctor

The EyeMed network has thousands of independent eye doctors and popular retailers. So you can see who you want to see when and where you want to see them. Visit eyemedvisioncare.com/deltadental to find a provider near you.

Schedule an appointment

Schedule an appointment online, call ahead or stop by one of the many eye doctors that offer walk-ins. Most offer evening and weekend hours to fit any schedule.

Use your discount

When you arrive, present this flyer to your EyeMed provider and save on your eyewear purchase.



POWERED BY



1.866.246.9041
ACCESS DISCOUNT PLAN

DELTA DENTAL
Discount Plan #:9231093

Signature: _____

This is not insurance. Dependents are eligible.

Member Services
Call 1.866.246.9041

EyeMed Doctors/
Providers Only
Visit eyemed.com to
receive plan information,
authorization online
or call 1.800.521.3605

Card must be presented to retailer. Discounts cannot be used with any other discounts, coupons, or promotional offers.

Please note your vision discounts cannot be combined with any other discounts, coupons or promotional offers.

Additional benefits for special needs

Oral health care can be overwhelming for members with special health care needs. That's why your Delta Dental of Iowa dental benefits plan automatically offers a Special Health Care Needs benefit to help remove barriers to care for your eligible covered members at no additional cost.

What is a special health care need?

Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive or emotional impairment or limiting condition that requires medical management, health care intervention and/or use of specialized services or programs.

The condition may be congenital, developmental, or acquired through disease, trauma or environmental cause, and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Who qualifies?

Covered members with a qualifying special health care need are eligible for this benefit. There is no age limit.

What's included?

- Consultations that can be helpful prior to the first treatment
- Unlimited exams for any patient deemed to have special health care needs by their provider
- Up to four total cleanings per calendar year
- Coverage for anesthesia/sedation and silver diamine fluoride

What's the cost?

There is no additional cost.

How is the benefit administered?

Eligible members should let their dental provider know that their Delta Dental plan includes the Special Health Care Needs Benefit and that they have a qualifying special health care need.



Contact your agent, visit deltadentalia.com or call Delta Dental at 877-423-3582 to learn more.

Life and AD&D

Reliance Standard

Life and Accidental Death & Dismemberment (AD&D) insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death or in the case of a covered accidental injury. Both of these plans are offered through Reliance Standard.



Basic Life & AD&D For You
Life Benefit:
\$25,000
AD&D Benefit:
\$25,000
Employer Paid



Vol. Life For You and Your Family
Employee:
Increments of \$10,000 up to a
maximum of 5X your annual earnings or
\$300,000.
Spouse:
Increments of \$5,000 up to a maximum of
\$50,000, not to exceed 100% of the employee
amount.
Child(ren) (birth to 20 years)*:
\$10,000
*age 26 if full-time student
Employer Paid

Guaranteed Issue and Evidence of Insurability

Employees who elect Voluntary Life coverage when they are first eligible can elect up to the **Guaranteed Issue (GI) amount of \$100,000** without Evidence of Insurability (EOI). The **Guaranteed Issue (GI) for your Spouse is \$30,000**. If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective. In addition, if you do not elect Voluntary Life Insurance when you are first eligible, you will be required to submit EOI for all coverage amounts.

Beneficiary Information

To ensure your family's financial security, keep your beneficiary information up-to-date. Be sure to designate a beneficiary through the open enrollment site. You must choose at least one beneficiary for each plan; however, you can update or change your beneficiary at any time during the year. Please contact your Human Resources Department for any questions related to your beneficiary information.

Disability

Reliance Standard

Disability insurance can keep you financially stable should you experience a qualifying disability and become unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience. Mechdyne Corporation provides full-time employees with long-term disability income benefits and pays the full cost of this coverage.

Long-Term Disability

Plan Overview	
Benefit Amount	60% of monthly salary
Own Occupation Period	5 Years
Elimination Period	90 Days
Maximum Benefit Period	Varies based on the age disability occurs. Please refer to your summary plan description for details.
Maximum Benefit Amount	\$6,000
Survivor Benefit	3 Months
Zero Day Residual	Zero day residual stipulates that full-time or part-time work in which the employee is performing all of the material duties of his or her regular, or some other occupation, will not interrupt the qualifying (elimination) period, or the period of disability.
Pre-Existing Condition Waiting Period	3/12 applies to all employees covered less than 12 months. In the event of a claim, the carrier will review information from 3 months prior to the employee being insured on this plan; if the disabling condition had been treated or diagnosed, there would be no LTD benefits for the first 12 months. After that time, benefits will be payable according to the terms of the contract.



Barrier-Free Access to Personalized Mental Health Solutions

Get seamless access to expert care, resources, and personalized support—whenever and wherever you need it.



Bree Health offers a comprehensive range of services designed to support your mental health and well-being. Our goal is to make accessing care as easy and effective as possible, so you can focus on what matters most.

→ Certified Life Coaching & Counseling

Access to Certified Life Coaching & Counseling for a variety of personal and professional needs, including managing stress, career growth, relationship challenges, and family matters.

→ Solutions Paths

Get personalized Solutions Paths with step-by-step guidance, tools, and resources that adapt to your needs, providing continuous support to reach your goals.

→ Legal & Financial Resources

Access no-cost 30-minute legal consultations, 90-minute financial consultations, a library of tools and resources, and discounted rates for continued services.

→ Bree Video Library

Access guided meditations, relaxation videos, educational content, and weekly mood-boosting insights to enhance your focus and refresh your mind.

→ Virtual Concierge Services

Provides dedicated Personal Assistants to help with research, referrals, and information on child/elder care, travel, events, entertainment, relocation, and more.

→ Employee Discounts

Enjoy exclusive savings on events, entertainment, travel, shopping, experiences, and more through our partner, Working Advantage.

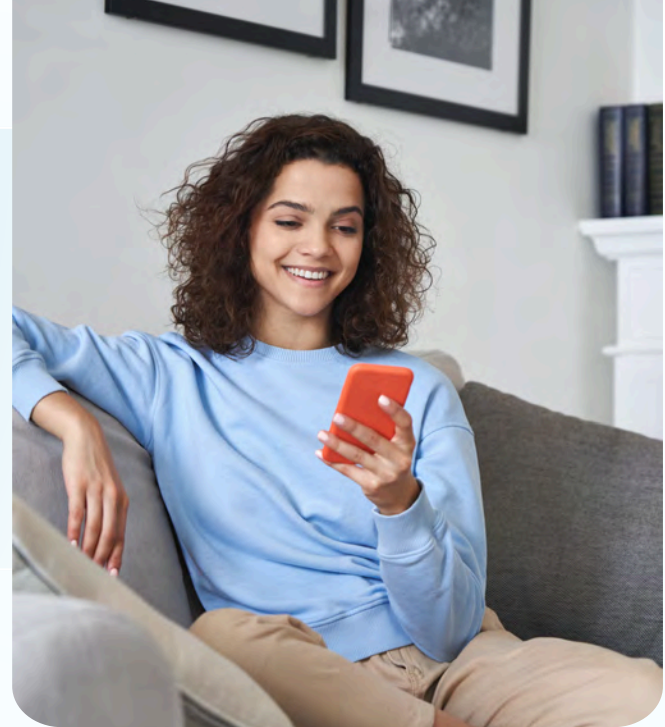
→ Health Advocacy

Get expert support navigating healthcare, from finding providers and managing billing issues to understanding insurance benefits and making informed care decisions.

EFFORTLESS ACCESS TO EXPERT COACHING AND MENTAL HEALTH SUPPORT

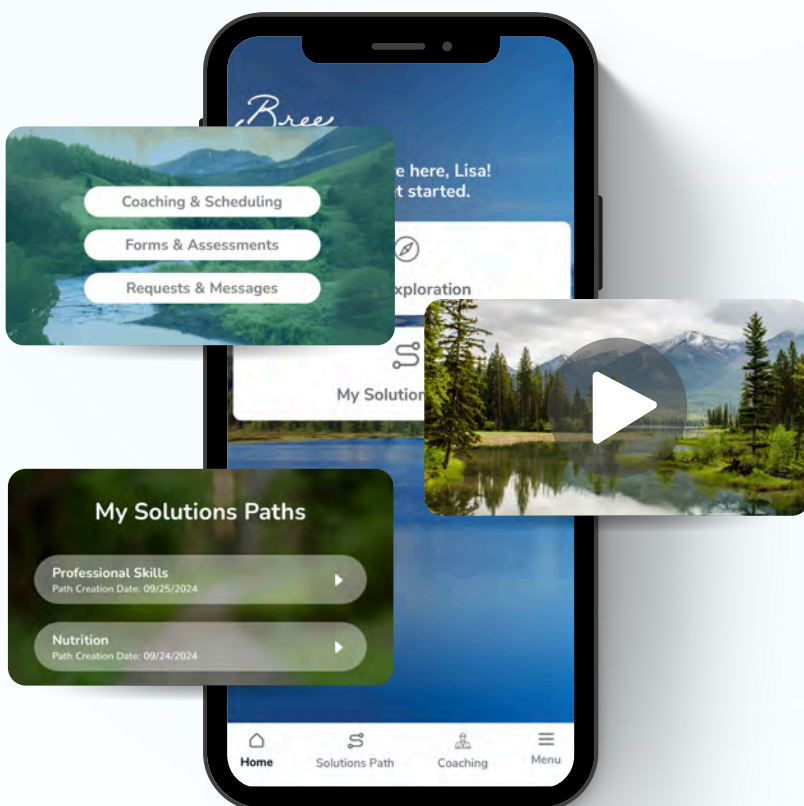
DISCOVER THE POWER OF THE BREE HEALTH APP

Take control of your mental health and well-being with the Bree Health App—your all-in-one solution for personalized, barrier-free access to essential support services. Whether you're managing stress, seeking mental health guidance, or navigating life's everyday challenges, our app is designed to make care effortless, accessible, and personalized to your needs.



CONFIDENTIAL ASSISTANCE

We ensure that your information and identity is kept completely confidential - even from your employer. Exceptions occur only when members are at risk of harming themselves or others or when the welfare of a child is in question.



BEGIN YOUR JOURNEY TO TOTAL WELL-BEING TODAY



COMPANY ID:

Visit login.breehealth.com or scan the QR code to download the app and take the first step toward a more balanced and fulfilling life.



Trustmark Universal LifeEvents® Insurance with Long-Term Care Benefit

Two important coverages for when you need them the most.

Financial security even after a loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income.

Universal LifeEvents can help.

Universal LifeEvents provides a **higher death benefit during your working years**, when your needs and responsibilities are the greatest. (See reverse for more on how Universal LifeEvents works.) You can choose a plan and benefit amount that provides the **right protection for you.**

Universal LifeEvents insurance can mean those left behind are still able to pursue their own dreams, and help ensure that the **ending** of one story won't stop the **beginning** of another.



Solving the long-term care issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents includes a **long-term care (LTC)** benefit that can help pay for these services at any age. This benefit **remains at the same** level throughout your life, so the full amount is always available when you most need it.

Here's how it works:

4%

You can **collect 4% of your Universal LifeEvents death benefit per month** for up to 25 months to help pay for long-term care services.

Flexible features available:

2x

PLUS: if you collect a benefit for LTC, your **full death benefit** is still available for your beneficiaries, as much as **doubling** your benefit.

Universal LifeEvents sample rates

Sample ranges of weekly rates for employee-only, non-smoker coverage with long-term care benefit. Your exact rate may depend on additional features selected by you and/or by your employer.

Age at purchase	\$25,000 Universal LifeEvents policy
30	from \$3.49 - \$4.59
40	from \$5.05 - \$6.71
50	from \$7.84 - \$10.71

Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.

Note: your rate is "locked in" at your age at purchase!

Once you have a policy, your rate will never increase due to age.

The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. The LTC benefits provided by this policy may not cover all of the policyholder's LTC expenses. Pre-existing condition limitation may apply. Your policy will contain complete details. You should consult a financial advisor to determine if the long-term care benefits and the retirement benefits provided by this policy are right for you.



Universal LifeEvents is **flexible permanent** life insurance designed to last a lifetime.



The younger you are when you enroll, the **more benefit** you receive for the same premium.



No medical exams or blood work – just answer a few simple questions.



What would happen if you weren't around?



1 in 3 households would have immediate trouble paying for living expenses if they lost their primary earner.¹



40% of Americans live paycheck to paycheck. Could your family afford to stay in your home?²



56% of Americans have less than \$10,000 saved for retirement – **1 in 3** have \$0 saved. Wouldn't it be nice to have some protection?³

How Universal LifeEvents works

- A **higher death benefit** during working years.
- **Long-term care (LTC)** benefits that **stay the same** throughout your life.

Example: \$25,000 policy

Before age 70

Death benefit **\$25,000**

LTC benefits **\$25,000**

After age 70

Death benefit **\$8,333**

LTC benefits **\$25,000**

Universal LifeEvents death benefit reduces to one-third at age 70 or the beginning of the 15th policy year, whichever occurs last. Issue age is 18-64.

Benefit for terminal illness

- **Use part of your death benefit** to help manage costs if you're diagnosed with a terminal illness.

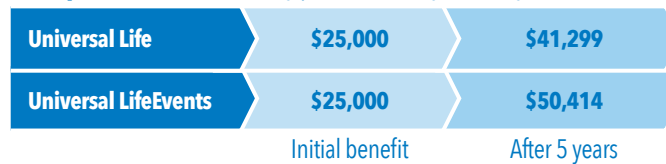
Additional advantages

- **Keep your coverage** at the same price and benefits if you change jobs or retire.
- **Apply for coverage for family members:** spouse, children and grandchildren.

Plus: grow your benefit with EZ Value

The EZ Value option can automatically **increase your benefit amount over time** – without any medical questions.

Example: \$1 increase in weekly premium each year for 5 years.



Example is for age 40, employee only, non-smoker coverage with long-term care benefit and no additional features. Actual values will vary by age, smoking status, benefits selected and interest rates.

**You care.
We listen.**

¹2018 Insurance Barometer Study LIMRA/Life Happens. ²nielsen.com/us/en/insights/news/2015/savingspending-and-living-paycheck-to-paycheck-in-america.html. ³gobankingrates.com/retirement/1-3-americans-0-saved-retirement. ⁴An A.M. Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A- (4th out of 16 possible ratings ranging from A++ to Suspended).

This provides a brief description of your benefits under GUL.205/IUL.205 and applicable riders HH/LTC.205, BRR.205, BXR.205, ABR.205, ADB.205, CT.205 and WP.205. Benefits, definitions, exclusions, form numbers and limitations may vary by state. This policy contains a provision that guarantees against lapse for a period of 10 years (14 years in OR; 15 years for Universal LifeEvents) as long as premiums are paid as planned. If you make changes to your coverage during this period, or pay only the minimum premium, you may prevent cash value accumulation or reduce your death benefit amount. If there is negative cash value at the end of the no-lapse period, you must pay enough premium to establish positive cash value. You may also need to maintain your policy with a higher premium than the one you paid to satisfy the no-lapse guarantee or coverage may expire prior to age 100 even if the premium shown is paid as scheduled. A policy illustration will be delivered with your policy. Your policy will contain complete information. For costs and further details of the coverage, including exclusions, any reductions or limitations and terms under which the policy may be continued in force, see your agent or write to the company. For exclusions and limitations that may apply, visit www.trustmarksolutions.com/disclosures/UL/ (A112-2216-UL). In California, review "A Consumer's Guide to Long-term Care from the Department of Aging" at: http://www.aging.ca.gov/aboutcda/publications/Taking_Care_of_Tomorrow_English/. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Trustmark® and LifeEvents® are registered trademarks of Trustmark Insurance Company.

Products underwritten by Trustmark Insurance Company
Rated A- (Excellent) for financial strength by A.M. Best.⁵

TrustmarkVB.com   





Trustmark Critical HealthEvents[®] Insurance

Critical illness insurance that offers a lifetime of benefits.



Major illnesses come with hidden costs

A critical illness, like cancer, heart attack or stroke, can be devastating. It can also be a huge and **unexpected financial challenge**. Medical insurance may not cover all costs, and you could face additional bills on top of those. **Critical HealthEvents[®] can help.**

While medical insurance pays your doctor for treatment, Critical HealthEvents **pays you cash** directly to help with your other needs. It's peace of mind having protection that helps with the high cost of severe illness.

Critical HealthEvents coverage helps take care of your budget in difficult times, so that you can fully focus on your **health**.

Critical HealthEvents sample rates

Sample ranges of weekly rates for employee-only, non-tobacco coverage. Your exact rate may depend on additional features selected by you and/or by your employer.

Age at purchase	\$15,000 policy
30	\$2.29 - \$5.22
40	\$4.15 - \$9.26
50	\$6.50 - \$14.94

Sample base rates are shown for illustrative purposes only. Rates may vary by age, tobacco use, state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.

Note: once you have a policy, your rates will not increase due to age.

Triple protection for critical illness

Critical HealthEvents is uniquely designed to help you manage a critical illness:

- 1 It pays for earlier diagnosis** - HealthEvents pays benefits not just for the most serious illnesses, but also for **earlier stages and early identification** of critical illnesses.¹ You can use these benefits to help get treatment sooner and preserve your health.
- 2 Your benefit refreshes annually** - Each calendar year, your **full benefit amount** is restored. There is **no lifetime maximum**. Even if you collect 100% of your benefit in one year, your full benefit will be available again on January 1 of the next year for a new diagnosis.
- 3 It's affordable, because it focuses on the most common conditions** - Critical HealthEvents focuses on **cancer, heart attack** and **stroke**. These conditions are responsible for 90% of critical illness insurance claims.²

¹Depending on diagnosis and stage, payments may be 100%, 50% or 10% of selected benefit amount. Policy/certificate will contain full list of covered conditions.

²U.S. Critical Illness Insurance Market Survey, 2012/2013 Results, conducted by Gen Re, A Berkshire Hathaway Company

Benefits are restored each year.
Example:



YEAR 1 (January 1st)
100% benefit available each and every year for any covered illness.



YEAR 1
Early identification - 10% benefit paid, 90% benefit remains



YEAR 1
Early stage diagnosis - 50% benefit paid, 40% benefit remains.



YEAR 2 (January 1st)
Benefit well is restored. 100% benefit is again available for a new diagnosis.



Each year, nearly **800,000** Americans have a heart attack³ and another **800,000** have a stroke.⁴

In addition, over **800,000** men and over **800,000** women in the USA are diagnosed with a new cancer each year.⁵

Additional advantages

- **Access to medical experts.** Critical HealthEvents includes access to **Best Doctors®**, the network of top doctors in the world, for free medical advice, second opinions, critical care support and more.
- **Keep your coverage** at the same price and benefits if you change jobs or retire.
- **Apply for coverage for family members:** spouse, children and dependent grandchildren.

Pre-existing condition limitation

No benefit will be paid for any condition caused by or resulting from a pre-existing condition.



More flexible features

- **Healthy living rider** - Provides **\$50** annually for one routine service for **early detection and prevention**. Benefits for additional tests may also be available.
- **Specified illness rider** - Provides a benefit at **10%, 50% or 100%**, once per lifetime per condition, for **additional illnesses**; see policy/certificate for all covered conditions.

Plus: grow your benefit with EZ Value

The EZ Value option can automatically **increase your benefit amount** over time - without any medical questions.





Example is for age 40, employee only, non-tobacco coverage, with no additional features. Actual values will vary by age, tobacco status and benefits selected.

**You care.
We listen.**

This is a brief description of benefits under CII 214 and applicable riders SIR 214, ASR 214, HLR 214, CGR 214, WPD 214, WPC 214, MAR 214, and EZV 214. This critical illness/specified disease insurance policy/group certificate provides supplemental health insurance coverage, which pays a limited, lump-sum benefit for specified diseases only. It is not a substitute for medical expense insurance, major medical expense insurance or a health benefit plan alternative. It does not provide comprehensive medical coverage. It is not intended to pay all medical costs associated with the specified diseases and is not designed to provide coverage for other medical conditions or illnesses. It is also not a Medicare Supplement policy, nor is it a policy of worker's compensation. Please refer to your policy/group certificate and outline of coverage, if applicable, for complete information. Limitations on pre-existing conditions may apply. A waiting period may apply before benefits are payable. Benefits, definitions, exclusions, form numbers and limitations may vary by state. For costs and coverage detail, including exclusions, limitations and terms, see your agent or write the company. Underwriting conditions may vary, and determine eligibility for the offer of insurance. For exclusions and limitations that may apply, visit [www.trustmarksolutions.com/disclosures/ACC/\(A112-2216-ACC\)](http://www.trustmarksolutions.com/disclosures/ACC/(A112-2216-ACC)).

³Heart Disease and Stroke Statistics 2017 At-a-Glance," American Heart Association/American Stroke Association. ⁴"Stroke Facts," Centers for Disease Control & Prevention.. ⁵"Cancer Facts & Figures 2017," American Cancer Society. ⁷An A.M. Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A- (4th out of 16 possible ratings ranging from A++ to Suspended).

Underwritten by Trustmark Insurance Company
Rated A- (EXCELLENT) A.M. Best⁷
TrustmarkVB.com   





Trustmark Accident Insurance

Coverage for when life takes a tumble.

Helping you prepare for the unexpected

Accidents happen. And medical insurance deductibles are going up, which can make **sudden expenses** like the medical costs associated with an accidental injury harder for your family to deal with.

Trustmark Accident insurance pays **cash directly to you** for treatment for covered accidents. The plan pays **regardless of other coverage** you have, and there are **no restrictions** on how you may use the money.

With Accident insurance, you can worry less about your bills, and **focus on recovering.**

Accident sample rates

The chart below lists sample weekly rates across all Trustmark plans nationwide, which vary by benefit amounts payable.

Covered person(s)	Rates
Employee	from \$2.28 - \$5.39
Employee + Spouse	from \$3.29 - \$8.01
Employee + Child(ren)	from \$4.95 - \$10.15
Family	from \$5.96 - \$12.77

Sample rates are shown for illustrative purposes only. Rates may vary by state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.

Benefits for injury and care

Accident insurance pays based on your injury and the care you receive. Benefits are included for medical services, including:



- Hospital admissions
- Ambulance transport
- Physical therapy
- Prosthetic devices or artificial limbs
- Skin grafts

... and for covered injuries, like:

- Fractures
- Dislocations
- Burns
- Concussion
- Amputations

These are just examples. A complete schedule of benefits will be listed in your policy.

Accident insurance pays you directly

Trustmark Accident insurance can be used any way you like, to help you pay for things like:

- Deductibles
- Co-payments
- Transportation and lodging costs
- Everyday bills

Accident insurance offers **coverage for certain non-work-related accidental injuries**, as well as for medical care and equipment to treat them.

Your affordable rate isn't based on your age - and it will **never increase** for as long as you have the policy.



Are you prepared to deal with an injury?



About **40 million** visits to the US emergency rooms each year are injury-related.¹

¹ National Center for Health Statistics, 2014.

Additional advantages

- **Apply for coverage for family members:** spouse, children, and dependent grandchildren.
- There are **no medical questions to enroll**, though spouses will need to answer a disability question if they choose to enroll.
- **Keep your coverage if you leave your job** with no change in premium or benefits.

More flexible features

- **Get paid** for health screening tests.
- **Receive a lump sum payment** in the event of the death of an insured person by a covered accident.

A waiting period may apply before benefits are payable. Feature availability may vary by state.

**You care.
We listen.**

This is a brief description of benefits under A-607 and applicable riders WB-607, HS-12000R, and LCWP-5/01. This is an accident only policy with limited benefits and does not pay benefits for diseases, sickness, or for loss from sickness. This is not a workers' compensation policy or a substitute for medical expense insurance, major medical insurance or a health benefit plan alternative. It is also not a Medicare Supplement policy. Please refer to your policy/group certificate and outline of coverage, if applicable, for complete information. Limitations on pre-existing conditions may apply. Benefits, definitions, exclusions, form numbers and limitations may vary by state. For costs and coverage detail, including exclusions, limitations and terms, see your agent or write the company. Underwriting conditions may vary, and determine eligibility for the offer of insurance. For exclusions and limitations that may apply, visit [www.trustmarksolutions.com/disclosures/ACC/\(A112-2216-ACC\)](http://www.trustmarksolutions.com/disclosures/ACC/(A112-2216-ACC)).

²An A.M. Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A- (4th out of 16 possible ratings ranging from A++ to Suspended).

Underwritten by Trustmark Insurance Company

Rated A- (EXCELLENT) A.M. Best²

TrustmarkVB.com   

ACC_NO-HSR-ADB_r



Required Notices

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

YOUR RIGHTS

You have the right to:

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

YOUR CHOICES

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

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

OUR USES AND DISCLOSURES

We may use and share your information as we:

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

YOUR RIGHTS

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

- You can ask us to 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.

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

YOUR CHOICES

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

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

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

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

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

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: <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
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

OUR RESPONSIBILITIES

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

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

CHANGES TO THE TERMS OF THIS NOTICE

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

- Effective Date of this Notice: January 1, 2026

Important Notice from Mechdyne Corporation 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 Mechdyne Corporation 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. Mechdyne has determined that the prescription drug coverage offered by Wellmark BCBS 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 Mechdyne Corporation 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 Mechdyne Corporation changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 2026 Plan Year

Name of Entity/Sender: Mechdyne Corporation

Contact--Position/Office: Sue Goodman – Human Resources

Address: 11 East Church Street, 4th floor, Marshalltown, IA 50158

Phone Number: 641-754-4649

Michelle's Law Enrollment Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because Mechdyne Corporation's group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of Mechdyne's group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, Mechdyne's group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the Mechdyne Corporation's group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

Mechdyne Corporation's group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and

1. To obtain additional information, please contact Human Resources.

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. If you would like more information on WHCRA benefits, call your plan administrator.

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 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.

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 July 31, 2025. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myalhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myalhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 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/health-insurance-premium-payment-program-hipp 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	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPPPROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 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: HHSHIPPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 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: 800-356-1561 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
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/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	cohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)
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/premium-assistance/famis-select 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 July 31, 2025, 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

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. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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” means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as “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 in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, please visit the Department of Health & Human Services No Surprises Act website by visiting www.cms.gov/nosurprises/consumers or call the Health & Human Services No Surprises Help Desk at 1-800-985-3059 for more information and for complaints. Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa members may contact the Iowa Insurance Division at 515-654-6600 or <https://iid.iowa.gov/consumers/filing-complaints>. Wellmark Blue Cross and Blue Shield of South Dakota members may contact the South Dakota Insurance Division at 605-773-3563 or <https://dir.sd.gov/insurance/default.aspx>.

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