Welfare Benefit Plan

Summary Plan Description

WRAP Plan

Mechdyne Corporation
Employee Benefits Plan

Mechdyne Corporation Employee Benefits Plan

Summary Plan Description

Your Employer maintains the Mechdyne Corporation Employee Benefits Plan ("the Plan") for the exclusive benefit of, and to provide health and welfare benefits to its eligible employees and their eligible dependents.

This Summary Plan Description (SPD) summarizes the important features of the Plan, including your benefits and obligations under the Plan. Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. These benefits are provided under various insurance contracts, as well as through self-insured plans funded by the general assets of your Employer. The Benefit Documents for each Benefit are part of this SPD only to the extent it provides detailed descriptions regarding each Benefits' eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions. You should keep this SPD with the Benefit Documents provided to you upon enrollment in each Benefit. You should also share this SPD with any family members you have elected to cover under the Plan.

The Plan is required to comply with certain federal laws and regulations that may change with the passage of new or revised laws. Your Employer reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. Any amendment, termination or other action by your Employer will be made in accordance with its normal operating procedures and any applicable laws.

Certain terms in the SPD have special meaning and are capitalized throughout the SPD. Such terms are defined in more detail in the DEFINITIONS section of the SPD. If any information in this SPD conflicts with the terms of the official Plan Document, the terms of the Plan Document—not this SPD—will apply.

Important Disclaimer: Benefits hereunder are provided pursuant to an insurance contract or governing written plan document adopted by the Employer. If the terms of this SPD conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will govern, rather than this SPD document, unless otherwise required by law.

Plan Contacts:

Below are the contacts you can reach out to for assistance regarding the Plan:

Contact for Participant Questions about the Plan:
Human Resources
Mechdyne Corporation
11 East Church Street, 4th Floor
Marshalltown, IA 50158
641-754-4649

Contact for COBRA Coverage Notifications:
COBRA Customer Service
iSolved Benefit Services
PO Box 737937
Dallas, TX 75373-7937
800-594-6957
qbmail@isolvedhcm.com

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EMPLOYER INFORMATION

Who established the Plan?

The Plan Sponsor of the Plan is: Mechdyne Corporation

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

Business Telephone Number: 641-754-4649

Federal Tax Identification Number: 42-1460417

Related Employers have adopted the Plan at the consent of Mechdyne Corporation to provide Benefits to their eligible employees and their eligible dependents. You may obtain additional details from your Human Resources representative.

PLAN INFORMATION

Amended and Restated Plan

The official Name of the Plan is: Mechdyne Corporation Employee Benefits Plan

Type of Plan: Welfare Benefit Plan

Plan Number: 501

Plan Year: January 1 through December 31 of the same calendar year.

The Plan originally took effect on: January 1, 2014.

This amended and restated SPD shall take effect on: January 1, 2026.

DEFINITIONS

When used in this SPD with initial capital letters, the following words will have the meanings described below unless the content indicates other meanings are intended. If any defined term in this SPD conflicts with the same term contained in an insurance contract or other document, the other document shall govern.

BENEFIT – Each benefit available under the Plan, as identified in Appendix A.

BENEFIT DOCUMENT – Any policy, contract, or other document that governs the terms of the Benefit.

CAFETERIA PLAN – A written plan that meets the requirements of Code Section 125 and offers eligible employees a choice between cash (or other permitted taxable benefits) and certain nontaxable benefits (such as health insurance), thereby allowing employees to pay for the benefits they choose on a pre-tax basis.

CHILD(REN) – Your child(ren) as defined in a Benefit Document.

CLAIM – A request for benefits made by you under the terms of the Benefit Document.

CLAIMS ADMINISTRATOR – The Plan Administrator or the third party appointed by the Plan Administrator to review claims submitted by you, including appeals, as applicable.

CONTRIBUTIONS – The amount paid by you or your Employer equal to the cost of coverage under a Benefit.

DEPENDENT – Your dependent as defined in the applicable Benefit Document.

DISABILITY PLAN – The Benefit that provides a Participant supplemental income during a limited or extended period of time due to the inability to work as a result of illness, injury, or accident. The Disability Plan includes a long-term disability plan.

DOMESTIC PARTNER – Your Domestic Partner as defined in the Benefit's insurance contract or other document for eligibility requirements.

ELIGIBLE DEPENDENT – A Dependent that is eligible for coverage under one or more of the Benefits.

EMPLOYER – Your Employer who adopted this Plan is Mechdyne Corporation. Your Employer will also serve as the Plan Administrator, as defined in the Employee Retirement Income Security Act (ERISA), who is responsible for the day-to-day operations and decisions regarding the Plan, unless a separate Plan Administrator is appointed for all or some of the Plan responsibilities.

HEALTH CARE PLAN – Any Benefit that provides medical care, including a Major Medical Option, dental, vision, flexible spending arrangement, or an employee assistance program.

MAJOR MEDICAL OPTION – A Benefit that provides medical benefits, other than vision or dental benefits, to eligible employees and their Eligible Dependents.

PARTICIPANT – An employee of your Employer who has satisfied the eligibility requirements and entered the Plan.

PLAN – The Plan described in this SPD is the Mechdyne Corporation Employee Benefits Plan.

PLAN ADMINISTRATOR – Your Employer is responsible for the day-to-day administration of the Plan and is the Plan Administrator unless an appointed Plan Administrator is named in the Administrative Information section of this SPD.

PLAN DOCUMENT – The official Plan document that sets out the official terms and conditions of the Plan.

PLAN SPONSOR – The Plan Sponsor is Mechdyne Corporation.

ELIGIBILITY

Q1. Who is eligible for Benefits?

An eligible employee with respect to the Plan is any common-law employee of the Employer who is eligible to participate in and receive Benefits under one or more of the Plan Components. Typically, seasonal or leased employees, or independent contractors, are not eligible, but the specific eligibility and participation requirements may vary depending on the particular Plan Component. You must satisfy the eligibility requirements under a particular Plan Component to receive benefits under that program (as described in more detail in Appendix B).

Q2. Are my Dependents eligible to be covered by the Plan?

Yes, certain individuals related to you, such as a spouse or your Dependents may be eligible for coverage under certain Plan Components.

Q3. How do I enroll in Benefits?

If you are eligible to participate in the Plan, you can become a Participant by properly and timely completing the prescribed paper or online enrollment forms. To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

To enroll, follow the procedures below:

Initial Enrollment

If you are eligible to participate in the Plan for the first time, you must submit your elections and any supporting documents, if applicable, in a timely manner in accordance with your Employer's enrollment procedures. If you miss your enrollment period, you may have to wait until the next open enrollment period or experience a qualifying life event to enroll in the Plan.

Annual Open Enrollment

You may change your coverage (or elect coverage in the Plan if you did not elect coverage when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment materials on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year.

Dependents

Dependent coverage for your eligible Dependents will begin on the date your coverage begins. However, coverage of Dependents may be contingent on receiving required documents, as requested by the Plan Administrator. If applicable, and you fail to provide the required documents in a timely manner and you enroll a Dependent in coverage, the Dependent may be removed retroactively to the first date of eligibility.

Q4. Can I change Benefits throughout the year?

Maybe. In order to pay your portion of Health Care Plan premiums on a pre-tax basis, the IRS limits election changes to the annual enrollment period UNLESS you experience one of the qualifying life events defined by the IRS, such as marriage, divorce, job change, birth, or adoption of a child, or when a dependent child reaches a Plan Component's limiting age. If you experience a qualifying life event you must notify the Plan Administrator within a specified timeframe following the event.

In addition, HIPAA special enrollment rights allow you and your eligible Dependents to enroll in a Major Medical Plan Component if 1) you or your Dependents experience a loss of coverage under another group health plan, health insurance, Medicaid, or CHIP; 2) you gain a new Dependent through marriage, birth, adoption, or placement for adoption; or 3) you or your Dependents become eligible for premium assistance through a state Medicaid or CHIP program.

See your Employer's "Cafeteria Plan" for a full list of adopted permissible election change events.

Effective Date of Enrollment Change: Election and salary reduction changes generally become effective no earlier than the first day of the next calendar month following the date that the election change request was filed, except that an election change on account of a HIPAA special enrollment right, attributable to the birth, adoption, or placement for adoption of a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively back to the date of the qualifying event. Participants who advise prior to their marriage date will have the coverage change occur on the date of marriage.

Q5. When does coverage begin and end?

Coverage begins on the date you meet any required waiting period and, depending on the Benefit, generally ends on the date or end of the month in which you cease to satisfy the eligibility requirements. Appendix B includes additional details on waiting periods and cessation of participation rules.

For example, coverage may end due to divorce, death, change in employment status (including termination), failure to pay Contributions, a Dependent Child reaching a Plan Component's limiting age, or a Plan amendment or termination. If you experience a divorce, you will not lose coverage, but your spouse will lose coverage. If your Dependent Child reaches a Plan Component's limiting age, you will not lose coverage, but your Child will lose coverage. If you experience a change in employment status that causes a change in Plan eligibility, you and your Dependents

may lose coverage. If the loss of coverage meets the criteria for COBRA continuation coverage eligibility, you and your Dependents may be able to continue coverage under certain Health Care Plan Components.

Coverage under the Plan or a particular Plan Component may terminate earlier if you fail to pay your share of the premiums, if your hours drop below any required eligibility threshold, if you submit false claims, and for certain other reasons described in the applicable Plan Component's Benefit Documents.

Q6. What should I do if an Eligible Dependent loses eligibility status?

If a Dependent loses eligibility—for example, due to death, divorce, loss of legal guardianship, or a Dependent Child reaching the Plan Component's limiting age—their coverage will end. Some Plan Components may automatically remove a Dependent once they no longer meet eligibility requirements, such as when a child reaches the limiting age.

If the Plan Component does not automatically remove a Dependent who loses eligibility, you must notify your Employer within 30 days of the event to request any allowed election changes. Failure to provide timely notice may limit your ability to make changes and may result in incorrect payroll deductions, which the Plan Administrator may correct, including recovering overpayments or requiring reimbursement back to the Plan for costs incurred.

If the loss of eligibility is a qualifying event for COBRA, your Dependent may elect continuation coverage if you notify your Employer in writing within 60 days of the later of: 1) the qualifying event, or 2) the date the Dependent loses (or would lose) coverage under the Plan.

BENEFITS AND FUNDING

Q1. What is the purpose of the Plan?

The Plan is a welfare benefit plan that is intended to provide you with a range of Benefits to promote your health and welfare.

Q2. What Benefits are provided by the Plan?

The Plan provides the Benefits listed on Appendix A to this SPD.

Q3. What is the Plan's funding method?

Each Benefit offered under the Plan is funded through one of the following sources:

- Insurance contracts.
- Self-insured arrangements paid through the general assets of the Employer.

Q4. What is the source of Contributions?

Depending on the Plan Component, the cost of your coverage is either paid by:

- Employer Contributions only; or,
- Employee Contributions only; or,
- Both Employer and employee Contributions.

Q5. How do I pay for Benefits?

Depending on the Benefit, the cost of your coverage will be deducted from your pay on either a pre-tax or post-tax basis. Pre-tax payroll deductions through a Cafeteria Plan lower your cost to participate in the Plan. Note that you do not pay Social Security taxes on the pre-tax dollars used, which could result in a small reduction in your Social Security benefits at retirement.

It is important to note that if you intend to enroll a non-tax Dependent, such as a Domestic Partner, the cost of their coverage cannot be paid for on a pre-tax basis and will be added to your wages as taxable income. We recommend you consult with your tax or legal advisor for further guidance before electing coverage for a non-tax Dependent.

COORDINATION OF BENEFITS

Q6. What happens if I am covered by two or more health plans?

If you or your Dependents are covered by more than one group health plan at the same time, the plans will coordinate benefits so that payments do not exceed the amount payable for the covered expense. This Coordination of Benefits (COB) section provides a high-level summary. Each underlying Benefit Document contains its own detailed COB provisions, which control in all cases. Participants must follow the COB procedures described in those documents, including any requirements to submit information needed to coordinate claims.

Order of Benefit Determination. When you are covered by more than one group health plan, the order in which benefits are paid is determined in accordance with the COB provisions of the applicable Benefit Documents. In general:

- The plan that covers the individual as an employee pays first (primary). The plan that covers the individual as a dependent pays second (secondary).
- When a child is covered under both parents' plans, most Benefit Documents apply the birthday rule, meaning the plan of the parent whose birthday (month and day) falls earlier in the calendar year pays first. If a Benefit Document uses a different rule (such as a custodial-parent rule in the case of divorce), that Benefit Document's rule will apply.

Q7. Will the Plan be primary or secondary payer if I am covered by Medicare?

Medicare Secondary Payer (MSP) rules apply separately and supersede normal coordination of benefits (COB) rules. If you are enrolled in Medicare, the Plan will coordinate benefits with Medicare according to federal MSP requirements. These rules determine whether this Plan pays primary or secondary based on factors such as:

- your employment status,
- the size of your employer,
- disability status, and
- whether you have End Stage Renal Disease (ESRD).

In general, the Plan pays primary for certain actively employed individuals and their dependents (including those eligible due to age or disability) when the employer meets specific size thresholds established under federal law. Medicare typically becomes the primary payer when coverage is due to retirement, COBRA continuation, certain small-employer situations, or after the ESRD coordination period ends.

Because Medicare coordination rules are federal requirements, you must follow MSP rules. For the most current federal guidance on when Medicare or a group health plan pays first, you may review the Centers for Medicare & Medicaid Services (CMS) information on Medicare Secondary Payer rules at: https://www.cms.gov/medicare/coordination-benefits-recovery/overview/secondary-payer.

The detailed Medicare coordination rules that apply to your coverage are also contained in the applicable Benefit Documents for each benefit option.

CLAIMS AND APPEALS

Q1. What Claims and appeal procedures apply?

You must follow the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document. Notwithstanding the foregoing, in no event shall the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document provide fewer rights to you than the rights prescribed in Labor Regulation section 2560.503-1.

If the applicable Benefit Document does not include Claims and appeals procedures, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section and Section Four of the Plan document.

Q2. How do I appeal a Claim or benefit determination?

If you disagree with a benefit or Claims determination, you must submit a written request to the Claims Administrator. Please see Appendix A for contact information, including the address of the Claims Administrator for the Benefit.

HEALTH CARE PLANS

Q3. What types of Health Care Claims can I appeal?

Under ERISA, a claim is a request for benefits made in accordance with a Plan Component's claims-filing procedures, including any request for a service that must be pre-approved. Questions concerning Plan benefits, coverage and eligibility questions, and other casual inquiries are generally not considered claims for benefits.

For purposes of Health Care Plan Components subject to ERISA (e.g. Medical, Dental, or Vision), there are four types of health claims:

- ***Urgent Care Claims*** – Claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that could cause severe pain.
- ***Pre-Service Claims (Non-Urgent)*** – Claims not involving urgent care that require notification or approval prior to receiving medical care.
- ***Post-Service Claims*** – Claims that are filed for payment of benefits after medical care has been received.
- ***Concurrent Care Claims*** – Claims for ongoing treatment that were already approved for a certain time period or number of visits. A Concurrent Care Claim happens when the Plan Component later reduces or stops coverage for those treatments, or the claimant asks to extend coverage for more treatments than originally approved. Depending on when the claimant submits the Claim during their treatment, it will be handled as one of the above Claim types.

Q4. After I submit a Claim, when should I expect a response?

The timeframe for a Plan Component to provide notice of a Claim determination varies based on the type of Claim filed:

CLAIM TYPE	DEADLINE FOR MAKING INITIAL DETERMINATION
Urgent care	As soon as possible, but no later than **72 hours** after receiving the Claim by the Plan Component.
Pre-service (Non-Urgent)	Within a reasonable time period, but no later than **15 days** after receiving the Claim
Post-service	Within a reasonable time period, but no later than **30 days** after receiving the Claim
Concurrent Care Related to Termination or Reduction of Treatment	If the Plan Component decides to reduce or stop the approved treatment before the original end date or number of visits (other than by plan amendment or termination), the claimant will be notified early enough so they can file an appeal and get a decision before benefits are reduced or stopped.
Concurrent Care Claim Related to Request for	If you need more approved treatment under an Urgent Care claim, when you request the extension:

CLAIM TYPE	DEADLINE FOR MAKING INITIAL DETERMINATION
Extension of Treatment	• At least 24 hours before your current approval ends, the Plan will review your request and give you a decision within 24 hours of receiving it. • Less than 24 hours before your approval ends, the Plan will review it as quickly as possible, and you will receive a decision no later than 72 hours after the Plan receives your request. If your request is not considered urgent, it will be treated as a regular Pre-Service or Post-Service claim and will follow the normal ERISA review timeframes for those types of claims.

Extension of Claim Determination Deadlines

- **Urgent Care Claims**. If the Plan Component needs more information, it must tell the Claimant within 24 hours and give the Claimant at least 48 hours to respond. Then the plan must decide the Claim within 48 hours after receiving the missing information or within 48 hours of the deadline for the Claimant to supply the missing information, whichever comes first.
- **Pre-Service Claims and Post-Service Claims**. The Plan Component may extend the time period up to 15 days more if, for reasons beyond its control, the plan cannot make the decision within the first deadline. If the Plan Component requests more information, the Claimant has at least 45 days to supply it. The Plan Component then must decide the Claim within 15 days after receiving the additional information or within 15 days of the deadline for the Claimant to supply the additional information, whichever comes first.

Q5. If my Health Care Claim is denied, will I receive a notification?

Yes, if your Claim is denied in full or in part, you will receive a written notice of adverse benefit determination. The notice must be provided in a manner calculated to be understood by the Claimant (including, if applicable, in a culturally and linguistically appropriate manner) and include information:

- Information sufficient to identify the Claim and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The specific reason(s) for the denial.
- Reference to the specific Plan Component's provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan Component's internal appeals and external review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on review, if applicable.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either a) an explanation of the scientific or clinical judgment for the determination, or b) a statement that such explanation will be provided free of charge, upon request.
- If the denial involves an urgent care Claim, the notice will also include a description of the expedited review process applicable to such Claims.

Q6. In addition to providing the notice of adverse benefit determination, is there anything else the Claims Administrator must do if a Health Care Claim is denied?

Yes, the Claims Administrator is required to take the following steps:

- Ensure that any notice includes information sufficient to identify the Claim, including the date of service, the health care provider, and the amount of the Claim. Moreover, the Plan must provide notice of the opportunity to request the diagnosis code, the treatment code, and its corresponding meaning;
- Ensure the notice includes the denial code and its corresponding meaning and the standard used to deny the Claim;
- Provide a description of the internal appeal and external review processes available under the Plan;
- Provide a description of how to initiate an appeal; and
- Disclose the availability of any applicable office of health insurance consumer assistance or ombudsman available to assist with internal Claims and appeals or external review processes, including contact information.

Q7. If my Health Care Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The Claims Administrator will review the appeal upon receipt and will follow the terms of the Plan. An appeal decision will be made within the time frame provided by the Plan and will be reviewed even if information or documents are missing from the appeal.

A document, record, or other information is relevant to a Claim if it

- was relied upon in making the Claim determination;
- was submitted, considered, or generated in the course of making the Claim determination, even if it was not used to make the Claim determination;

- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim reviews follow the terms of the Plan has been applied consistently; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by you relating to the Claim, even if the information was not submitted or considered in the initial Claim review. The review will not rely on the initial denial and will be performed by a fiduciary of the Plan who is neither the individual who denied the Claim nor a direct report of that individual.

Q8. Is there an expedited process for an urgent care Claim?

Yes, you are entitled to an expedited review process that permits you to submit your request orally or in writing and that permits all necessary information to be shared by telephone, fascimile, or other similarly expeditious method.

Q9. If I appeal a Claim determination, what happens next?

First Appeal

Once you have submitted an appeal, you will receive a written response, as follows:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal by the Plan Component.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal by the Plan Component.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan Component**.**
- **Concurrent Care Claim.** Before treatment ends or is reduced, where the adverse determination is the decision to reduce or terminate concurrent care early, or, if the Component Plan denies your request to extend treatment, within the appropriate time period based upon the type of Claim.

Voluntary Second Appeal

If specified in the Benefit Documents for each Plan Component or in documentation given to you by the Claims Administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

The appeal decision with respect to any second appeal will be made according to the following schedule:

- **Urgent Care Claim**. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- **Concurrent Claim**. The response will be made in the appropriate time period based upon the type of Claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

Q10. Will I receive a written notification of a claim determination on review (i.e., an appeal)?

Yes, you will receive a final notice of adverse benefit determination. The notice will include the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial, including a discussion of the decision.
- Reference to the specific Plan provisions on which the denial was based.
- A description of the Plan's review procedures and the time limits applicable to the procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, or (ii) a statement that such explanation will be provided free of charge, upon request.
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Q11. If my appeal is denied, do I have any other rights?

Yes, you may have the right to request an independent, external review. Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

DISABILITY PLANS

Q12. Which types of Claims are considered "Disability Claims"?

A Disability Claim is a claim for benefits that requires the Claimant to prove a disability with respect to which the plan makes its own determination of whether the Claimant is disabled, regardless of whether it is characterized as a pension benefit or a welfare benefit and regardless of whether it is offered by a pension plan or a welfare plan. However, if someone other than the plan makes the determination of disability, for purposes other than the plan's benefit determination (e.g., the Social Security Administration or a different benefit plan), the claim is not a Disability Claim.

Q13. When will I receive a Disability Claim determination?

You will receive a written or electronic notification of the Plan's Claim decision within a reasonable time but not later than 45 days after receipt of a Claim by the Plan Component

Q14. Will the Disability Claim determination period ever be extended?

Yes, the Plan may extend the review period twice, each time by 30 days, if the extension is necessary due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan will notify you in writing.

Q15. What if I did not submit all the necessary information to process my Disability Claim?

The Plan will send you a written notice and will provide a description of the required documents or information. You will then have 45 days to submit the additional information to the Plan.

Q16. Will I receive a notice if my Disability Claim is denied?

Yes, you will receive a notice that will contain the following information, which must be provided in a "culturally and linguistically appropriate" manner calculated to be understood by the Claimant:

- Information sufficient to identify the Claim.
- The specific reason for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either a) an explanation of the scientific or clinical judgment for the determination, or b) a statement that such explanation will be provided free of charge, upon request.

Q17. If my Disability Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Q18. If I appeal a Disability Claim determination, what happens next?

Once you have submitted an appeal, you will receive a written response within 45 days after receipt of your request to review a Claim determination. The 45-day period may be extended by 45 days if the Plan determines that special circumstances require an extension. If an extension is required, you will receive a written notification.

NON-HEALTH/NON-DISABILITY PLANS

Q19. What is the definition of non-health, non-disability Claims?

These are Claims that are not group health Claims or disability Claims (e.g., Claims for severance or death Benefits).

Q20. What if a Plan Component is not a Health Care or Disability Component?

Generally, any Plan Component that is not a Health Care or Disability Component will review a Claim within 90 days and provide written notification of its decision. The 90-day period may be extended by 90-days in certain circumstances. If you disagree with the Claim decision, you may file an appeal within 60 days of your receipt of the written notice of denial of a Claim. The Plan administrator will then render a decision within 60 days after receipt of the request for review. In special circumstances, the Plan may make a determination within 120 days after the receipt of your request for review. If such an extension is required, you will be notified in writing.

LEGAL ACTIONS

Q21. What should I do if I want to pursue a legal action against the Plan?

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this SPD or, if applicable, the Benefit Documents of a Plan Component, you may lose the right to file suit in state or federal court in the state of Iowa.

The individual named below can be served with legal papers regarding the Plan.

Mechdyne Corporation
Attn: Corporate Legal Counsel
11 East Church Street, 4th Floor
Marshalltown, IA 50158
703-994-9712

Service of legal process also may be directed to the Plan Administrator.

Q22. What is the time limit to bring a lawsuit?

Please refer to the applicable Benefit Document for information about the time period applicable to your Claim. If the Benefit Document does not contain any such provision, as permitted by law, you must bring a lawsuit within the following time frames:

- Before bringing any lawsuit seeking benefits under a Plan Component, you must complete the applicable claims procedure of the Plan or the Component Plan (and comply with all applicable deadlines established as part thereof). Failure to properly exhaust the claims procedure will extinguish the Claimant's right to file a lawsuit with respect to the claim.
- In the case of a Plan Component that is self-insured by your Employer, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Plan Component, the time period for bringing any lawsuit against the insurance company issuing such Plan Component or the Plan will be determined by the terms of the applicable Plan Component. If the Plan Component does not set forth such a time period, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits must be brought within one year of the act or omission giving rise to the claim.

MISCELLANEOUS

LEAVE OF ABSENCE

Q1. What happens to my Benefits if I take a leave of absence?

Depending on the leave policies and procedures adopted by your Employer, you may be able to continue certain Benefits while on an approved leave of absence. If you are eligible to continue certain Benefits, you may be required to complete certain forms or documents and pay towards the cost of coverage.

Q2. Is my Employer required to comply with the Family and Medical Leave Act (FMLA)?

Yes, your Employer is required to comply with FMLA. The Plan Administrator must continue Health Care Plan coverage while you are on leave protected by the FMLA.

Q3. What happens if my leave is protected by FMLA?

If your leave is protected under FMLA, you may continue your group health care coverage under the Plan (e.g. Medical, Dental, Vision, or Health FSA) for you and any covered Dependents as long as you continue to pay your portion of the cost for your Benefits during the leave, or if allowed, after the leave.

Your Employer may offer the following options for payment of Contributions:

- ***Paid Leave*** – Contributions will be automatically deducted from payroll.
- ***Unpaid Leave*** – You will be required to submit payment to your Employer for any required Contributions. If you do not pay Contributions in a timely manner, your Employer has at least 15 days before cessation of your coverage to provide you with a notice of the cancellation. Unless your Employer has adopted a longer grace period, you will have **15 days** from the date of the notice to make the required payment. If you fail to make the payment in the permitted time, your coverage will be cancelled.

Any coverage that is terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required Contributions, including any catch-up payments, if applicable, attributable to the period prior to your return from leave.

Depending on the policies adopted by your Employer, payment of Contributions may be paid 1) in installments during the leave; 2) before commencing FMLA leave; or 3) through "catch up" salary reductions upon returning from leave.

Q4. What happens if I experience a "change in status" while on FMLA leave?

If you experience a "change in status" (e.g., change in marital status, number of Dependents, residency, or employment status), you may change your coverage election as if you were actively employed.

Q5. What happens if I do not return to work following my FMLA leave?

If you do not return to work following your FMLA leave, you may be entitled to COBRA continuation coverage, if applicable. You may also be required to reimburse your Employer for costs of coverage provided to you while you were on unpaid FMLA leave.

Q6. What happens if my leave is protected under USERRA?

If you are going into or returning from military service, your Benefits may be protected under USERRA. Under USERRA, you may elect to continue coverage under the Plan for up to 24 months. To continue coverage, you must comply with the terms of the Plan, including election and payment of coverage. Moreover, upon return from leave protected under USERRA, your coverage will be reinstated (i.e., begin again).

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the Contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (and any amount for dependent coverage) who is not on military leave.

LEGAL MATTERS

Q7. Can I assign my rights under the Plan to another person or third party?

Except as otherwise specifically provided in the Plan or required by law, Benefits payable to you or your Dependents under the Plan may not be assigned, transferred or in any way made over to another party.

Even if an assignment is permitted under the Benefit Document, the Plan Administrator, or any delegated third-party, has the right to determine the validity of the assignment.

Q8. Is this document a contract between me and my Employer?

No, this document is an SPD and is intended to summarize general provisions of the Plan. This document does not constitute a contract of any type between you and your Employer. Nothing in this document shall give you any right of employment.

ADMINISTRATIVE INFORMATION

Q1. Who has the authority to make determinations under the Plan?

The Plan Administrator has discretionary authority to interpret and make determinations under the Plan. The Plan Administrator may delegate its authority to third parties regarding Claims administration (e.g., the review and processing of Claims), ministerial services (e.g., recordkeeping, mailing of notices, etc.), and other services, as necessary.

Q2. What are some of the duties of the Plan Administrator?

The Plan Administrator's duties include, but are not limited to, the following:

- Appointing and supervising a third-party administrator to pay Claims;
- Administering the Plan in accordance with its terms;
- Delegating to any person or entity powers, duties, and responsibilities, as necessary;
- Determining all questions of eligibility, status, and coverage under the Plan;
- Interpreting the Plan, including ambiguities, inconsistencies, omissions, and disputed terms;
- Making factual findings;
- Deciding disputes that may arise relative to a covered person's rights;
- Recommending procedures for filing a Claim for Benefits, review Claim denials, and appeals relating to them, and uphold or reverse such denials;
- Keeping and maintaining the Plan document and all other records pertaining to the Plan;
- Performing all necessary reporting, as required by ERISA, if applicable;
- Establishing and communicating procedures to determine an order's status as a qualified medical child support order; and
- Performing functions necessary for the Plan's administration.

Q3. Can changes be made to the Plan?

Yes. While the Employer intends to maintain the Plan indefinitely, the Employer may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending Benefits provided under the Plan. If an amendment, suspension, or termination is enacted, the Employer will provide notice, as required by law.

Q4. What happens if the Plan Administrator or its delegates makes a clerical error?

If the Plan Administrator or its delegated agent make a clerical error, the error will not invalidate coverage. Rather, coverage effective dates will be determined solely in accordance with the provisions of the Plan, including any Benefit Document. Moreover, as permitted by law, the Plan Administrator will make an equitable adjustment as a result of an error or delay.

Q5. Who is responsible for the day-to-day operations of the Plan?

Your Employer is responsible for the Plan's day-to-day administration.

To assist in operating the Plan efficiently and accurately, your Employer may appoint additional persons or organizations to act on its behalf or to perform certain functions. The Plan Administrator may provide the Claims administration through a third-party Claims Administrator.

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Plan Administrator has the exclusive right to interpret the Plan's provisions. You may contact the Plan Administrator for any further information about the Plan.

Q6. Who is responsible to administer the Plan's Claims?

The Claims Administrator is responsible to administer the Plan's Claims. The Claims Administrator is:

- The Insurance Issuer or self-insured plan administrator appointed by the Employer.
- The Employer.

Refer to the chart in Appendix A for Claims Administrator contact information.

Q7. How can I obtain additional information about the Plan?

For additional information regarding the Plan, contact the person or department listed on Page i of this SPD, or refer to the Benefit Documents. Copies of the Plan document, this SPD, and incorporated Benefit Documents are available free of charge from your Employer upon request.

Q8. If I receive a medical child support order, what should I do?

If you receive a medical child support order, send the order to the Plan Administrator. The Plan Administrator will then review the order to determine if it is a "qualified medical child support order" (QMCSO). If it is determined the order is a QMCSO, the Plan will automatically change your coverage to extend coverage to the Child. Coverage for the Child will begin on the date specified in the order, or if none is specified, the date of the order, as permitted under a Benefit.

You are permitted to obtain, without charge, a copy of the policy and/or procedures governing the QMCSO from the Plan Administrator.

Q9. When can the Plan Administrator retroactively terminate coverage provided under a Health Care Plan?

A retroactive termination of coverage is referred to as a "rescission." The Plan Administrator may retroactively terminate your coverage or the coverage of your Eligible Dependent if you commit fraud or if you intentionally misrepresent a material fact to the Plan.

Q10. What is considered fraud or intentional misrepresentation?

Fraud or intentional misrepresentation occurs when you obtain Benefits by fraudulently or intentionally misrepresenting a material fact to the Plan. If you fraudulently or intentionally misrepresent a fact, the Plan Administrator may take certain action, as permitted by law, at its sole discretion.

YOUR RIGHTS UNDER ERISA

Q1. Is the Plan subject to the Employee Retirement Income Security Act (ERISA)?

Yes, the Plan is subject to ERISA and you have certain rights summarized in this section.

Q2. What are my legal rights and protections under the Plan?

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (if required by ERISA to be prepared) and updated SPD. The administrator may charge a reasonable fee for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary Annual Report.

Continue Health Care Plan Coverage

The Plan Administrator is required to continue Health Care Plan coverage for you or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within a certain period of time. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's Claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTINUATION OF COVERAGE RIGHTS

This section explains your rights to COBRA continuation coverage, a temporary extension of your group health coverage when it would otherwise end. It also describes when COBRA may be available, who qualifies, how to elect coverage, how long it can last, how much it costs, and other coverage options available to you and your family.

You may also be eligible for other coverage—such as the Health Insurance Marketplace, Medicare, Medicaid/CHIP, or another employer plan through a special enrollment period. For example, by enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

Q1. What is COBRA continuation coverage?

COBRA continuation coverage is a temporary continuation of Plan coverage that you and your family may be able to elect when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event occurs, COBRA continuation coverage must be offered to each individual who is considered a "qualified beneficiary."

Under federal law, a qualified beneficiary generally includes the employee, the employee's legal spouse, and the employee's dependent children, if they lose coverage under the Plan due to a qualifying event.

Each qualified beneficiary must pay the full cost of COBRA continuation coverage. This includes both the employee and employer share of the cost of coverage, plus up to a 2% administrative fee (or up to 150% of the cost during a disability extension).

Cost of COBRA

You pay up to 102% of the total cost of coverage. If you qualify for a disability extension, your cost may be up to 150% for the additional 11 months.

Qualifying Events:

For employees:

- Your employment ends for any reason other than gross misconduct; or
- Your hours are reduced so you no longer meet eligibility.

For spouses:

- The covered employee dies;
- The covered employee's hours are reduced;
- The covered employee's employment ends (for reasons other than gross misconduct);
- The covered employee becomes entitled to Medicare (Part A, Part B, or both); or
- You divorce or become legally separated from the covered employee.

For dependent children:

- The covered employee dies;
- The covered employee's hours are reduced;
- The covered employee's employment ends (for reasons other than gross misconduct);
- The covered employee becomes entitled to Medicare;
- The parents divorce or become legally separated; or
- The child loses dependent eligibility under the Plan.

Q2. Can I elect continuation for my Domestic Partner?

Unlike a spouse, a covered Domestic Partner of an employee does not have an independent statutory right to elect COBRA coverage. However, once a plan extends coverage to Domestic Partners or their children, certain COBRA rights and obligations may arise. For example, if an employee and covered Domestic Partner lose coverage due to the employee's termination of employment or reduction of hours, the employee may elect to continue the coverage in place prior to the qualifying event, which included coverage for the Domestic Partner. On the other hand, the death of the employee would not trigger any COBRA continuation coverage rights for a Domestic Partner, and no COBRA rights would be available upon the termination of a domestic partnership. Contact the person or department listed on Page i of this SPD for additional information on the Plan's extension of certain COBRA coverage rights to Domestic Partners.

Q3. When is COBRA continuation coverage available?

COBRA is available only after the Plan Administrator is notified that a qualifying event has occurred. The Employer must notify the Plan Administrator if the qualifying event is the end of employment, reduction of hours, death of the employee, or the employee's Medicare entitlement.

Participant Notice:

For divorce/legal separation or a dependent child's loss of eligibility, you must notify the Plan Administrator. **Your notice deadline: You must notify the Plan Administrator within 60 days of the latest of**:

- the date of the qualifying event,
- the date coverage would be lost because of the event, or
- the date you were informed of your responsibility and the procedures to give notice.

How to give notice:

- By mail: Your notice must be postmarked no later than the last day of the 60-day period.
- By electronic means (if allowed): Follow the Plan Administrator's reasonable procedures.

Your notice must include:

- Plan name: Mechdyne Corporation Employee Benefits Plan;
- The participant's name and address and the names of all affected qualified beneficiaries;
- The qualifying event and its date; and
- Proof of the event (e.g., divorce decree).

Send your notice to the contact listed on page i of this SPD.

FMLA note: If an employee does not return to work at the end of an FMLA leave, COBRA may be available.

Q4. How is COBRA continuation coverage provided?

Once notified of a qualifying event, the Plan Administrator will send a COBRA Election Notice describing your rights and how to enroll. Each qualified beneficiary has an independent right to elect COBRA. A covered employee may elect for a spouse, and a parent may elect for a child.

Q5. How long does COBRA continuation coverage last?

These are maximum periods. COBRA can end earlier (see Q8).

Employee coverage:

- 18 months after a termination of employment or reduction of hours.
- 29 months if any qualified beneficiary is disabled (as determined by the Social Security Administration) before the 60th day of COBRA and remains disabled during the initial 18 months. The 11 month extension follows the first 18 months.
- Disability notice deadline: You must notify the Plan Administrator of the SSA disability determination within 60 days of the determination and before the 18 month period ends.

Dependent (QB) coverage:

- 36 months if coverage is lost due to loss of dependent status.
- Up to 36 months if the employee became entitled to Medicare less than 18 months before the termination/reduction in hours—measured from the Medicare entitlement date.
- Up to 36 months after a second qualifying event during COBRA (death of employee, divorce/legal separation, Medicare entitlement, loss of dependent status). You must notify the Plan of the second event; the 36 months is measured from the original COBRA start date.

Limited COBRA Coverage Period for Health FSA Benefits

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Plan Year. Health FSA COBRA coverage will only last until the end of the Plan Year during which the qualifying event occurred. The use-it-or-lose rule will continue to apply, so any unused funds (in excess of any carryover amount, if applicable) will be forfeited at the end of the Plan Year (and grace period if applicable) and the Health FSA COBRA coverage will be terminated.

If applicable, any carryover funds remaining in a Health FSA account after the end of the Plan Year in which a qualifying event occurred will continue to be available to reimburse health care expenses until the qualified beneficiary's other COBRA coverage (e.g. medical, dental, vision) ends.

Q6. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

The election period is the time period within which the qualified beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of 1) the date the qualified beneficiary would lose coverage because of the Qualifying Event, or 2) the date notice is provided to the qualified beneficiary of the qualified beneficiary's right to elect COBRA continuation coverage.

Q7. Will a waiver made before the end of the election period end a qualified beneficiary's election rights?

No. If you waive COBRA during the election period, you can revoke that waiver any time before the election period ends and elect COBRA prospectively. Coverage is not retroactive to the loss date unless the Plan permits and you timely pay all amounts due. A waiver or revocation counts on the date you send it to the Plan Administrator (or designee).

Q8. How do I timely pay for my COBRA continuation coverage?

Your first COBRA payment is not due until at least 45 days after you elect COBRA continuation coverage. After the initial payment, all ongoing payments must be made within 30 days of the start of each coverage period. Payment is considered made on the date on which it is postmarked to those providing COBRA continuation coverage.

If you make a timely payment and the payment is less than the amount the Plan requires, the Plan Administrator may consider the amount timely if 1) the amount owed is insignificant, and 2) you pay the amount owed within a reasonable period. A reasonable period is 30 days, and an insignificant amount is considered $50 or 10% of the required amount. Please see the Plan document for additional information.

Q9. When may a qualified beneficiary's COBRA continuation coverage be terminated?

A qualified beneficiary may waive COBRA continuation coverage during the election period. Except for an interruption of coverage in connection with a waiver, a qualified beneficiary's COBRA continuation coverage must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates.

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the qualified beneficiary.
- The date upon which your Employer ceases to provide any health Plan (including a successor Plan) to any employee.
- The date, after the date of the election, that the qualified beneficiary first becomes covered under a health Plan.
- The date, after the date of the election, that the qualified beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- The later of the following two dates if the qualified beneficiary is entitled to a disability extension.
    1. The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.
    2. The earlier of 1) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled, or 2) 29 months after the date of the Qualifying Event.

The Plan can terminate for cause a qualified beneficiary's coverage on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries (for example, for submitting a fraudulent Claim).

If the Plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, and an individual who is not a qualified beneficiary receives coverage under the Plan solely because of the individual's relationship to a qualified beneficiary, the Plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Q10. Are there other coverage options besides COBRA continuation coverage?

Yes. You and your family may have other options that may cost less than COBRA, including:

- Marketplace coverage at www.HealthCare.gov (premium tax credits and cost-sharing reductions may apply);
- Medicare (if eligible);
- Medicaid/CHIP; or
- Another group health plan (e.g., a spouse's plan) through a special enrollment period.

Q11. Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

If you delay Medicare Part A or B because you were still employed, you get an 8-month Medicare special enrollment period that starts the month after the earlier of:

- Your employment ends, or
- Your group health coverage based on current employment ends.

If you choose COBRA instead of Medicare, you may face a Medicare Part B late-enrollment penalty and a coverage gap later. If you enroll in Medicare after electing COBRA, the Plan may terminate COBRA early. If your Medicare was effective on or before your COBRA election date, your COBRA cannot be terminated just because of Medicare entitlement (though COBRA will be secondary to Medicare).

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

Q12. Is COBRA continuation coverage available if a qualified beneficiary has Medicare?

Yes. If you are already entitled to Medicare on or before the date you elect COBRA, you may still elect COBRA. However, if you become entitled to Medicare after electing COBRA, the Plan may terminate COBRA early for the Medicare-entitled individual. When you have both Medicare and COBRA, Medicare generally pays first and COBRA pays second.

Q13. What if I have additional questions?

Contact the Plan Administrator listed on page i of this SPD.

For help with your rights under ERISA, COBRA, the ACA, or other group health plan laws, contact the nearest U.S. Department of Labor EBSA office or visit www.dol.gov/ebsa.

For Marketplace information, visit www.HealthCare.gov.

Q14. How do I protect my COBRA rights?

Keep Your Plan Administrator Informed of Address Changes. To protect your family's rights, you should keep the Plan Administrator informed of any changes in your family members' addresses. You should also keep a copy, for your records, of any notices that you send to the Plan Administrator or its designee.

PRIVACY AND SECURITY RIGHTS

This section provides a summary of the privacy and security requirements that apply to the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and, where applicable on or after February 16, 2026, the federal confidentiality rules for Substance Use Disorder (SUD) records under 42 C.F.R. Part 2. This summary does not replace the Plan's full HIPAA Notice of Privacy Practices (NOPP), which describes in detail how the Plan may use and disclose protected health information (PHI) and your rights with respect to that information. You may obtain the Plan's full HIPAA NOPP from the Privacy Officer upon request.

Uses and Disclosures of Your Information

The Plan Administrator on behalf of the Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan—including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your Claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and Claims management purposes. Note that the Genetic Information Nondiscrimination Act (GINA) prohibits using PHI that is genetic information for underwriting purposes. In addition, the Plan may disclose your PHI to the Plan Administrator so that the Plan Administrator can perform administrative functions on behalf of the Plan, such as facilitating Claims or appeals.

The Plan also may use or disclose your PHI where required or permitted by law. The Plan Administrator on behalf of the Plan is permitted to use or disclose PHI:

- when required by law;
- for public health activities;
- to report Child or domestic abuse;
- for governmental oversight activities;
- pursuant to judicial or administrative proceedings;
- for certain law enforcement purposes;
- for a coroner, medical examiner, or funeral director in order to obtain information about a deceased individual;
- for organ, eye, or tissue donation purposes;
- for certain government-approved research activities;
- to avert a serious threat to an individual's or the public's health or safety;
- for certain government functions, such as related to military service or national security;
- to comply with workers' compensation laws;
- to a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- to notify a family member or other individual involved in the care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

For any other uses and disclosures of your PHI, the Plan will obtain your written authorization. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes. You may revoke this authorization in writing at any time, provided the Plan has not yet acted while relying on your authorization.

Stricter State Privacy Laws – Under the HIPAA privacy and security rules, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

Your Rights With Respect To Your Health Information

You have several rights with respect to your PHI, which are described below. Please contact your Employer's Privacy Officer if you have questions about your rights.

- You have the right to request restrictions on how your PHI may be used or disclosed. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.

- You have the right to receive your PHI confidentially, such as at a location other than your home, if you state in writing that disclosing the information through normal means could endanger you.
- You have the right to inspect and copy your PHI that is maintained by the Plan in a designated record set or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies.
- You have the right to request an amendment to your PHI that the Plan maintains in a designated record set. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.
- You have a right to request an accounting of disclosures that the Plan has made of your PHI during the six years before your request, except for disclosures that you have authorized or for disclosures related to routine treatment, payment, or health care operations of the Plan.
- You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

Substance Use Disorder (SUD) Records — Additional Federal Protections (42 C.F.R. Part 2)

We may maintain certain records related to substance use disorder treatment that are protected by federal law (42 CFR Part 2). Effective February 16, 2026, these records have extra privacy protections:

- We will not use or disclose your SUD information without your written consent, unless permitted by Part 2 (for example, in a medical emergency, certain audits, or as required by a valid court order).
- Your SUD records cannot be used in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent or a court issues a Part-2-compliant order.
- If your SUD information is disclosed to a HIPAA-regulated entity under your written consent for treatment, payment, or health care operations, that entity may redisclose the information only as permitted under the HIPAA Privacy Rule and Part 2. Redisclosure for legal proceedings remains prohibited without proper authorization or court order.
- A single written consent may authorize future uses and disclosures of your SUD records for treatment, payment, and health care operations until you revoke it.
- You may revoke your written consent at any time, except to the extent we have already acted in reliance on it.
- You have the right to request a list of when and to whom your SUD information has been disclosed as required by Part 2.
- You may request restrictions on certain uses or disclosures of your SUD information. We will consider your request and comply where required.
- If your SUD information is breached, the Plan will follow the HIPAA Breach Notification Rule to notify you and any required federal agencies.

Our Duties With Respect To Your Individually Identifiable Health Information

The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice (NOPP) of its legal duties and privacy practices with respect to your PHI.

Questions?

The Privacy Officer is responsible for developing and implementing the Plan's privacy policies and procedures. If you have questions or would like more information about the Plan's privacy policies, you may contact the Privacy Officer or the individual listed below who can relate any issues or questions to the Privacy Officer as applicable:

Mechdyne Corporation
Attn: Human Resources Director
11 East Church Street, 4th Floor
Marshalltown, IA 50158
641-754-4649 or sue.goodman@mechdyne.com

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing such a complaint.

OTHER LEGAL NOTICES

Q1. Do I have any other legal rights and protections under the Plan?

Yes, the Plan is required to comply with other federal regulations, which guarantee certain legal rights and protections, as follows.

Your Rights Under the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA or ACA) provides certain consumer protections, including the elimination of annual and lifetime limits on benefits, the provision of preventive services without cost sharing, the limitation of out-of-pocket annual costs, the coverage of essential health benefits, the elimination of waiting periods of more than 90 days for coverage to begin, the elimination of pre-existing conditions, and the guarantee of issue and renewal of coverage. As applicable, these provisions are contained within the Benefit Document of the Major Medical Option.

Your Rights Under the Americans With Disabilities Act

The Americans with Disabilities Act (ADA) ensures that individuals with disabilities are provided with equal access to health care services and Benefits. You have the right to receive information about your Plan coverage in accessible formats, request reasonable accommodations, and

access the same level of care and services as other Participants. If you believe your rights under the ADA are not being upheld, you have the right to file a complaint and seek resolution.

Your Rights Under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides that Health Care must be maintained during any period of unpaid leave covered by FMLA under the same conditions as if you continued to work. Moreover, FMLA requires that you be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA. If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse your Employer for its share of health care premiums or Contributions paid on your behalf during your FMLA leave.

Your Rights Under the Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) provides that your Employer may not discriminate against you on the basis of genetic information, including eligibility, adjusting premiums and contribution amounts. GINA generally prohibits employers with more than 15 employees from the collection or use of genetic information unless in an aggregate form that does not identify the individual. When GINA applies, genetic information is treated as Protected Health Information ("PHI") under HIPAA.

Your Rights Under the Health Insurance Portability and Accountability Act (Special Enrollment)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain special enrollment rights if you decline coverage in the Major Medical Option for yourself or your Eligible Dependents because of other coverage. If you or your Eligible Dependents lose eligibility for that other coverage or if your Employer stops contributing toward your or your Dependent's other coverage, you may be able to enroll yourself and your Eligible Dependent in the Major Medical Option. Generally, you must request enrollment within 30 days after your or your Eligible Dependent' other coverage ends or after your Employer stops contributing toward the other coverage.

If the other coverage is Medicaid or the Children's Health Insurance Program (CHIP), you must request enrollment within 60 days after you or your Eligible Dependents' Medicaid or CHIP coverage ends. Finally, if you have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Your Rights Under the Health Insurance Portability and Accountability Act (Health Factors)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the Major Medical Option from discriminating against you or your Eligible Dependents based on a health factor. Health factors include your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. Compliance with this provision is not determinative of compliance with any other federal or state laws, including COBRA or ADA.

Your Rights Under the Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provides that if any Major Medical Option under the Plan 1) provides for both medical and surgical benefits and mental health or substance use disorder benefits, and 2) is not subject to increased cost exemption (within the meaning of the MHPAEA), the following conditions apply:

- The Major Medical Option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Major Medical Option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential Participant upon request.
- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant will, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the Participant in accordance with the Claims procedures applicable to the group medical coverage feature.
- The Plan will be operated and constructed in all respects in compliance with the MHPAEA.

"Mental health benefits" and "substance use disorder benefits" are defined in the Major Medical Option applicable to the health insurance option, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.

Your Rights Under Michelle's Law

Michelle's Law provides that a Major Medical Option of the Plan that requires a certification of student status for any period of coverage of an Eligible Dependent will comply with Public Law No. 110-381 (2008), as amended from time to time. Eligibility for such coverage for an Eligible Dependent who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the Eligible Dependent to lose eligibility for coverage under any Major Medical Option's coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the medically necessary leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier.

Your Rights Under Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (NMHPA) provides that the Major Medical Option of the Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as

applicable). In any case, the Major Medical Option may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, in order to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to provide the Plan with advance notice of services or providers related to the hospital stay. For information on precertification, contact your Plan Administrator.

Your Maternity Hospital Stay Rights under Iowa State Law

Group insurance contracts issued in the State of Iowa that provide maternity benefits must not terminate inpatient benefits or require discharge of a mother or the newborn from a hospital following delivery earlier than determined to be medically appropriate by the attending physician after consultation with the mother and in accordance with guidelines adopted by rule by the state insurance commissioner. The guidelines adopted by rule must be consistent with or may adopt by reference the guidelines for perinatal care established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that provide that when complications are not present, the postpartum hospital stay ranges from a minimum of 48 hours for a vaginal delivery to a minimum of 96 hours for a cesarean birth, excluding the day of delivery. The guidelines adopted by rule by the commissioner also must provide that in the event of a discharge from the hospital prior to the minimum stay established in the guidelines, a postdischarge follow-up visit will be provided to the mother and newborn by providers competent in postpartum care and newborn assessment if determined medically appropriate, as directed by the attending physician, in accordance with the guidelines.

Your Rights Under Title VII of the Civil Rights Act of 1964

Generally, benefits provided under a group health plan must be provided without regard to the race, color, sex (including pregnancy), national origin, or religion of the eligible employee and his or her eligible dependents. A group health plan cannot discriminate on the basis of: eligibility to receive coverage under the Plan; the terms and conditions on which coverage is provided; or, what an employee is charged for coverage.

In addition, under the Pregnancy Discrimination Act of 1978, group health plans must provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as coverage for nonpregnancy-related conditions.

Your Rights Under USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of Health Care Plan coverage if you are called for active-duty military service. The maximum length of extended coverage under USERRA is the lesser of

- 24 months beginning on the date that the military leave begins, or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional two-percent administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the U.S. Department of Veterans Affairs) incurred as a result of the military service.

Your Rights Under Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires that a Major Medical Option that provides medical and surgical benefits with respect to a mastectomy provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, copays, and coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable medical option. Please refer to the Major Medical Option's summary of benefits coverage for additional information. If you have other questions, please contact the Plan Administrator.

Your Rights Under Consolidated Appropriations Act 2021

The Consolidated Appropriations Act, 2021 (CAA 2021) includes several provisions that affect participants in group health plans. Here is a brief list of some key impacts:

- Surprise Billing Protections: The CAA 2021 includes the No Surprises Act, which protects participants from surprise medical bills for emergency services, non-emergency services provided by out-of-network providers at in-network facilities, and air ambulance services.
- Transparency Requirements: Group health plans must provide participants with clear and accurate information about their coverage, including cost-sharing information, provider network status, and any changes to the plan.
- Mental Health Parity: The act strengthens mental health parity requirements, ensuring that mental health and substance use disorder benefits are comparable to medical and surgical benefits.
- Prescription Drug Reporting: Plans are required to report detailed information about prescription drug costs and spending, which aims to increase transparency and help control costs.
- Continuity of Care: If a provider or facility leaves the plan's network, participants undergoing treatment for certain conditions can continue to receive care at in-network rates for a limited period.
- Direct Primary Care and Health Care Sharing Ministries: The act allows for the inclusion of direct primary care arrangements and health care sharing ministries as part of the definition of "qualified medical expenses."

These provisions aim to enhance protections, improve transparency, and ensure better access to care for participants in group health plans. Contact your Plan Administrator for this information as it pertains to a particular Benefit.

Q2. Is there anything else I should know if I want to enroll my Domestic Partner?

Yes. Unless otherwise provided by the Plan Documents, you must be aware of the following:

- Under current federal income tax laws, the value of providing benefits to a Domestic Partner and the partner's Eligible Dependent Children may be considered taxable to you—unless they are considered your Dependents for purposes of federal income taxes. This means you will pay federal, state, and local income taxes, as well as employment taxes, on the full value of the coverage provided to your Domestic Partner and the partner's Dependents. This type of taxable income is known as imputed income, and your Employer will report it on your Form W-2 at the end of each year. It is important for you to understand the tax implications of covering a Domestic Partner and the partner's Eligible Dependent Children. Please consult a tax advisor to determine the full tax and financial effect of electing this coverage.
- While Domestic Partners are not considered qualified beneficiaries under COBRA, they may be eligible for COBRA coverage if the Employee elects to continue their coverage through COBRA continuation benefits.

Appendix A
Mechdyne Corporation Employee Benefits Plan

Plan Components and Claims Administrators

Benefit Documents are part of this SPD. Any update to the Benefit Document will replace any earlier versions for the period defined in the updated Benefit Document.

Fully-Insured Benefits	Policy/Group No.	Type of Benefit	Claims Administrator *(Use the address & phone number on your ID Card if different)*	
Bree Health Bristol Place 4819 Emperor Boulevard Raleigh, NC 27703	ENIEAP	Employee Assistance Program (EAP)	Bree Health Bristol Place 4819 Emperor Boulevard Raleigh, NC 27703	888-868-9790 https://breehealth.com
Delta Dental of Iowa 9000 Northpark Drive Johnston, IA 50131	34970	Vision	First American Administrators PO Box 8504 Mason, OH 45040-7111	800-544-0718 claims@deltadentalia.com www.deltadentalia.com
Reliance Standard Life Insurance Company 2001 Market Street, Suite 1500 Philadelphia, PA 19103	GL154772	Basic Life/AD&D Voluntary Life/AD&D	Reliance Standard PO Box 7307 Philadelphia, PA 19101	800-351-7500 ClaimsIntake@rsli.com www.reliancematrix.com
	LTD126842	Long-Term Disability	Reliance Standard PO Box 7749 Philadelphia, PA 19101-7749	800-351-7500 claimsintake@rsli.com www.reliancematrix.com
Trustmark Insurance 400 North Field Drive Lake Forest, IL 60045	410600000	Voluntary Accident Voluntary Critical Illness Voluntary Whole Life	Trustmark PO Box 2906 Clinton, IA 52733-2906	877-201-9373 Whole Life: lifeclaimsvb@trustmarkbenefits.com Accident: AccidentClaimsVB@trustmarkbenefits.com Critical Illness: DICIClaimsVB@trustmarkbenefits.com www.trustmarkbenefits.com/claims

Self-Insured Benefits	Contract No.	Type of Benefit	Claims Administrator *(Use the address & phone number on your ID Card if different)*	
Delta Dental of Iowa 9000 Northpark Drive Johnston, IA 50131	34970000002	Dental – PPO	Delta Dental of IA PO Box 9000 Johnston, IA 50131-9000 Appeals: Delta Dental of IA PO Box 9010 Johnston, IA 50131-9010	800-544-0718 claims@deltadentalia.com www.deltadentalia.com
Wellmark Blue Cross Blue Shield of Iowa 1331 Grand Avenue Des Moines, IA 50309	58237	Medical – HDHP Medical – PPO Prescription Drugs	Wellmark BCBS Mail Station 1E238 PO Box 9291 Des Moines, IA 50306-9291 *Appeals:* Wellmark BCBS Station 5W189 PO Box 9232 Des Moines, IA 50306-9232	800-524-9242 www.wellmark.com

Self-Insured Benefits	Contract No.	Type of Benefit	Claims Administrator *(Use the address & phone number on your ID Card if different)*	
iSolved Benefit Services 15 East Washington Street Coldwater, MI 49036	124195	General-Purpose Health FSA Limited-Purpose Health FSA	iSolved PO Box 448 Coldwater, MI 49036	866-370-3040 FSA@isolvedhcm.com www.isolvedhcm.com/login/benefits

Appendix B
Mechdyne Corporation Employee Benefits Plan

Eligibility and Participation Requirements

An employee who is determined to be benefit-eligible as of their start date shall be able to participate in the Plan as of the Coverage Date specified below.

Employee Class	Working Hours Minimum	Benefits Offered	Date Coverage Begins
Full-Time Employees	30 hours per week	All Benefits Included in Appendix A	First day of the month coinciding with or following 30 days of employment

Dependent Eligibility

Unless specified otherwise under the applicable Plan Component's benefit documents, coverage for dependents, if elected, begins on the date the Employee's coverage begins (provided the Employee timely enrolls them in coverage). Mid-Plan Year elections for newly acquired Dependents may also be permitted under certain circumstances.

Dependent Definitions. For purposes of eligibility and participation in this Plan, Dependent definitions shall have the same meaning set forth in each applicable Plan Component's benefit documents, or if not defined in the applicable Plan Component documents, in accordance with the policies adopted by the Employer.

Proof of Dependent Status. Your Employer reserves the right to verify a Dependent is eligible or continues to be eligible for coverage under the Plan. Documents requested may include (but are not limited to) copies of birth certificates, court orders, divorce decrees or marriage certificates as needed to establish dependent status. Dependent eligibility determinations made by your Employer shall be final, binding and conclusive on all parties claiming an interest in the Plan.

Dual Coverage Prohibited. Except as specifically provided otherwise in an applicable Plan Component's Benefit Documents, in no event will an employee be covered under a Plan Component as both a participant and a dependent, or a dependent be covered under a Plan Component as a dependent of more than one participant.

Rehire Rule

Unless otherwise specified to the contrary in the Benefit Documents for a Component Plan, an employee who is rehired prior to the end of a 13-consecutive week period of time after date of termination will be credited with hours of service met towards the eligibility waiting period during his or her preceding period of employment. Otherwise, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and participation requirements for his or her employment class.

Special Eligibility Rules for Variable Hour, Part-Time, and Seasonal Employees

If, based on the facts and circumstances on the start date of a new employee, your Employer determines that such employee is not reasonably expected to be employed an average of at least 30 hours of service per week (or 130 hours of service per month) or is a seasonal employee, then your Employer will determine the Employee's eligibility or ineligibility for certain Plans Components (e.g. major medical benefits) based on separate rules described in Appendix C to this SPD.

Cessation of Participation

Unless otherwise stated in the applicable Benefit Documents, your coverage will cease upon the earliest of the following:

- The date or end of the month (as applicable under each Plan Component) in which you cease to satisfy the eligibility requirements for a particular Plan Benefit. This may result from your death, reduction in hours, or termination of active employment, or if your hours of service are tracked under the ACA Look-Back Measurement Method, it may result because you lose ACA full-time status during a subsequent Standard Stability Period;
- The end of the period for which you paid your required Contribution if the Contribution for the next period is not paid when due;
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") as described in the "Your Rights Under USERRA" section; or,
- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the contract or agreement, or by discontinuance of Contributions for your Employer.

Coverage for your spouse and other Dependents (including your Domestic Partner) terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Documents for the Plan Components. In addition, their coverage will terminate:

- The date or end of the month on which your covered spouse, Domestic Partner or Child is no longer considered an eligible Dependent;
- The date, end of the month, or end of the Plan Year in which your Dependent Child attains a Plan Component's limiting age (unless the Plan Component allows for the continuation of coverage for a mentally or physically disabled Child who is primarily dependent on you for support);
- The end of the pay period in which you stop making Contributions required for Dependent coverage; or,
- The date that a Child is no longer covered under QMCSO, if the Child is not otherwise eligible to participate in the Plan.

Depending on the reason for termination of coverage, you and your covered Dependents may have the right to continue health coverage temporarily under COBRA. See the "COBRA" section of this SPD for details.

APPENDIX C
Mechdyne Corporation Employee Benefits Plan

ACA Special Eligibility Rules for Variable Hour, Part-Time, and Seasonal Employees

If, based on the facts and circumstances on your start date, the Employer determines that you not reasonably expected to be employed an average of at least 30 hours of service per week (or 130 hours of service per month, or are seasonal, then the Employer will determine your eligibility or ineligibility for the Plan Component(s) listed below by using the following Measurement Method. Your Employer intends to administer these provisions in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

Look-Back Measurement Method: For purposes of the Look-Back Measurement Method, an Employee will achieve "ACA-FT" status during a period of time spanning a specific number of consecutive months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the "Stability Period." The "initial" periods apply if you were recently hired. The "standard" periods apply if you are a continuing Employee. The administrative period is the period used by the Employer to determine your ACA-FT status, provide information or enrollment materials, and perform other administrative functions.

Your Employer has selected the following measurement periods:

Newly hired employees who are not initially eligible for benefits.		
Measurement Period *(for tracking hours of service)*	**Administrative Period** *(for determining ACA-FT Status/offering Benefits)*	**Stability Period** *(for locking in eligibility or ineligibility)*
12 Months following date of hire	1 Month	12 Months

Ongoing employees who have completed their Initial Measurement Period noted above:		
Measurement Period *(for tracking hours of service)*	**Administrative Period** *(for determining ACA-FT Status/offering Benefits)*	**Stability Period** *(for locking in eligibility or ineligibility)*
December 1 to November 30 of the following calendar year	December 1 to December 31 of the same calendar year	January 1 to December 31 of the same calendar year
Standard Measurement Periods Example: A Standard Measurement Period from 12/1/25 to 11/30/26 will be followed by a Standard Administrative Period from 12/1/26 to 12/31/26. An ACA-FT employee will have their eligibility or ineligibility locked in during a Standard Stability Period from 1/1/27 to 12/31/27.		

Employee Classes. The following employee classes will be placed on the Look-Back Measurement Method to determine their eligibility:

- Part-Time Employee. An employee who, based on the facts and circumstances at the employee's start date, is reasonably expected to work fewer than 30 hours of service per week;
- Seasonal Employee. An employee who is hired into a position for which the customary annual employment is six months or less, occurring at approximately the same time each year; and,
- Variable Hour Employee. An employee who, based on the facts and circumstances at the employee's start date, cannot reasonably be expected to work at least 130 hours of service per month (or 30 hours of service per week) during the Initial Measurement Period because his or her hours of service are variable or otherwise uncertain.

Benefits Offered: Employees who achieve ACA-FT status will be offered the following benefits under the Plan:

- Group Medical Benefits only

Changes in Employment Status. If you are treated as an ACA-FT employee based on a prior measurement period, you will remain eligible for coverage for the entire stability period, even if your scheduled hours are reduced, as long as you continue to be employed. If you were initially hired into a variable-hour position but later move into a position in which you are reasonably expected to work full-time, the Plan will offer coverage following the ACA's required timelines. This generally means coverage will begin no later than the first day of the fourth full month after the change in status, or earlier if required under the ACA.

Breaks in Service Rule. If you are a Variable Hour, Part-Time or Seasonal Employee, as defined above, and you stop working for 13 or more consecutive weeks, the ACA requires the Employer to treat this as a Break in Service. In this situation the Plan Administrator will treat you as a new employee, and you will begin a new Initial Measurement Period to determine if you qualify for benefits.

However, if you return to work before 13 full weeks have passed, the ACA requires the Employer to treat you as a continuing employee, not a new hire. This means you keep the measurement period you were previously in, and any time you already worked toward your Look-Back Measurement Period continues to count.

For additional information regarding your full-time Employee status, please contact your Human Resources representative.

Permissible Election Changes

You generally cannot change your pre-tax benefit elections under the Plan or vary the salary reduction amounts that you have selected during the Plan Year. However, you may revoke a Benefit election (including, but not limited to, an election not to receive Benefits under the Plan) after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year if both the revocation and new election are on account of and consistent with a qualifying life event (as described below).

Election and salary reduction changes shall be effective on a prospective basis only (i.e., election changes will generally become effective no earlier than the first day of the next calendar month following the date that the election change request was filed), except that an election change on account of a HIPAA Special Enrollment Right, attributable to the birth, adoption, or placement for adoption of a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively back to the date of the qualifying event.

If you undergo a qualifying life event, you must inform the Plan Administrator and complete the required change-in-coverage enrollment materials within 30 days after the occurrence of the qualifying life event (or within 60 days in the case of a Special Enrollment Right due to loss of eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage).

In the event of a conflict between the following provisions and the Internal Revenue Code ("IRC") Section 125 plan adopted by Mechdyne, the IRC Section 125 plan shall control. The Plan Administrator reserves the right to determine whether an Employee has experienced a qualifying life event and whether the Employee's requested election is consistent with such event.

Change of Status

Qualifying life events include a change of status due to one of the following events permitted under the rules and regulations adopted by the Department of the Treasury, but only if the qualifying life event changes the individual's eligibility for the applicable Benefit. These changes in status rules apply to elections for all qualified Benefits (e.g., accident or health coverage, group term life, Health FSA), except that election changes are generally not permitted for Health FSA Benefits if the qualifying life event is a change in residence:

- **Legal Marital Status**. Events that change an employee's legal marital status, including marriage, death of employee's spouse, divorce, legal separation, and annulment.
- **Number of Dependents**. Events that change the number of employee's dependents, including following birth, death, adoption, placement for adoption.
- **Employment status**. Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; or a change in worksite. In addition, if the eligibility conditions of this Plan or other employer-sponsored plan of the employee, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection.
- **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements**. Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, change in student status, or any similar circumstance.
- **Residency Change**. A change in the place of residence of the employee, spouse, or dependent that results in a loss of eligibility for coverage (e.g. relocates outside the current plan's service area).

HIPAA Special Enrollment Rights

An employee may change an election for group health coverage during a Plan Year and make a new election that corresponds with HIPAA Special Enrollment Rights, including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), as long as the employee meets the notice requirements. Special Enrollment Rights can occur when:

- You lose eligibility for coverage under a group health plan or other health insurance coverage (such as if you and your dependents lose coverage under your spouse's plan) or if your employer terminates contributions toward health coverage.
- You gain a new dependent through marriage, birth, adoption, or being placed for adoption.
- You or your dependents lose coverage under a CHIP or Medicaid or become eligible to receive premium assistance under those programs for group health plan coverage.

ACA Marketplace/Exchange Enrollment

Qualifying life events include the opportunity to enroll in the ACA Marketplace/Exchange or other plans that offer minimum essential coverage under the ACA. These qualifying life events apply to elections for group health plan coverage that is not Health FSA benefit coverage and that provides minimum essential coverage under the ACA:

- **ACA Marketplace/Exchange Election**. You may elect to cancel contributions for and payment of your portion of the group health plan premiums if (1) you are eligible for a special enrollment period to enroll in a "qualified health plan" through an ACA Marketplace or (2) you are seeking to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.

  In addition, you may prospectively drop some or all covered family members from the group health plan consistent with their enrollment or intended enrollment in an ACA Marketplace/Exchange.
- **ACA Reduction in Hours**. You may elect to cancel contribution for and payment of the employee-paid portion of group health plan premiums if (1) you had been reasonably expected to average at least 30 hours of service per week and subsequently move to a position in which you are reasonably expected to average less than 30 hours of service per week, even if you continue to be eligible under your employer-sponsored group health plan; and (2) your revocation of the election of coverage under the group health plan corresponds to your (and any dependents') intended

enrollment in another plan that provides ACA minimum essential coverage with the new coverage effective no later than the first day of the second month following the month in which the original coverage is revoked.

Change in Cost or Coverage

A change in cost or coverage, as follows, may allow an election change. The following qualifying life events do not apply to the election of Health FSA benefits:

- **Change in Coverage under Another Employer's Plan**. You may make a new election if there is a change in coverage (for you, your spouse or your dependent) under a plan provided by another employer. Your new election must be on account of the change in the other employer's plan and correspond with that change. Among other things, this rule permits you to make election changes during another plan's open enrollment period.
- **Significant Coverage Decrease with or without Loss of Coverage**. If your coverage under a benefit is significantly curtailed or ceases during a Plan Year, you may revoke your election of such benefit and, in its place, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- **Significant Improvement or Addition of a New Benefit**. If, during the period of your coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then you may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, if you are not participating in the Plan when these options are added or changed, you may opt to become a participant and elect the new or newly improved benefit package option.
- **Significant Cost Increase**. If the cost of one of your benefit options increases significantly, you may either make corresponding changes in your payments or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.
- **Significant Cost Decrease**. If the cost of your benefit option decreases significantly, you may make corresponding changes in your payments. In addition, if you are not enrolled in the Plan and the cost of an option decreases significantly, you may elect coverage under the corresponding benefit package.

  In addition, if the expenses for a Component Plan increase or decrease during a Plan Year, the Plan may automatically increase or decrease accordingly your required periodic contribution for such health insurance benefits.

Other Situations

Other situations that may permit an election change:

- **Court Order**. A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) that requires accident or health coverage for an employee's child or for a foster child who is a dependent of the employee. The employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.
- **Entitlement to Medicare or Medicaid**. If an employee or an employee's spouse or dependent who is enrolled in an employer-sponsored accident or health plan becomes enrolled under Part A or Part B of Medicare or under Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), the employee may make an election change to cancel or reduce coverage of that employee, spouse, or dependent under the accident or health Component Plan. In addition, if an employee or an employee's spouse or dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the employee may make an election to commence or increase his or her coverage or the coverage of his or her spouse or dependent, as applicable, under Mechdyne's accident or health plan.
- **Loss of Coverage under Health Plan of a Governmental or Educational Institution**. If an employee or an employee's spouse or dependent is enrolled in a group health coverage sponsored by a governmental or educational institution and loses such coverage, the employee may make an election change to add coverage under a corresponding Mechdyne plan. Group health coverage sponsored by a governmental or educational institution includes (but is not limited to) coverage under: a state children's health insurance program (SCHIP); a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; and a foreign government group health plan.
- **FMLA Leaves of Absence**. Mechdyne will (a) allow an employee going on FMLA leave to either revoke or continue group health coverage; or (b) require that group health coverage continue but allow the employee to delay paying his or her share of the premiums until the employee returns to active work.
- **COBRA Premiums**. If the employee or the employee's spouse or dependent becomes eligible for continuation coverage under an employer's group health plan as provided in Code section 4980B or any similar state law, the employee may elect to increase contributions under the Plan in order to pay for the continuation coverage.
- **Correcting Discrimination Issues under the Code.** If Mechdyne determines before or during a Plan Year that the Plan or one of its Plan Components will fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated or key employees, Mechdyne may decrease or revoke the elections of affected highly compensated or key employees to ensure compliance with such nondiscrimination requirements or benefit limitation.

APPENDIX E
Mechdyne Corporation Employee Benefits Plan

Premium Assistance under Medicaid and CHIP

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP+	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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