2027

Employee Benefits





Mechdyne





Welcome to Your Benefits!





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

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

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Welcome!

We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs. Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best. This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

Qualifying Life Events

Your benefit elections made during Open Enrollment will be effective January 1, 2027. You may not make changes to your elections unless you experience a qualifying life event, including change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or if you gain/lose coverage elsewhere.



TAKE ACTION!

OPEN ENROLLMENT

November 18 – December 4

This Open Enrollment is a passive enrollment meaning if you do not want to make any changes you do not need to do anything and your benefits from 2026 will rollover beginning **January 1, 2027.** The only exception to this is your FSA elections. **You must make an election to participate in FSA's for 2027.** You will not be able to make changes until the next Open Enrollment unless you experience a Qualifying Life Event (QLE) .

IMPORTANT

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation WITHIN 30 DAYS of the qualifying life change event.

Contact HR or login to Trustmark to process a Qualifying Life Event.

Contacts

Coverage	Contact	Phone	Website
Medical	Wellmark	(800) 524-9242	www.wellmark.com
Health Savings Account	HSA Bank	(800) 357-6246	www.hsabank.com
Flexible Spending Accounts	Surency	(888) 818-8805	www.surency.com
Dental	Delta Dental	(877) 423-3582	www.deltadentalia.com
Vision	Avesis	(800) 522-0258	www.avesis.com
Life and AD&D	Reliance Standard	(800) 351-7500	www.reliancestandard.com
Employee Assistance Program	Bree Health	(800) 327-2255	www.login.breehealth.com
Voluntary Products **Accident, Critical Illness, Universal Life**	**Trustmark**	Billing Questions: (800) 514-3446 Policy Questions: (800) 918-8877 Claims Questions: (877) 201-9373	www.trustmarksolutions.com

Helpful resources regarding Mechdyne Corporation's benefits:

- Mechdyne Corporation - Benefit Overview Site
- Benefit Enrollment Site



How Do I Enroll?

1 Log In

Log into the Avant/Trustmark website at https://trustmark.benselect.com

2 Choose Your Plan

Utilize the benefit guide to help choose the lowest-cost, best-value health plan based on your medical needs.

3 Enroll By Date

If you don't take action, most of your current benefit elections will roll over to next year with the exception of the FSA. If you would like to participate in the FSA for 2027 you must make an active election.

All employees will need to log into the Avant/Trustmark website to make benefit elections or changes for the 2027 plan year. Be sure to review your current benefit elections, verify your personal information and make changes if necessary.

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

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

The benefits you elect during open enrollment will be effective from January 1, 2027, through December 31, 2027.

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

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

Benefits Eligibility

You and your eligible family members may participate in the 2027 employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week.

New-Hire Eligibility

New hires can join the plan the first of the month following date of hire. Spouses and dependent children of the employee are also eligible to participate in our benefit plans.

Dependent Eligibility

You can enroll the following dependents in our group benefit plans:



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

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

Employee Contributions

Rates will be paid on a monthly basis

Basic Coverages	Monthly Premium	Employee Pays	Employer Pays
Medical			
Traditional Plan			
Single:	$740.24	$293.88	$446.36
Employee/Spouse:	$1,484.36	$881.39	$602.97
Employee/Children:	$1,374.29	$747.61	$626.68
Family:	$2,209.30	$1,353.88	$855.42
High Deductible Health Plan			
Single:	$644.87	$36.11	$608.76
Employee/Spouse:	$1,289.03	$518.70	$770.33
Employee/Children:	$1,193.76	$356.93	$836.83
Family:	$1,916.60	$792.52	$1,124.08
Dental			
Single:	N/A	$2.94	Actual Claims
Employee/Spouse:	N/A	$17.26	Actual Claims
Employee/Child(ren):	N/A	$19.92	Actual Claims
Family:	N/A	$42.35	Actual Claims
Life and AD&D *(Employee only)*	N/A	$0	100%
Long-Term Disability	N/A	$0	100%
Flexible Spending Accounts *(Admin Fees)*	N/A	$0	100%
Health Savings Account *(Admin Fees)*	N/A	$0	100%
Voluntary Products	**Monthly Premium**	**Employee Pays**	**Employer Pays**
Vision:			
Single:	$8.67	100%	0%
Employee/Spouse:	$16.49	100%	0%
Employee/Child(ren):	$18.61	100%	0%
Family:	$24.59	100%	0%
Voluntary Life:	Varies (see below)	100%	0%
Accident Insurance:	Varies	100%	0%
Critical Illness Insurance:	Varies	100%	0%
Universal Life Insurance:	Varies	100%	0%

Voluntary Life/AD&D

Monthly Cost for Each $10,000 of Employee Life Insurance Coverage											
Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.80	$1.00	$1.10	$1.60	$2.50	$4.10	$6.50	$8.70	$13.50	$23.30	$40.20
Monthly Cost for Each $5,000 of Spouse Life Insurance Coverage											
Rate	$0.30	$0.40	$0.45	$0.70	$1.15	$1.95	$3.15	$4.25	$6.65	$11.55	$20.00
Monthly Cost for Each $10,000 of Children Life Insurance Coverage											
Child(ren)	$0.60										

MEDICAL PLAN

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

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

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

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

Preferred Provider Organization (PPO)

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

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

Qualified High Deductible Health Plan (QHDHP)

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

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

REGISTER ONLINE

Your connection to great healthcare is only a click away. Register for an online account at Wellmark.com so you can access time- saving tools, tips for healthy living, view lab results, choose a doctor, manage your EOBs, and more!

DOWNLOAD THE MOBILE APP

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

Wellmark

Medical Plan Comparison

Wellmark Blue Cross & Blue Sheild

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

	$2,500 PPO		$4,000 HDHP (Embedded)	
Calendar Year Deductible	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Individual	$2,500	$5,000	$4,000	$8,000
Family	$5,000	$10,000	$8,000	$16,000
Calendar Year Out-of-Pocket Maximum *(Includes Deductible)*				
Individual	$5,000	$10,000	$4,000	$10,000
Family	$10,000	$20,000	$8,000	$20,000
Coinsurance / Copays				
Preventive Care	Covered at 100%	Deductible, 40% Coinsurance	Covered at 100%	Deductible, 40% Coinsurance
Primary Care Physician	$25 Copayment	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance
Specialist	$50 Copayment	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance
Eye Exam *(Adult and Child)*	Covered at 100%	Deductible, 40% Coinsurance	Covered at 100%	Deductible, 40% Coinsurance
Doctor On Demand	Covered at 100%	Not Covered	Covered at 100%	Not covered
Urgent Care	$25 Copayment	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance
Emergency Room	$250 Copayment	$250 Copayment	Deductible	Deductible
Inpatient Facility Services	Deductible, 30% Coinsurance	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance
Outpatient Facility Services	Deductible, 30% Coinsurance	Deductible, 40% Coinsurance	Deductible	Deductible, 40% Coinsurance

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





Pharmacy

Wellmark- BlueRx Value Plus

	$2,500 PPO	$4,000 HDHP
Retail (30-day Supply)	Tier 1: $8 Tier 2: $40 Tier 3: $60	Deductible
Specialty	PrudentRx Eligible: $0 All Other Specialty: $100	Deductible
Mail Order (90-day Supply)	3 Copays	Deductible

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

Prudent Rx

PrudentRx* offers a third-party (manufacturer) copay assistance program that may help save you money on your specialty medications. If you have a chronic condition and take specialty medications on the PrudentRx Drug List you could pay nothing out of pocket!

Enrollment in the program will be started automatically, but you must speak with a PrudentRx advocate to finalize enrollment. If you are currently taking a specialty medication, you will receive a letter in the mail; shortly after, PrudentRx will begin their telephonic outreach.

Send Medications Right to Your Home

Home delivery is a convenient, cost-effective and safe option for medications you take regularly. There are four ways to place a new home delivery order:

ePrescribe
Your doctor can send an electronic prescription

Call the toll-free number on your ID card

Visit the website on your ID card

For any questions about BlueRX Value Plus, or your prescription drugs, call 800-524-9242

MEMBER SERVICES: WELLMARK

myWellmark



Get the most from your health insurance benefits.

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

Doctor On Demand



Visit a doctor on your smartphone, tablet or computer from virtually anywhere at no cost!

- Download the Doctor on Demand app or visit **Wellmark - Doctor on Demand**
- Have your Wellmark member ID card ready
- Create an account or sign in

Wellmark Mobile App



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

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

Blue365



Exclusive discounts on wellness products and services.

- Go to **Wellmark.com/Blue365**
- Have your email address and the first three characters of your Wellmark ID number ready

IDX Identity



Free access to identity protection services.

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

To access member services please visit Wellmark.com.

Wellmark®



Health insurance **made easy**

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

Get more from your health plan by registering at myWellmark.com.

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

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

With myWellmark, you can:

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

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

Get the information you need

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

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

Keep tabs on claims and spending

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

Know your benefits inside and out

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

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



For illustrative purposes only

Your health care — at your fingertips.

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

With the mobile app, you can:

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

*If supported by your mobile device.

Wellmark

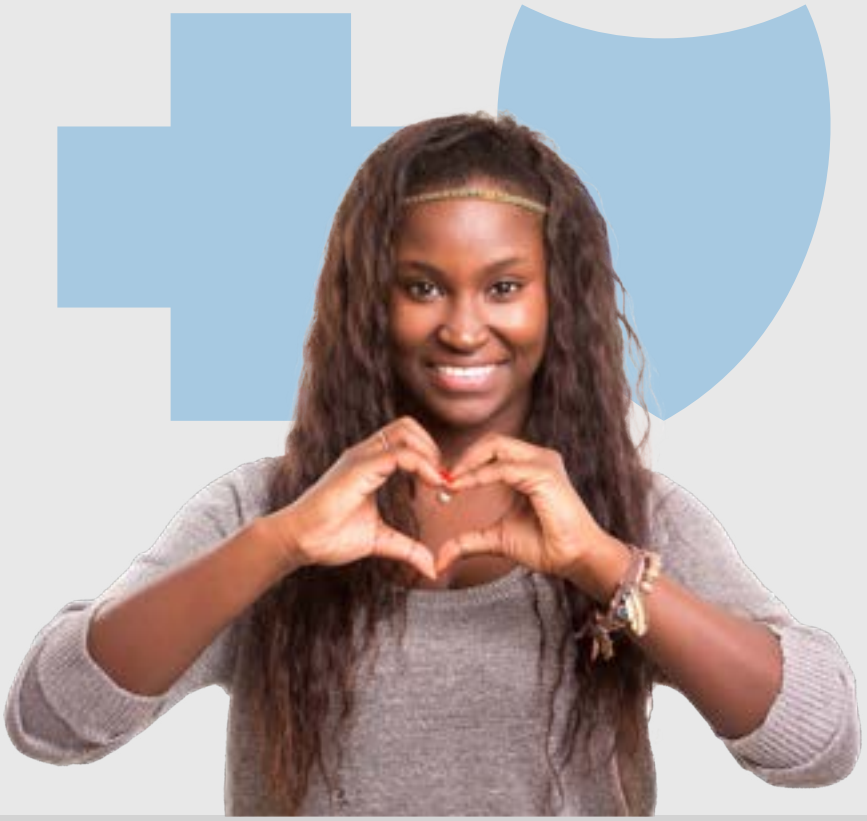
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Wellmark

Feeling better **should be easy**



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

Connect in minutes

Same day mental health appointments are available. You can also choose your provider and see a therapist or psychiatrist within days rather than months. Plus, get treatment for 90 percent of all common ER complaints, from common colds to uncommon rashes, whenever and wherever you're comfortable.

Get treatment for:

- **Mental health**[1]
- **Cold and flu**
- **Bronchitis and sinus infections**
- **Urinary tract infections**
- **Sore throats**
- **Allergies**
- **Fever**
- **Headache**
- **Pink eye**
- **Skin conditions**

[1] Mental health coverage includes psychiatry services and medication management along with treatment for psychological conditions, emotional issues and chemical dependency. For more information, call Wellmark with the number on the back of your ID card.



Getting started is easy.

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

24/7 QUESTIONS: Call 800-997-6196

Callers could experience longer wait times between 10 p.m. and 6 a.m. CST or may be directed to schedule an appointment in some instances.

Health Savings Account (HSA)

HSABank

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

How a HSA Works



HSA Eligibility

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

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

Eligible Expenses

You choose what to do with the money in your HSA

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

Tax Advantages

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

Medicare and HDHP/Health Savings Accounts

Turning age 65 soon and on a HDHP with HSA? We have some important reminders/things to consider!

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

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



Invest your HSA today to benefit tomorrow

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

Investing your HSA: A healthy boost for your future

1. **The only way to get three tax perks:** You don't pay federal taxes on contributions, distributions for qualified healthcare expenses, or investment earnings.
2. **Build long-term retirement savings:** Investments cover future healthcare costs and build your retirement savings.
3. **The money is yours — for life:** HSA funds carry over every year, even if you change jobs or retire.
4. **Access funds as needed:** You can liquidate investment funds at any time to pay for IRS-qualified healthcare expenses from your HSA cash balance.

The HSA Invest program

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

Your investment options

Choice

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

Select

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

Managed

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

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

Simplified and efficient investment management

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

Fees

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

SECURITIES AND INVESTMENTS

Not Insured by FDIC or Any Other Government Agency	Not Bank Guaranteed	Not Bank Deposits or Obligations	May Lose Value

You may be required to keep a minimum in your HSA cash balance to invest funds in the HSA Invest program.

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

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

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

hsabank™

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Plan Administrative Services and Benefit Services are administered by Webster Servicing LLC.
HSA_Invest_021425

Flexible Spending Account (FSA)

Surency

Mechdyne Corporation offers Flexible Spending Accounts (FSAs), which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. Effective 1/1/2027, the FSAs will be administered by Surency. Mechdyne's plan has a 90-day run out period at the end of the 12-month flex plan year (December 31, 2026) in which you may continue to submit claims for 2026 expenses. Participants are allowed to roll over up to $700 of unused FSA dollars into the 2026 plan year. These funds will roll over into the new plan year once the current plan year's 90-day runout period has ended.

How FSAs Work

Three Types of FSAs are available to you:

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

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

Health Care FSA

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

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

For a complete list of eligible expenses and esources, visit Surency FSA Eligibility Guide.

Limited Purpose FSA

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

Annual Contribution Amount

You can contribute up to a maximum of $3,500 this year to the Health Care FSA.

Check out the websites below for eligible FSA items.

- Amazon FSA
- FSA Store

What's an Eligible Expense?

Health Care FSA – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at www.irs.gov.

Dependent Care FSA – Child day care, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at www.irs.gov.

Health Care FSA Debit Card

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

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

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

Dependent Care FSA

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

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

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

Eligible Dependent Care Expenses

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

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

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

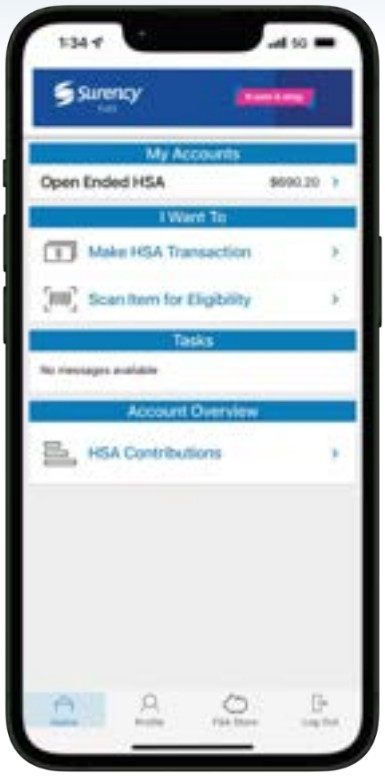
- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

Annual Contribution Amount

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

BENEFITS OF THE SURENCY FLEX APP

Once logged in to your ***Surency Mobile App*** account, you can view account activity, check balances, tax statements, access forms and more!



PURCHASE ELIGIBLE EXPENSES:

Access the ***FSAStore.com*** and/or ***HSAStore.com*** to purchase eligible items (contact lenses, first aid kits, sunscreen, etc.) with your ***Surency Benefits Card***.

FSA store®

HSA store®

USE THE APP TO:

- Submit claims for: FSA, DCFSA, LP FSA. HSA, LSA, HRA, and Commuter Benefits.
- Snap a photo of receipts within the app to submit with new or existing claims.
- Make repayments for ineligible expenses.
- HSA: Request distributions, make contributions and manage investments.
- Add and manage your Bank Account(s).
- Access account funds to pay yourself back or to pay your doctor.
- Scan items at the store to find out if they are eligible expenses.
- Report a lost/stolen Surency Benefits Card.

Download the Surency Mobile App at Surency.com/App!

Scan to download the Surency Mobile App!

©Surency

LOGGING IN TO YOUR MEMBER ACCOUNT

To access your Member Account, you must be enrolled through your employer or a Surency representative. Once your enrollment is complete and your coverage is active, you can log in or register for your Member Account to view plan details and confirm dependent information. If you were enrolled in a previous plan year, you may continue using your existing login credentials. If this is your first time enrolling, you will need to complete the registration process to create your account.

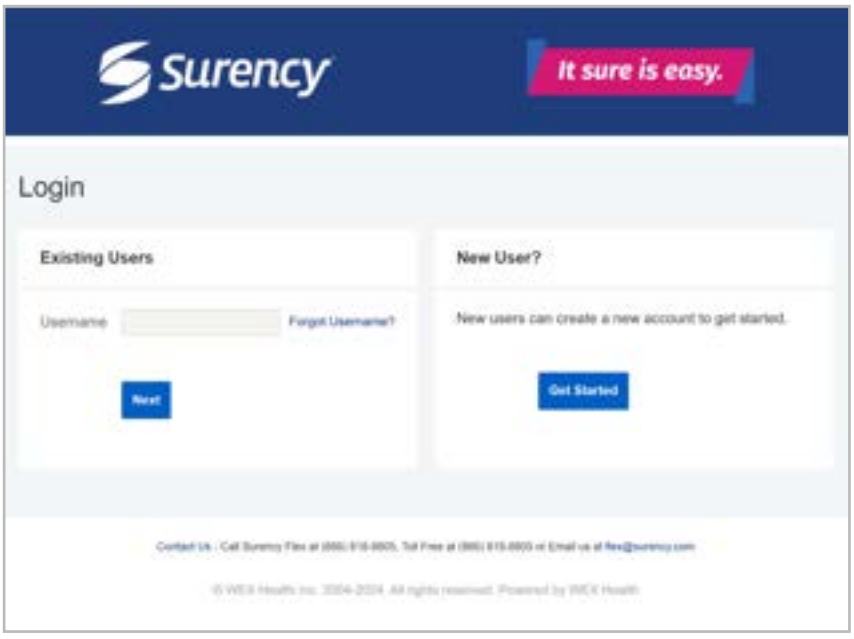
We recommend using Google Chrome when registering for and/or visiting your Surency Member Account. If you need assistance logging in, please contact Customer Service at 866-818-8805.

Steps to Login:

1. Visit ***Surency.com***. Select ***Login*** in the top right hand corner, then select ***Member - Reimbursement Account.***



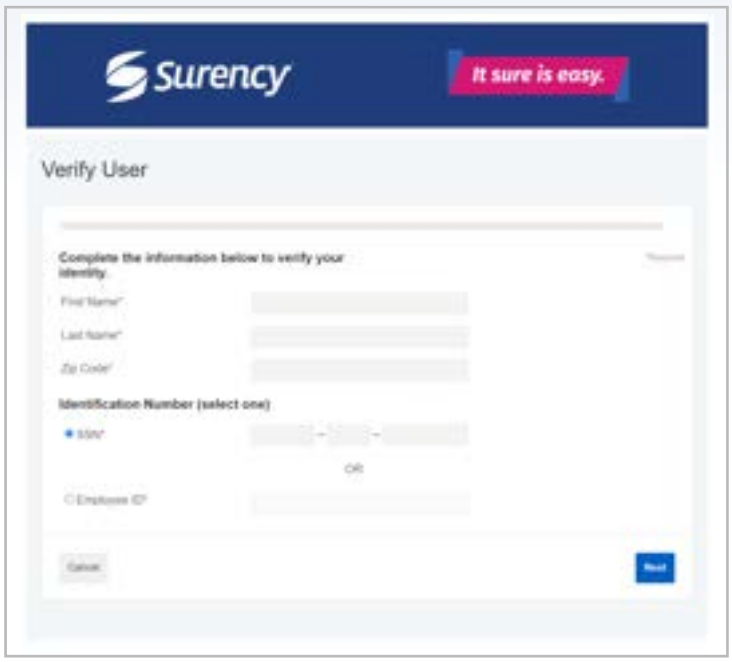
2. If you are a new member, select ***Get Started*** under ***New User*** on the right side of the screen. Returning members may enter their existing username and password to log in.



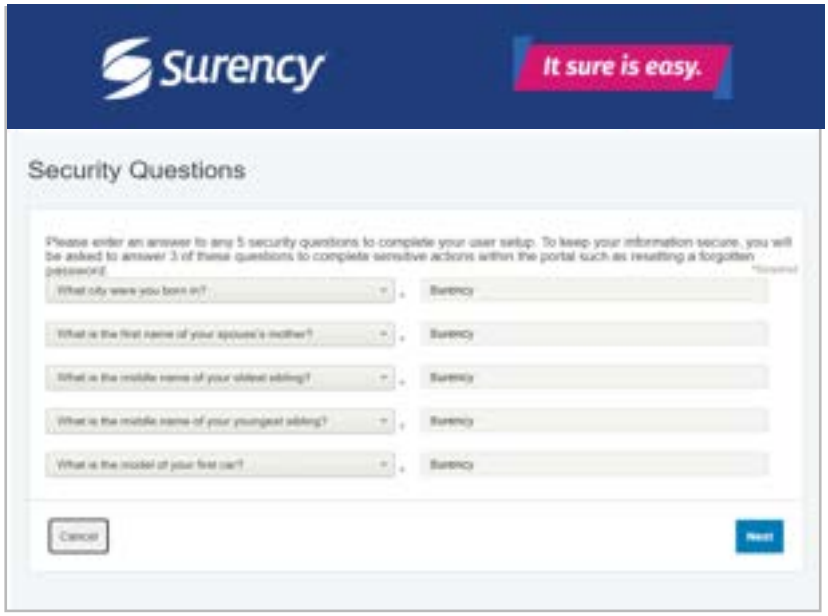
Scan to download the Surency Mobile App!

©Surency

3. To protect your information, you will be asked to verify your identity by providing basic personal details.



4. Choose and answer your security questions. These will be used to help protect your account and assist with password recovery if needed.

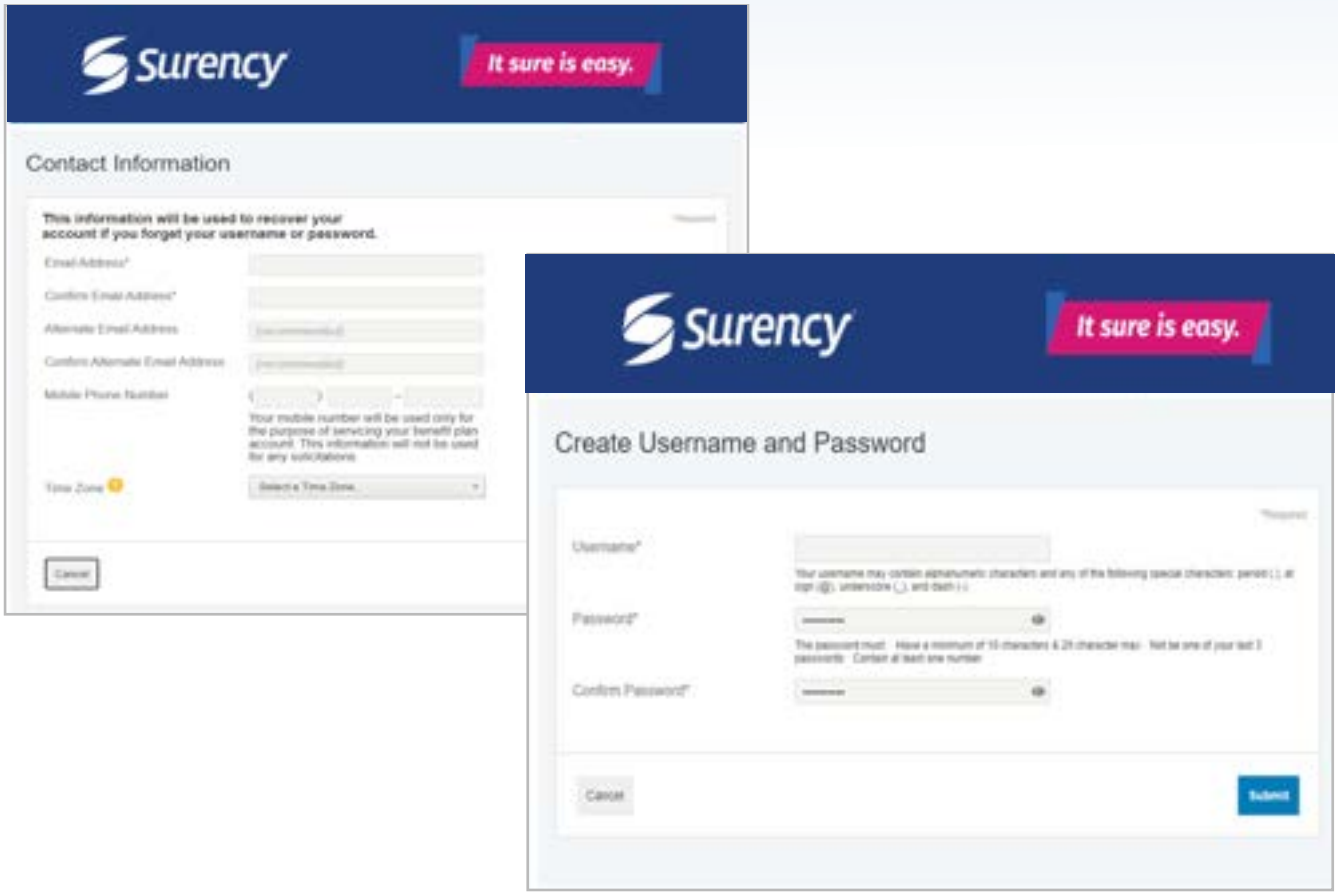


Scan to download the Surency Mobile App!

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SURENCY MEMBER ACCOUNT: LOGIN INSTRUCTIONS

5. Confirm your contact information and create your login credentials. Once complete, your account setup is finished.



You're all set! You are now ready to begin managing your benefits online or through the Surency Mobile App.

Scan to download the Surency Mobile App!

©Surency

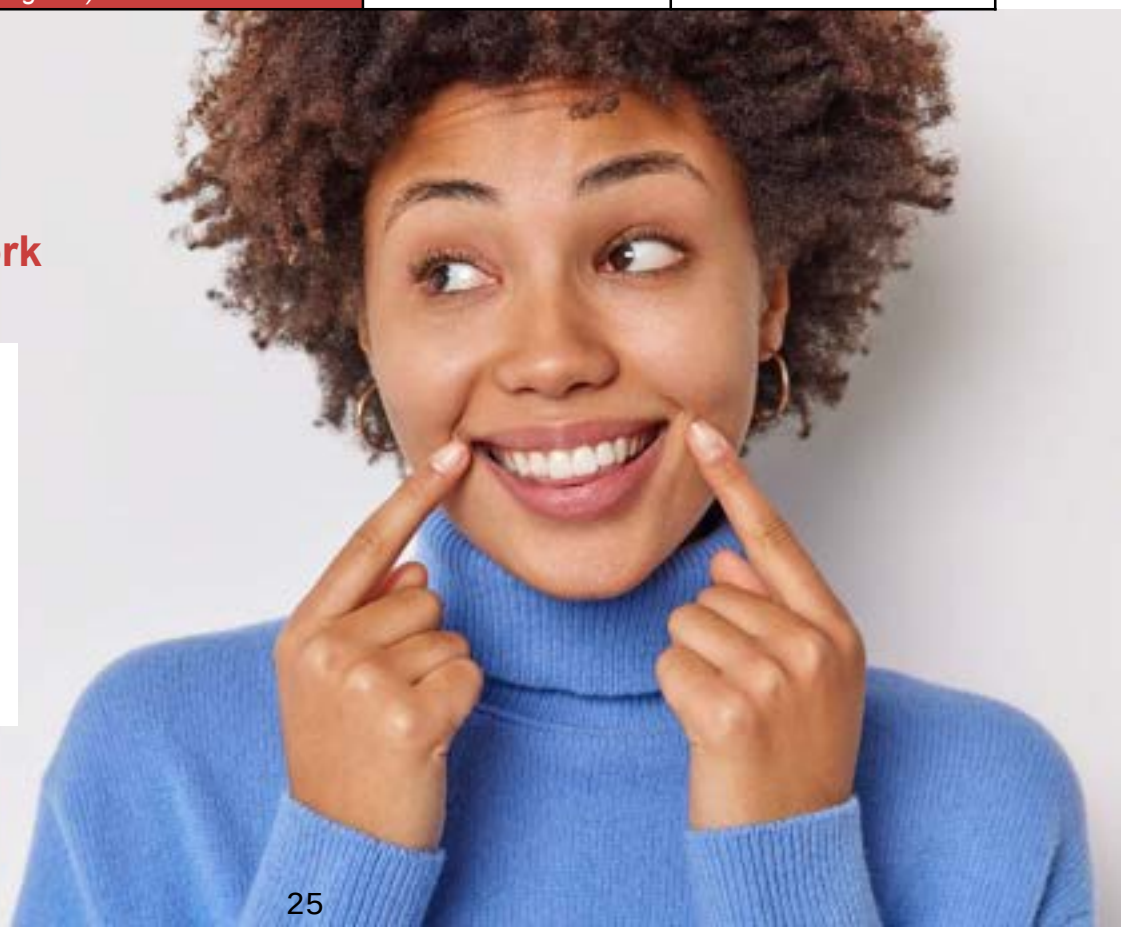
Dental Plan

Delta Dental

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. Dental coverage is offered for basic and major services. You and your eligible dependents may enroll in the dental plan option administered by Delta Dental.

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

To find an in-network provider visit



DELTA DENTAL®

DeltaVision®

Listen Up

Your ears could be telling you something



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

What causes hearing loss?

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

When should I get my hearing checked?

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

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

1 in 9

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

Delta Dental of Iowa now offers hearing discount benefits.

See back for benefit information >>

FOR MORE INFORMATION
Call 866-925-1698
or visit deltadentalia.com/hearing

[1] https://www.asha.org/articles/untreated-hearing-loss-in-adults/

DELTA DENTAL®

DeltaVision®

Worried about your hearing?
We have you covered.

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

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

\+

Complimentary Aftercare*

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

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

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

Take advantage of these benefits and start hearing better today!

FOR MORE INFORMATION
Call 866-925-1698
or visit deltadentalia.com/hearing

2619-F10222 04/2023

DELTA DENTAL®

Additional benefits for special needs



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

What is a special health care need?

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

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

Who qualifies?

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

What's included?

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

What's the cost?

There is no additional cost.

How is the benefit administered?

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

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

2865-F10409 12/2024

Mechdyne Corporation

avēsis

Effective Date: 01/01/2027

Member Copay	
Vision Exam	$10 copay
Materials Applies to frame or spectacle lenses, if applicable.	$10 copay

Frequency	
Vision Exam	Once every 12 months
Lenses or Contact Lenses	Once every 12 months
Frame	Once every 24 months

Vision Care Services	In-Network*	Out-of-Network Reimbursement
Vision Exam		
Includes refraction	$10 copay	Up to $35
Retinal Imaging	Up to $45 member out-of-pocket (OOP) maximum	N/A
Contact Lens Fit and Follow-up (CLEFFU)		
Standard CLEFFU	Covered in full	Up to $25
Custom CLEFFU	Covered in full	Up to $25
Frame Allowance		
Up to 20% discount above frame allowance.*	$130 allowance	Up to $45
Standard Spectacle Lenses		
Single Vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $50
Lenticular	$10 copay	Up to $80
Preferred Pricing Options*	**Level 13 Option Package**	
Polycarbonate (Single Vision/Multi-Focal)	$0 copay	Up to $10
Standard Scratch-Resistant Coating	$0 copay	Up to $5
Ultraviolet Screening	$0 copay	Up to $6
Solid or Gradient Tint	$0 copay	Up to $4
Standard Anti-Reflective Coating	$45 member OOP maximum	N/A
Standard Progressives†	$50 allowance	Up to $40
Premium Progressives	$50 allowance + up to 20% off balance*	Up to $40
Plastic Photochromic (Single Vision/Multi-Focal)	$70/$80 member OOP maximum	N/A
Polarized	$75 member OOP maximum	N/A
PGX/PBX	$40 member OOP maximum	N/A
Other Lens Options	Provider discount up to 20%*	N/A
Contact Lenses‡		
Elective	$130 allowance	Up to $110
Medically Necessary	$0 copay	Up to $250
Refractive Laser Surgery		
Up to 25% provider discount.¥	Onetime/lifetime $150 indemnity allowance	Onetime/lifetime $150 indemnity allowance

Here's How It Works

1. Find a provider at www.avesis.com.
2. Make an appointment.
3. Visit the provider for service.
4. Pay any copays or additional expenses.

How can we help you?

Avēsis Website:
www.avesis.com

Customer Service:
855-214-6777
7 a.m. - 8 p.m. EST

LASIK Provider:
877-712-2010

^Hearing Provider:
844-366-0039 TTY: 711

*Discounts are not insured benefits and may vary by provider.

†After $50 allowance, the member's out of pocket cost is $75 for Standard progressives or $110 for Premium progressives.

‡In lieu of frame and spectacle lenses.

¥Save up to 25% on average LASIK prices when you use Qualsight (visit avesis.qualsight.com for more information).

^Discounts available on hearing tests and hearing aids via Amplifon.

Contact lens allowance available through 1-800-Contacts. Log in to member portal for more details.

At participating Walmart/Sam's locations, retail frame pricing for your plan is $68. At participating Costco locations, retail frame pricing is $74.99.

Avēsis vision insurance products are underwritten by Fidelity Security Life Insurance Company® (FSL), Kansas City, MO, when insured by FSL. Approved by FSL 03/26. Administered by Avēsis. Policy # VC-16, Form M-9059.

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Using Out-of-Network Providers

Members who elect to use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avēsis for reimbursement, unless the provider accepts an assignment of benefits. Reimbursement levels are in accordance with the out-of-network reimbursement schedule previously listed. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits, and limitation and exclusion provisions of the plan, and are in lieu of services provided by a participating Avēsis provider. Out-of-network claim forms can be obtained by contacting Avēsis' Customer Service Center or your group administrator, or by visiting www.avesis.com.

Termination Provisions

The coverage will continue as long as the group policy remains in force, the premiums are paid, and as long as the employee and any covered dependents remain eligible and the employees coverage remains in force.

Notes and Disclaimers

The contact lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only. Refractive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Avēsis is not responsible for the outcome of any refractive surgery. Discounts on materials are not available at Walmart locations. Members may not use their contact lens allowance toward fitting fees at Walmart and are responsible for any out-of-pocket fees associated with fittings there. Discounts on materials are not available at Costco locations. ID cards are not required for services.

Limitations and Exclusions

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence.

Limitations

Vision Examination and Vision Materials. Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

With the exception of the contact lens allowance, benefit allowances provide no remaining balance for future use within the same Benefit Period.

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses;
2. Medical and/or surgical treatment of the eye, eyes, or supporting structures;
3. Any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy;
4. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof;
5. Plano (non-prescription) lenses;
6. Non-prescription sunglasses;
7. Two pair of glasses in lieu of bifocals; or
8. Services or materials provided by any other group benefit plan providing vision care.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

Refractive Surgery Vision Benefit Exclusions

Benefits are not payable for any of the following:

1. Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames, or contact lenses; or
2. Medical or surgical procedures, services, or treatments:
   a. not specifically covered under this Rider;
   b. provided free of charge in the absence of insurance
   c. payable under any Workers' Compensation law or similar statutory authority
   d. payable under governmental plan or program, whether Federal, state, or subdivisions thereof.

Avēsis
1295 W. Washington Street, Suite 212
Tempe AZ 85281

avesis.com

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avēsis

Member Resources

Member Resources

At Avēsis, we strive to give you the simplicity you seek when using your benefits and signing up online to manage them. Here, we show you exactly what you'll need to get started.

Signing Up Online

1. Visit **www.avesis.com** and click Members from the top navigation.
2. Click **Sign Up** to register your account. You'll be required to enter your first and last names, date of birth, mobile phone number, and email address.
3. Create a username and password that conforms with the password requirements.
4. Click **Submit** & Get Started.

Once you're registered, you'll get a confirmation message that your registration was successful. Log in and use the dashboard to search for providers; check eligibility; view vision benefits, claim status, and forms and documents; print an ID card; get messages; and edit your profile.

Learn more about sight through our FAQs, glossary, and vital vision facts.

Using Your Benefits

1. Select a provider from our Provider Directory at **www.avesis.com**. Search by provider type, name, zip code, location, mile radius, and more, then further narrow your search to include other preferences.
2. Call to schedule an appointment, identifying yourself as an Avēsis member; confirm the provider accepts Avēsis. No ID cards are necessary to receive services.
3. At your visit, pay any copays and non-covered expenses.

That's it! It really is as easy as 1-2-3.

Submitting Claims

Go paperless! Now you can submit your out-of-network vision claims through our member portal. It's faster, easier, and better for the environment than submitting paper claims. And you'll even be reimbursed faster!

Need Assistance?

Our Customer Care Center can be reached at 855-214-6777.

Monday through Friday,
7:00 a.m. to 8:00 p.m. EST.

Approved by FSL® 9/1/2021

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Avēsis
10400 N 25th Ave.,
Suite 200
Phoenix, AZ 85021

avesis.com

Life Insurance

Reliance Standard

Basic Life & Accidental Death & Dismemberment (AD&D)

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment or paralysis. This benefit is sponsored by Mechdyne, so you will automatically be enrolled at no cost to you. Your coverage will be $25,000.

Supplemental Life Insurance

You may purchase additional life insurance at group rates:

- Available in increments of $10,000 up to 5x your annual earnings or $300,000.
- You pay the full cost of this plan, and the amount deducted depends on the age of the associate and the amount of coverage elected.
- If you do not elect this coverage when first becoming eligible or an election over $100,000 is made, you are subject to medical underwriting by Reliance Standard.

Life Insurance for Spouses & Dependents

You may purchase additional dependent life insurance at group rates:

- Spousal life is available in increments of $5,000 up to a max of $50,000, not to exceed 100% of the employee amount.
- Can elect up to $30,000 without medical underwriting as a new hire.
- Child life is available from birth to 20 years old*: $10,000.
  - Children are not subject to medical underwriting
  - The cost remains the same regardless of the number of children you have
  - *Age 26 if full-time student

Benefit Reduction

For more information about age-reduction schedules, please review your Summary Plan Description.

Benefit Reduction Schedule:

Age	65	70	75+
Rate	35%	23%	15%

Note: *Employee rates automatically increase with age.*

TAKE ACTION!

Don't forget to designate a beneficiary!

Note: Upon loss of eligibility or termination of employment, you and/or your dependents may elect to continue your employer-sponsored Basic or Voluntary Term Life Insurance coverage by either porting or converting it.

If you can continue your life insurance policy, you can port it, which means continuing the same type of policy, or you can convert it, which means change it to a new type of individual policy. Remember, no matter which option you choose, you become responsible for the premiums.

GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

Disability Insurance

Reliance Standard

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

Long-Term Disability (LTD)

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

You can contact Reliance Standard by phone or website.



Employee Assistance Program

Bree Health

We understand that we all face serious problems at some time in our lives and Mechdyne Corporation is committed to providing help during those times.

The EAP is designed to assist staff members and families with personal challenges in many different areas including: depression, stress management, drug and alcohol abuse, relationships, grief, domestic violence, legal and financial issues, parenting, childcare and elder care.

Participation in the EAP is voluntary, confidential. For those who require referrals for long-term treatment, there may be fees for the services of outside providers.

However, EAP counselors will coordinate referrals, whenever possible, to take advantage of existing insurance coverage and community resources in order to minimize costs. We encourage you and your eligible family members to take advantage of our EAP benefit and to reach out to Bree Health.

24 HOURS A DAY, 7 DAYS A WEEK

Professional counselors are available to provide you with support, guidance and resources. Spanish and TTY/TDD phone lines also available.

Login.breehealth.com

(800) 327-2255

Mobile App: Bree Health

Company ID: 10106

Trustmark Accident Insurance

Coverage for when life takes a tumble.



Helping you prepare for the unexpected

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

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

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

Accident sample rates

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

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

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

Benefits for injury and care

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

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

… and for covered injuries, like:

- Fractures
- Dislocations
- Burns
- Concussion
- Amputations

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

Accident insurance pays you directly

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

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

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

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

See reverse for more information on Accident insurance from Trustmark Insurance Company.



Are you prepared to deal with an injury?

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

[1] National Center for Health Statistics, 2014.

Additional advantages

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

More flexible features

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

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

You care.
We listen.

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

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

Underwritten by Trustmark Insurance Company
Rated A- (EXCELLENT) A.M. Best[2]
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ACC_NO-HSR-ADB_r

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A112-2210 (3-18)

Trustmark Critical HealthEvents® Insurance



Critical illness insurance that offers a lifetime of benefits.

Major illnesses come with hidden costs

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

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

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

Critical HealthEvents sample rates

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

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

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

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

Triple protection for critical illness

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

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

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

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

Benefits are restored each year. *Example:*



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



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



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



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

See reverse for more information on Critical HealthEvents insurance from Trustmark Insurance Company.



Each year, nearly **800,000** Americans have a heart attack[3] and another **800,000** have a stroke.[4]

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

Additional advantages

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

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

More flexible features

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

Plus: grow your benefit with EZ Value

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

Example: $1 increase in weekly premium each year, for 5 years.	$15,000 Initial benefit	$25,554 After 3 years	$39,590 After 5 years

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

You care. We listen.

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

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

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Rated A- (EXCELLENT) A.M. Best[7]
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Trustmark Universal LifeEvents® Insurance with Long-Term Care Benefit

Two important coverages for when you need them the most.



Financial security even after a loss

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

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

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

Universal LifeEvents sample rates

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

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

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

Note: your rate is "locked in" at your age at purchase!
Once you have a policy, your rate will never increase due to age.

Solving the long-term care issue

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

Here's how it works:

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

Flexible features available:

2x **PLUS:** if you collect a benefit for LTC, your **full death benefit** is still available for your beneficiaries, as much as **doubling** your benefit.

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

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

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

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

See reverse side for more information on Universal LifeEvents insurance from Trustmark Insurance Company.

What would happen if you weren't around?

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

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

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

How Universal LifeEvents works

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

Example: $25,000 policy

Before age 70	
Death benefit	**$25,000**
LTC benefits	**$25,000**
After age 70	
Death benefit	**$8,333**
LTC benefits	**$25,000**

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

Benefit for terminal illness

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

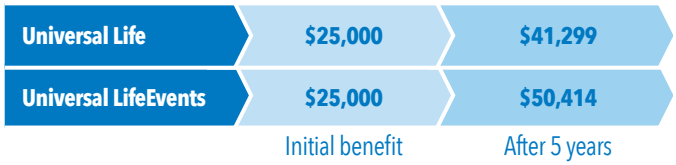
Additional advantages

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

Plus: grow your benefit with EZ Value

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

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



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

You care. We listen.

[1]2018 Insurance Barometer Study LIMRA/Life Happens. [2] nielsen.com/us/en/insights/news/2015/savingspending-and-living-paycheck-to-paycheck-in-america.html. [3]gobankingrates.com/retirement/1-3-americans-0-saved-retirement. [5]An A.M. Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A- (4th out of 16 possible ratings ranging from A++ to Suspended).

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

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

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REQUIRED NOTICES

HIPAA Special Enrollment Rights Notice

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

LOSS OF OTHER COVERAGE

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

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

MARRIAGE, BIRTH OR ADOPTION

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

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

MEDICAID OR CHIP

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

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

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact Sue Goodman, 641-754-4649, sue.goodman@mechdyne.com.

HIPAA NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice is effective January 1, 2027.

This notice describes:

- How medical information about you may be used and disclosed and how you can get access to this information;
- How health information about you may be used and disclosed;
- Your rights with respect to your health information; and
- How to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information

Please review this notice carefully.

You have a right to a copy of this notice (in paper or electronic form) and to discuss it with Sue Goodman, 641-754-4649, sue.goodman@mechdyne.com if you have any questions.

YOUR RIGHTS

You have the right to:

- Consent to most uses and disclosures of your health information
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information, including but not limited to, health care providers who have received your information through certain third parties
- Get a copy of this privacy notice
- Discuss this notice with someone in our program
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

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

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

With your consent or as otherwise permitted under HIPAA, we can use and share your information as we:

- Process and Pay Claims
- Communicate with applicable providers treating you
- Administer the Plan
- Coordinate benefits with other coverage
- Fulfill your requests to share information with your consent
- Comply with appliable laws and regulations

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive, including but not limited to, helping with medical emergencies, communicating within our program and with our contractors
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues such as reporting crimes and threats of crimes and suspected child abuse and neglect
- Aid scientific research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits, legal actions, court orders, audits and evaluations

In these circumstances, we must protect your information and limit how we use and share it. To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

YOUR RIGHTS

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Discuss this notice with someone in our program

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

YOUR CHOICES

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

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

- Share information with your family, close friends, or others involved in payment for your care or payment for your care;
- Share information in a disaster relief situation; or
- Share information with someone authorized to act on your behalf

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

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

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

- Marketing purposes (except as expressly permitted by HIPAA);
- Sale of your information; or
- Any other use or disclosure requiring your prior authorization under applicable law.

You may revoke any authorization at any time, except to the extent we have already relied on the authorization by notifying us in writing

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

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

Help manage the health care treatment you receive & communicate within ours substance use disorder programs and with contractors

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

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

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

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary. We may also use and share your information to prevent multiple enrollments in withdrawal management or maintenance treatment substance use disorder programs, to report participation in treatment required by the criminal justice system and to report prescribed substance use disorder treatment medications to a state prescription drug monitoring program when required by law.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, or legislative investigations or proceedings against you without (1) your consent or (2) a court order or subpoena.

Help with public health and safety issues

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

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

For your medical emergencies

We can share your information during a bona fide medical emergency with the personnel and health care providers responding to your emergency, even when you are unable to consent because of the emergency. We can also share your identifying information to assist the federal Food and Drug Administration in notifying you or your doctor about unsafe products you may be using.

Aid scientific research

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

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Legal Proceedings, court orders, and respond to lawsuits and legal actions

We may use or share your health information as permitted or required by law when responding to legal proceedings. This includes disclosures in response to a valid court order, warrant, subpoena, or other lawful process, consistent with HIPAA's rules for judicial and administrative proceedings (45 CFR §164.512(e)) and law enforcement requests (45 CFR §164.512(f)).When responding to legal requests, we disclose only the information required and follow all conditions and limitations imposed by HIPAA. We can share health information about you in response to a court or administrative order, or in response to a subpoena. With respect to information related to substance use disorder program, we must follow certain procedures before using or sharing your information for investigations and legal proceedings.

- We will not use or share your information or provided testimony about your information in any civil, administrative, criminal or legislative proceedings against you with your written consent or a court order.
- We will only respond to a court order to use or share your health information if it is accompanied by a subpoena or other similar legal mandate requiring us to comp.
- We will only use or share your information in proceedings against you based on a court order after we have received notice and an opportunity to be heard or you tell us that you have received notice.
- We may use or share your information to respond to legal proceedings against our substance use disorder program based on a court order and you may not be notified in advance. You have the right to seek to overturn or change the court order after you learn about it.

With respect to substance use disorder program we may use or disclose your information in order to:

Respond to management and financial audits and substance use disorder program evaluations

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

Assist with cause of death inquiries

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

Report suspected child abuse and neglect or prevent or reduce crime

We will only report the information required by law. We may report to law enforcement when a patient commits or threatens to commit a crime within our program or against our staff.

Communicate within our program and with contractors

We may use and disclose your information within our health plan and with organizations that help us administer our program, including contractors and business associates who perform services for us. These disclosures occur only as permitted by HIPAA for health care operations.

OUR RESPONSIBILITIES

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

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

REDISCLOSURE ACCORDING TO HIPAA

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

CHANGES TO THE TERMS OF THIS NOTICE

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

Michelle's Law Enrollment Notice

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

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

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

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

To obtain additional information, please contact: Sue Goodman, 641-754-4649, sue.goodman@mechdyne.com.

Women's Health and Cancer Rights Act Initial Notice

ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 641-754-4649.

No Surprises Act: Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

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

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

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

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

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

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

If you believe you've been wrongly billed, you may contact Iowa Insurance Division, 515-654-6600, **complaints@iid.iowa.gov**, Mailing Address: Iowa Insurance Divion, 1963 Bell Avenue, Suite 100 Des Moines, IA 50315 OR Centers for Medicare & Medicaid Services (CMS) 1-800-985-3059

Visit **www.cms.gov/medical-bill-rights** for more information about your rights under federal law or call 1-800-985-3059 to file a federal complaint.

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

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

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

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

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

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

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

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	The AK Health Insurance Premium Payment Program: myakhipp.com Email: customerservice@myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	HIPP Website: www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Email: hipp@dhcs.ca.gov	Phone: 916-445-8322 Fax: 916-440-5676
Colorado Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: healthfirstcolorado.com CHP+: hcpf.colorado.gov/child-health-plan-plus Health Insurance Buy-In Program (HIBI): mycohibi.com	Health First Colorado: 800-221-3943 Relay 711 CHP+: 800-359-1991 Relay 711 HIBI: 855-692-6442
Florida Medicaid	Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	GA HIPP: medicaid.georgia.gov/health-insurance-premium-payment- program-hipp GA CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	GA HIPP: 678-564-1162, press 1

		GA CHIPRA: 678-564-1162, press 2
Illinois Medicaid	Illinois Medicaid Premium Assistance Information Medicaid applicaiton website: abe.illinois.gov HIPP Email: **mhfs.boc.hipp@illinois.gov**	217-524-8268
Indiana Medicaid	HIPP: **https://www.in.gov/fssa/dfr/** All other Medicaid: **in.gov/medicaid**	Family & Social Services: 800-403-0864 Member Services: 800-457-4584
Iowa Medicaid and CHIP (Hawki)	Medicaid: **hhs.iowa.gov/programs/welcome-iowa-medicaid** Hawki: **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki** HIPP: **hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp**	Medicaid: 800-338-8366 Hawki: 800-257-8563 HIPP: 888-346-9562
Kansas Medicaid	Website: **kancare.ks.gov**	Medicaid: 800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: **chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** KI-HIPP Email: **KIHIPP.PROGRAM@ky.gov** KCHIP: **kynect.ky.gov** Medicaid: **chfs.ky.gov/agencies/dms**	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	Medicaid website: **ldh.la.gov/healthy-louisiana** Medicaid email: **healthy@la.gov** LaHIPP website: **www.ldh.la.gov/lahipp** LaHIPP email: **La.HIPP@la.gov** LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084	Medicaid: 888-342-6207 LaHIPP Phone: 877-697-6703 LaHIPP Fax: 888-716-9787
Maine Medicaid	Enrollment: www.mymaineconnection.gov/benefits/s/?language=en_US Private health insurance premium: **maine.gov/dhhs/ofi/applications-forms**	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY: Maine Relay: 711
Massachusetts Medicaid and CHIP	Website: www.**mass.gov/masshealth/pa** Email: **masspremassistance@accenture.com**	800-862-4840 TTY: 711
Minnesota Medicaid	**mn.gov/dhs/health-care-coverage**	800-657-3672
Missouri Medicaid	**dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana Medicaid	Website: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Email: **HHSHIPPProgram@mt.gov**	800-694-3084
Nebraska Medicaid	**ACCESSNebraska.ne.gov**	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: **dhcfp.nv.gov**	800-992-0900

New Hampshire Medicaid	Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Phone: 603-271-5218 Toll Free HIPP: 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY: 711
New York Medicaid	www.health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	www.medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	www.hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	www.insureoklahoma.org	888-365-3742
Oregon Medicaid	www.healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	www.eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte Share Line)
South Carolina Medicaid	www.scdhhs.gov	888-549-0820
South Dakota Medicaid	www.dss.sd.gov	888-828-0059
Texas Medicaid	www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP Website: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion Website: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select HIPP Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	www.hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	bms.wv.gov/mywvhipp.com/	Medicaid: 304-558-1700

		CHIP: 855-MyWVHIPP (855-699-8447)
Wisconsin Medicaid and CHIP	www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	www.health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

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

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

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

Important Notice from Mechdyne Corporation About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. If you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Mechdyne Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Mechdyne Corporation changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 2027 Plan Year
Name of Entity/Sender: Mechdyne Corporation
Contact--Position/Office: Sue Goodman – Human Resources
Address: 11 East Church Street, 4th floor, Marshalltown, IA 50158
Phone Number: 641-754-4649

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

For more information, see the **Frequently Asked Questions (FAQs)** About the Newborns' and Mothers' Health Protection Act.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Mechdyne Corporation	42-1460417
5. Employer address	**6. Employer phone number**
11 E Church Street, 4th Floor	641-754-4649

7. City	8. State	9. ZIP code
Marshalltown	IA	50158

10. Who can we contact about employee health coverage at this job?	
Gena Lytle	
11. Phone number (if different from above)	**12. Email address**
	Gena.lytle@mechdyne.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  All employees. Eligible employees are:

  ☐

  ☒ Some employees. Eligible employees are:

  regular, full-time employees working a minimum of 30 hours per week.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Children under the age of 26; legal spouse or qualified domestic partner; children over the age of 26 and full-time student.

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.











Mechdyne