

A photograph of a family of four walking through a grassy park. A man is carrying a young child on his shoulders, and a woman is holding the hand of another child. They are all smiling and looking towards the right. The background is filled with lush green trees.

**2025**

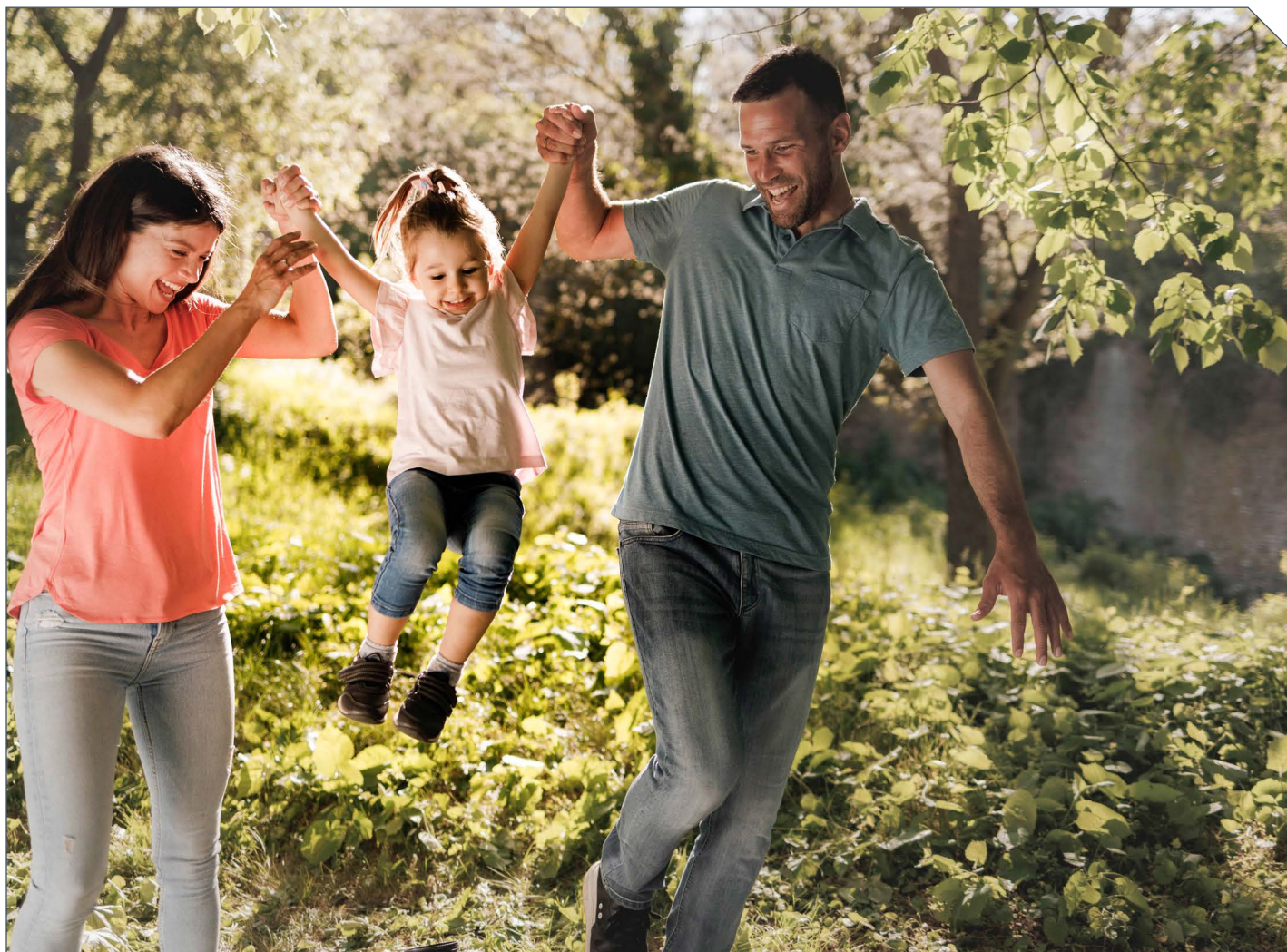
***Benefits  
Guide***

This publication contains important information about your employee benefit program.

**Please read thoroughly.**

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# Eligibility and Enrollment

AWP Safety cares about you and your family. We offer a comprehensive benefits program that allows you to choose the benefits that are best for you. This guide provides an overview. Please review your plan documents for more details.

## New Hire Enrollment

Welcome to our team! As a new team member, your benefits begin on the 1st day of the month following eligibility.

## Annual Enrollment

Annual enrollment is your opportunity to review your benefits and make changes for the next plan year. You can add, change, or decline coverage and add or drop family members.

## Changing Benefits Mid-Year

Once you make your elections, you won't be able to change them until next year's annual enrollment, unless you experience a qualifying life event.

Examples of qualifying events:

- ▶ Change of legal marital status (e.g., marriage, divorce, death of spouse, legal separation)
- ▶ Change in number of dependents (e.g., birth, adoption, death of dependent, ineligibility due to age)
- ▶ Change in employment or job status

You must make changes to your benefits within 30 days of your qualifying life event. Please be prepared to share proof of your qualifying life event. If you miss the deadline, you may have to wait until next year's annual enrollment.

## Benefits Eligibility

### Covering Yourself

You may enroll in the benefits program if you are an ongoing full-time team member or a full-time equivalent team member (i.e., 1 year of continuous service and 1,560 worked hours).

### Covering Your Family Members

Eligible dependents generally include your legally married spouse and children up to age 26. This includes natural and adopted children, step-children, and children for whom you are the court-appointed legal guardian. Some age limitations may apply to specific insurance programs.

Note: If you reside in California or Hawaii, and elect the Kaiser plan, you can cover domestic partners on the medical plan. All domestic partner rates are subject to imputed income.

### Eligibility Documentation

Please be prepared to share dependent eligibility information during enrollment, including dates of birth and Social Security numbers. Other documentation may be required depending on your elections.

# Enrollment Instructions

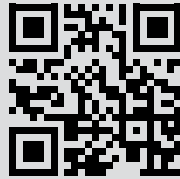
## Annual and New Hire Benefits Enrollment

Online: [www.awpsafety.com](http://www.awpsafety.com). Next, click on UKG at the bottom right-hand side of the screen.

### Special Instructions

Please follow [UKG Life Events Instructions](#) for all life events.

Visit <https://awpbenefits.com> to view all benefits-related information throughout the year.



# Medical and Prescription Plan

AWP Safety partners with UnitedHealthcare to offer medical and prescription drug insurance. If you reside in California or Hawaii, you have the option of enrolling in Kaiser.

## Plan Highlights

You have the option of choosing one of 3 plans. Our plans offer coverage for most healthcare services. When you receive care in-network, you benefit from our negotiated discounts with UnitedHealthcare.

## UnitedHealthcare Member Site

Visit [www.myuhc.com](http://www.myuhc.com):

- ▶ Search for in-network providers and pharmacies under the **Choice Plus** Network
- ▶ See a list of covered medications under the **Flex Base 3 Tier** Formulary listing
  - ▷ If on an HDHP, core preventive drugs are covered at no cost
- ▶ View your temporary ID card or request a new one
- ▶ Review claims information

### What is a Network?

Through the UHC Choice Plus Network your plan contracts with a group of providers for discounted rates. You will almost always pay less when you receive care from these in-network providers.

If you choose to see an out-of-network provider, you may be balance billed, which means you will be responsible for charges above UHC's reimbursement amount.

## UnitedHealthcare® App

- Find care and compare costs for providers and services in your network
- Check your plan balances, view your claims and access your health plan ID card
- Access wellness programs and view clinical recommendations
- 24/7 Virtual Visits – Connect with providers by phone or video to discuss common medical conditions and get prescriptions, if needed
- View your health care financial account(s) such as HSA
- Compare prescription costs and order refills



### Important Insurance Terms

- ▶ **Deductible:** the amount of money you're responsible for paying upfront before your plan shares your costs
- ▶ **Coinsurance:** the percentage you and the plan pay; in our plans, you pay a smaller percentage and the plan pays a larger percentage
- ▶ **Copay:** a fixed amount for certain services you pay in some of our plans
- ▶ **Out-of-pocket maximum:** the limit on your expenses; once you reach this limit, the plan covers all eligible expenses for the remainder of the plan year

# Medical and Prescription

You have a choice of medical plans with a range of coverage levels and costs, so you have the flexibility to select the option that’s best for you. UnitedHealthcare (UHC) and Surest are some of our health insurance carriers for 2024. You have two plan options through UHC and one through Surest, providing both in- and out-of-network coverage (you pay less when you stay in-network).

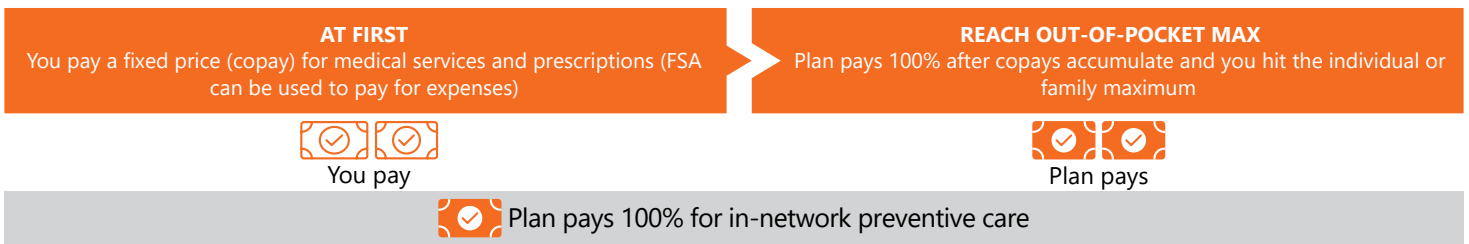
- 1. UHC PPO:** This is a Preferred Provider Organization (PPO) Plan. You pay a copay for office visits or urgent care from an in-network provider. You also pay a copay for most covered prescription drugs. For other covered services, you pay the deductible plus coinsurance. When you reach your annual out-of-pocket maximum, the plan pays 100% for the rest of the year. If you enroll in this option, you can enroll in the Health Care Flexible Spending Account.



- 2. UHC \$3,300 High Deductible Health Plan w/Optional HSA:** This option has a higher deductible compared to the other UHC plan, but lower premiums. You pay 100% of medical and prescription costs until you meet your deductible. Then the plan pays 90% of covered costs. If you reach your out-of-pocket maximum, the plan pays 100% until year end. This HDHP is paired with a tax-advantaged Health Savings Account (HSA) to help you pay out-of-pocket expenses.



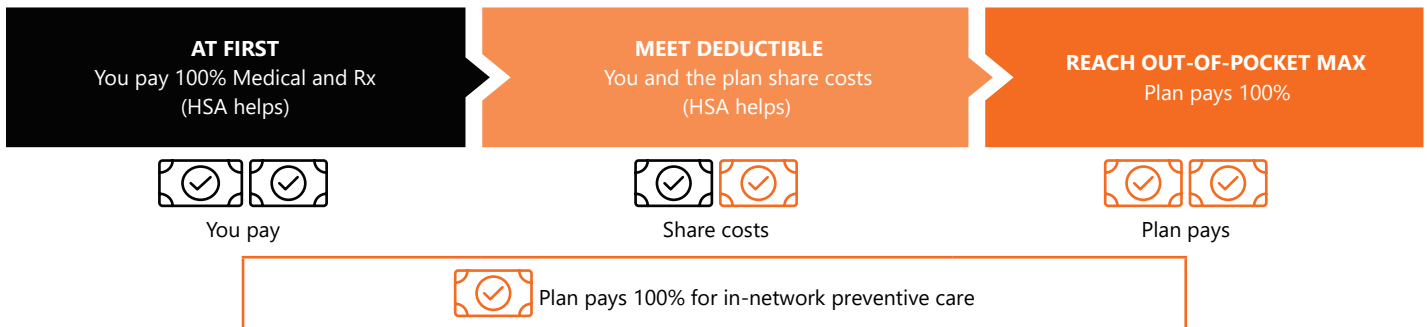
- 3. Surest PPO Plan:** With this plan, there’s no deductible or coinsurance. Instead, all your healthcare purchases have a fixed price (copay) for your out-of-pocket costs. So you know the cost of your treatment options before you go to the doctor. If you enroll in this option, you can enroll in a Health Care Flexible Spending Account.



**Give your doctor’s office this information:** The Surest network is UnitedHealthcare Choice Plus.

## How a High-Deductible Health Plan Works

Whether you're new to the concept of High-Deductible Health Plans or they're old hat, you might benefit from an overview of how they work—and how they're different from a more-traditional Preferred Provider Organization or PPO plan.



## ...and How it Compares to a PPO

### How They're Alike

**You choose providers from a network.** Like PPOs, HDHPs have a network of providers. You can choose any provider you like, but you'll almost always pay less when you use providers and facilities in the network.

**You pay nothing for preventive care.** Both HDHPs and PPOs cover in-network preventive care at 100%; you don't have to pay a deductible.

### How They're Different

**You pay the full cost for other services until you reach the deductible.** With an HDHP, you pay the full cost when you visit the doctor, get a test, or pick up a prescription. When your out-of-pocket costs meet the deductible, the plan starts paying 100%, and you pay 0% for in-network care. If you reach the out-of-pocket maximum—and most people never do—the plan pays 100% of the cost for in-network care.

With a PPO, you pay less upfront, because you only pay a copayment when you go to the doctor or get a prescription.

**A Health Savings Account can help you save money.** With an HDHP, you can enroll in a Health Savings Account or HSA. It is like a bank account where you set aside money to help pay those upfront costs.

PPOs don't include an HSA.

**HDHP premiums are lower.** Premiums for an HDHP plan are typically lower than those for a PPO. That's the tradeoff for having to pay most costs upfront.

### The Bottom Line

The HDHP puts you in the driver's seat, giving you more options to manage your care and save money. In most cases, team members pay less for an HDHP because of the lower premiums. Many never reach the deductible, and their total costs for the year are less than those for a competitively priced PPO.

# How Your Medical Plans Work

## Surest Medical Plan

Surest is a copay-only plan, unlike traditional medical plans. There are no deductibles or coinsurance payments for care.

Services and doctors have a specific copay price, which you can see through Surest's easy-to-use digital platform. With just a click, you can get clear answers about costs, coverage and options before you choose your care.

Even better, lower prices are assigned to higher-value care providers and facilities—from preventive to emergency care, colds to cancer treatment. You will pay a single copay for each event or service, providing clear an upfront cost for your care.

Also, guidance and advocacy are built into the platform—giving you more control of your healthcare experience.

Surest allows you to make the best healthcare decisions for your family and budget.

### Surest highlights

- ▶ No deductible, no coinsurance
- ▶ Copay price based on service and provider selection
- ▶ Upfront pricing (you know what you owe in advance)
- ▶ Easily search your symptoms within the Surest app\* or website
- ▶ Opportunities to pay less for quality care

\* Download the Surest app from Google Play or the App Store. The Surest app doesn't link to [myuhc.com](https://myuhc.com) or UnitedHealthcare's wellness program.

### Explore Surest: Smarter, Simpler Health Plan

View the demo here: <https://www.surest.com/how-it-works>

Surest, a modern health plan designed to give you clear, upfront costs and more control over your healthcare choices. Discover how Surest offers flexibility, transparency, and savings for both employers and employees.

### What to Expect

- ▶ A walkthrough of the Surest platform
- ▶ Key features and benefits
- ▶ How it empowers employees to make informed healthcare decisions

## How Your Plan Options Compare

Here's an overview of how your two plan options compare based on 2025 costs.

	PPO \$1,500	HDHP \$3,300	Surest
Individual Annual Premium—2025	\$3,471.36	\$1,859.64	\$1,104.48
Individual Annual In-Network Deductible	\$1,500	\$3,300	\$0
Primary Care Office Visit (per visit)	\$30 copay	10% after deductible	\$50-\$160
Specialist Office Visit (per visit)	\$50 copay	10% after deductible	\$50-\$160

## Medical Plan Premiums

	Weekly			Bi-Weekly			Monthly		
	PPO \$1,500	HDHP \$3,300	Surest	PPO \$1,500	HDHP \$3,300	Surest	PPO \$1,500	HDHP \$3,300	Surest
Employee	\$66.76	\$35.76	\$21.24	\$133.51	\$71.52	\$42.48	\$289.28	\$154.97	\$92.04
Employee + Spouse	\$182.53	\$110.95	\$72.91	\$365.06	\$221.90	\$145.83	\$790.97	\$480.78	\$315.96
Employee + Children	\$143.16	\$84.11	\$61.58	\$286.33	\$168.22	\$123.15	\$620.38	\$364.47	\$266.83
Family	\$289.90	\$168.22	\$110.87	\$579.80	\$336.43	\$221.75	\$1,256.24	\$728.94	\$480.45



## Medical Plan Details

	PPO \$1,500		HDHP \$3,300		Surest	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Calendar Year Deductible</b>						
Individual	\$1,500	\$4,000	\$3,300	\$3,300	\$0	\$0
Family	\$4,500	\$8,000	\$6,600	\$6,600	\$0	\$0
<b>Out-of-Pocket Maximum (includes deductible)</b>						
Individual	\$5,000	\$8,000	\$7,050	\$10,000	\$8,000	\$16,000
Family	\$10,000	\$16,000	\$14,100	\$20,000	\$16,000	\$32,000
<b>Physician Office Visits</b>						
Preventive Care	Covered at 100%	40% coinsurance after deductible	Covered at 100%	40% coinsurance after deductible	Covered at 100%	\$215 copay
Primary Care Visit	\$30 copay per visit	40% coinsurance after deductible	10% coinsurance after deductible	40% coinsurance after deductible	\$50-\$160 copay	\$215 copay
Specialist Visit	\$50 copay per visit	40% coinsurance after deductible	10% coinsurance after deductible	40% coinsurance after deductible	\$50-\$160 copay	\$215 copay
Telemedicine	\$5 copay per visit	40% coinsurance after deductible	10% coinsurance after deductible	40% coinsurance after deductible	\$0 copay	Not covered
Urgent Care	\$100 copay per visit	40% coinsurance after deductible	10% coinsurance after deductible	40% coinsurance after deductible	\$110 copay	\$200 copay
<b>Hospital Services</b>						
Inpatient	20% coinsurance after deductible	40% coinsurance after deductible	10% coinsurance after deductible	40% coinsurance after deductible	\$80-\$5,500 copay	Up to \$13,000 copay
Outpatient	20% coinsurance after deductible	40% coinsurance after deductible	10% coinsurance after deductible	40% coinsurance after deductible	\$80-\$5,500 copay	Up to \$13,000 copay
Emergency Room	\$300 copay per visit	\$300 copay per visit	10% coinsurance after deductible	10% coinsurance after deductible	\$1,000 copay	\$1,000 copay
<b>Prescription Drugs (Base Flex 4 Tier Formulary)</b>						
<b>Please note:</b> for the HDHP plans, all prescription drug expenses are subject to the medical deductible. Once you meet your deductible, copays or coinsurance will apply.						
Generic	\$10 copay per prescription drug	50% coinsurance	\$10 copay	40% coinsurance after deductible	\$10 copay	Not covered
Preferred Brand Formulary	\$35 copay per prescription drug	50% coinsurance	\$35 copay	40% coinsurance after deductible	\$90 copay	Not covered
Non-Preferred Brand Formulary	\$70 copay per prescription drug	50% coinsurance	\$60 copay	40% coinsurance after deductible	\$200 copay	Not covered
Specialty	20% up to \$200	Not covered	20% up to \$200	Not covered	\$550-\$650 copay	Not covered
<b>Mail Order</b>						
Generic	\$25 copay per prescription drug	Not covered	\$25 copay	Not covered	\$25 copay	Not covered
Preferred Brand Formulary	\$85 copay per prescription drug	Not covered	\$85 copay	Not covered	\$225 copay	Not covered
Non-Preferred Brand Formulary	\$175 copay per prescription drug	Not covered	\$150 copay	Not covered	\$500 copay	Not covered
Specialty	20% up to \$500	Not covered	20% up to \$500	Not covered	N/A	Not covered

PPO: The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

HDHP: The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

# Medical Insurance Plan Option For California Team Members

## Kaiser Permanente

### (Available to California-based team members only)

We will continue to offer the Kaiser HMO plan for those team member in California. An HMO is a system of managed healthcare providing comprehensive medical services within a specific geographic area. Benefits are provided only when services have been authorized or provided by your Primary Care Physician (PCP) or Primary Medical Group (PMG). When you enroll in an HMO, you are required to select a PCP. Kaiser Permanente has its own doctors, physician assistants, nurse practitioners, and operates its own hospitals and outpatient facilities. If you elect Kaiser, you do not have the option to seek treatment outside of Kaiser Permanente-contracted facilities, except in emergencies.

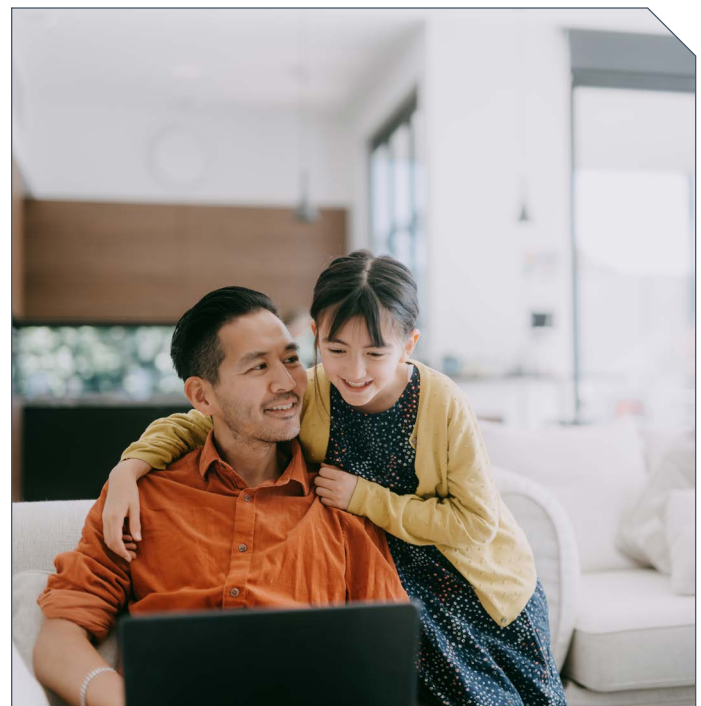
#### MEDICAL PLAN DETAILS

Kaiser Permanente	
Calendar Year Deductible	
Individual	\$750
Family	\$1,500
Out-of-Pocket Maximum (includes deductible)	
Individual	\$3,000
Family	\$6,000
Coinsurance	20%
Physician Office Visits:	
Preventive Care	Covered at 100%
Primary Care Visit	\$20 copay
Specialist Visit	\$30 copay
Hospital Services	
Inpatient Hospitalization	20% after deductible
Emergency Room	\$200 copay
Urgent Care	\$30 copay
Outpatient Services:	
X-Ray and Lab Tests	\$10 copay
Surgery	20% after deductible
Prescription Drugs	
Generic	\$10 copay
Formulary/Brand	\$30 copay
Non-Formulary	\$60 copay
Specialty	20% up to \$250

#### MEDICAL PLAN PREMIUMS

	Weekly	Bi-Weekly	Monthly
Employee	\$20.29	\$40.58	\$87.93
Employee/Spouse	\$83.88	\$167.75	\$363.46
Employee + Child(ren)	\$74.40	\$148.81	\$322.42
Family	\$125.81	\$251.62	\$545.18

Domestic partners are eligible for coverage, but rates are subject to imputed income.



# Medical Insurance Plan Option For Hawaii Team Members

## Kaiser Permanente HMO

An HMO is a system of managed healthcare providing comprehensive medical services within a specific geographic area. There are copays, for services such as office visits, specialist visits and hospitalization, but no deductibles. Generally, coinsurance is 100%, or services are covered in full after the specified copays. Benefits are provided only when services have been authorized or provided by your Primary Care Physician (PCP). Kaiser Permanente has its own doctors, physician assistants, nurse practitioners and nurses, and operates its own hospitals and outpatient facilities. If you elect Kaiser, you do not have the option to seek treatment outside of Kaiser Permanente contracted facilities, except in emergencies.

Kaiser Permanente	
HMO (HI) Gold PPO Plan	
In-Network Only	
Annual Deductible—Individual	\$0 (None)
Annual Deductible—Family	\$0 (None)
Annual Out-of-Pocket Limit	\$2,500
Individual Annual Out-of-Pocket Limit	Family: \$7,500
Coinsurance	20%
PCP Office Visit	\$15 copay (18+); \$0 copay (through age 17)
Specialist Office Visit	\$15 copay
Preventive Visit	\$0 (covered at 100%)
Chiropractic Services	\$20 copay (max 12 visits)
Inpatient Hospitalization	20%
Emergency Room	20%
Urgent Care Facility	\$15 copay
Outpatient Services	
X-Ray and Lab Tests	Basic \$15 copay/day; Specialty 20%
Pharmacy Benefits	
Generic	\$10 copay (\$3 OTC)
Formulary/Brand	\$45 copay
Specialty	\$200 copay

	Medical Plan Premiums		
	Weekly	Bi-Weekly	Monthly
Employee (EE)	\$9.42	\$18.85	\$40.84
EE + Spouse	\$93.60	\$187.21	\$405.62
EE + Child(ren)	\$84.24	\$168.48	\$365.05
Family	\$145.42	\$290.84	\$630.15

Domestic partners are eligible for coverage, but rats are subject to imputed income.



# Health Savings Account (HSA)

A health savings account (HSA) is a tax-favored personal savings account that works with your high deductible health plan. You can use it to pay qualified medical expenses such as deductibles, copays, dental, and vision care. For a complete list of qualified medical expenses, see IRS Publication 502 at [www.irs.gov](http://www.irs.gov).

## HSA Major Benefits

- ▶ Your account always belongs to you; you can take it with you when you leave or retire.
- ▶ Your balance rolls over from year to year.
- ▶ Contributing lowers your taxable income.
- ▶ The account helps you build a healthcare nest egg for emergencies or retirement.

## Triple Tax Savings

- ▶ Tax deduction when you contribute to your account.
- ▶ Tax-free earnings through investment.
- ▶ Tax-free withdrawal for qualified expenses.

2025 HSA Funding Limits	
Coverage Level	Limit
Individual Coverage	\$4,300
Family Coverage	\$8,550
Age 55 or Older	Contribute an additional \$1,000 on top of these amounts

## Opening an HSA

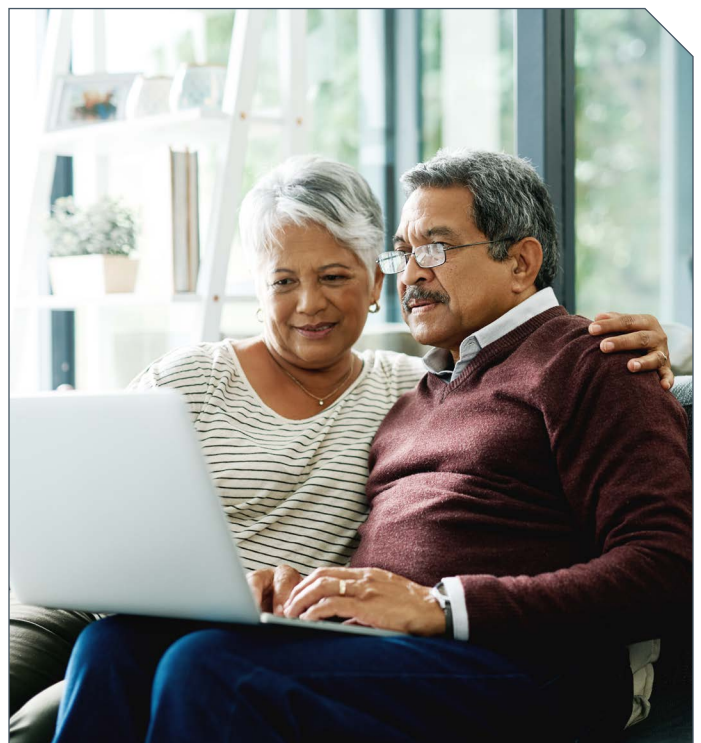
We partner with Optum Bank for our HSA program. Follow these steps to open an account.

- ▶ Select the health savings account option during your UKG (previously known as UltiPro) enrollment.

### HSA Eligibility

You may open and contribute to an HSA if you're enrolled in the AWP Safety HDHP and you:

- ▶ Are not enrolled in a traditional PPO plan through your spouse or other employer-sponsored plan options.
- ▶ Are not enrolled in a government-sponsored program (Medicare, Medicaid, Tricare, etc.).
- ▶ Have not received VA benefits within the last three months (unless for a service-related disability).
- ▶ Are not claimed as a dependent on someone else's tax return.
- ▶ Do not have a healthcare FSA; your spouse also cannot have a healthcare FSA through their own employer.



# Flexible Spending Accounts (FSAs)

Flexible spending accounts (FSAs) allow you to set aside pre-tax dollars from your paycheck to cover qualified expenses you would normally pay out of your pocket. We offer two types of FSAs.

## Healthcare FSA

The healthcare FSA helps you pay IRS-approved medical expenses. The maximum contribution for 2025 is \$3,200\*.

Funds you elect to contribute to the healthcare FSA are available in full on the first day of the plan year. For example, if you elect to contribute \$1,000, the full election is available on day one. You can only open an FSA if you aren't enrolled in an HDHP.

## Dependent Care FSA

The dependent care FSA helps you pay for dependent care. You can contribute up to \$5,000\* (or \$2,500\* if married and filing separately) per plan year. Your account works like a debit card; you need to accumulate the funds before you can use them.

## Use It or Lose It

Carefully consider your FSA contribution amounts for the plan year. At the end of the year you may carry over up to \$660 into the new 2026 plan year. You will lose any balance above the \$660.

\* These limits are subject to change. Visit [IRS.gov](https://www.irs.gov) for more information.

### Eligible Expenses

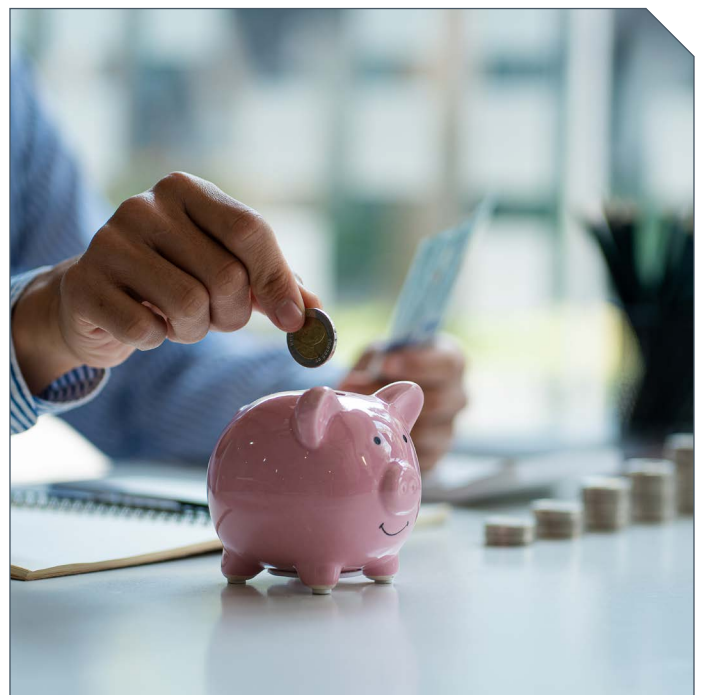
#### HEALTHCARE FSA

- ▶ Doctor's visit copays
- ▶ Prescription drug copays
- ▶ Medical and dental deductibles
- ▶ Over-the-counter medications (with a written prescription)
- ▶ Hearing aids
- ▶ Eyeglasses

#### DEPENDENT CARE FSA

- ▶ Child or adult daycare\*
- ▶ Nursery school
- ▶ Preschool (excluding kindergarten)

\* An eligible dependent is a tax dependent child under age 13 or a tax dependent spouse, parent, or child unable to care for themselves.



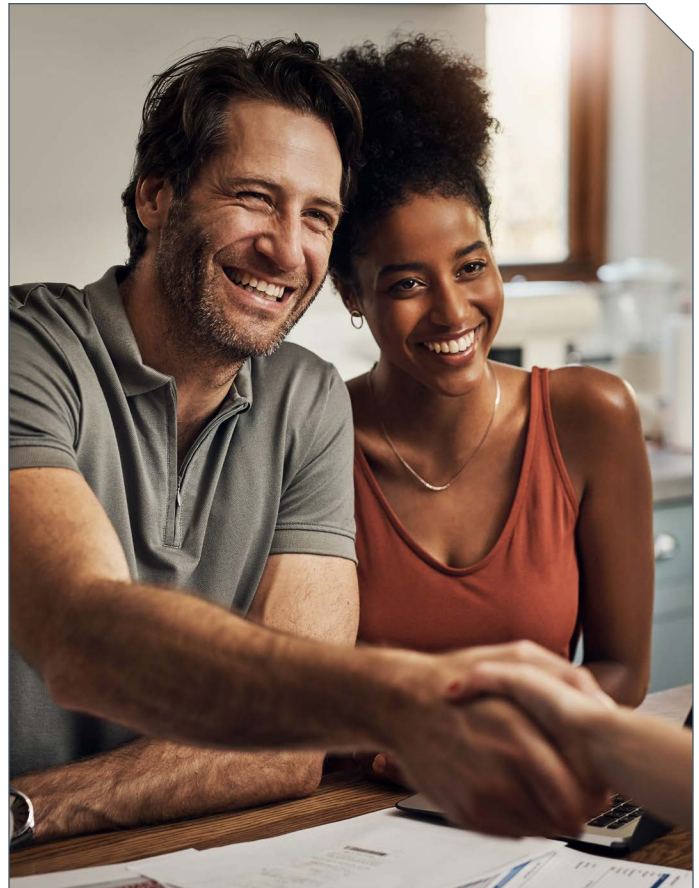
## HSA vs. Healthcare FSA: Which is Right for You?

Health Savings Accounts (HSAs) and Healthcare Flexible Spending Accounts (FSAs) are two ways to save pre-tax money to pay for your eligible healthcare costs. But how do you know which one is right for you? They look a lot alike, and you need to know the differences.

Health Savings Account (HSA)	Healthcare Flexible Spending Account (FSA)
Only available with a High-Deductible Health Plan (HDHP).	Best paired with a PPO.
An HSA is a permanent bank account that's yours to keep, even if you leave the company or retire.	An FSA is only available while you're actively employed at the company.
You don't have to use the money in your account right away. You can save it for the future.	You must use all the money in your account each year. You lose what you don't use. (Exception: You can roll up to \$660 over to the next year.)
You can only use what's in your account at that time.	You can use the entire annual amount at any time, no matter how much is in your account.
You can contribute to your account. The 2025 limit is \$4,300 for individuals and \$8,550 for families. If you're 55 or older, you can add \$1,000.	Only you contribute to your account. The 2025 limit is \$3,200.
You can start, stop, or change your contribution amounts at any time.	You can't make changes during the year unless you have a qualified life event.
You can invest your account once it reaches \$2,000.	You cannot invest your account.
You can use your account to pay for medical, dental, and vision expenses.	

### Important information

- ▶ To start, stop, or change your HSA contribution:
  - ▷ Complete the life event in UKG called "Change HSA Contribution (ONLY)"; for questions, call **800.343.2650**
- ▶ To check your balance, request a debit card or invest your HSA account:
  - ▷ Visit [optumbank.com](https://optumbank.com) or download the Optum Bank app from your mobile app store



# Dental

We partner with Delta Dental to offer you and your family members dental insurance. Visit [www.deltadentaloh.com](http://www.deltadentaloh.com) to find in-network providers and access a variety of online tools and programs.

	Base DPPO In/Out-of-Network	Buy-Up DPPO In/Out-of-Network
<b>Calendar Year Deductible</b>		
Individual	\$50	\$50
Family	\$150	\$150
<b>Calendar Year Maximum</b>		
	\$1,000	\$2,500
<b>Coinsurance</b>		
Preventive	Covered at 100%	Covered at 100%
Basic	20% after deductible	10% after deductible
Major	50% after deductible	40% after deductible
<b>Orthodontia</b>		
OON Reimbursement	90th UCR	90th UCR
Coinsurance	50% after deductible	50% after deductible
Lifetime Maximum	\$1,000	\$2,500
Benefit Applies to	Children	Children

	Base DPPO		
	Weekly	Bi-Weekly	Monthly
Team Member	\$2.19	\$4.38	\$9.50
Team Member + Spouse	\$4.62	\$9.23	\$20.01
Team Member + Children	\$4.32	\$8.64	\$18.72
Family	\$7.11	\$14.23	\$30.83

	Buy-Up DPPO		
	Weekly	Bi-Weekly	Monthly
Team Member	\$5.04	\$10.08	\$21.85
Team Member + Spouse	\$10.81	\$21.62	\$46.85
Team Member + Children	\$9.40	\$18.80	\$40.73
Family	\$15.81	\$31.62	\$68.52

## Dental Premiums

### Finding In-Network Providers

Remember to visit in-network dentists to receive the deepest level of discount. You also have the option of visiting a Premier dentist and your benefits will be in-network, meaning no balance billing.

To find in-network dentists, visit [www.deltadentaloh.com/findadentist](http://www.deltadentaloh.com/findadentist) Select Delta Dental PPO and Delta Dental Premier

### EXAMPLES OF SERVICES

- ▶ **Preventive**—exams, cleanings, fluoride, X-rays, and sealants
- ▶ **Basic**—fillings, extractions, periodontics, repairs, and oral surgery
- ▶ **Major**—crowns, inlays, dentures, and dental implants

# Vision

We partner with UnitedHealthcare to offer you and your family members vision insurance. Visit [myuhcvision.com](https://myuhcvision.com) to find in-network providers and access a variety of online tools and programs.

	In-Network	Out-of-Network
<b>Copay</b>		
Exam	\$10 copayment	Up to \$40
Materials	\$25 (100% of the billed charge to a maximum of \$130)	Up to \$45
<b>Lenses</b>		
Single	\$25 copayment	Up to \$40 reimbursement
Bifocal	\$25 copayment	Up to \$60 reimbursement
Trifocal	\$25 copayment	Up to \$80 reimbursement
Lenticular	\$25 copayment	Up to \$80 reimbursement
<b>Frames</b>		
	Up to \$130 allowance	Up to \$45
<b>Contact lenses</b>		
Covered Contact Lens Selection	100% after \$25 copay	Up to \$125 reimbursement
Other Contact Lens Option	Up to \$125 allowance	Up to \$125 reimbursement
Medically Necessary Contact Lenses	100% after \$25 copay	Up to \$210 reimbursement
<b>Frequency</b>		
Exam	Every 12 months	
Lenses	Every 12 months	
Contacts (in lieu of glasses)	Every 12 months	
Frames	Every 24 months	

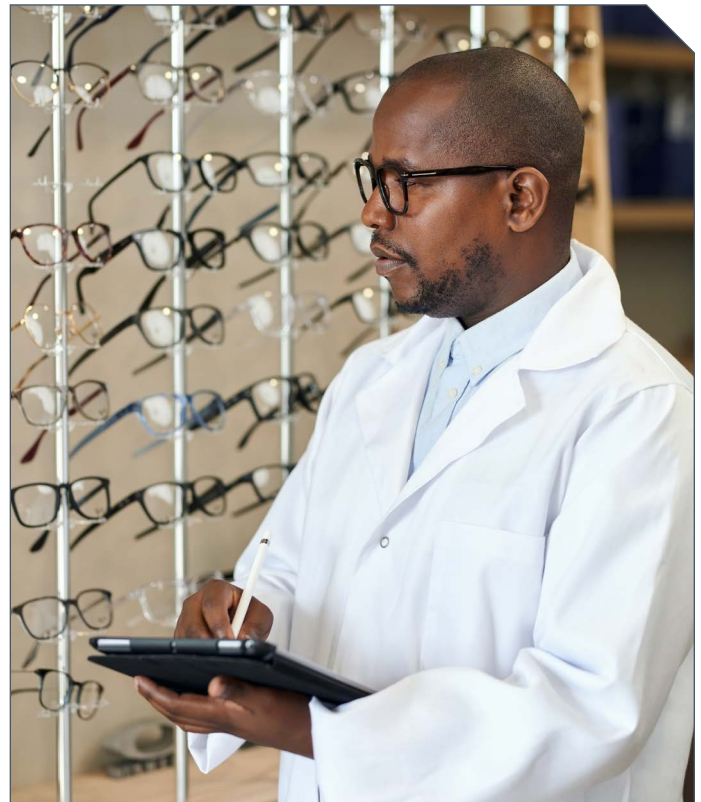
## Finding In-Network Providers

Remember to visit in-network providers to receive the deepest discount.

To find in-network providers, visit [myuhcvision.com](https://myuhcvision.com) or call **800.638.3120**.

## Vision Premiums

	Weekly	Bi-Weekly	Monthly
Employee	\$1.05	\$2.09	\$4.53
Employee + Spouse	\$1.98	\$3.97	\$8.60
Employee + Children	\$2.33	\$4.65	\$10.08
Family	\$3.27	\$6.55	\$14.19



# Life and Disability Insurance

Life and disability insurance is provided through Lincoln Financial.

## Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

The company automatically provides a flat amount of \$50,000 at no cost to you.

## Team Member Voluntary Life

You're eligible to purchase additional life insurance in increments of \$10,000, up to 5 times your annual salary up to a maximum benefit of \$500,000. The Guarantee Issue amount is \$200,000.

## Spouse and Dependent Voluntary Life

If you elect voluntary life coverage for yourself, you can also elect voluntary life coverage for your spouse available in \$5,000 increments up to 2.50 times the team member's annual salary (rounded to the next higher \$5,000), not to exceed 50% of the team member's benefit amount up to \$250,000. The Spouse Guarantee Issue amount is \$30,000. Dependent child life coverage is available in a coverage level of \$10,000. The Child Life maximum age is 26.

**Annual Limited Enrollment:** If you are a continuing team member, you can increase your coverage amount by two levels without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined or withdrawn, you may be required to submit evidence of insurability.

### What is Evidence of Insurability (EOI)?

EOI is information about your health, which the insurance company may require to approve you for coverage.

If you're newly eligible and have not previously waived coverage, you can elect up to the guaranteed issue amount without submitting EOI. You may be required to submit EOI if you have previously waived this coverage or if you elect an amount above the guaranteed issue amount.

In order to start an EOI form please follow these instructions:

1. Log in to my [MyLincolnPortal.com](https://mylincolnportal.com).  
First time user? Register using company code: AWPINCOH
2. Click "Complete Evidence of Insurability."

## Voluntary Short Term Disability (STD)

You are eligible to purchase short term disability (STD) insurance to replace a portion of your income until you get back on your feet and return to work. The plan covers 60% of your pre-disability earnings for up to 13 weeks to a weekly maximum benefit amount of \$1,000 dollars. There is a 8-day waiting period for illnesses, but coverage for an accident will begin immediately.

## Voluntary Long Term Disability (LTD)

You are eligible to purchase long term disability (LTD) insurance to replace a portion of your income in the event you're unable to work for an extended period. The plan covers 60% of your pre-disability earnings. The maximum benefit of base coverage is \$5,000 monthly.



# Monthly Voluntary Life Insurance Premium

## Calculate Your Premium

### Group Life Rates for You

Employee Age Range	Life Premium Rate
0 - 29	\$0.060
30 - 34	\$0.080
35 - 39	\$0.100
40 - 44	\$0.150
45 - 49	\$0.250
50 - 54	\$0.410
55 - 59	\$0.660
60 - 64	\$0.880
65 - 69	\$1.380
70 - 74	\$2.400
75+	\$4.170

### Group Life Rates for Your Spouse

Employee Age Range	Life Premium Rate
0 - 29	\$0.060
30 - 34	\$0.080
35 - 39	\$0.100
40 - 44	\$0.150
45 - 49	\$0.250
50 - 54	\$0.410
55 - 59	\$0.660
60 - 64	\$0.880
65 - 69	\$1.380
70 - 74	\$2.400
75+	\$4.170

### Group Life Rates for your Dependent Child(ren)

Child(ren) Life Premium Rate
\$2.000

One affordable monthly premium covers all of your eligible dependent children.

Note: To be eligible for coverage, a spouse or dependent child cannot be confined on the date the increase or addition is to take effect, it will take effect when the confinement ends

## CALCULATE YOUR COST

Use the appropriate rate provided in the tables above to calculate your cost based on the amount of coverage you select. The following example calculates the monthly cost for a 36-year-old employee who would like to purchase \$100,000 in employee voluntary term life insurance coverage.

Calculation Example	Example	You
Step 1	Using the table above, enter the rate that corresponds with your age.	\$0.100
Step 2	Enter the desired coverage amount in dollars.	\$100,000
Step 3	Enter the desired coverage amount in increments of \$1,000. To calculate, divide the coverage amount by \$1,000.	\$100
Step 4	Calculate the monthly cost. Multiply Step 1 by Step 3.	\$10.00

Note: Rates are subject to change and can vary over time.

# Employee Assistance Program (EAP)

We partner with Lincoln Financial, utilizing their EAP services, EmployeeConnect. EmployeeConnect is an employee assistance program to help you and your family members find solutions and resources to tackle life's challenges. From simple topics such as quick ways to de-stress or how to find more time in your schedule, to more difficult issues such as finding support after the loss of a loved one, your program is there to work with you and offer suggestions, options, and information.

EAP specialists will confidentially discuss challenges you may be facing and provide consultation, information, action plans, and resources. EmployeeConnect offers unlimited access to master's level consultants by telephone, resources and tools online, and up to 5 face-to-face visits (per person, per issue, per year) for help with a short-term problem.

## Accessing the EAP

- ▶ Phone consultations: **888.628.4824**; unlimited calls, 24/7
- ▶ Online tools and resources: [GuidanceResources.com](https://www.guidanceresources.com) or download the GuidanceNow<sup>SM</sup> mobile app
  - ▷ Username: LFGSupport
  - ▷ Password: LFGSupport1
- ▶ Face-to-face counseling: 5 sessions per year, call or email [GuidanceResources.com](https://www.guidanceresources.com) to get started

Strict standards of confidentiality are in place to protect your privacy. Treatment information is not shared with anyone without your written permission.

### Counseling and Work Life Services

- ▶ Stress management
- ▶ Work and home relationships
- ▶ Depression and grief
- ▶ Alcohol and substance abuse
- ▶ Child, adult, and elder care
- ▶ Legal and financial consultations
- ▶ Identity theft

## Additional Resources

### TravelConnect®

#### GLOBAL ASSISTANCE PROGRAM

Provided by On Call International

Medical, security, and travel assistance services for participants traveling 100+ miles from home.

Visit [mysearchlightportal.com](https://mysearchlightportal.com) and enter Group ID #: LFGTravel123 for access to plan documents, international calling instructions, and destination information.

### LifeKeys

- ▶ Save money on shopping and entertainment
- ▶ Help with important life matters
- ▶ Protection against identity theft
- ▶ Online will preparation
- ▶ Guidance and support for your beneficiaries

It's easy to access LifeKeys® services. Just visit [GuidanceResources.com](https://www.guidanceresources.com), download the GuidanceNow mobile app, or call **855.891.3684**. (First-time user: Enter Web ID LifeKeys)

# Voluntary Benefits

Voluntary benefits, administered by Lincoln provide an added layer of financial protection for you and your family. These benefits will help cover any extra out-of-pocket expenses if you suffer an unexpected serious illness or qualifying accident. You'll be able to elect Accident, Critical Illness, and Hospital Indemnity Insurance when you enroll.

## Accident Insurance

Accident insurance provides direct payments to you in the case of an off-the-job accident that results in:

- ▶ Emergency care and/or follow-up care
- ▶ Hospital admission
- ▶ Hospital confinement
- ▶ Accidental death

## Critical Illness

Critical illness insurance provides direct payments to you if you are diagnosed with a covered critical illness such as:

- ▶ Cancer
- ▶ Heart attack
- ▶ Stroke
- ▶ Major organ transplant
- ▶ End stage renal failure

## Hospital Indemnity

The Hospital Indemnity plan insurance provides direct payments if you are hospitalized. It includes separate amounts for events such as:

- ▶ Hospital admission
- ▶ Hospital confinement
- ▶ Hospital intensive care

## Accident Insurance Premiums

Coverage Level	Monthly Contribution
Employee	\$13.10
Employee + Spouse	\$22.29
Employee + Children	\$24.93
Family	\$33.83

## Critical Illness Premiums

Option(s) of \$10,000, \$15,000, or \$20,000 of Coverage on Yourself For Your Spouse, You Can Purchase Either \$10,000 or \$15,000		
Age	Employee Monthly per \$1,000	Spouse Monthly per \$1,000 (based off employee's age)
Under 24	\$0.348	\$0.348
25-29	\$0.474	\$0.474
30-34	\$0.599	\$0.599
35-39	\$0.804	\$0.804
40-44	\$1.207	\$1.207
45-49	\$1.867	\$1.867
50-54	\$2.658	\$2.658
55-59	\$3.606	\$3.606
60-64	\$5.155	\$5.155
65-69	\$7.273	\$7.273
70+	\$7.369	\$7.369
Child(ren) monthly rate per \$1,000 of coverage \$0.573		

\* Spouse premiums are based on Employee's age.

## Hospital Indemnity Premium

Coverage Level	Monthly Contribution
Employee	\$25.45
Employee + Spouse	\$55.66
Employee + Children	\$40.53
Family	\$73.95

## Wellness Benefit Payment

If enrolled in Voluntary Benefits through Lincoln, this payment is available each year when you and your covered dependents complete a health screening test. Health screening tests include: accident/fall prevention counseling (adult only); annual physical; child immunizations (DTP, MMR, Rotavirus, Chickenpox, Meningitis); child sports/school physicals; child concussion screening; dental preventative exams; depression screening; eye exam; hearing exam; osteoporosis screening (adult only); substance abuse screening/counseling; tetanus immunization.

	Critical Illness Insurance	Accident Insurance
Health Screening Benefit	\$50	\$50

For more information, visit [www.LincolnFinancial.com](http://www.LincolnFinancial.com).

### Jaime's Story

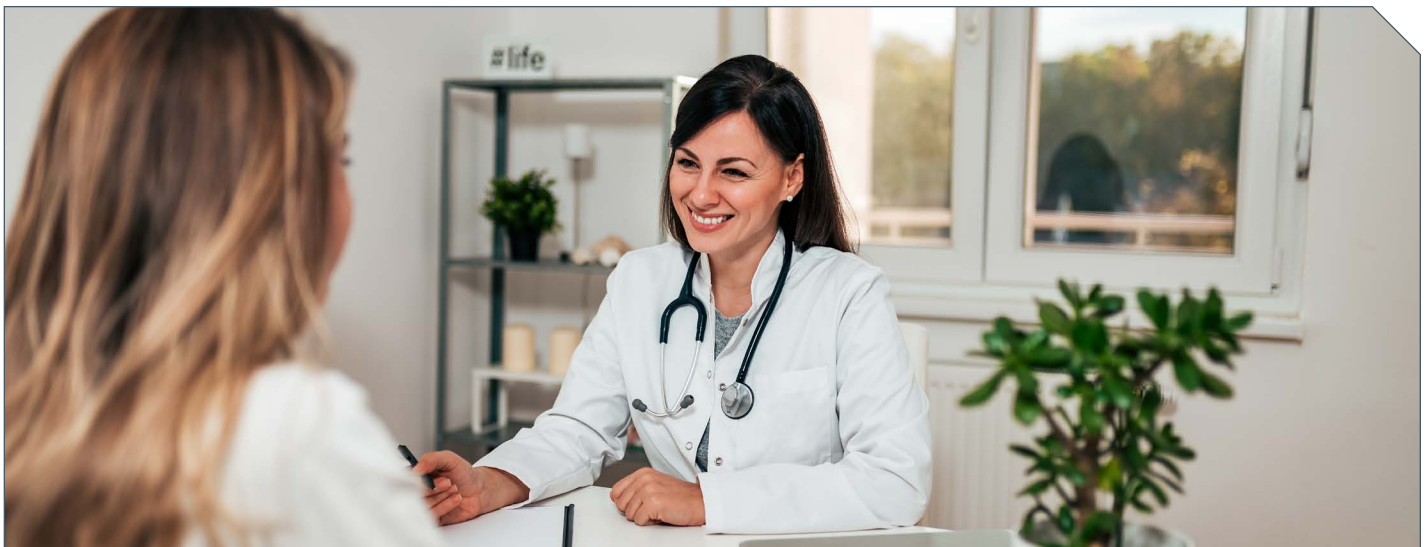
Jaime's enjoyable bike ride takes a turn when he's struck by a car and sustains a fractured arm and concussion. He's taken by ambulance to the hospital. His medical expenses total \$2,760. Jaime was enrolled in the Lincoln Accident plan, which paid him \$975 to assist with his out-of-pocket expenses.

Amount Paid to Jaime	
Ambulance	\$225
Emergency Room	\$150
Arm Fracture	\$450
Concussion	\$150
<b>Total Direct Benefit Payment to Jaime</b>	<b>\$975</b>

### Donna's Story

Donna's life turned upside down when she suffered a heart attack, which was followed by a stroke only a month later. She missed work and so did her husband, as he helped her recover. Their income took a hit and bills piled up. Donna was enrolled in the Lincoln Critical Illness plan with no pre-existing exclusions and a \$20,000 benefit per diagnosis. She received \$40,000 in her family's time of need.

Amount Paid to Donna	
Heart Attack	\$20,000
Stroke	\$20,000
<b>Total Direct Benefit Payment to Donna</b>	<b>\$40,000</b>



# Voluntary Benefits

During these unprecedented times, it is important to safeguard not only our physical health, but our digital and financial health as well. With an identity theft protection plan from IDShield and a legal protection plan from LegalShield, you can have peace of mind knowing your identity and legal rights are secure.

## Legal Insurance— LegalShield

Services include:

- ▶ Legal Consultation and Advice
- ▶ Court Representation
- ▶ Dedicated Provider Law Firm
- ▶ Legal Document Preparation and review
- ▶ Will Preparation
- ▶ Letters and Phone Calls Made on Your Behalf
- ▶ Speeding Ticket Assistance
- ▶ 24/7 Emergency Legal Access

## ID Theft—IDShield

Benefits offered:

- ▶ Identity Consultation and Advice
- ▶ Dedicated Licensed Private Investigators
- ▶ Identity, Credit, and Financial Account Monitoring
- ▶ Child Monitoring (Family Plan Only)
- ▶ Full-Service Identity Restoration
- ▶ Real-Time Alerts
- ▶ 24/7 Emergency Access
- ▶ Social Media Monitoring and Online Privacy Reputation Management

## LegalShield Only

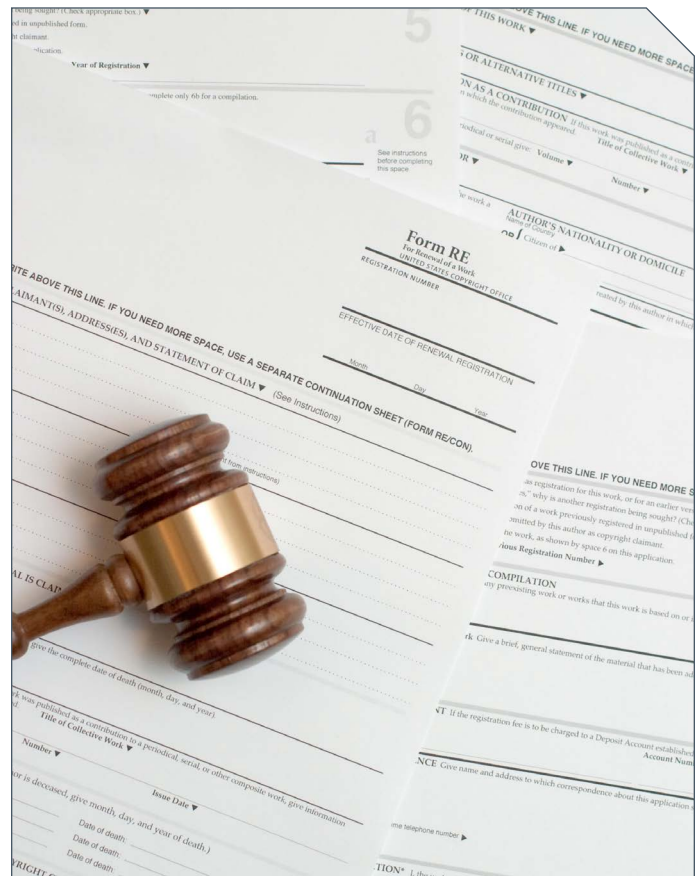
	Monthly	B-Weekly	Weekly
Composite Rate	\$16.30	\$7.52	\$3.76

## IDShield Only

	Monthly	B-Weekly	Weekly
Employee	\$7.45	\$3.44	\$1.72
Family	\$14.05	\$6.48	\$3.24

## IDShield IF Legal is Purchased

	Monthly	B-Weekly	Weekly
Employee	\$6.45	\$2.98	\$1.49
Family	\$12.05	\$5.56	\$2.78



# How to Save on Medical Costs

## Know Where to Go

To get the right care when you need it, it's important to understand your options. You can save time and money by going to an urgent care center instead of the ER if you need care right away. The three medical plans have different costs for services. If you need help deciding where to go, call the number on the back of your medical ID card.

You May Want to Visit...	To Take Care of...
Your Doctor's Office	Routine checkups, preventive care, immunizations, managing your general health
An Urgent Care Center	Sprains, minor infections, minor broken bones (like a finger), or minor burns
A Hospital Emergency Room	Life-threatening conditions, major broken bones, difficulty breathing, chest pain, severe injuries, or burns



## Access Preventive Care

Preventive care like physicals, immunizations, well woman exams, and routine screenings are important for managing your health, because many of the major risk factors leading to serious health conditions are preventable.

- ▶ Knowing your numbers, like cholesterol level, blood pressure, blood sugar, and body mass index (BMI) can also help you learn what you need to do to stay healthy.
- ▶ Visiting your doctor for a physical and other routine preventive screenings can help you identify your risk factors and learn how to deal with them.
- ▶ All three medical plans cover in-network preventive care at 100% with no copay or deductible.
- ▶ UnitedHealthcare also offers tools and resources to help you keep track of your health and live a healthy lifestyle. Find information on their website at [www.myuhc.com](http://www.myuhc.com).

## Be a Smart Healthcare Consumer

1. **Consider which medical plan is best for you when enrolling.** Take into account how frequently you visit the doctor throughout the year to determine if the PPO or High Deductible plan would work best for you.
2. **Save time and money by using in-network doctors and pharmacies.** You'll pay less out-of-pocket and there's no need to fill out forms.
3. **Ask for generic drugs.** Generic drugs are required to have the same active ingredients as their brand-name counterparts, they are FDA approved, and they save you money.
4. **Use the Discount Drug Programs.** Walmart, Target, and most major grocery chains offer hundreds of generic drugs at steep discounts. Check to find out if any of your generic drugs are provided either free or at a reduced cost.
5. **Keep yourself and your family healthy.** Exercising, eating right, managing stress and not smoking are just some of the ways to prevent health problems from developing. Take advantage of preventive health services covered by the medical plan. It is less costly to prevent illness than to treat a disease.
6. **Only go to the hospital emergency room for true emergencies.** If you need medical care when your regular doctor is not available, think about going to an urgent care center rather than a hospital emergency room. This can often be a tough call, but for a cold or a minor sprain, avoiding the ER can save you money.

## Meet "Consumerism Connie"

Takeaways: "Know Before You Go" time investment can help achieve higher quality outcome and save money!

### Her Story

Consumerism Connie's doctor, Conrad, recommended a hip replacement surgery. Connie's first inclination was to have the procedure done within Dr. Conrad's health system, Centerville City Care Center, that she and the doctor have been part of for decades. But, being the cost-conscious consumer that Connie is (she loves a bargain!), she also wants quality care, and conducts due diligence/research on her proposed procedure.

After logging-in to UHC's website ([www.myuhc.com](http://www.myuhc.com)), Connie uses the Care & Cost Finder tool to review alternatives, ratings, and pricing, much like a consumer does. A review of her findings is summarized below.

### TOP FOUR "CONSUMERISM" TAKEAWAYS

1. **Choice**—There were four in-network options where Connie could have the procedure done.
2. **Convenience**—All 4 options were only 1.1-3.8 miles away.
3. **Cost**—Total estimated cost ranged from \$33.0K-\$41.4K, although would hit her OOP maximum regardless.
4. **Quality**—Average star rating ranges from 3.0 to 4.0.

# AWP Contributes to Your 401(k)!

AWP partners with Principal Financial to help you prepare for life after your career. Whether you're a new investor or have been saving for years, it's always a good time to think about saving for retirement. Do not miss out on AWP's 401(k) match. If you are eligible\* for the match and not contributing at least 6% to our 401(k), you are leaving free money on the table. AWP will fund an employer match directly into your 401(k) of 25% on the first 6% of your contribution. For example:

Team Member Contribute 6% Per Paycheck	
Your Contribution Is	\$60
The AWP Contribution (match)	\$15
<b>For a Total Contribution of</b>	<b>\$75</b>

You are always 100% vested in the funds you contribute which means you always own those funds. For the company match contributions, you are 50% vested after one year and 100% vested after 2 years.

## Are Roth or Regular Contributions Right for You?

The difference between Roth contributions and regular contributions has a lot to do with when you pay taxes. Figuring out when it is best for you to pay taxes—now or later—can be tricky but could make a difference for you in retirement.

### Regular Contributions to Your AWP 401(k)

- ▶ You **do not** pay taxes now on the money you contribute.
- ▶ You **do** pay taxes on the money later when you withdraw it from your 401(k).
- ▶ May be a good option if you think your tax rate will go **down** in retirement.

### Roth Contributions to Your AWP 401(k)

- ▶ You **do** pay income tax now on the money you contribute.
- ▶ You **do not** pay taxes on the money later when you withdraw it from your 401(k), if you're at least 59½ years old and the money has been in the account for at least five years.
- ▶ May be a good option if you think your tax rate will be **higher** in retirement.

\* All U.S. non-union team members across the AWP family of brands are eligible.

## Contact Principal

Principal has a dedicated team to answer your questions at **800.986.3343**. Download the Principal app for account management and a customized user experience.

APP STORE



GOOGLE PLAY



## Register for Principal



# Contact Information



## MEDICAL AND PRESCRIPTION

UnitedHealthcare  
Group #929408  
**833.404.2736**  
[www.myuhc.com](http://www.myuhc.com)  
Surest  
**866.683.6440**  
[www.surest.com](http://www.surest.com)



## ACCIDENT, HOSPITAL INDEMNITY AND CRITICAL ILLNESS

Lincoln Financial Group  
Customer #AWPINCOH  
**800.423.2765**  
[LincolnFinancial.com/claimforms](http://LincolnFinancial.com/claimforms)



## KAISER PERMANENTE HI

Group Number 8799  
**800.966.5955**  
[www.kp.org](http://www.kp.org)



## DENTAL

Delta Dental  
Group #10620  
**800.524.0149**  
[www.deltadentaloh.com/findadentist](http://www.deltadentaloh.com/findadentist)

## KAISER PERMANENTE CA

SCAL Group #230430  
NCAL Group #603125  
**800.464.4000**  
[www.kp.org](http://www.kp.org)



## VISION

UnitedHealthCare  
Group # 929408  
**800.638.3120**  
[myuhcvision.com](http://myuhcvision.com)

## TELEMEDICINE

UnitedHealthcare  
[myuhc.com/virtualvisits](http://myuhc.com/virtualvisits)

## LIFE AND DISABILITY



Lincoln Financial Group  
Customer #AWPINCOH  
**800.487.1485**  
[www.lfg.com/public/individual/contactformsclaims/disabilityinsurance](http://www.lfg.com/public/individual/contactformsclaims/disabilityinsurance)



## HEALTH SAVINGS ACCOUNT (HSA)

Optum Bank  
**877.470.1771**  
[www.optumbank.com/health-accounts](http://www.optumbank.com/health-accounts)

## LEGALSHIELD AND IDSHIELD



Group #303193  
**888.807.0407**  
[benefits.legalshield.com/awp](http://benefits.legalshield.com/awp)



## FLEXIBLE SPENDING ACCOUNT (FSA)

Surency  
**866.451.3399**  
[www.surency.com/](http://www.surency.com/)

## GENERAL BENEFITS QUESTIONS



**800.590.9857**  
Ask for AWP's Benefits Coordinator  
[awpbenefits@lockton.com](mailto:awpbenefits@lockton.com)



## 401(K)

Principal  
Policy Number 473063  
**800.986.3343**  
[www.principal.com/welcome](http://www.principal.com/welcome)



## EMPLOYEE ASSISTANCE PROGRAM

**888.628.4824**  
[guidanceresources.com](http://guidanceresources.com)  
Username: LFGSupport  
Password: LFGSupport1  
Download the GuidanceNow<sup>SM</sup> mobile app

# AWP Safety

## HEALTH PLAN NOTICES

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1. Medicare Part D Creditable Coverage Notice
2. HIPAA Comprehensive Notice of Privacy Policy and Procedures
3. Notice of Special Enrollment Rights
4. General COBRA Notice
5. Women’s Health and Cancer Rights Notice
6. Michelle’s Law Notice
  - This notice is still required when a health plan permits dependent eligibility beyond age 26, but conditions such as eligibility on student status. Further, the notice is still necessary if the plan permits coverage for non-child dependents (e.g., grandchildren) that is contingent on student status. The notice must go out whenever certification of student status is requested.
7. Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

### IMPORTANT NOTICE

**This packet of notices related to our health care plan includes a notice regarding how the plan’s prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, “Important Notice From AWP Safety About Your Prescription Drug Coverage and Medicare.”**

**MEDICARE PART D CREDITABLE COVERAGE NOTICE IMPORTANT NOTICE FROM AWP  
SAFETY 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 AWP Safety and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. AWP Safety has determined that the prescription drug coverage offered by the AWP Safety Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

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Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

**Enrolling in Medicare—General Rules**

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

**Late Enrollment and the Late Enrollment Penalty**

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

**Special Enrollment Period Exceptions to the Late Enrollment Penalty**

There are “special enrollment periods” that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes “creditable” prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

**Compare Coverage**

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. See the AWP Safety Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting us at the telephone number or address listed below.

**Coordinating Other Coverage With Medicare Part D**

Generally speaking, if you decide to join a Medicare drug plan while covered under the AWP Safety Plan due to your employment (or someone else’s employment, such as a spouse or parent), your coverage under the AWP Safety Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your AWP Safety prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan’s eligibility and enrollment rules. You should review the Plan’s summary plan description to determine if and when you are allowed to add coverage.

**For More Information About This Notice or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information, or call 330-617-4651. **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 AWP Safety changes. You also may request a copy.

**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](http://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](http://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 whether or not you are required to pay a higher premium (a penalty).**

Date:	November 1, 2024
Name of Entity/Sender:	Lorissa Amorose
Contact—Position/Office:	Sr. Manager, Total Rewards
Address:	4244 Mt. Pleasant St. NW N. Canton, OH 44720
Phone Number:	330-617-4651

**HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY  
AND PROCEDURES**

**AWP Safety  
Important Notice  
Comprehensive Notice of Privacy Policy and Procedures**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice is provided to you on behalf of:

**AWP, Inc. DBA Area Wide Protective\***

\* This notice pertains only to healthcare coverage provided under the plan.

**The Plan’s Duty to Safeguard Your Protected Health Information**

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan’s Privacy Official, described below), and will be posted on any website maintained by AWP Safety that describes benefits available to employees and dependents.

**Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents’) right to coverage under the Plan is determined solely under the terms of the Plan.**

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

### How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
  - **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as AWP Safety) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

### **Your Rights Regarding Your Protected Health Information**

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

### **How to Complain About the Plan's Privacy Practices**

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

### **Notification of a Privacy Breach**

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

### **Contact Person for Information, or to Submit a Complaint**

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

### **Privacy Official**

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Lorissa Amorose  
Sr. Manager, Total Rewards  
330-617-4651

### **Effective Date**

The effective date of this notice is: November 1, 2024.

## NOTICE OF SPECIAL ENROLLMENT RIGHTS

### AWP SAFETY EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *60 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within *60 days* of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within *60 days* after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *60 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Lorissa Amorose  
Sr. Manager, Total Rewards  
330-617-4651

*\* This notice is relevant for healthcare coverages subject to the HIPAA portability rules.*

## GENERAL COBRA NOTICE

### Introduction

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

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

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

### What is COBRA continuation coverage?

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

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

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

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

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

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

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

**When is COBRA continuation coverage available?**

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

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

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.**

**How is COBRA continuation coverage provided?**

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

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

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

**Disability extension of 18-month period of COBRA continuation coverage**

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

**Second qualifying event extension of 18-month period of continuation coverage**

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

**Are there other coverage options besides COBRA Continuation Coverage?**

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period<sup>1</sup> to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

**If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan contact information**

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Lorissa Amorose  
Sr. Manager, Total Rewards  
4244 Mt. Pleasant St. NW  
N. Canton, OH 44720  
330-617-4651

**WOMEN'S HEALTH AND CANCER RIGHTS NOTICE**

AWP Safety Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The AWP Safety Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

PPO \$1,000	In-Network	Out-of-Network
Individual Deductible	\$1,000	\$4,000
Family Deductible	\$3,000	\$8,000
Coinsurance	20%	40%
HDHP \$3,200	In-Network	Out-of-Network
Individual Deductible	\$3,200	0
Family Deductible	\$6,400	0
Coinsurance	0%	40%

HDHP \$6,000	In-Network	Out-of-Network
Individual Deductible	\$6,000	\$6,000
Family Deductible	\$12,000	\$12,000
Coinsurance	20%	40%

If you would like more information on WHCRA benefits, please refer to your Policy Booklet or contact your Plan Administrator at:

Lorissa Amorose  
Sr. Manager, Total Rewards  
330-617-4651

### MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Lorissa Amorose, Sr. Manager, Total Rewards, 330-617-4651.







This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.