AWP Safety

2026

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). You may enroll in the benefits program only during the **next annual enrollment period**.

If you reside in Hawaii, you are only eligible for the Hawaii Kaiser Plan.

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**. 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.

Benefits Resource Center

Your Choice, Our Commitment

REWARDS DESIGNED FOR YOU

All employees have access to our Benefits Helpline. Benefits Specialists are available by phone and email to provide one-on-one employee service and education, including comprehensive understanding of benefits options and the benefit enrollment process.

The benefits specialist team is available to:

- Answer employee questions on AWP Safety's comprehensive benefits package.
- Provide a personal way for you to understand your benefits.
- Assist new hires.
- Answer basic claims questions.
- Navigate benefit updates and changes if experiencing a QLE.
- Transfer and/or provide contact information for internal resources or vendor partners.
- Provide open enrollment support.

Benefits Helpline

Monday-Friday, 8:30 a.m. to 5 p.m. CST
AWPBenefits@lockton.com
800.590.9857

Medical and Prescription Plan

AWP Safety partners with UnitedHealthcare to offer medical and prescription drug insurance. If you reside in California, you have the option of enrolling in Kaiser. **If you reside in Hawaii, you are only eligible for the Hawaii Kaiser Plan.**

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**:

- Search for in-network providers and pharmacies under the **Choice Plus** Network
- See a list of covered medications under the **Advantage** 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 healthcare financial account(s) such as HSA
- Compare prescription costs and order refills

GET IT ON Google Play Download on the App Store

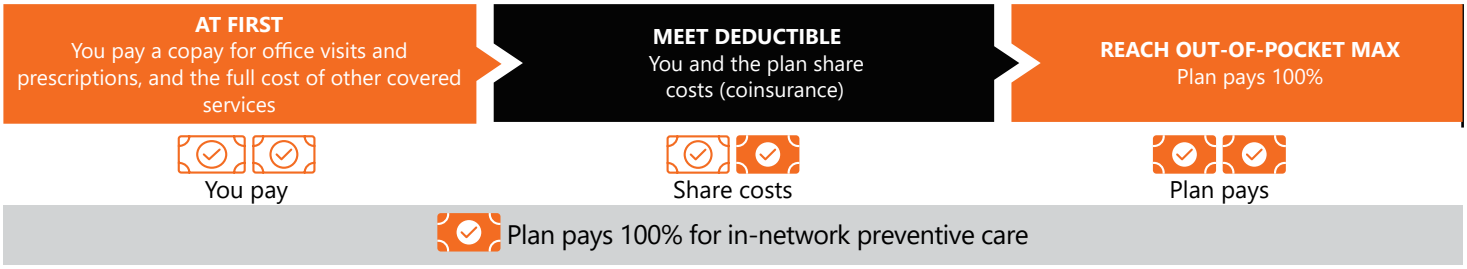
Important Insurance Terms

- **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

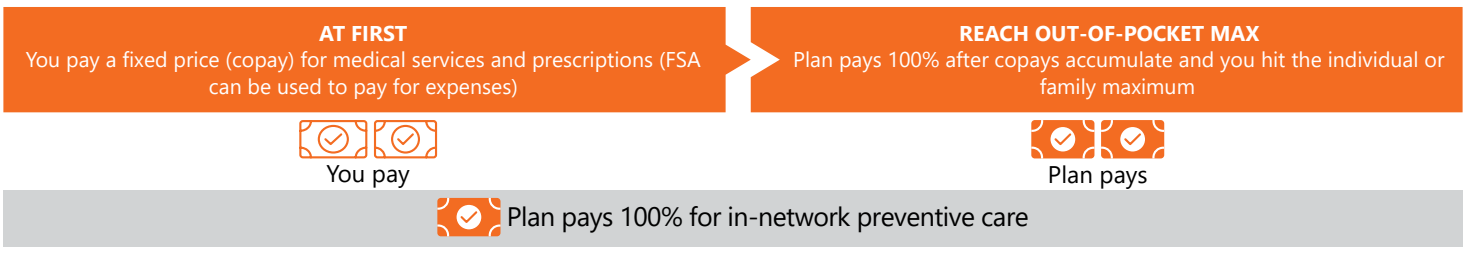
You have a choice of medical plans with a range of coverage levels and costs, so you have the flexibility to select the option that's best for you. UnitedHealthcare (UHC) and Surest are some of our health insurance carriers for 2026. You have two plan options through UHC and one through Surest, providing both in- and out-of-network coverage (you pay less when you stay in-network). **If you reside in Hawaii, you are only eligible for the Hawaii Kaiser Plan.**

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 Healthcare Flexible Spending Account.



2. **UHC $3,400 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.

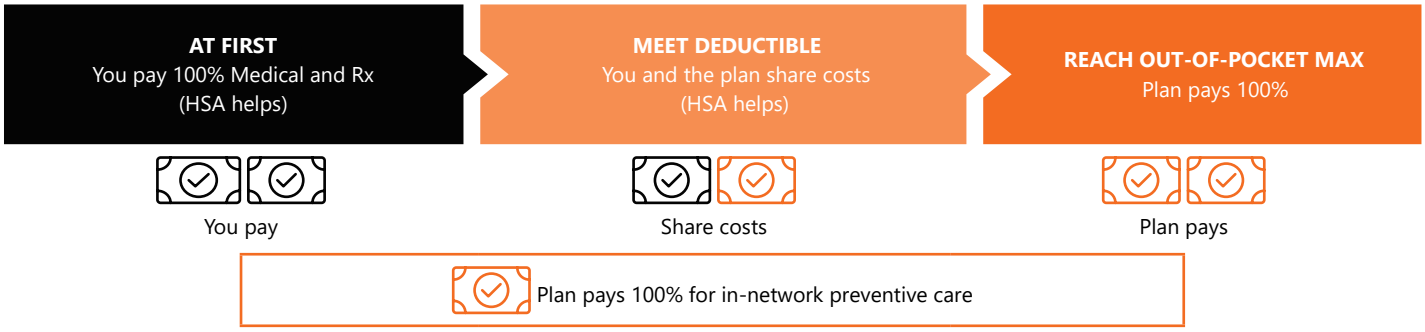
3. **Surest PPO Plan:** With this plan, there's no deductible or coinsurance. Instead, all your healthcare purchases have a fixed price (copay) for your out-of-pocket costs. So you know the cost of your treatment options before you go to the doctor. If you enroll in this option, you can enroll in a Healthcare 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 well-acquainted with them, 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** 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 three plan options compare based on 2026 costs.

	PPO $1,500	HDHP $3,400	Surest
Individual Annual Premium—2026	$3,471.36	$1,859.64	$1,104.48
Individual Annual In-Network Deductible	$1,500	$3,400	$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 $3,400	Surest	PPO $1,500	HDHP $3,400	Surest	PPO $1,500	HDHP $3,400	Surest
Employee	$76.03	$42.55	$29.19	$152.06	$85.11	$58.38	$329.47	$184.40	$126.48
Employee + Spouse	$216.49	$132.72	$99.07	$432.98	$265.44	$198.15	$938.13	$575.12	$429.32
Employee + Children	$163.05	$98.87	$70.47	$326.10	$197.75	$140.94	$706.56	$428.45	$305.37
Family	$330.17	$197.22	$139.15	$660.35	$394.44	$278.31	$1,430.75	$854.61	$603.00

Medical Plan Details

	PPO $1,500		HDHP $3,400		Surest	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible						
Individual	$1,500	$4,000	$3,400	$3,400	$0	$0
Family	$4,500	$8,000	$6,800	$6,800	$0	$0
Out-of-Pocket Maximum (includes deductible)						
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
Physician Office Visits						
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
Hospital Services						
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
Prescription Drugs (Advantage Formulary)						
Please note: 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
Mail Order						
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.

Discover a new way to better health

virta

Take control of your health with a proven, no-cost nutrition program

- Virta is an online, personalized nutrition program that helps you lose weight, lower blood sugar, and even reverse type 2 diabetes
- It is backed by doctors and trusted by thousands – no calorie counting, medications, or extra gym visits needed.

At no cost to you, you'll receive:

- Personalized health coaching
- Connected weight scale and blood meter
- Exclusive nutrition resources and recipes
- Dedicated medical guidance

Join the thousands of people using Virta and transforming their lives

"Because there is no calorie counting on Virta, I'm not hungry. And because I'm not hungry, I'm not craving unhealthy foods. **I've never gone longer than 6 months on the diets I've tried. But It's been a little over a year since I started Virta and I feel incredible."**

-Allison, benefits leader and Virta member

Visit www.virtahealth.com to explore how Virta works

*Virta is available to individuals over the ages of 18 and are enrolled in a covered health plan. There are some serious medical conditions that would exclude patients from Virta.

Type 2 diabetes reversal on Virta is defined by reaching HbA1c below 6.5% without the use of diabetes medications beyond metformin. Diabetes and related issues can return if lifestyle changes are not maintained.

Frequently Asked Questions

What is Virta Health?

Virta is a guided nutrition program to lose weight and reverse type 2 diabetes. Personalized and flexible to your lifestyle, learn to eat foods that are right for you. On demand support from providers and health coaches along with personalized feedback empower you to lose weight, lower your blood sugar, and transform your health.

What Does it Mean to Reverse an Issue Like Type 2 Diabetes?

Reversal of type 2 diabetes on Virta is defined by reaching an A1c below 6.5% without the use of diabetes medications beyond metformin. Diabetes and related issues can return if lifestyle changes are not maintained.

What Results can Members see?

Based on a clinical study, in just 10 weeks, Virta members lost 18 lbs on average, reduced their A1c by 1.0 on average, and 87% were able to stop or reduce medications. Members have also seen improvements in sleep and blood pressure.

Am I Covered for Care?

Virta is fully covered by AWP and available at no cost to you.

What's Included in a Care Plan?

Your custom Virta plan is designed to meet your preferences, budget, and lifestyle. Every member has exclusive access to:

- An app for continuous health insights
- Digital weight scale and blood meter that syncs with their phone
- One-on-one health coach support
- Personalized plan backed by clinical research
- Medical provider to safely reduce unwanted medications

Is Virta Right for Me?

Virta takes a personal approach to care. This has helped members of diverse backgrounds, needs, and lifestyles find success.

Virta is not a good fit if you:

- Are younger than 18 years old
- Are pregnant or nursing
- Have stage 4 or 5 chronic kidney disease
- Have end-stage renal disease on dialysis
- Had diabetic ketoacidosis in the past 12 months

How Do I Enroll?

Individuals will start their journey by creating a Virta account, where their eligibility will be confirmed. They'll then complete a health screening, where they'll share lab work results and meet with a Virta clinician for medical clearance.

Download the Virta app

Open your smartphone's camera to scan the QR code and download the Virta app today

Download on the App Store

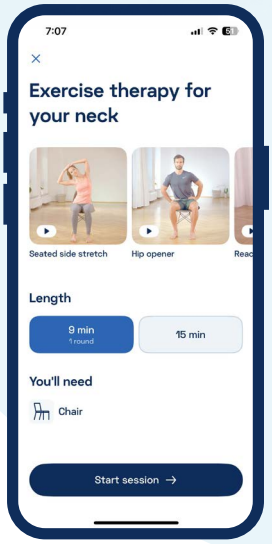
GET IT ON Google Play

"I feel like I have control of my pain and I absolutely love the exercise!"

kaia health

Struggling with joint and muscle pain?

We have partnered with Kaia Health to provide therapy for back, neck, shoulder, knee, hip pain, and more **- at no cost to you.**



- **Personalized therapy** sessions that take 15 minutes
- A dedicated **health coach** to help you meet your goals
- An app that you can use **anywhere, anytime** - no appointments
- $0 Unlimited access for the full year **at no cost to you** and your dependents

Join 500,000+ members who have turned to Kaia to reduce their pain

Scan the QR code to learn more and apply at
startkaia.com/now

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	$1,000
Family	$2,000
Out-of-Pocket Maximum (includes deductible)	
Individual	$3,800
Family	$7,600
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	20% after deductible
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	$29.80	$59.60	129.14
Employee/Spouse	$101.15	$202.31	438.33
Employee + Child(ren)	$85.15	$170.29	368.97
Family	$126.72	$253.44	549.13

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

Medical Insurance Plan Option for Hawaii Team Members

Kaiser Permanente HMO

(Available to Hawaii-based team members only)

If you reside in Hawaii, you are only eligible for the Hawaii Kaiser Plans. 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)	$9.65	$19.30	$41.82
EE + Spouse	$95.85	$191.70	$415.35
EE + Child(ren)	$86.26	$172.52	$373.80
Family	$148.91	$297.81	$645.26

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

We're pleased to introduce the Kaiser Permanente Point-of-Service Plan as a new buy-up option for 2026. This plan offers greater flexibility and provider choice while maintaining access to Kaiser Permanente's high-quality care and services.

Why Choose the Buy-Up Plan?

This plan is ideal for members who want the freedom to choose providers both inside and outside the Kaiser Permanente network, with tiered coverage options that balance flexibility and cost.

Three Tiers of Provider Access:

- Tier 1: Kaiser Permanente Providers
- Tier 2: Participating Network Providers
- Tier 3: Nonparticipating Providers

This plan offers a "best of both worlds" solution—the coordinated care of Kaiser Permanente with the flexibility to see outside providers when needed.

Kaiser HI Buy-Up

	Buy-Up	
	In-Network—Tier 1	Contracted Network Tier 2 and Out-of Network Tier 3
Deductible		
Single	$0 (none)	$100
Family	$0 (none)	$300
Out-of-Pocket Maximum		
Single	$2,000	$2,000
Family	$6,000	$6,000
Coinsurance		
	20%	
Physician Office Visits		
Preventive Care	Covered at 100%	
Primary Care Visit	$20	Coinsurance/deductible
Specialist Visit	$20	Coinsurance/deductible
Urgent Care	$15	
Hospital Services		
Inpatient	10%	20%
Outpatient	10%	20%
Emergency Room	$100	
Pharmacy—Retail		
Generic Maintenance	$3	20%
Other Generic	$10	20%
Brand	$45	20%
Specialty	$200	20%

Medical Plan Premiums			
	Weekly	Bi-Weekly	Monthly
Employee (EE)	$79.09	$158.17	$342.70
EE + Spouse	$196.61	$393.22	$851.98
EE + Child(ren)	$180.55	$361.11	$782.40
Family	$333.36	$666.72	$1,444.55

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**.

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.

2026 HSA Funding Limits	
Coverage Level	Limit
Individual Coverage	$4,400
Family Coverage	$8,750
Age 55 or Older	Contribute an additional $1,000 on top of these amounts

Opening an HSA

We partner with Forma 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 2026 is $3,400*.

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 $7,500* (or $3,750* 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 $680 into the new 2027 plan year. You will lose any balance above the $680.

* *These limits are subject to change. Visit 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 2026 limit is $4,400 for individuals and $8,750 for families. If you're 55 or older, you can add $1,000.	Only you contribute to your account. The 2026 limit is $3,400.
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 **joinforma.com** or download the Forma 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** 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
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Calendar Year Maximum		
	$1,000	$2,500
Coinsurance		
Preventive	Covered at 100%	Covered at 100%
Basic	20% after deductible	10% after deductible
Major	50% after deductible	40% after deductible
Orthodontia		
OON Reimbursement	90th UCR	90th UCR
Coinsurance	50% after deductible	50% after deductible
Lifetime Maximum	$1,000	$2,500
Benefit Applies To	Children	Children

Dental Premiums

	Base DPPO		
	Weekly	Bi-Weekly	Monthly
Team Member	$2.27	$4.53	$9.82
Team Member + Spouse	$4.77	$9.55	$20.69
Team Member + Children	$4.47	$8.93	$19.35
Family	$7.35	$14.71	$31.87

	Buy-Up DPPO		
	Weekly	Bi-Weekly	Monthly
Team Member	$5.21	$10.43	$22.59
Team Member + Spouse	$11.18	$22.36	$48.44
Team Member + Children	$9.72	$19.44	$42.11
Family	$16.42	$32.84	$71.15

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** 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** to find in-network providers and access a variety of online tools and programs.

	In-Network	Out-of-Network
Copay		
Exam	$10 copayment	Up to $40
Materials	$25 (100% of the billed charge to a maximum of $130)	Up to $45
Lenses		
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
Frames		
	Up to $130 allowance	Up to $45
Contact lenses		
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
Frequency		
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** 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**.
   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.	$0.10	
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	

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** or download the GuidanceNow℠ mobile app
  - Username: LFGSupport
  - Password: LFGSupport1
- Face-to-face counseling: 5 sessions per year, call or email **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** 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**, 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**.

Jaime's Story

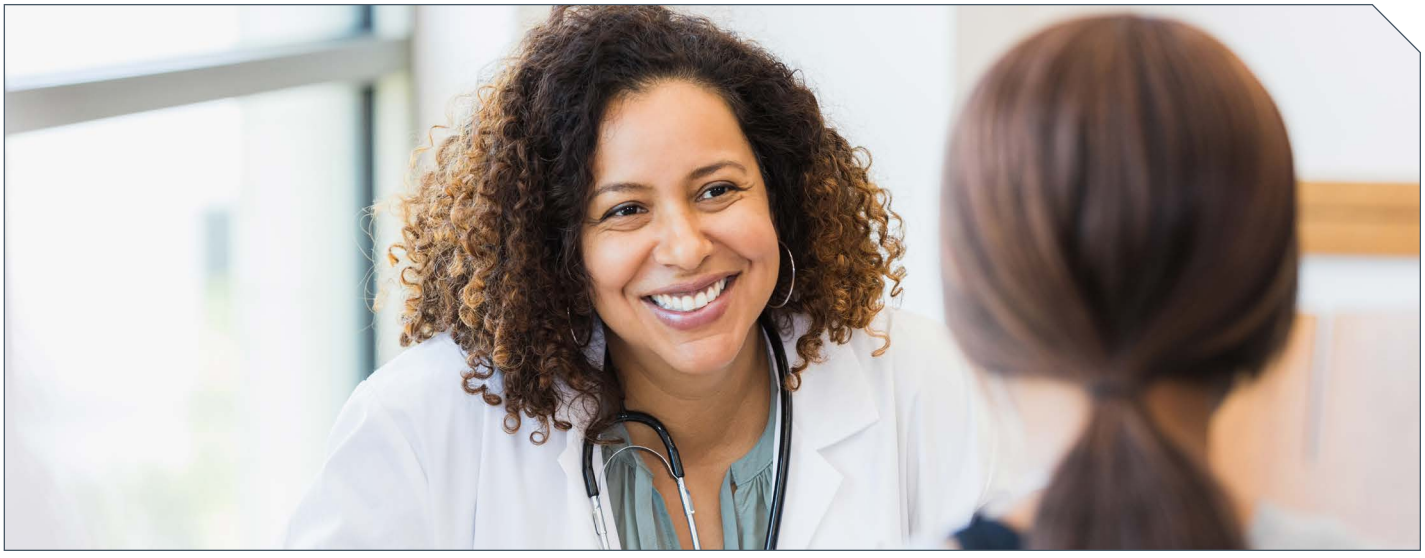
Jaime's enjoyable bike ride takes a turn when he's struck by a car and sustains a fractured arm and concussion. He's taken by ambulance to the hospital. His medical expenses total $2,760. Jaime was enrolled in the Lincoln Accident plan, which paid him $975 to assist with his out-of-pocket expenses.

Amount Paid to Jaime	
Ambulance	$225
Emergency Room	$150
Arm Fracture	$450
Concussion	$150
Total Direct Benefit Payment to Jaime	**$975**

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
Total Direct Benefit Payment to Donna	**$40,000**



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**.

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**), 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
For a Total Contribution of	**$75**

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

SCAN ME

GOOGLE PLAY

SCAN ME

Register for Principal

Contact Information

MEDICAL AND PRESCRIPTION

UnitedHealthcare
Group #929408
833.404.2736
www.myuhc.com
Surest
Group #1709188
866.683.6440
www.surest.com

KAISER PERMANENTE HI

Group Number 8799
800.966.5955
www.kp.org

KAISER PERMANENTE CA

SCAL Group #230430
NCAL Group #603125
800.464.4000
www.kp.org

TELEMEDICINE

UnitedHealthcare
myuhc.com/virtualvisits

HEALTH SAVINGS ACCOUNT (HSA)

Forma
844.902.2902
joinforma.com

FLEXIBLE SPENDING ACCOUNT (FSA)

Forma
844.902.2902
joinforma.com

401(K)

Principal
Policy Number 473063
800.986.3343
www.principal.com/welcome

ACCIDENT, HOSPITAL INDEMNITY, AND CRITICAL ILLNESS

Lincoln Financial Group
Company Code LF1842AWP
800.423.2765
LincolnFinancial.com/claimforms

DENTAL

Delta Dental
Group #10620
800.524.0149
www.deltadentaloh.com/findadentist

VISION

UnitedHealthcare
Group # 929408
800.638.3120
myuhcvision.com

LIFE AND DISABILITY

Lincoln Financial Group
Company Code LF1842AWP
800.487.1485
www.lfg.com/public/individual/contactformsclaims/disabilityinsurance

LEGALSHIELD AND IDSHIELD

Group #303193
888.807.0407
benefits.legalshield.com/awp

GENERAL BENEFITS QUESTIONS

800.590.9857
Ask for AWP's Benefits Coordinator
awpbenefits@lockton.com

EMPLOYEE ASSISTANCE PROGRAM

888.628.4824
guidanceresources.com
Username: LFGSupport
Password: LFGSupport1
Download the GuidanceNow℠ mobile app

AWP Safety

HEALTH PLAN NOTICES

TABLE OF CONTENTS

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.

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)844-0059. **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.

- 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 whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2026
Name of Entity/Sender:	Kristen Davis
Contact—Position/Office:	Director, Total Rewards
Address:	4244 Mt. Pleasant St NW North Canton, OH 44720
Phone Number:	(330)844-0059

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.

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 Safety Health & Welfare Benefit Plan*

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

For the remainder of this notice, AWP Safety is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if

he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include

disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

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

Kristen Davis
Director, Total Rewards
(330)844-0059

The Plan's Deputy Privacy Official(s) is/are:

Kristen Davis
Director, Total Rewards
(330)844-0059

Effective Date

The effective date of this notice is: January 1, 2026.

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 *30 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 *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Kristen Davis
Director, Total Rewards
(330)844-0059

**** 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**.

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[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

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

Kristen Davis
Director, Total Rewards
4244 Mt. Pleasant St NW
North Canton, OH 44720
(330)844-0059

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

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 $1,500	In-Network	Out-of-Network
Individual Deductible	$1,500	$4,000
Family Deductible	$4,500	$8,000
Coinsurance	80%	60%
HDHP $3,400	In-Network	Out-of-Network
Individual Deductible	$3,400	$3,400
Family Deductible	$6,800	$6,800
Coinsurance	90%	60%

Surest	In-Network	Out-of-Network
Individual Deductible	$0	$0
Family Deductible	$0	$0
Coinsurance	N/A	N/A

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

Kristen Davis
Director, Total Rewards
(330)844-0059

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 Kristen Davis, Director, Total Rewards, (330)844-0059.

Notes

Notes

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.

[Rev 11/05/25] AWPIN 26BG Direct 5683572.pdf