AIR CONTROL CONCEPTS

Employee Benefits Guide

AIR CONTROL CONCEPTS, LLC

FAMILY OF COMPANIES

JANUARY 1, 2025 - DECEMBER 31, 2025

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BENEFIT INFORMATION

YOUR BENEFITS PLAN

Air Control Concepts, LLC offers a variety of benefits, allowing you the opportunity to customize a benefits package that meets the need of you and your family.

In the following pages, you'll learn more about the benefits offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health, and financial wellbeing now and into the future.

ELIGIBILITY

Employees working 30 or more hours a week are eligible to enroll once the eligibility waiting period has been satisfied. Healthcare, Life and Voluntary plans will begin on the first of the month following date of hire. Disability coverage will begin on the first of the month following 6 months of employment. You may also add any eligible dependents to select benefits at the time of enrollment.

WHO'S AN ELIGIBLE DEPENDENT?

- Your legal spouse or domestic partner
- Your married or unmarried natural children, step-children living with you, domestic partner's children, legally adopted child(ren) and any other child(ren) for whom you have legal guardianship, up to age 26.

WHEN CAN YOU ENROLL?

You can sign up for benefits at any of the following times:

- As a new hire, at your initial eligibility date.
- During the annual open enrollment period.
- Within 30 days of a qualifying life event.

If you do not enroll during one of the above times, you may enroll at the next open enrollment period. Open enrollment elections are effective January 1st of the following year.

MAKING CHANGES

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change your benefit elections during the plan year if you have one of the below qualifying life events.

- Your marriage or divorce
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects your benefits
- Change in your work status that affects your benefits
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

You must notify and provide the Benefits Team with the necessary documentation within 30 days from the life event. The IRS allows changes to be made within 60 days for those eligible for Medicaid or CHIP under HIPAA Special Enrollment Rights.

If you fail to submit your qualifying life event change request within 30 days, you will need to wait until the next annual enrollment period to make benefit changes unless you have another qualifying life event.

MEDICAL INSURANCE

Air Control Concepts, LLC offers medical insurance through Anthem. The chart on the following pages provides an overview and comparison of each plan. Please refer to the medical plan certificate of coverage for further detail. **Air Control Concepts, LLC pays for a portion of this benefit.**

To find an in-network provider visit www.anthem.com or utilize the Sydney Health mobile app.

Use your smartphone camera to scan and download the Sydney Health mobile app.

TERMS TO KNOW

Copays

Copays are set dollar amounts you pay for specific services. These cost are typically collected at the time of service. EX: you have a $30 copay for a visit to your primary care physician.

Deductible

Services not subject to a copay are subject to your deductible. You pay first dollar costs for claims subject to your deductible and you receive the discounted rate for all covered claims with an in-network provider.

Coinsurance

Coinsurance is a cost share. Once you meet the deductible Anthem will share in the cost of your care. The percent shown on the next page is the cost for the claim you are responsible for. The amounts you pay in coinsurance apply to your out of pocket maximum.

Out-of-Pocket Maximum

This amount is the maximum amount you will pay towards covered services on the plan for the calendar year. This includes the amounts you pay in deductible, coinsurance, copays, and prescription copays.

MEDICAL INSURANCE

For additional plan information and out-of-network coverage, please consult your Summary of Benefits and Coverage. **These plans utilize the KeyCare network.**

KeyCare PPO Plan

WHAT YOU PAY	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual / Family	$2,000 / $4,000	$5,000 / $10,000
COINSURANCE		
In / Out-of-Network	20%	40%
MAXIMUM OUT-OF-POCKET		
Individual / Family	$4,000 / $8,000	$8,000 / $16,000
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)		
PREVENTIVE CARE		
Preventive Care / screenings / immunizations	No cost to you	40% after ded
FACILITY VISITS		
Primary Care Physician	$30 Copay	40% after ded
Specialist Visits	$50 Copay	40% after ded
Urgent Care	$50 Copay	40% after ded
Inpatient Hospital	20% after ded	40% after ded
Outpatient Surgery	20% after ded	40% after ded
Emergency Room	20% after ded	20% after ded
PRESCRIPTIONS		
Retail (30-day supply)		
Tier 1 (Generic)	$10 Copay	40% after ded
Tier 2 (Preferred Brand)	$50 Copay	40% after ded
Tier 3 (Non-Preferred Brand)	$100 Copay	40% after ded
Tier 4 (Specialty)	20% up to $300 max	40% after ded
Mail Order (90-days)	2.5 x Retail	Not Covered

COST PER PAY MONTH	UNDER $80K	OVER $80K
Employee Only	$150	$250
Employee + SP/DP	$400	$500
Employee + Child(ren)	$300	$400
Employee + Family	$550	$650

MEDICAL INSURANCE

For additional plan information and out-of-network coverage, please consult your Summary of Benefits and Coverage. **These plans utilize the KeyCare network.**

KeyCare High-Deductible Health Plan (HDHP)

WHAT YOU PAY	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual / Family	$3,300 / $6,600	$6,600 / $13,200
COINSURANCE		
In / Out-of-Network	20%	40%
MAXIMUM OUT-OF-POCKET		
Individual / Family	$5,000 / $10,000	$10,000 / $20,000
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)		
PREVENTIVE CARE		
Preventive Care / screenings / immunizations	No cost to you	40% after ded
FACILITY VISITS		
Primary Care Physician	20% after ded	40% after ded
Specialist Visits	20% after ded	40% after ded
Urgent Care	20% after ded	40% after ded
Inpatient Hospital	20% after ded	40% after ded
Outpatient Surgery	20% after ded	20% after ded
Emergency Room	20% after ded	40% after ded
PRESCRIPTIONS		
Retail (30-day supply)		
Tier 1 (Generic)	$10 Copay after ded	40% after ded
Tier 2 (Preferred Brand)	$50 Copay after ded	40% after ded
Tier 3 (Non-Preferred Brand)	$100 Copay after ded	40% after ded
Tier 4 (Specialty)	20% up to $300 max after ded	40% after ded
Mail Order (90-days)	2.5 x Retail after ded	Not Covered

COST PER PAY MONTH	UNDER $80K	OVER $80K
Employee Only	$50	$100
Employee + SP/DP	$200	$250
Employee + Child(ren)	$150	$200
Employee + Family	$300	$350

HDHP with Health Savings Account (HSA)

A High Deductible Health Plan (HDHP) is a plan with a **high deductible** that when paired with a Health Savings Account (HSA) can give you more financial flexibility in the way you spend your healthcare dollars.

Office visits and prescription drugs are subject to the deductible. This means you pay a Anthem negotiated discount price instead of a fixed copay until you reach your deductible.

Basic Benefits of the High Deductible Health Plan

- Same provider network as a traditional PPO plan
- Preventive care visits are covered at 100%
- Lower monthly premiums
- Tax free savings opportunity when you fund your HSA.

What is a Health Savings Account (HSA) and How Does it Work?

A Health Savings Account is a tax-advantaged healthcare savings account that allows you to take charge of your health, your savings and your future. You must be enrolled in the HDHP plan in order to enroll in the HSA.

Advantages of an HSA

- Contributions to your HSA are tax free
- Interest earned in your HSA is tax free
- Medical expenses can now be paid for tax free when you pay using your HSA card
- Funds in this account roll over from year to year. There are no "use it or lose it" rules
- Funds in your HSA are always yours and can never be forfeited if you leave your employer

Who is Eligible to Contribute to the Anthem HSA?

- You must be enrolled in the Anthem HDHP
- You cannot be covered by any other medical plan that is not a qualified HDHP
- You cannot be enrolled in any part of Medicare
- You cannot be claimed as a dependent on another person's tax return
- You cannot be covered by a spouse's Health Care Flexible Spending Account (unless it is a limited FSA)

HDHP with Health Savings Account (HSA) - Continued

Who Will Administer the HSA?

Anthem administers the HSA for employees that are enrolled in the HDHP. Health Savings Accounts will automatically be opened for employees who enroll in the high deductible health plan.

2025 HSA Contribution Limits

	HSA CONTRIBUTION LIMITS
Employee Only	$4,300
Employee + SP/DP	$8,550
Employee + Child(ren)	$8,550
Family	$8,550
Catch up for age 55+	$1,000

Please note these are combined limits for employer and employee contributions.

When do I Use My HSA?

When visiting a physician, facility, or pharmacy, your medical claim will be submitted to Anthem for processing. Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles and coinsurance) billed by the physician, facility, or pharmacy. You may also choose to save your HSA dollars for a future healthcare expenses. Your HSA dollars can also be used to pay for any eligible healthcare expenses as defined by the IRS.

Where Can I Find More Information on HSAs?

To learn more about HSAs and what are considered eligible expenses, please visit: https://www.irs.gov/publications/p969

Effective 1/1/2025, the company will match 100% of the amount you contribute to your health savings account up to the maximums below:

HSA CONTRIBUTION MATCH MAXIMUMS	
Employee Only	$500
Employee + SP/DP	$1,000
Employee + Child(ren)	$1,000
Family	$1,000

You must activate your Anthem HSA to receive the employer match.

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSAs) allow you to have pre-tax money deducted from your paycheck to pay for eligible expenses. The FSA program is administered by WEX. Since contributions are made through payroll deductions with pre-tax dollars, you decrease your taxable income and increase your take home pay by taking advantage of this benefit.

Healthcare FSA
The Healthcare FSA allows you to use pre-tax money to pay for eligible medical, dental and vision expenses incurred by you or an eligible dependent. A list of eligible and non-eligible expenses are listed on the next page. You are eligible to participate in the Healthcare FSA if you enroll in the PPO medical plan. Those on enrolling in the HDHP may not have a Healthcare FSA.

Limted FSA
The Limited allows you to use pre-tax money to pay for eligible dental and vision expenses, and can be paired with a health savings account (HSA). You are eligible to participate in the Limited FSA if you enroll in the HDHP medical plan.

Dependent Care FSA
The dependent care FSA allows you to use pre-tax money to pay for eligible dependent care expenses. Examples of eligible dependent care expenses include childcare center, babysitter or nanny, summer day camp, before- or after-school care for children under 13, disabled dependent and/or spouse care and elder care for a tax-dependent adult living in your household.

Debit Card Convenience
When you elect to participate in the healthcare or limited FSA you will automatically receive a FSA debit card. You can use this card to pay for eligible expenses directly from your account. The FSA debit card eliminates the need to spend out-of-pocket and wait for a reimbursement check. Please be sure to obtain itemized receipts for all services paid for with the debit card, as you will be required to submit them to the FSA administrator to validate that your purchase is eligible under the plan.

Maximum Contribution Amounts

2025 FSA CONTRIBUTION LIMITS	
HealthCare FSA	$3,300
Dependent Care FSA	$5,000

Please be sure to set your election amounts conservatively as FSAs have a **use it-or-lose** it provision. Any unused funds at the end of the plan year will be forfeited. You will have 90 day run-out period in which you may submit for reimbursement of claims after the end of the plan year, but claims must have been incurred during 2025.

DENTAL INSURANCE

Dental coverage is offered through MetLife. This plan allows you to use in-network or out-of-network benefits. If out-of-network dentists are used, you will be responsible to pay the difference between MetLife's allowed amount and what the dentist may charge, also known as “balance billing”. **This benefit is partially paid for by the company.**

To find an in-network dentist (MetLife PDP Plus Network), go to www.metlife.com

	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Individual	$50	$50
Family	$150	$150
ANNUAL MAXIMUM		
Per covered person	$1,500	$1,500
PREVENTATIVE CARE		
Oral Exams, X-Rays, Cleanings, Sealants	0%, no ded	10% U&C, no ded
BASIC PROCEDURES		
Endodontics, Periodontics, Fillings, Oral Surgery	20% after ded	30% U&C after ded
MAJOR PROCEDURES		
Cowns, Inlays / Onlays, Bridges, Dentures, Implants	50% after ded	40% U&C after ded
ORTHODONTIA (ADULTS AND CHILDREN)		
Coverage	50%, no ded	50% U&C, no ded
Lifetime Maximum	$1,500	$1,500

COST PER PAY MONTH	UNDER $80K	OVER $80K
Employee Only	$0.00	$30.00
Employee + SP/DP	$45.00	$55.00
Employee + Child(ren)	$50.00	$65.00
Employee + Family	$65.00	$90.00

Note: Out-of-Network Usual & Customary (U&C) is reimbursed at the 80th percentile.

VISION INSURANCE

Vision coverage is offered through MetLife. The vision plan uses the MetLife Superior Vision network and allows you to use in-network or out-of-network benefits. **This benefit is 100% employee paid.**

To find an in-network (MetLife Superior Vision Network) provider visit www.metlife.com

	IN-NETWORK	OUT-OF-NETWORK
EYE EXAM	**ONCE EVERY CALENDAR YEAR**	
Routine Eye Exam	$10 Copay	Reimbursement up to$45
Standard Contact Lens Fitting	$0 Copay	Reimbursement up to $35
LENSES	**ONCE EVERY CALENDAR YEAR**	
Single Vision	$25 Copay	Reimbursement up to $40
Bifocal Lenses	$25 Copay	Reimbursement up to $60
Trifocal Lenses	$25 Copay	Reimbursement up to $80
FRAMES	**ONCE EVERY 2 CALENDAR YEARS**	
One pair of frames	$130 Allowance + 30% off balance	Reimbursement up to $45
CONTACT LENSES	**ONCE EVERY CALENDAR YEAR**	
Elective (Conventional)	$130 Allowance	Reimbursement up to $105
Elective (Disposable)	$130 Allowance	Reimbursement up to $105
Medically Necessary	Fully covered	Reimbursement up to $210

COST PER MONTH	
Employee Only	$5.39
Employee + SP/DP	$12.07
Employee + Child(ren)	$12.94
Employee + Family	$21.13

GROUP LIFE AND AD&D INSURANCE

Life insurance can help provide for your loved ones if something were to happen to you. Full-time employees are provided with an employer-paid life benefit equal to **1 x annual salary** (please refer to Employee Navigator for the maximum benefit). Benefits are reduced by 35% at age 65, and 50% at age 70. Your Life and AD&D insurance is provided through MetLife.

This benefit is 100% covered at no cost to you. Please make sure to designate a beneficiary when enrolling for the first time.

VOLUNTARY LIFE AND AD&D INSURANCE

Voluntary life and AD&D coverage is available on an employee-paid basis. With voluntary life and AD&D insurance, you are responsible for paying the full cost of coverage through payroll deductions. **Employees can elect a benefit in increments of $10,000 up to the lesser of $500,000 or 5x annual earnings.** The chart below outlines the monthly costs of purchasing additional coverage. **Spouse coverage is available in increments of $5,000 up to 100% of the employee amount or $100,000. You may also cover your children with elections of $5,000, or $10,000.** The cost for one child covers all unmarried children to age 26. **This benefit is 100% employee paid.** All coverage terminates at retirement.

Age	MONTHLY RATES (PER $1,000 OF COVERAGE)
Employee & Spouse Vol. Life/AD&D	
<30	$0.112
30-34	$0.120
35-39	$0.163
40-44	$0.240
45-49	$0.379
50-54	$0.589
55-59	$0.897
60-64	$1.370
65-69	$2.220
70+	$3.698
Dep. Child(ren) Life	$0.200

Guaranteed Issue

The guaranteed issue amount is $150,000 for employee coverage and $30,000 for spousal coverage.

These guaranteed issue amounts are for when you first become eligible for voluntary life and during 2025 open enrollment period.

If you request coverage amounts over the guaranteed issue limits, sign up for coverage outside your initial eligibility or the 2025 open enrollment period, you will be required to complete **Evidence of Insurability** (a medical questionnaire). Amounts of coverage that require EOI will not go into effect until approved by MetLife.

This year only (during open enrollment), all eligible employees may elect coverage up to the guaranteed issue limits without needing evidence of insurability.

DISABILITY INSURANCE

Short and Long Term Disability coverage is available to protect against disabilities that prohibit you from working for an extended period of time. **Short-Term Disability coverage is provided at no cost to you.**

Long-Term Disability coverage is a 100% employee paid benefit.

	SHORT TERM DISABILITY	VOLUNTARY LONG TERM DISABILITY
BENEFITS BEGIN (INJURY/SICKNESS)	8th day	91st day
BENEFIT PERCENTAGE	50%	50%
BENEFIT MAXIMUM	$2,000/week	$5,000/month
BENEFIT DURATION	Up to 12 weeks	SSNRA*
PRE-EXISTING CONDITION LIMITATION**	None	3/12

*SSNRA is Social Security normal retirement age

**A pre-existing condition is an injury or sickness (including pregnancy) and all related conditions and complications, in the three months prior to your effective date under this policy, for which you: Received medical treatment, consultation, care or service; or were prescribed or took prescription medications. A disability for a pre-existing condition will not be covered for the first 12 months after your effective date.

You will automaticaly be enrolled in Short Term Disability coverage at no cost to you.

You may elect Long-Term Disability coverage on a voluntary basis. The monthly cost to you is $0.221 per $100 of covered earnings.

NOTE: Confirm with HR how your benefit amount is determined. Your Benefit amount is equal to your primary benefit minus other income sources.

VOLUNTARY ACCIDENT INSURANCE

Accident Insurance is offered to you as a voluntary benefit through MetLife. Accident Insurance pays you a lump sum cash benefits for specific injuries and events resulting from a covered accident. The benefit amount depends on the type of injury and care received. You have the option to elect Accident Insurance to meet your needs and are responsible for the cost. **This benefit is 100% employee paid.**

Below is a summary of the benefits provided by this plan. Please view the benefit summary for more details.

ACCIDENT BENEFIT	LOW PLAN PAYMENT	HIGH PLAN PAYMENT
Dislocations	$100 - $8,000	$200 - $10,000
Fractures	$100- $8,000	$200 - $10,000
Burns	$75 - $10,000	$100 - $15,000
Eye injury	$450	$600
Paralysis	$10,000 - $20,000	$20,000 - $40,000
Concussion	$250	$500
Lacerations	$50 - $400	$75 - $700
Hospital Admission	$1,500	$2,000
Surgery	$150 - $1,500	$200 - $2,000
Emergency Dental	$25 - $300	$50 - $400
Life and Dismemberment Losses	$5,000 - $75,000	$10,000 - $150,000
Medical Services - (Rx, PT/Visit, Exam)	$75 - $1,500	$100 - $2,000
Medical Devices	$75 - $750	$150 - $1,000

If you or any other covered family member has an eligible wellness/health screening performed, **you may be eligible for a $50 benefit**. This benefit is payable once per calendar year, per covered person.

ACCIDENT MONTHLY RATES		
	LOW PLAN	HIGH PLAN
Employee Only	$5.98	$9.66
Employee + Spouse	$10.35	$16.10
Employee + Child(ren)	$11.50	$16.79
Family	$16.56	$25.81

VOLUNTARY CRITICAL ILLNESS INSURANCE

Critical Illness is offered to you as a voluntary benefit through MetLife. This benefit pays a lump-sum benefit if you are diagnosed with a covered illness or condition on or after your coverage effective date. **This benefit is 100% employee paid.**

- **As an employee you can choose between the $10,000, $20,000 and $30,000 plan.**
- **You can elect coverage for your spouse equal to the employee election.**
- **You can also elect coverage for your child(ren) to age 26 equal to 50% of the employee election.**
- **No medical questions or evidence of insurability are required.**

SOME COVERED CONDITIONS - REFER TO THE BENEFIT SUMMARY FOR BENEFIT AMOUNTS	
CORE CONDITIONS	Stroke, Kidney Failure, Major Organ Transplant, Coronary Artery Bypass Graft, Heart Attack, Sudden Cardiac Arrest.
CANCER CONDITIONS	Invasive Cancer, Noninvasive Cancer, Benign Brain Tumor, Skin Cancer
OTHER CONDITIONS	Coma, Paralysis, Severe Burns, Complete loss of sight/hearing/speech, ALS, Multiple Sclerosis, Parkinsons, Alzheimer's.
CHILDHOOD CONDITIONS	Cystic Fibrosis, Cerebral Palsy, Sickle Cell Anemia, Spina Bifida, Type 1 Diabetes, Cleft Lip/Palate, Down Syndrome.

If you, your spouse, or your child have a covered wellness/health screening performed, **you may be eligible for a $100 benefit.** This benefit is payable only once per calendar year per covered person and does not count toward the critical illness maximum lifetime benefit amount.

VOLUNTARY CRITICAL ILLNESS RATES

MetLife

CRITICAL ILLNESS MONTHLY RATES (PER $1,000 OF COVERAGE)				
EMPLOYEE'S AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
<25	$0.41	$0.80	$0.72	$1.17
25-29	$0.47	$0.92	$0.78	$1.29
30-34	$0.51	$1.01	$0.82	$1.37
35-39	$0.60	$1.19	$0.91	$1.56
40-44	$0.77	$1.52	$1.08	$1.89
45-49	$1.05	$2.11	$1.36	$2.47
50-54	$1.37	$2.80	$1.69	$3.15
55-59	$1.82	$3.74	$2.13	$4,10
60-64	$2.48	$5.12	$2.80	$5.48
65-69	$3.28	$6.74	$3.58	$7.11
70-74	$4.31	$8.87	$4.62	$9.23
75-79	$5,71	$11.71	$6.01	$12.07
80-84	$6.60	$13.53	$6.91	$13.89

VOLUNTARY HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance is offered to you as a voluntary benefit through MetLife. This coverage pays you a lump sum cash benefits when you are admitted or confined in the hospital or intensive care unit (ICU). **This benefit is 100% employee paid.**

Below is a summary of the benefits provided by this plan. Please view the benefit summary for more details.

BENEFIT SUMMARY			
	LOW PLAN	HIGH PLAN	BENEFIT LIMITS
Hospital Admission	$1,000	$1,500	4 times per year
ICU Admission	$1,000	$1,500	4 times per year
Hospital Confinement	$100 per day	$200 per day	15 days per year
ICU Confinement	$100 per day	$200 per day	15 days per year
Newborn Nursery Care	$50 per day	$75 per day	2 days per confinement

If you or any other covered family member has an eligible wellness/health screening performed, **you may be eligible for a $50 benefit**. This benefit is payable once per calendar year, per covered person.

HOSPITAL INDEMNITY MONTHLY RATES		
	LOW PLAN	HIGH PLAN
Employee Only	$8.74	$13.11
Employee + Spouse	$22.58	$33.87
Employee + Child(ren)	$15.90	$23.85
Family	$29.74	$44.61

VOLUNTARY IDENTITY THEFT PROTECTION

WHAT IS METLIFE + AURA IDENTITY & FRAUD PROTECTION?

This AI-powered solution covers the broad spectrum of identity theft, financial fraud, and digital security for employees and their loved ones – all in one easy-to-use app.

FINANCIAL FRAUD PROTECTION: Monitors credit, asset titles, and financial accounts for suspicious activity, one-tap credit lock, and financial tools to help keep money and assets safe.

IDENTITY THEFT PROTECTION: Get alerted to threats to personal information, online accounts, social media and more. Plus, we automatically request removal of personal info from data broker sites to protect it from thieves and spammers.

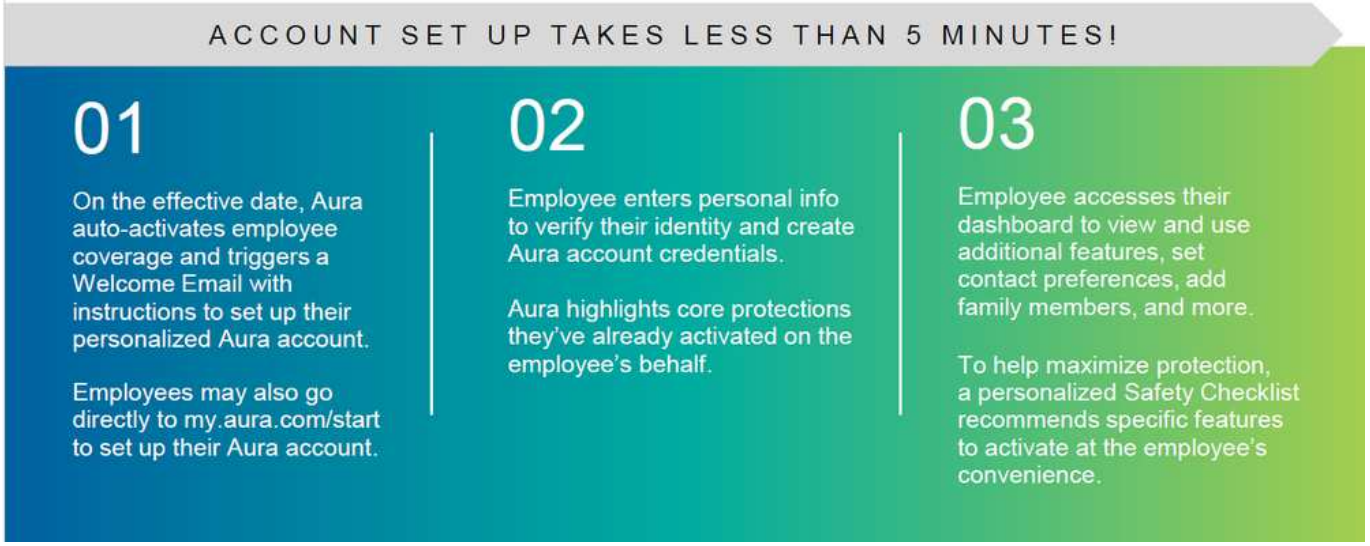
PRIVACY & DEVICE PROTECTION: Tools to manage passwords, protect devices from malware and viruses, secure public Wi-Fi connections, keep browsing activity private, and more.

FAMILY SAFETY (WITH FAMILY PLANS): Fully integrated family safety tools help parents and caregivers keep a pulse on loved ones' online safety. Inclusive family plans cover unlimited dependent minors and up to 10 additional adult loved ones with no restrictions.

SERVICES & SUPPORT: 24/7 US-based customer support, white glove fraud resolution services, access on-the-go via the all-in-one Aura app, and more.

ID THEFT INSURANCE POLICY: Each adult is backed by their own separate $5M ID theft insurance policy to reimburse for eligible losses and expenses resulting from ID theft.

ID THEFT PROTECTION MONTHLY RATES	
Employee Only Coverage	$8.03
Family Coverage	$13.25



VOLUNTARY LEGAL INSURANCE

MetLife

We all need an attorney at some point in our lives, whether it's when starting a family, buying a house or caring for elderly parents. But it doesn't have to be expensive — or stressful. With MetLife Legal, you, your spouse and your dependents have access to legal expertise from a network of over 18,000 attorneys in all 50 states. Network attorneys are carefully selected and monitored and have an average of 25 years of experience in the practice of law. MetLife Legal includes assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter.

For a convenient payroll deduction $17.25 per month, an expert is on your side as long as you need them.

Covered services include: preparation of wills & trusts, real estate matters, debt matters, identity theft defense, document preparation and review, defense of traffic tickets and juvenile matters, family law including adoptions.

MetLife Legal Plan provides you with access to experienced attorneys and eliminates effort on your end. It's a smart, simple, affordable way to get the legal help you need.

Award-winning service
- Regularly recognized for excellence in customer service[1]
- Experienced service team available from 8 am to 8 pm ET

Top-quality attorney network
- Average of 25 years of experience and vetted regularly
- Nationwide network with a range of specialties

Convenient online help
- 24/7 access to our attorney locator and case numbers
- Tools and resources, including an easy-to-use mobile app
- Access to over 300 self-help legal documents in our online library

Ease of use[2]
- All billing is handled between MetLife and the attorney
- No claims forms, hidden fees or deductibles

To learn more about your coverages, view our attorney network or grant your dependents access, create an account at members.legalplans.com or call 800-821-6400 Monday—Friday 8:00 a.m. to 8:00 p.m. ET.

VOLUNTARY PET INSURANCE

Pet Insurance is offered to you as a voluntary benefit through MetLife. Pet Insurance helps you cover veterinary expenses so you can provide your pets with the best care possible - without worrying about the cost. Employees may enroll at any time throughout the year and the discounted premium will be billed directly to you. This benefit is 100% employee paid.

Choose a plan that works for you! Options include reimbursement levels from 50%-90%, your annual deductibles from $0-$2,500 and benefits maximum from $500 to Unlimited.

Coverage Includes:

- Accidents
- Illnesses
- Exam fees
- Surgeries
- Medications
- Ultrasounds
- Hospital stays
- X-rays and diagnostic tests
- Hereditary/congenital conditions
- MORE!

Additional Included Benefits for Dogs and Cats:

- Optional wellness coverage
- Lost pet advertising and reward expense
- Emergency boarding
- Loss due to theft
- Mortality benefit
- Telehealth concierge service

Telehealth Concierge Services

Veterinary experts are available 24/7 through MetLife's Telehealth Concierge. Members may call, email or chat through the MetLife Pet mobile app to get live help from licensed veterinarians with any pet health concern, including identifying urgent care needs. These professionals can guide you on whether your pet requires emergency care, a routine checkup, or just home monitoring. This can help you make informed decisions about your pet's health quickly, and may help you avoid the cost of unnecessary vet visits.

To Get A Quote/Enroll Visit:
www.metlife.com/getpetquote or call 1-800-GETMET8

MetLife Employee Assistance Program (EAP)

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward. We can help you and your family, those living at home, get professional support and guidance to make life a little easier.

Our Employee Assistance Program (EAP) is available to at no cost to you.

The EAP program's experienced counselors provided through TELUS Health can talk to you about anything going on in your life, including:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Your program includes up to 5 in person, phone or video consultations with licensed counselors for you and your eligible household members per year. EAP services are completely confidential.

To access the EAP:

Call (888) 319-7819
or
Log on to one.telushealth.com
username: metlifeeap
password: eap

TRAVEL ASSISTANCE

MetLife

MetLife selected AXA Assistance USA, Inc. (AXA) to provide the Travel Assistance program because they are an industry leader, best known for intervening in medical emergencies in foreign countries. AXA administers emergency medical assistance services when you or a family member becomes ill or injured while traveling 100 miles or more away from home. AXA is an independently owned company and is not associated with or an affiliate of MetLife. This benefit is available at no cost to you.

Call Travel Assistance if you need:

- Advice before you travel
- Medical assistance while traveling
- Medical evacuation
- Evacuation due to natural disaster or political unrest
- Assistance while traveling with your pet
- Help with lost documents, credit cards or luggage while traveling
- Replacement prescription medication while traveling
- Identity theft assistance

Call toll-free (800) 454-3679 (within the U.S.) or call collect (312) 935-3783 (outside the U.S.)

Visit www.metlife.com/travelassist

ANTHEM WELLBEING PROGRAM

Focus on your well-being and earn rewards up to $200.
The Wellbeing Solutions program rewards you when you complete any of the activities listed below. When you complete an activity of your choice, you'll earn rewards to put toward electronic gift cards for select retailers.

Activity Type	Activities	Amount
Preventive care	Have an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test[1]	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam[2]	$25
	Get an annual flu shot	$20
Activity Type	**Activities**	**Amount**
Condition management programs	ConditionCare: Work one on one with your health coach and earn rewards for participating in and completing the program[3]	Up to $50 ($20/$30)
	Building Healthy Families: Support is available through the Sydney℠ Health app wherever you are in your family planning process, such as trying to conceive or raising your toddler[4]	Up to $40 ($10/$10/$10/$10)
	Well-being Coach – Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward[5]	$25
	Well-being Coach – Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward[6]	$25
Digital & wellness activities	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $25 ($5 per action plan)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[7]	Up to $20 ($4 per milestone)
	Update your contact information	$10

To view your rewards:
1. Open the Sydney Health app or go to anthem.com.
2. Next, go to My Health Dashboard.
3. Select Redeem Rewards to see how much you've earned.

Use your rewards toward electronic gift cards from popular retailers, including Amazon, Uber, Gap, and more!

ANTHEM EMPLOYEE ASSISTANCE PROGRAM (EAP)

Have 24/7 access to support, advice and resources. The Anthem EAP can help you and your household through difficult times. The following resources are private, confidential, and available 24/7 at no cost to you.

- **Counseling and mental health:** Get 3 free visits for in-person or virtual counseling per person in your household, per issue each year
- **Work-life resources:** Find information on career, parenting, and balancing work and family. Find high-quality child, elder, and pet care. Receive special discounts on a range of products and services, including food, travel, and clothing.
- **Legal:** Book a no-cost consultation and receive a discounted rate from participating local attorneys on continued legal services
- **Financial Planning:** Have unlimited phone consults with a financial professional and access online financial calculators and budgeting tools.
- **Identity Theft Support:** Register to get help with identity monitoring and theft resolution to minimize or recover from the effects of identity theft.
- **24/7 Crisis Support:** Get in-the-moment support when experiencing a personal crisis. Find help with navigating resources and getting support if you're impacted by a tragedy or natural disaster.

Call your EAP at 800-999-7222 or visit anthemeap.com/anthemvirginia for 24/7 support.

ADDITIONAL ANTHEM OFFERS

NationsHearing
Receive hearing screenings and in-home service at no additional cost. You also can receive hearing aids at a discounted rate.

Hearing Care Solutions
Receive no-cost hearing exams and discounts on hearing aids. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, batteries for two years, and unlimited visits for one year.

Amplifon
Save on top-quality care and ongoing service and support for your hearing aids.

BREVENA
Enjoy a discount on BREVENA skin care creams and balms for smooth, rejuvenated skin from head to toe.

ChooseHealthy
Discounts are available on acupuncture, chiropractic, massage, podiatry, physical therapy, and nutritional services. You also have discounts on fitness equipment, wearable health trackers, and health products such as vitamins and nutrition bars.

LifeMart
Receive deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services, yoga classes, sports gear, and vision care.

Active&Fit Direct
Choose from more than 12,000 participating fitness centers and 5,800 premium exercise studios nationwide and receive a discounted membership. This program is offered through American Specialty Health Fitness, Inc.

Fitbit
Work toward your fitness goals with Fitbit trackers and smartwatches that fit your lifestyle and budget.

Garmin
Discounts are available on select Garmin wellness devices.

Husk Wellness
Discounts are available for gym memberships, fitness equipment and technology, and fitness and nutrition coaching.

ADDITIONAL ANTHEM OFFERS

23andMe
Save on health and ancestry kits to learn about your wellness, ancestry, and more.

WINFertility
Save up to 40% on infertility treatment. WINFertility helps make quality treatment more affordable.

Puritan's Pride
Choose from a large selection of discounted vitamins, minerals, and supplements.

Allergy Control Products and National Allergy Supply
Save on select doctor-recommended products, such as allergy-friendly bedding, air purifiers and filters, and asthma products. Some orders qualify for no-cost ground shipping within the contiguous U.S.

The Living Well Courses
Choose one of the online wellness programs and save on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or address alcohol or substance dependence.

To learn more about Anthem's Special Offers:
Log in to anthem.com
choose Care, and select Discounts.

CARRIER CONTACTS

BENEFIT	CARRIER AND POLICY NUMBER	PHONE NUMBER	WEBSITE AND NETWORK
Medical/ Rx/HSA	Anthem Policy #L11418	(800) 331-1476	www.anthem.com Network: KeyCare
Dental	MetLife Policy #263777	(800) 438-6388	www.metlife.com Network: PDP Plus
Vision	MetLife Policy #263777	(800)438- 6388	www.metlife.com Network: Superior Vision
Life and AD&D	MetLife Policy #263777	(800) 438-6388	www.metlife.com
Disability	MetLife Policy #263777	(800) 438-6388	www.metlife.com
Supplemental Insurance	MetLife Policy #263777	(800) 438-6388	www.metlife.com
FSA	WEX	(866) 451-3399	www.wexinc.com
Enrollment	Employee Navigator	N/A	www.employeenavigator.com

Contact the Benefits Team with any questions
Benefits@aircontrolconcepts.com

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery, to less than 48 hours, and (2) following a cesarean section, to less then 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

1. Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
2. Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
3. Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage;
4. Require a mother to give birth in a hospital; or
5. Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

SECTION 111

Effective January 1, 2009 group health plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extensions of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claims assignments. In other words, it will help establish who pays first. The mandate requires group health plans to collect additional information, more specifically Social Security numbers for all enrollees, including dependents 6 months of age or older. Please be prepared to provide this information on your benefits enrollment form when enrolling into benefits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires Air Control Concepts, LLC to notify you, as a participant or beneficiary of the Air Control Concepts, LLC Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical compilations of the mastectomy, including lymphedema

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

MICHELLE'S LAW

The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. This law applies to medically necessary leaves of absence that begin on or after January 1, 2010

If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if your child was (1) covered under the plan and (2) enrolled as at student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).

Your employer will require a written certification from the child's physician that states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

HIPAA PRIVACY POLICY FOR FULLY-INSURED PLANS WITH NO ACCESS TO PHI

The group health plan is a fully-insured group health plan sponsored by the "Plan Sponsor". The group health plan and the plan sponsor intend to comply with the requirements of 45 C.F.R. §164.530 (k) so that the group health plan is not subject to most of HIPAA's privacy requirements.

I. **No access to protected health information (PHI) except for summary health information for limited purpose and enrollment / dis-enrollment information.**

Neither the group health plan nor the plan sponsor (or any member of the plan sponsor's workforce) shall create or receive protected health information (PHI) as defined in 45 C.F.R. §160.103 except for (1) summary health information for purpose of (a) obtaining premium bids or (b) modifying, amending, or terminating the group health plan, and (2) enrollment and dis-enrollment information.

II. **Insurer for group health plan will provide privacy notice**

The insurer for the group health plan will provide the group health plan's notice of privacy practices and will satisfy the other requirements under HIPAA related to the group health plan's PHI. The notice of privacy practices will notify participants of the potential disclosure of summary health information and enrollment / dis-enrollment information to the group health plan and the plan sponsor.

III. **No intimidating or retaliatory acts**

The group health plan shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights , filing a complaint, participating in an investigation, or opposing any improper practice under HIPAAA.

IV. **No Waiver**

The group health plan shall not require an individual to waive his or her privacy rights under HIPAA as a condition of treatment, payment, enrollment or eligibility. If such an action should occur by one of the plan sponsor's employees, the action shall not be attributed to the group health plan.

PATIENT PROTECTION:

If the Group Health Plan generally requires the designation of a primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professionals, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

Premium Assistance Under Medicaid And The Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid

Website: http://www.dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Medicaid (HFC) & CHIP (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://wwwmycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA– Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline)
or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740. TTY: Maine relay 711

MASSACHUSETS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA– Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid

Website:
http://dphhs.my.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA - Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON– Medicaid & CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid & CHIP

Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND - Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid

Website: https://www.schhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA– Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid website: https://medicaid.utah.gov/
CHIP website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid & CHIP

Website:
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website:
https://www.coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://www.coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid and CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid & CHIP

Website: https://dhhr.wv.gov.bms
http://mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-699-8447 (MyWVHIPP)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisonsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

MEDICARE PART D

This notice applies to employees and covered dependents who are eligible for Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anthem and about your options under Medicare's prescription drug Plan. If you are considering joining, you should compare your current coverage including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription 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. Anthem has determined that the prescription drug coverage offered by the Welfare Plan for Employees of Air Control Concepts, LLC under the KeyCare options are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You should also know that if you drop or lose your coverage with Anthem and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

When can you join a Medicare Drug Plan?

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

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

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Anthem of VA coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current Anthem of VA coverage, be aware that you and your dependents will be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about your options under Medicare prescription drug coverage...
Contact our office for further information (see contact information below). 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 Anthem of VA changes. You also may request a copy of this notice at any time.

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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 notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: 1/1/2025
Name of Entity/Sender: Air Control Concepts, LLC
Contact: HR

GENERAL NOTICE OF COBRA RIGHTS

Continuations coverage rights under cobra

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 may elect COBRA continuation coverage, but they may be required to pay for the 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 to the employer sponsoring the Plan.

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.

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, Medicaid, 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.

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.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.

The information discussed in this booklet was prepared by