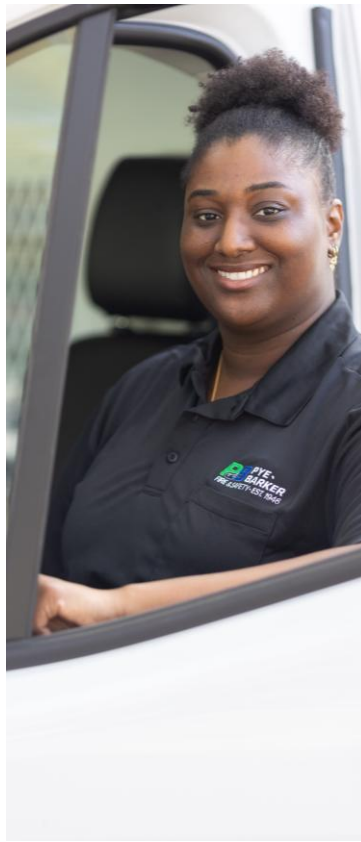


2026



BENEFITS GUIDE



MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the legal notices in the back of this guide for more details.

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ENROLLMENT

When Do I Enroll?

NEW HIRE PERIOD

Pye-Barker's New Hire period is **30 days from date of hire**. This is your one opportunity to make any elections necessary that are right for you and your family! After this period ends, you will **not** be able to make changes to your benefits until the upcoming annual enrollment window or unless you experience a qualifying life event (see below).

QUALIFYING LIFE EVENTS

Outside of annual enrollment and new hire enrollment, you can't change your benefits unless you experience a qualifying life event (QLE) like marriage, divorce, birth, adoption, death, loss of dependent status or loss of coverage.

If you have a QLE, you must make changes within 30 days of the event date. Be prepared to submit documentation as proof of the QLE upon request.

When Do Benefits Become Effective?

For newly hired employees, the effective date is the 1st of the month following 30 days of employment. You must enroll within 30 days of hire.

Ongoing, Pye-Barker new plan years begin January 1st of the upcoming year. Your Human Resources team will provide communication on the annual open enrollment period for each plan year.

How do I Enroll?

ONLINE

- Log in to your Workday account at www.myworkday.com
- Select "Change Benefits", located under "Awaiting Your Action"
- Select "Let's Get Started"
- Select your benefit elections
- Select "Submit"
- Download and print a copy of your enrollment confirmation

PHONE

For questions about enrollment and your benefits, call a Brain Patten benefits counselor at **(833) 271-4977** for assistance, available **Monday-Friday from 8am to 6pm ET**.

Who's Eligible?

You're eligible for coverage if you are a full-time employee working 30 hours per week or more.*

If you're eligible, you may also add coverage for your eligible dependents to certain plans. Eligible dependents include your legal spouse and your children up to age 26.*

You'll need the names, dates of birth, Social Security numbers, current addresses and phone numbers for you and any dependents you wish to enroll.

If you enroll new dependents, the enrollment system will prompt you to verify that they are eligible for coverage. You must upload the requested verification documents within 30 days, or your dependents will not be enrolled.

** Please note, this is an overview of eligibility. For complete details, including who is an eligible family member, refer to your summary plan document.*

MEDICAL

Medical Plan Options

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to primary care doctors. It also provides important financial protection if you have a serious medical condition. We offer 3 medical plan options through United Healthcare (UHC) so you can pick the best fit for you and your family.

THE CHOICE PLUS COPAY PLAN

If you anticipate having more extensive health care expenses during the plan year, such as surgery or pregnancy, the Choice Plus Copay Plan may be the best option for you. This plan costs more out of paycheck but will provide greater coverage once you meet the deductible.

THE HSA CHOICE PLUS PLAN

If you anticipate only minor health care expenses during the plan year, such as office visits and prescription drugs, the HSA Choice Plus Plan is great for you. This plan also gives you access to a health savings account (HSA) to help offset the cost of your healthcare expenses.

THE SUREST PLAN

The Surest Plan is the most cost-effective option. This plan's payment strategy allows us to reduce our costs across the whole company while continuing to provide you with competitive, meaningful benefits. You may choose to go to any facility, but your cost will be lowest when you follow the plan's recommendations. Plan advocates are available to help you get the best care at the best cost. Advocates help keep prices fair and as low as possible by monitoring your case, making recommendations, and negotiating costs when needed.



UNDERSTANDING THE LINGO

Healthcare terms can sometimes be confusing. This **quick video** will help you understand the different words, like copay and deductible, that make-up your medical benefits.

	Choice Plus Copay Plan	HSA Choice Plus Plan	Surest Plan
Deductible	\$1,800*	\$3,400*	\$0*
Preventive Care	100% covered*	100% covered*	100% covered*
Health Savings Account	No	Yes	No

* Please note that this represents an individual employee receiving in-network services. For more details, please refer to the medical plan comparison chart on page 5.

MEDICAL

Medical Plan Comparison Chart			
	Choice Plus Copay Plan	HSA Choice Plus Plan	Surest Plan
Plan Provision	In-network	In-network	In-network
Deductible <i>Individual/Family</i>	\$1,800/\$3,600	\$3,400/ \$6,600	\$0/\$0
Out-of-Pocket Max <i>Individual/Family</i>	\$3,600/\$7,200	\$6,000/ \$12,000	\$5,500/ \$11,000
Preventive Care	No charge	No charge	No charge
Office Visit/Exam	\$25-\$50 Copay	20% coins*	\$20-\$125 Copay
Emergency Room	\$500 Copay	20% coins*	\$750 Copay
X-Ray/Lab	No charge Outpatient: 20% coins*	20% coins*	\$0-\$900 Copay
Hospital Facility	20% coins*	20% coins*	\$300-\$3,500 Copay
Outpatient Services	20% coins*	20% coins*	\$50- \$3,500 Copay
Retail Prescription Drugs 30 Day Supply			
Generic preventive	\$10	20% coins*	\$10
Generic	\$10	20% coins*	\$10
Preferred	\$20	20% coins*	\$35
Non-preferred	\$50	20% coins*	\$70
Mail Order Prescription Drugs 90 Day Supply			
Generic preventive	\$25	20% coins*	\$25
Generic	\$25	20% coins*	\$25
Preferred	\$50	20% coins*	\$50
Non-preferred	\$125	20% coins*	\$125

*indicates after deductible.

MEDICAL- California

For team members who reside within the state of California, Pye-Barker offers you medical plan options through United Healthcare and Kaiser:

	Kaiser
Plan Provision	In-network
Deductible <i>Individual/Family</i>	\$1,000/\$2,000
Out-of-Pocket Max <i>Individual/Family</i>	\$3,000/\$6,000
Preventive Care	No charge
Office Visit/Exam	\$20-\$30 Copay
Emergency Room	\$250 Copay
X-Ray/Lab	\$10 Copay
Hospital Facility	20% Coinsurance*
Outpatient Services	20% Coinsurance*
Retail Prescription Drugs 30 Day Supply	
Generic	\$10 Copay
Brand Formulary	\$30 Copay
Non-Formulary	\$30 Copay
Specialty	20% Coinsurance (up to \$150)
Mail Order Prescription Drugs 90 Day Supply	
Generic	\$20 Copay
Brand Formulary	\$60 Copay
Non-Formulary	\$60 Copay
Specialty	Not Covered

*indicates after deductible.

MEDICAL- Northwest

For team members who reside within the states of Oregon and Washington, Pye-Barker offers you medical plan options through United Healthcare and Kaiser:

Plan Provision	Kaiser	
	Kaiser \$2,500 Copay	Kaiser \$0 Copay
	In-network	In-network
Deductible <i>Individual/Family</i>	\$2,500/\$5,000	\$0
Out-of-Pocket Max <i>Individual/Family</i>	\$5,000/\$10,000	\$3,000/ \$6,000
Preventive Care	No charge, ded. does not apply	No charge
Office Visit/Exam	\$25-\$35 Copay, ded. does not apply	\$30-\$40 Copay
Emergency Room	20% Coins*	\$250 Copay Copay is waived if admitted
X-Ray/Lab	\$10 Copay	\$10 Copay
Hospital Facility	20% Coins*	\$500/day up to \$1,500/admission Copay
Outpatient Services	20% Coins*	\$500 Copay
Retail Prescription Drugs 30 Day Supply		
Generic	\$15 Copay, ded. does not apply	\$15 Copay
Preferred	\$35 Copay, ded. does not apply	\$35 Copay
Non-preferred	\$70 Copay, ded. does not apply	\$70 Copay
Specialty	20% Coins (up to \$250)	20% Coins (up to \$250)
Mail Order Prescription Drugs 90 Day Supply		
Generic	\$30 Copay, ded. does not apply	\$30 Copay
Preferred	\$70 Copay, ded. does not apply	\$70 Copay
Non-preferred	\$140 Copay, ded. does not apply	\$140 Copay
Specialty	Not Covered	Not Covered

*indicates after deductible.

Learn More about Surest

Understanding Surest, Your Value Based Medical Plan

Our Surest medical plan through United Healthcare (UHC) uses a value-based pricing model, which is designed to keep your medical costs low and competitive.

WHAT DOES THIS PLAN MEAN FOR ME?

- **Lowest paycheck cost:** Premiums are the lowest of all our medical plans.
- **Savings when you use the plan:** Instead of paying a rate negotiated by the medical plan carrier, you'll pay a percentage of the actual value of the service you're getting. That means both you and the Company likely pay less.
- **Same services and benefits:** You'll have access to the same services and benefits as you do on our other medical plans, but unlike our other medical plans, there is no *hospital* network. You'll now have the freedom to go to any hospital or facility of your choice, and the plan will share the same portion of the cost for covered services.
- **No referrals necessary:** You do not need a referral from a primary care physician in order to see a specialist.
- **Concierge access:** If you have challenges with your medical plan in any way — as you show up at the doctor, when you get a bill in the mail, should you hear about a new diagnosis — the Surest customer service is ready to help.

SO, WHAT'S THE CATCH?

To be honest, sometimes it's *confusion*. Some doctors aren't familiar with this vendor or type of plan. If your doctor's office has questions, have them call Surest.

You may get a bill that doesn't quite match your explanation of benefits (EOB). That's possible with any plan, but since not all providers are familiar with this type of plan, Surest is committed to making sure you aren't paying more than you're supposed to. If you get a bill that doesn't match your EOB, **do not pay it!** Contact Surest at 1-866-683-6440 immediately and a customer service representative will be assigned your case — ready to work directly with your provider to resolve the issue and keep you informed at every step of the way.

Some providers may be more familiar with reference-based pricing than others. To find providers who are less likely to send you a balance bill, call Surest at 1-866-683-6440 or visit join.surest.com/PyeBarker to search for doctors and hospitals in your area.





Save the customer service number 1-866-683-6440 into your phone. They are your concierge for all your medical plan questions!

MEDICAL



Know Where to Go for Care

Take control of your health care spending by using the best resources for your health concern or condition. You'll save the most when you see in-network doctors. Go to member.uhc.com/myuhc and click the "Find a Provider" tab.





VIRTUAL VISITS

Use virtual visits when you have a minor medical concern and need to see a doctor quickly from anywhere. With telehealth, you can speak to a doctor in just a few clicks on your smart phone or tablet. While your health care should always start with your primary care provider, virtual visits are available when your doctor may not be and are less expensive than a typical office visit. Virtual visits are designed for non-emergent medical problems such as cold or flu symptoms, allergies, sinus infections or sprains.





IN PERSON PRIMARY CARE

Visit your primary care physician annually for a check-up, for treatment of a chronic condition, and any time you want to see a doctor who knows your history and has access to your medical records. Primary care physicians typically require appointments and are not available nights and weekends, so you'll need to plan ahead. But remember, annual preventive care screenings with your primary care doctor are covered at no cost to you.



URGENT CARE

Visit urgent care when you have a pressing medical concern, but not an emergency. Urgent care is the best fit for sprains, strains, minor broken bones, minor infections, small cuts that need a few stitches, minor burns and x-rays. Urgent care facilities are commonly open on nights and weekends. Plan ahead and find an urgent care close to you so that you have a plan for problems like these before they arise.



EMERGENCY ROOM

Emergency rooms are designed to treat life threatening incidents. Yet, the most diagnosed condition in ER patients is the common cold. This causes emergency rooms to become overcrowded and deliver care less efficiently because they are busy with patients who have routine illnesses and non-emergencies. If you visit the emergency room when you are not having an emergency, you'll have a long wait and you'll pay the most out-of-pocket. So, make sure you only use this option when you are experiencing an emergency.

Where you go impacts how much you pay. [Watch this video](#) for information about when to choose the urgent care and when to use the emergency room.

MEDICARE

Nearing age 65?

Choosing a Medicare plan is one of the most important decisions you'll make

Alliant Medicare Solutions

This **free** resource can help you, your family, and your friends figure out the best Medicare options for your situation.

Just Make a Call

- At least 3 months before your 65th birthday (or if it's already passed) gather your current health insurance information.
- Call Alliant Medicare Solutions at **(877) 888- 0165** and talk to a licensed insurance agent about your Medicare options.
- The team can help you compare your employer plan to Medicare plans available in your area.
- Alliant Medicare Solutions helps you enroll or emails your policy details to review.

For More Information

- Download Your Guide to Medicare at <https://neb.alliant.com/your-guide-to-medicare/full-view.html>.
- Watch Medicare 101 at brainshark.com/alliant/medicare101
- Visit Alliant Medicare Solutions online at alliantmedicareolutions.com.
- For comprehensive information about Medicare, visit medicare.gov.

COMMON QUESTIONS

- Can I keep my employer plan? How does that work? What about my dependents?
- When am I eligible for Medicare? When should I enroll? (And do I **have** to?)
- What does Medicare cost?
- What options could work best for my situation?
- What does Medicare **not** cover?

Decisions related to healthcare and an individual's enrollment in Medicare should be based on the specific circumstances of the individual and made in consultation with their own advisors. Alliant Medicare Solutions shall not have any liability for direct, indirect, incidental, special, exemplary, or consequential damages, under any theory of liability, whether in contract or tort, arising out of the use of Alliant Medicare Solutions. Alliant Medicare Solutions is not connected with or endorsed by the United States government or the federal Medicare program.

Alliant Medicare Solutions is provided by Insuractive, a Senior Market Sales Company, both wholly owned by Alliant Insurance Services.

HEALTH & WELLBEING



Available to all UHC and Surest Plan Members

Calm Health – Mental Health Support: Listen to and read mindfulness content for a variety of health experiences and life stages.

Real Appeal – Weight Management: Practical online weight management program available to you and eligible family members at no additional cost. Get started at enroll.realappeal.com.

OnePass Select – Fitness Program: Find a routine and membership tier that fits your lifestyle and provides everything you need for whole-body health in one easy, affordable plan. Learn more at onepassselect.com

AbleTo – Virtual Behavioral Health: 8-week coaching program that includes a dedicated mental health coach, digital activities, confidential and virtual weekly meetings with a coach. Visit ableto.com/exploremore to get started.



Available to UHC Choice Plus Copay and HSA Choice Plus Plan Members Only

Cancer Support: Access a nurse who can help you navigate cancer treatment options and find a network provider from a high-quality Centers of Excellence (COE) facility. Learn more at myuhc.phs.com/cancerprograms.com

Advocate4Me Elite Customer Service Support: Receive support from UHC experts around finding care options, claims issues, clinical advisement, care coordination and appointment scheduling, and more. To receive support, call the member number on your ID card or log into myuhc.com and click chat with an advocate.



Available to Surest Plan Members Only

2nd.MD – Second Opinion: Connect with highly skilled clinicians who can help you navigate the healthcare system and answer questions about possible surgeries, medications, conditions, and treatment plans. Visit www.2nd.md/activate/step1/surest to learn more.

Kaia Health – Musculoskeletal Support: At no cost, find lasting relief from chronic muscle and joint pain, all through a digital therapy app. Get started by verifying your eligibility through Surest and downloading the [Kaia app](#).

HEALTH & WELLBEING

Available to Kaiser Plan Members Only

Calm Health – Meditation and Sleep: Listen to guided meditations, sleep stories, mindfulness moments, and more to support mindfulness and sleep. Visit kp.org/selfcareapps to get started.

Headspace – Emotional Support: Offers 1-on-1 emotional support coaching and self-care activities to help with many common challenges through text messaging with coaches. Visit kp.org/selfcareapps to get started.

OnePass Select – Fitness Program: Find a routine and membership tier that fits your lifestyle and provides everything you need for whole-body health in one easy, affordable plan. Learn more at onepassselect.com



TAX ADVANTAGED ACCOUNTS

Tax-advantaged accounts give you the opportunity to set aside money pre-tax so that you pay less in taxes on eligible expenses. Our tax advantage accounts are administered by United Healthcare (UHC).

If you elect the...	Choice Plus Copay Plan	HSA Choice Plus Plan	
Type of Account	Access to Health Care Flexible Spending Account (FSA)	Access to Health Savings Account (HSA)	Access to a Limited Purpose Flexible Spending Account (FSA)
What sort of expenses can I use this account for?	Eligible medical, dental, and vision expenses, including deductibles, coinsurance, glasses, orthodontia, fertility, and more.	Eligible dental and vision expenses only —including glasses, orthodontia, and more.	
Does it help me pay less in taxes?	Yes, funds are pre-tax		
Does the company pay me a contribution?	No	Yes, \$300-\$600 annually <i>(prorated for new hires)</i>	No
Does my balance roll over?	Yes, up to \$680 of your balance this year	Yes — this money is yours now and in the future, with no “use it or lose it” risk	Yes, up to \$680 of your balance this year
Is the account portable if I leave or retire?	No	Yes, your account and balance are yours even if you change medical plans or leave the company	No
What are the contribution limits?	\$3,400	\$4,400 individual / \$8,750 family Additional \$1,000 catch-up contribution if age 55 or older. <i>Limits include the company funding.</i>	\$3,400
Can I change my payroll deduction?	No, only if you experience a qualifying life event	Yes, at any time	No, only if you experience a qualifying life event

WATCH AND LEARN



Under [a high-deductible health plan](#), all expenses prior to meeting the deductible are paid out of pocket, including prescriptions. Savings in your HSA can help you be prepared for these initial expenses.

Learn more about the differences between an FSA and an HSA [with this video](#).

TAX ADVANTAGED ACCOUNTS

Health Savings Account (HSA)

The HSA is a smart way to save money while paying for your healthcare costs today and building a nest egg for future healthcare and retirement expenses.

HSA Eligibility:

- Must be enrolled the UHC Choice Plus \$3,400 Plan
- Cannot be covered by any other medical that is not a HDHP. This includes a spouse medical coverage unless it's a HDHP
- Cannot be enrolled in a traditional health care FSA in 2026
- Cannot be enrolled in Medicare (Parts A or B), Medicaid, or Tricare
- Cannot be claimed as a dependent on another person's tax return

	2026 HSA Annual Maximum Contribution Limits	Pye-Barker Annual Weekly Contribution*
Employee Only	\$4,400	\$300 \$5.77
Family	\$8,750	\$600 \$11.54
55+ Catch Up	Additional \$1,000	N/A

*Prorated for new hires

Reasons to Love Your HSA

The HSA gives you:



More money in your paycheck with low weekly premiums.



More ways to save with triple-tax benefits. HSA contributions reduce your taxable income, any interest grown is not taxed and money that is withdrawn is also tax-free.



More flexibility in how you pay for healthcare services.



More opportunities to build long-term healthcare and retirement savings.

Wondering How Much to Save?

Recent research shows the average HSA user contributes about \$70 every two weeks and saves nearly \$300 in taxes as a result. What you save in your HSA is up to you and your budget. Here are a few strategies:

- To see the biggest tax advantage, max out your contributions up to the annual federal IRS limits.
- To be prepared for a rainy day, set aside enough each month to fund the annual deductible or out-of-pocket maximum. That way, you have funds available should you be faced with big medical bills.
- To simplify your savings, set aside \$10 per paycheck per enrolled family member. For a family of four, that will give you about \$1,000 set aside each year to help you cover the cost of an unexpected doctor's visit or a monthly generic medication.

TAX ADVANTAGED ACCOUNTS

Flexible Spending Accounts (FSAs)

How the Flexible Spending Account works

- Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- You can withdraw the money tax-free when you pay for eligible healthcare and dependent care expenses.
- Estimate carefully! FSA's are "use-it-or-lose-it" accounts. You generally must use the money in the FSA within the plan year or forfeit the remaining balance. Be sure to only set aside what you think you will spend in 2026.

Pye-Barker offers you the following FSAs:

Healthcare FSA

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year – such as plan deductibles, copays, coinsurance, and other health care expenses.

How the Healthcare FSA works

- You estimate what you and your dependents' out-of-pocket costs will be for the coming year and can set aside up to \$3,400 in 2026, the annual limit set by the IRS.
- When you enroll in a Healthcare FSA, you will receive a debit card, which you can use to pay for eligible expenses. Depending on the transaction, you may need to submit receipts or other documentation to your FSA administrator to substantiate expense amounts.

Limited-Purpose FSA

If you enroll in the HDHP and have a Health Savings Account, you are not eligible to open a traditional Healthcare FSA, however, you can open a Limited-Purpose FSA.

A Limited-Purpose FSA allows you to use pre-tax dollars to pay for dental and vision expenses. You can set aside up to \$3,400 in 2026, the annual limit set by the IRS.

Dependent Care FSA

A Dependent Care FSA allows you to set aside money from your paycheck, before taxes, to pay for work-related childcare expenses. It can help families potentially save hundreds of dollars per year on daycare.

How the Dependent Care FSA works

- Eligible expenses include not only day care, but also before-and after-school care programs, preschool, and summer day camp for children younger than 13.
- The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.
- You can set aside up to \$7,500 in 2026, the annual limit set by the IRS. You can pay your dependent care provider directly from your FSA Account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

DENTAL & VISION

DENTAL

Dental health is part of your overall good health. With dental coverage through MetLife, you have access to dental services to keep you smiling all year. To find an in-network provider visit MetLife's [Dental Insurance Center](#).

	Base Plan (in-network)	Buy-Up (in-network)
Annual Deductible <i>Employee Only</i> <i>Employee + Family</i>	\$50 \$150	\$50 \$150
Preventive/Diagnostic Care <i>X-rays, cleanings</i>	No charge; ded. waived	No charge; ded. waived
Basic <i>Oral evaluations, space maintainers, sealants, emergency exams</i>	20% after ded.	20% after ded.
Major <i>Crowns, jackets, cast restorations, fixed/removable bridges, partial/full dentures, crown & bridge repairs, implants, surgical periodontics</i>	50% after ded.	50% after ded.
Orthodontia	Not covered	50% after ded.

Benefits are shown for in-network providers and are based on negotiated fees. Out-of-network coverage is based on reasonable and customary charges

VISION

Your eyes are a window into your health. Routine vision care is an important part of your overall wellness. You have access to vision plan options through United Healthcare (UHC).

Vision Plan	In-Network	Out-of-Network
Frequency	Every calendar year	Every calendar year
Preventive Eye Exam <i>Copay</i>	\$10 Copay	Up to \$40 Copay
Prescription Glasses <i>Copay</i> <i>Frame Allowance</i>	\$15 Copay \$180 frame allowance	\$40-\$80 Copay Frames: \$45 allowance
Lenses <i>Single vision, lined bifocal & lined trifocal</i>	\$15, \$15, \$15, \$15	\$40, \$60, \$80, \$80 allowance
Contact Lenses <i>Elective</i> <i>Medically Necessary</i>	\$150 allowance 100% covered	Up to \$150 Up to \$210

Money-saving tip

Remember, you can use your HSA or FSA for qualified out-of-pocket dental and vision expenses.

EMPLOYEE ASSISTANCE PROGRAM

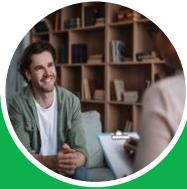
Your well-being matters, so Pye Barker has partnered with Sun Life to sponsor your employee assistance program (EAP). The EAP is a free counseling resource to help all our Team Members, and their dependents, confidentially manage personal needs, including:

- Stress, depression, and anxiety
- Relationship issues
- Job stress or work conflicts
- Family and parenting problems
- Anger, grief, and loss
- Disordered eating, mental health, and additional issues



To learn more about why we offer an EAP, watch [this short video](#).

To access these great perks, visit www.guidanceresources.com and enter Web ID EAPComplete, or call 1-877-595-5284.



In-Person Guidance

Some matters are best resolved by meeting with a professional in person. You and your family can receive in-person help for short-term issues (up to 5 sessions with a counselor per person, per issue, per year)



Unlimited Assistance

You and your family can access the following services any time — online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning and consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning



Online Resources

The EAP offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets and more

EMERGENCY CARE

When you need urgent mental health support, you can call **988** to reach trained counselors that are part of the existing National Suicide Prevention Lifeline network. These trained counselors will listen, understand how your problems are affecting you, provide support, and connect you to resources, if necessary.

BASIC LIFE AND AD&D

If you have loved ones who depend on your income for support, having life and accidental death and dismemberment (AD&D) insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

Pye-Barker Provided Life Insurance

Basic life insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, hearing, or if you die in an accident. **You automatically receive a basic life benefit of \$50,000 and AD&D coverage in the amount of \$50,000 at no cost to you.**

Additional Voluntary Life Insurance Coverage

You may choose to buy additional coverage for yourself or your family by enrolling in optional life and AD&D insurance. You must enroll in optional employee life/AD&D to enroll in the spouse and/or child(ren) optional life/AD&D options.

For your initial enrollment as a new hire, you may elect up to the guaranteed issue amount without Evidence of Insurability (EOI).

You may purchase		
	Voluntary Life	Voluntary AD&D
For you:	Up to 5x your salary or \$500,000 whichever is less (in \$10,000 increments). GI amount of \$300,000	Up to 5x your salary or \$500,000 whichever is less (in \$10,000 increments)
For your spouse:	Up to \$250,000 in \$5,000 increments (not exceeding 50% of employee amount). GI amount of \$50,000	Up to 40% of employee amount or 50% if no dependent children are covered
For your child(ren):	Up to \$10,000 in \$2,000 increments (not exceeding 100% of employee amount) No EOI required for children	10% of employee coverage amount or 15% if no spouse coverage

Statement of Health Requirements (EOI)

Electing voluntary life coverage that exceeds the Guaranteed Issue (GI) Amounts, declining to elect voluntary life coverage when it's first available and wanting to elect it later, or wanting to increase coverage will require health questions. Health questions should be answered by filling out Sun Life's Evidence of Insurability application, which must be approved by Sun Life before coverage takes effect.



You, your beneficiary, and your loved ones have access to end-of-life planning and support through Wellthy when enrolling in Sun Life's life insurance. Visit [wellthy.com/member/sunlife-yourjourney](https://www.wellthy.com/member/sunlife-yourjourney) to access this benefit.

DISABILITY

Disability plans, offered through Sun Life, are intended to replace a portion of your income if an illness or injury leaves you unable to work. Disability benefits are subject to applicable taxes and are offset by any other income or disability benefits you receive (or are eligible to receive), such as Social Security and workers' compensation.

Pye-Barker Provided Short-Term Disability

You are automatically enrolled in this coverage at no cost to you. Short-term disability (STD) coverage pays you a benefit if you temporarily can't work because of an injury, illness or maternity leave. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition.

Voluntary Long-Term Disability

Long-term disability (LTD) coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long period of time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security. Refer to your SPD for any exclusions that may apply.

	Short-Term Disability	Voluntary Long-Term Disability
Who Pays:	Company-paid benefit	Employee-paid benefit
Benefit Provided	Up to 60% of your weekly salary	Up to 60% of your monthly salary
Max Benefit Payable:	\$1,000 per week	\$5,000 per month
Max Benefit Duration:	11 weeks	5 years with reducing benefit schedule
Waiting Period:	Illness and Injury: 14 days	90 days



Be sure to name a beneficiary for all your life benefits within Workday.

VOLUNTARY BENEFITS

If you are looking for more protection for your family, you may consider electing optional coverage, some of which are offered at group discounts.



Supplemental Health Insurance

Supplemental health benefits can be used in conjunction with medical insurance to pay a lump sum benefit for specific health situations. The money can be used however you need it — to pay for medical expenses, home healthcare, mortgage/rent payments. Cost of coverage is based on level of coverage. These benefits are available through Sun Life.



CRITICAL ILLNESS INSURANCE

Critical illness insurance can offset the financial effects of a catastrophic illness or condition. Examples of a covered illness or conditions are heart attack, stroke, cancer and permanent paralysis. Plus, the Health Navigator Help Line provides guidance for a health situation you are facing.



ACCIDENT INSURANCE

Accident coverage is designed to help meet the out-of-pocket expenses and extra bills that can follow an accidental injury. Indemnity lump sum benefits through Sun Life are paid directly to you based on the amount of coverage listed in the schedule of benefits.



HOSPITAL INDEMNITY

Hospital Indemnity coverage provides supplemental payments for expenses that your medical plan doesn't cover when you are admitted to the hospital for a covered stay.



Allstate Identity Theft

Identity fraud can happen to anyone. That's why Pye-Barker provides Allstate Identity Projection Pro+ Cyber that includes:

- Cyber protection with military-grade VPN, password manager, and network security plus device protection tools for up to 5 devices – up to 10 devices with a family plan.
- Privacy and data monitoring with Allstate Digital Footprint, data breach notifications, Robocall blocker and ad blocker, solicitation reduction, and more.
- Identity and financial monitoring with Identity Health Status, Allstate Security Pro, high-risk transaction monitoring, and more.
- Comprehensive credit monitoring with annual credit report, credit lock, credit freeze assistance, and more.
- Identity restoration with US-based support and up to \$1 million in stolen funds reimbursement and ransomware expenses* plus up to \$2 million for identity theft expenses with a family plan.

WEALTH – 401(K) SAVINGS PLAN

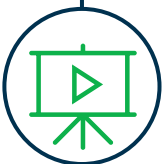
The company offers eligible Team Members the opportunity to participate in the 401(k) plan. You can participate in the company 401(k) if you are at least 18 years old and have completed 90 days of service. This applies to both part-time and full-time team members.

You should receive notification, along with an enrollment kit, once you become eligible to enroll in the 401(k) savings plan. If you don't receive notification within 90 days of your hire day, please contact your HR department.

The company will match 100% up to 4% of your contributions. You can modify your contribution up to IRS annual limits at any time.

You are immediately and always 100% vested — so the funds are yours even if you leave Pye-Barker. The plan offers you a variety of investment options. It's important to carefully consider your investment goals, retirement time frame, and risk tolerance when deciding how to invest your plan contributions.

The information provided in this section is only intended as a high-level summary of some key 401(k) plan features. Please ensure that you read and understand the complete plan details by referencing your Mercer Welcome Kit or by accessing [mercerwise.com](https://www.mercerwise.com), or call Empowerment Financial Services directly at 833-637-2379.



WATCH AND LEARN
Watch this video to think through more factors about your retirement needs.

2026 RATES (PER PAYCHECK)

UHC Medical Weekly	UHC \$1,800 Copay	UHC Choice \$3,400 HSA	Surest
Employee	\$38.47	\$18.61	\$12.90
Employee + Spouse	\$188.52	\$125.70	\$100.76
Employee + Child(ren)	\$170.85	\$115.27	\$94.71
Family	\$268.80	\$184.70	\$149.12

MetLife Dental Weekly	Base Plan	Buy-Up Plan
Employee	\$5.44	\$8.67
Employee + Spouse	\$10.89	\$17.37
Employee + Child(ren)	\$11.41	\$18.18
Family	\$17.47	\$27.85

UHC Vision Weekly	Base Plan
Employee	\$1.86
Employee + Spouse	\$3.72
Employee + Child(ren)	\$3.98
Family	\$6.36

2026 RATES (PER PAYCHECK)

SunLife Supplemental Life (Rates per \$1,000)		
Age Band	Employee	Spouse
<25	\$0.075	\$0.075
25-29	\$0.075	\$0.075
30-34	\$0.120	\$0.120
35-39	\$0.135	\$0.135
40-44	\$0.150	\$0.150
45-49	\$0.225	\$0.225
50-54	\$0.344	\$0.344
55-59	\$0.644	\$0.644
60-64	\$0.988	\$0.988
65-69	\$1.901	\$1.901
70-74	\$3.084	\$3.084
75+	\$3.084	\$3.084

SunLife Critical Illness (Rates per \$1,000)		
Age Band	Employee	Spouse
<25	\$0.2400	\$0.2400
25-29	\$0.3000	\$0.3000
30-34	\$0.3700	\$0.3700
35-39	\$0.4800	\$0.4800
40-44	\$0.7400	\$0.7400
45-49	\$1.1800	\$1.1800
50-54	\$1.6600	\$1.6600
55-59	\$2.1900	\$2.1900
60-64	\$3.1400	\$3.1400
65-69	\$4.3800	\$4.3800
70-74	\$5.1800	\$5.1800
75+	\$5.4700	\$5.4700

SunLife Supplemental Life Child (Rates per \$1,000)	
Child	
	\$0.070

SunLife Supplemental AD&D (Rates per \$1,000)	
Employee	
	\$0.020

2026 RATES (PER PAYCHECK)

SunLife Accident Weekly Rates			
	Option 1	Option 2	Option 3
Employee	\$1.38	\$1.82	\$2.40
Employee + Spouse	\$2.16	\$2.86	\$3.80
Employee + Child(ren)	\$2.56	\$3.52	\$4.77
Family	\$3.34	\$4.56	\$6.16

SunLife Hospital Indemnity Weekly Rates	
Employee	\$1.31
Employee + Spouse	\$2.95
Employee + Child(ren)	\$2.52
Family	\$4.43

Allstate Identity Theft CyberPro+ Weekly Rates	
Employee	\$2.19
Family	\$4.27

SunLife Voluntary Long-Term Disability (Rates per \$100)	
Age Band	Employee
<25	\$0.18
25-29	\$0.20
30-34	\$0.24
35-39	\$0.34
40-44	\$0.49
45-49	\$0.68
50-54	\$0.90
55-59	\$1.24
60-64	\$1.56
65+	\$1.56

IMPORTANT CONTACTS

Benefit	Provider	Phone Number	Website
Medical	United Healthcare	1-866-314-0335	myuhc.com
Medical	Surest	1-866-683-6440	join.surest.com/ PyeBarker
Pharmacy (Rx)	Optum	1-888-290-7789	UHC: myuhc.com Surest: benefits.surest.com
Spending Accounts: - Health savings account (HSA) - Flexible spending accounts (FSAs)	Chard-Snyder	1-800-982-7715	www.chard-snyder.com
Dental	MetLife	1-800-438-6388	metlife.com/mybenefits
Vision	United Healthcare	1-800-638-3120	myuhcvision.com
Employee assistance program (EAP)	Sun Life	1-877-595-5284	www.guidanceresources.com
Life and AD&D insurance	Sun Life	1-866-806-3619	www.sunlife.com/us
Disability & Leave	Sun Life	1-866-806-3619	www.sunlife.com/us
Accident, Critical Illness, & Hospital Indemnity	Sun Life	1-866-806-3619	www.sunlife.com/us
Health Navigator Help Line	Sun Life / Critical Illness	888-888-8318	Sunlife.com/helpline
Benefits Navigation	Brian Patten & Associates	833-271-4977	https://calendly.com/pye-barker-benefits
401(k) savings plan	Empower Financial Services	833-637-2379	mercerwise.com
Medicare Solutions	Alliant	877-888-0165	Alliantmedicareolutions.com

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Medicare Part D Notice

Important Notice from Pye-Barker Fire & 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 Pye-Barker Fire & Safety and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 Pye-Barker Fire & Safety coverage will not be affected. See below for more information about what happens to your current

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coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Pye-Barker Fire & Safety's medical plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Pye-Barker Fire & Safety prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Pye-Barker Fire & Safety and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further. 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 Pye-Barker Fire & Safety 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.

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For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://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 800-MEDICARE (800-633-4227). TTY users should call 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 [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

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

Date: 10/24/2025
Name of Entity/Sender: Pye-Barker Fire & Safety
Contact-Position/Office: Kristine Cooke – Senior Director, Total Rewards
Address: 2500 Northwinds Parkway, Alpharetta, GA 30009
Phone Number: 800-927-8610 ext. 6

Women’s Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator 800-927-8610 ext. 6.

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Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 800-927-8610 ext. 6.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Pye-Barker Fire & Safety's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Pye-Barker Fire & Safety's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Pye-Barker Fire & Safety's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

RIGHT TO SPECIAL ENROLLMENT IN ANOTHER PLAN

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in healthcare laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for Protecting Your Health Insurance Coverage).

These publications and other useful information are also available on the Internet at:

<http://www.dol.gov/ebsa>, the DOL's interactive web pages – Health Laws, or www.cms.hhs.gov/healthinsreformforconsume/.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Pye-Barker Fire & Safety describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Pye-Barker Fire & Safety's Human Resource Department.

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Notice of Choice of Providers

The Pye-Barker Fire & Safety Kaiser plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 800-927-8610 ext. 6.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Pye-Barker Fire & Safety 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 our network who specializes in obstetrics or gynecology. The health care professional, 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, contact the [plan administrator at 800-927-8610 ext. 6.

Notice of Availability of Alternative Standard for Wellness Plan

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your HR department and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

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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 (see next page), you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility—

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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: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (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://www.mycohibi.com/> | HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.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

Health Insurance Premium Payment Program All other Medicaid Website: <https://www.in.gov/medicaid/> | <http://www.in.gov/fssa/dfr/> | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: [Iowa Medicaid | Health & Human Services](#) | Medicaid Phone: 1-800-338-8366
Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#) | Hawki Phone: 1-800-257-8563
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)
HIPP Phone: 1-888-346-9562

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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: KIHIPPPROGRAM@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

MASSACHUSETTS – 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/health-care-coverage/> | Phone: 1-800-657-3672

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084 | email: HSHIPPProgram@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. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/> | Phone: 800-356-1561

CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

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: <https://www.hhs.nd.gov/healthcare> | Phone: 1-866-614-6005

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

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

2026 ANNUAL NOTICES

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: KIHIPPPROGRAM@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

MASSACHUSETTS – 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/health-care-coverage/> | Phone: 1-800-657-3672

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084 | email: HSHIPPProgram@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. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/> | Phone: 800-356-1561

CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

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: <https://www.hhs.nd.gov/healthcare> | Phone: 1-866-614-6005

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

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

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PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html> | Phone: 1-800-692-7462

CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](#) | CHIP Phone: 1-800-986-KIDS (5437)

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.scdhhs.gov> | Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](#)

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>

Email: upp@utah.gov | Phone: 1-888-222-2542 |

Adult Expansion Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select> or <https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/> or <http://mywvhipp.com/>

Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.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

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

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

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

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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.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

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Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the [Access to Care and Treatment Benchmark Plan](#) and the [Pediatric Dental Plan](#) to reference the pages listed below.

Employer Name:	Pye-Barker Fire & Safety
Employer State of Situs:	Georgia
Name of Issuer:	Pye-Barker Fire & Safety, LLC Health & Insurance Plan
Plan Marketing Name:	Pye-Barker Fire & Safety, LLC Health & Insurance Plan
Plan Year:	2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

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2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	No
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes

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17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	No
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	No
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	No
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes

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33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	Yes
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes
<p><i>Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.No</i></p>				

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The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

[View a sample notice and consent form \(PDF\).](#)

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the

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same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

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

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

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

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

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

When balance billing isn’t allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

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- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit [No Surprises Act | CMS](#) for more information about your rights under federal law.

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

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Exchange Notice

PART A: General Information

When key parts of the health care law took effect in 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.02% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. In addition, this employer contribution -as well as your employee contribution to employer- offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

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How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

**An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.*

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Fixed Indemnity Plan Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

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Summary of Rights and Obligations Regarding COBRA Continuation Coverage

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 Human Resources Department.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following

qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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.

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to PYE-BARKER FIRE & SAFETY and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Human Resources Department has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Human Resources Department of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 Human Resources Department within 60 days after the qualifying event occurs. How is COBRA Coverage Provided?

Once the Human Resources Department 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.

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COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Human Resources Department in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Human Resources Department informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Human Resources Department.

Plan Contact Information: Call your plan administrator at 800-927-8610 ext. 6.

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Creditable Coverage Drug Coverage & Medicare Important Notice from Pye-Barker Fire & Safety.

About Your Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Pye-Barker Fire & Safety's medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. This is known as "creditable coverage."

Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during 2026 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D) and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by your employer's drug plans listed in your annual benefit guide, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2026. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer

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coverage. In this case, the employer plan will continue to pay primary or secondary, as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop your employer's coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Pye-Barker Fire & Safety plan.

You should know that if you waive or leave coverage with Pye-Barker Fire & Safety and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Pye-Barker Fire & Safety coverage changes, or upon your request.

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 & your handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

Visit www.medicare.gov for personalized help.

Call your state Health Insurance Assistance Program (see a copy of the Medicare & your handbook for the telephone number) or visit the program online at <https://www.shiptacenter.org/>.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

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Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Kristine Cooke

Senior Director, Total Rewards

Pye-Barker Fire & Safety

2500 Northwinds Parkway

Alpharetta, Georgia 30009

800-927-8610 ext. 6

Provider-Choice Right Notice

The Pye-Barker Fire & Safety Kaiser plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, call your plan administrator at 800-927-8610 ext. 6. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Pye-Barker Fire & Safety 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 our network who specializes in obstetrics or gynecology. The health care professional, 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, call your plan administrator at 800-927-8610 ext. 6.

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FMLA Poster

Higher resolution copy for the following content is available [here](#).

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #2BM(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, to request FMLA leave you **must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call 1-866-487-9243 or visit dol.gov/fmla to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**



WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR



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