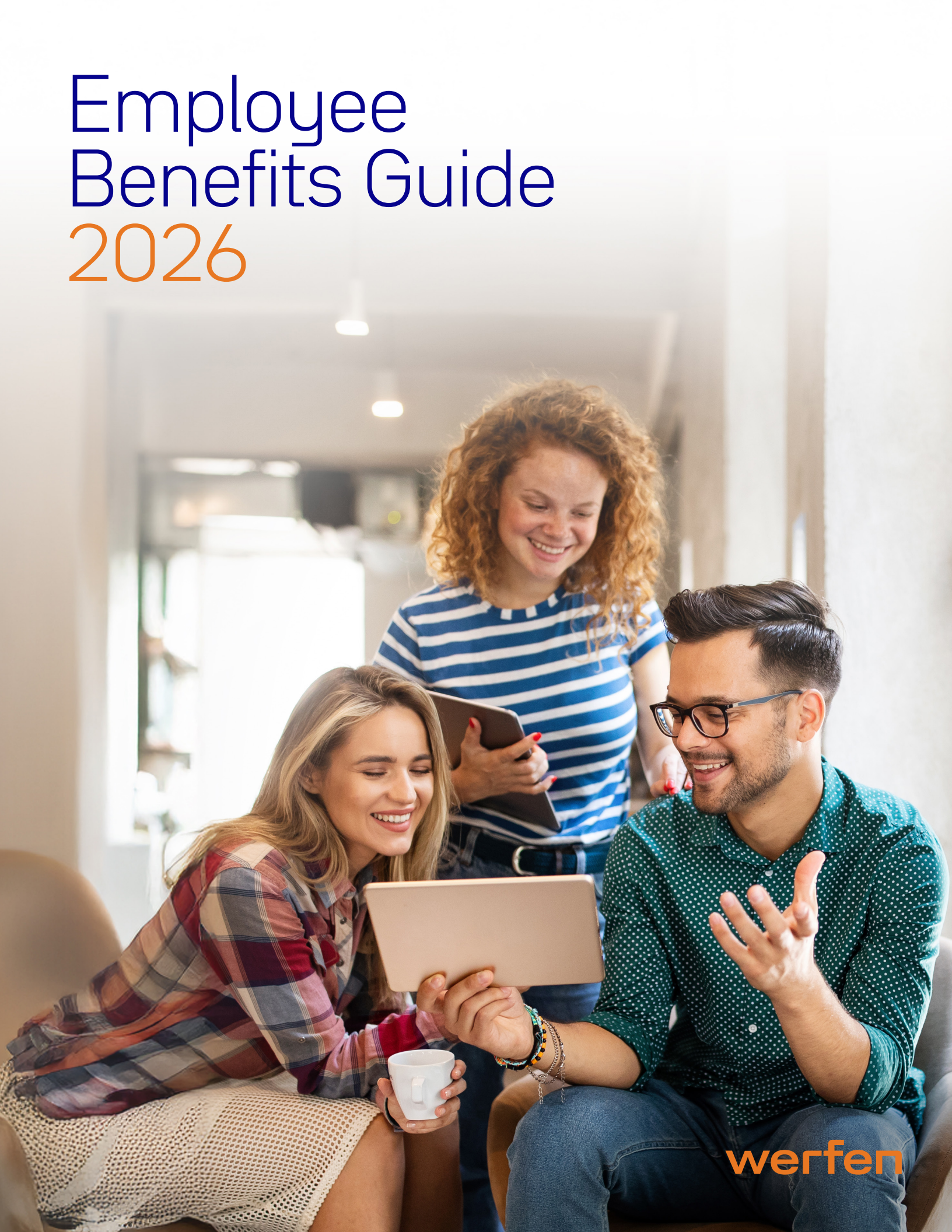
Employee Benefits Guide 2026



Werfen takes pride in providing a comprehensive employee benefits program, and we recognize the important role employee benefits play as a critical component of your overall compensation. We strive to maintain a benefits program that is competitive within our industry.

What's inside

Eligibility

Who is eligible for benefits?

All full-time and part-time employees who work a minimum of 20 hours per week are eligible for benefits. For new hires, most benefits are effective on your date of hire.

In addition to enrolling yourself, you may also enroll any eligible dependents. Eligible dependents are defined below:

- **Spouse:** a person to whom you are legally married
- **Child(ren):** Your biological, adopted, or legal dependents up to age 26 regardless of student, financial, and marital status

Qualifying Life Event

The benefits plan year runs January 1 through December 31. Unless you have a qualifying life event that impacts your eligibility and the change is allowed under the terms of the plan document, you cannot make changes to the benefits you elect until the next Open Enrollment period. Some examples of qualifying life events are highlighted below:

- Marriage or divorce
- Change in employment, or employment status for you, your spouse, or your dependent child
- Birth, adoption, or death
- Change in coverage under another employer plan, such as a change made during your spouse's Open Enrollment

Benefit changes must be consistent with your qualifying life event. Changes must be submitted in ADP within 30 days of the event; documentation supporting the change will be required.

Don't understand what a Qualifying Life Event is?

Scan the QR code or visit www.brainshark.com/hilbgroup/ChangeInStatusEvents to watch a short video.

Employee Resources

Plan	Group Number	Phone Number and Website / Email
Medical Blue Cross Blue Shield MA	4956749	1-800-262-2583 www.bcbsma.com
Anthem Blue Cross	166480	1-800-700-3351 www.anthem.com/ca
Dental Delta Dental MA	016380	1-800-872-0500 www.deltadentalma.com
Vision EyeMed	1061725	1-866-939-3633 www.eyemed.com
Health Savings Account Health Equity	–	1-866-346-5800 www.healthequity.com
Flexible Spending Accounts Health Equity	–	1-877-924-3967 www.healthequity.com
Life, Disability, Voluntary Accident, Critical Illness & Hospital Indemnity Insurance Prudential	72675	1-800-778-4357 www.prudential.com
Employee Assistance Program (EAP) Magellan	–	1-800-523-5668 https://member.magellanhealthcare.com/account-selection
Home & Auto Farmers	–	1-833-905-0408 www.farmers.com/groupselect
Legal MetLife	–	1-800-821-6400 https://www.legalplans.com/whyenroll
Fraud & Identity Protection Aura	–	1-844-931-2872 https://www.metlife.com/identity-and-fraud-protection/
Pet Insurance MetLife	270667	1-800-GET-MET8 www.metlife.com/getpetquote
FIGO	–	https://bit.ly/3fHcA7U
401(k) Retirement Plan T. Rowe Price	–	1-800-922-9945 www.rps.troweprice.com

There's an app for that!

↘ Many of our providers have mobile apps that provide personalized access to your benefits when and where you need it! There are also a variety of FREE health and fitness related apps available. Browse and download apps to your smartphone or tablet from the App Store or Google Play.

Medical and Prescription Overview

Contact

Blue Cross Blue Shield of Massachusetts
Customer Service: 1-800-262-BLUE (2583)
www.bcbsma.com

HMO: Anthem Blue Cross
Customer Service: 1-800-700-3351
www.anthem.com/ca

Choosing your Medical Plan

You can choose between three Preferred Provider Organization (PPO) plans administered by Blue Cross Blue Shield of Massachusetts. A PPO plan provides freedom of choice as members have access to both in-network and out-of-network providers. You'll pay less for your service if you see an in-network provider. If you live in California, you also have the choice of enrolling in the Anthem Select HMO Plan. Please note GLP-1s will no longer be covered under any plan for weight loss.

PPO $750/ $1,500

Under the Core Plan, In-Network coverage has a $750 deductible per member, capped at $1,500 per family. Once the deductible has been met, you will pay 20% coinsurance for eligible services until the $4,000 per individual, capped at $8,000 per family out-of-pocket maximum is met. Office visit copays, ER and Urgent Care copays, and prescription drug copays are not subject to the deductible, but do apply to the out-of-pocket maximum.

High Deductible Health Plans "HDHP" - HDHP $2,000/$4,000 & HDHP $3,000/$5,000

These plans offer the benefit of a Health Savings Account (HSA), an employee owned, portable account funded with pre-tax dollars to help pay for out-of-pocket expenses.

When you enroll in the HDHP Plan, Werfen will also contribute to a Health Savings Account, $500 for an individual and $1,000 for employee plus dependents (prorated for new hires or new enrollments during the year) as long as you are employed by the company.

Anthem HMO (California Residents ONLY)

Employees that reside in California will have access to Anthem's Select HMO Premier option. Members are required to choose a Primary Care Physician who participates in the Select HMO network and obtain referrals for specialist care. There is no coverage outside of the Select HMO network beyond emergency care.

Telehealth Benefit

You have access to licensed doctors and providers for minor medical and behavior health care using video visits from the convenience of your home!

Medical Waiver Benefit

Werfen offers a medical waiver benefit if you are covered under another employer sponsored group health plan and do not enroll in medical. It will be equal payments over the course of the year, totaling $1,000 annually.

More Information

The chart on the following page provides a summary of the medical plans. Please visit https://workforcenow.adp.com for more detailed Summaries of Benefits ond Coverage.

To search for a doctor in the Blue Cross Blue Shield network, visit https://myfindadoctor.bluecrossma.com and select the "EPO or PPO" network.

To search for a doctor in the Anthem network, visit www.anthem.com/ca/find-care/. Use the drop down to choose "Select HMO" as your network.

Medical and Prescription Plan Highlights

Plan Features	PPO $750/$1,500	HDHP $2,000/$4,000	HDHP $3,000/$5,000	Anthem Select HMO (California ONLY)
	In-Network YOU PAY	In-Network YOU PAY	In-Network YOU PAY	In-Network YOU PAY
HSA Funding	N/A	$500 individual $1,000 family	$500 individual $1,000 family	N/A
Annual Deductible	$750 individual $1,500 family	$2,000 individual $4,000 family	$3,000 individual $5,000 family	$250 individual $500 family
Annual Out-of-Pocket Maximum	$4,000 individual $8,000 family	$4,000 individual $8,000 family	$5,000 individual $10,000 family	$3,500 individual $7,000 family
Preventive Services	No charge	No charge	No charge	No charge
OFFICE VISITS, LABS, AND TESTING				
PCP/Specialist Office Visits	$25/$40	10% (AD)	20% (AD)	$20 / $40
Diagnostic Test - Lab / X-Ray	20% (AD)	10% (AD)	20% (AD)	10% (AD)
Imaging (MRI/CT)	20% (AD)	10% (AD)	20% (AD)	$125
HOSPITAL				
Inpatient / Outpatient	20% (AD)	10% (AD)	20% (AD)	10% (AD)
URGENT AND EMERGENCY CARE				
Urgent Care Facility	$25	10% (AD)	20% (AD)	$20
Hospital Emergency Room	$150	10% (AD)	20% (AD)	$200
OUT-OF-NETWORK BENEFITS*				
Annual Deductible	$1,500 individual $3,000 family	$4,000 individual $8,000 family	$5,000 individual $10,000 family	N/A
Coinsurance	20% or 40%	10% or 30%	20% or 40%	N/A
Annual Out-of-Pocket Maximum	$8,000 individual $16,000 family	$8,000 individual $16,000 family	$10,000 individual $20,000 family	N/A
PRESCRIPTION DRUGS				
Rx Copay - Retail Generic / Preferred Brand/ Non-Preferred Brand / Specialty	$10/$35/$60/$100	Deductible applies: $10/$35/$60/$100	Deductible applies: $10/$35/$60/$100	$5/$20/$40/$60
Mail Order - 90-day supply Generic / Preferred Brand/ Non-Preferred Brand / Specialty	$25/$90/$150/$250	Deductible applies: $25/$90/$150/$250	Deductible applies: $25/$90/$150/$250	$10/$40/$100/$150

This chart is intended for comparison purposes only. If there are any discrepancies, the official plan documents will govern.
**Out-of-network providers and facilities may balance bill you for any charges in excess of the amount paid by the plan.*
***PPO Enhanced will be closed to any new enrollments*
AD = After Deductible

Medical Bi-Weekly Employee Contributions

Tier	PPO $750/$1,500	HDHP $2,000/$4,000	HDHP $3,000/$5,000	Anthem Select HMO (California ONLY)
Employee Only	$48.21	$44.07	$39.26	$48.92
Employee + Spouse	$182.57	$179.52	$160.00	$185.23
Employee + Child(ren)	$132.46	$117.95	$105.22	$134.39
Family	$192.18	$188.96	$168.42	$194.98

Dental Plan Highlights

Werfen offers dental coverage through **Delta Dental**. You can visit any licensed dentist, but your costs are lowest with an in-network dentist. The in-network dentists accept reduced fees for covered services; out-of-network dentists may balance bill you the difference between their usual fee and what the plan pays.

The features of your dental plans are highlighted in the table below. Please refer to your plan description for full details.

Plan Features	Core Plan		Enhanced Plan	
	In-Network YOU PAY	Out-of-Network* YOU PAY	In-Network YOU PAY	Out-of-Network* YOU PAY
Annual Deductible Amount you must pay per year before the plan begins to pay benefits	$50 individual $150 family		None	
Annual Benefit Maximum Maximum amount the plan will pay per year	Plan pays $1,500 per person per year		Plan pays $2,000 per person per year	
Preventive and Diagnostic Services	No charge	No charge*	No charge	No charge*
Basic Services	20% after deductible	20%* after deductible	20%	20%*
Major Services	50% after deductible	50%* after deductible	50%	50%* Included coverage for implants
Orthodontia	50% up to $1,500 lifetime per person; Children up to age 19		50% up to $2,500 lifetime per person; Adults and Children	

This chart is intended for comparison purposes only. If there are any discrepancies, the plan document will govern.
**Out-of-network providers and facilities may balance bill you for any charges in excess of the amount paid by the plan.*
The Annual Benefit Maximum and the Orthodontia maximum are separate maximums - not combined.

Dental Bi-Weekly Employee Contributions

Tier	Core Plan	Enhanced Plan
Employee Only	$4.75	$8.94
Employee + Spouse	$14.26	$29.95
Employee + Child(ren)	$9.66	$16.74
Family	$15.00	$31.53

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Need to locate a participating, in-network provider?

Visit:
www.deltadentalma.com
or call 1-800-872-0500.

Vision Plan Highlights

Your vision coverage includes a full range of vision care services provided through **EyeMed**.

You may receive care from any provider you choose, but your benefits are greater when you see a participating in-network provider. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form to EyeMed for reimbursement.

Plan Features	In-Network	Out-of-Network Reimbursement
Vision Exam *Once every 12 months*	$10 copay Plus Provider: $0	Up to $40 Plus Provider: Up to $40
Eyeglass Frames *Once every 12 months*	$150 plan allowance; 20% off balance	Up to $105
Plus Providers	$0 copay; 20% off balance over $200	Up to $105
Eyeglass Lenses *Once every 12 months* Single vision Lined bifocal Lined trifocal	 $25 copay $25 copay $25 copay	 Up to $30 Up to $50 Up to $70
Contact Lenses *Once every 12 months in lieu of eyeglasses*	$150 allowance; 15% off remaining balance	Up to $130
Medically Necessary	Paid in full	Up to $300

This chart is intended for comparison purposes only. If there are any discrepancies, the plan document will govern. Limitations and exclusions may apply.

Bi-Weekly Contributions

Tier	EyeMed Vision
Employee Only	$1.56
Employee + Spouse	$3.96
Employee + Child(ren)	$3.12
Family	$4.17

Did you know your eyes can tell an eye care provider a lot about you?

Vision insurance can make routine eye care more affordable, especially if you are among the majority of people who wear prescription eyeglasses or contact lenses.

In addition to getting a vision screening, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

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Need to locate a participating, in-network provider?

Visit:
www.eyemed.com
or call 1-866-939-3633.

Health Savings Account (HSA)

Administered through Health Equity

If you enroll in the HDHP $2,000/ $4,000 or HDHP $3,000/ $5,000 HSA eligible plans, you are automatically enrolled in a Health Savings Account (HSA).

An HSA can help you save money by allowing you to pay for qualified expenses with tax-free dollars. You can use the funds to pay for qualified expenses, such as medical and prescription drug expenses, as well as dental and vision expenses, for you, your spouse, and all dependents you claim on your tax return or could have claimed except that the individual had gross income in excess of the exemption amount—even if they are not covered under your medical plan!

Reasons to love an HSA

- Triple Tax Savings
  - You can contribute to your HSA using tax-free dollars.
  - You can use the money in your HSA to pay for qualified expenses with tax-free money.
  - Money in the account accumulates year over year, and earns interest that is tax-free as long as you use the HSA money for qualified expenses.
- You decide how and when to use the funds in your account; you can use the funds to pay for your qualified expenses or save them for future health care costs.
- The account may be used to build funds for retirement. Once you reach age 65, you can withdraw the money for non-medical reasons without a penalty. Withdrawal of funds prior to 65 will result in funds being taxable.
- Your account is owned by you, which means you take it with you if you leave, resign, or retire from the company.
- Increased earning potential with investments—once your HSA balance reaches a certain amount, you may invest your funds for increased earning potential that is also tax-free.

To contribute to an HSA, you must meet the HSA eligibility criteria below:

- You must enroll in a Qualified High Deductible Health Plan (QHDHP) each year, and you cannot be covered by any other medical plan or coverage that is not a QHDHP. This would include being enrolled in your spouse's non-QHDHP plan as secondary coverage, Medicare coverage, an executive medical reimbursement plan, or a Health Care FSA (either yours or your spouse's)unless it is a Limited Purpose HealthCare FSA.
- You must not be eligible to be claimed as a dependent on another individual's tax return.
- You must be enrolled in the plan on the first day of the month (otherwise, your eligibility to make contributions to your HSA begins the first day of the following month). If you are eligible as of December 1, under the last month rule you may make the maximum annual HSA contribution for the year regardless of the month you became eligible. Any contributions made under the last month rule will be subject to a testing period during which you must maintain HSA eligibility in the following year in order for the contribution to remain tax favored.

Important Reminders

- To pay for qualified expenses, your HSA must be opened prior to incurring those expenses.
- You may not have any other health insurance coverage, including through your spouse, a Health Care FSA, or Medicare.
- If your child is under the age of 26, they may be covered under your medical plan, but your HSA funds can only be used for expenses for that dependent if they are claimed on your tax return or could have claimed except that they had gross income in excess of the exemption amount.

Funding your HSA

The IRS establishes a limit that you can contribute each year you are enrolled in a qualifying health plan. The limits are based on whether your qualifying health plan covers just you (individual) or you and others (family).

The contribution limits set forth by the IRS for 2026 (for a full year of coverage or if the last month rule applies) are below:

	2026 Limits	Werfen Contributions*	Employee Maximum Contribution
Individual	$4,400	$500	$3,900
Family	$8,750	$1,000	$7,750

*Werfen HSA contributions will be distributed per payroll

Individuals age 55 and over may make an additional "catch-up" contribution of $1,000 per year. Contributions to the account must stop once you are enrolled in Medicare; however, you can still use your HSA funds to pay for eligible medical expenses tax-free.

Please note the limits are based on a calendar year and subject to change each year based on IRS regulations.

If you have money left in your HSA at the end of the year, it will simply roll over and grow over time through the accrual of tax-free interest. What a great way to invest for the future!

Qualified Expenses

- You can use your HSA to pay for eligible health care expenses, such as:
- Copays
- Deductibles Coinsurance
- Vision
- Dental
- Certain medical supplies

For a complete list of eligible expenses, go to:
https://www.irs.gov/publications/p502

Using Your HSA

You can use money in your HSA to pay for any qualified medical expense permitted under federal tax law. This includes most medical care and services as well as dental and vision care.

A partial list of allowable expenses is below:

- Prescription drugs or insulin
- Prescribed birth control
- Over-the-counter medications
- Medical equipment, such as a wheelchair, crutches, artificial limbs, and wigs (where prescribed by a physician for mental health or due to hair loss because of disease)
- Treatments and therapies, such as treatment for alcoholism or drug addiction, acupuncture to treat a medical condition, physical therapy, and smoking cessation programs
- Dental and orthodontic care, such as x-rays, braces, or dentures
- Vision care expenses, including eye exams, eyeglasses, and contacts
- Hearing aids
- Assistance for the handicapped, such as a guide dog, braille book, and home or car equipment for a handicapped person's needs
- Mental health institute treatment
- Other fees and services such as hospital services, home care services, laboratory fees, surgical fees, x-rays, and chiropractic fees

Please consult your tax advisor should you require specific tax advice. This list is subject to change.

Flexible Spending Accounts (FSA)

Administered through Health Equity

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses for you and your family.

Health Care FSA

Employees who do not enroll in a Health Savings Account (HSA) have the ability to contribute to a Health Care FSA. Health Care FSAs help you stretch your budget for health care expenses for you and your dependents by allowing you to pay for these expenses using tax-free dollars. You may set aside up to **$3,400** annually, which is deducted out of your pay throughout the year on a pre-tax basis. Funds can be used to pay for qualified health expenses such as deductibles, medical and prescription copays, dental expenses, and vision expenses. You can use the FSA for expenses for yourself, your spouse, and your eligible children—even if they are not covered under your medical or dental plan!

Your annual contribution amount is credited to your account and is available to you at the beginning of the plan year. As you incur expenses, simply use your debit card to pay for your expenses or submit a claim to be reimbursed.

Limited Purpose Health Care FSA

A Limited Purpose Health Care FSA is a flexible account option for those enrolled in a qualified high deductible health plan (QHDHP) with a Health Savings Account (HSA). The Limited Purpose Health Care FSA is restricted to eligible preventive care (as defined by the IRS), dental, and vision expenses including expenses such as insulin, statins, inhaled corticosteroids, dental cleanings, orthodontics, fillings, crowns, contact lenses, eyeglasses, and vision correction.

Dependent Care FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars. You may set aside up to **$5,000** annually in pre-tax dollars, or $2,500 if you are married and file taxes separately from your spouse.

Contributing to a Dependent Care FSA allows you to pay dependent care expenses so that you and your spouse can work, look for work, or attend school full-time. Eligible expenses include daycare (center or individual daycare), before/after school care, summer day camp, and elder care.

Eligible expenses are listed below:

- Care for your dependent child who is under the age of 13 that you can claim as a dependent for tax purposes
- Care for your dependent child who resides with you and who is physically or mentally incapable of caring for him/herself
- Care for your spouse or parent who is physically or mentally incapable of caring for him/herself

While you are enrolled in the Health Care FSA, you cannot make or receive Health Savings Account contributions through your employer. You may still enroll in the Limited Purpose Health Care FSA or Dependent Care FSA.

Do I need to enroll each year?

In order to participate in the FSA, **you must enroll each plan year**. Your annual contribution stays in effect during the entire plan year. The only time you can change your election is during Open Enrollment or if you experience a qualified change-in-status event that impacts your eligibility and the change is allowed under the terms of the plan document.

Will I lose my money if I don't use it in a year?

Any remaining funds over **$680*** in a Health Care FSA or Limited Purpose HCFSA and any amount left in your Dependent Care FSA at the end of the plan year will be forfeited. You will have 90 days after the end of the plan year to submit claims incurred during that plan year.

When submitting a Dependent Care claim

You can only be reimbursed up to the amount you have contributed to date, less any previous reimbursements. You may only receive reimbursements for services already incurred. An expense is incurred when a service is received, not when a bill is paid. Even though your service provider may require payment at the beginning of the service period, you cannot request reimbursement until after the service is provided.

401(k) Retirement Plan

You can enroll in the Instrumentation Laboratory Savings Plan, the 401(k) retirement savings plan, through T. Rowe Price, at any time during the year.

Our 401(K) plan allows employees to set aside up to 75% of your income up to the IRS annual limits. Werfen will match your contributions dollar for dollar up to the first 8% of your eligible pay. If you are not contributing at least 8%, you are passing up free money. The company match is made each pay period.

You can contribute up to $24,500 annually (and an additional $7,500 if you are over age 50 to 60 or over age 64, employees who are age 60 to 63 can contribute an additional $2,500) through 401(k) and/or Roth contributions. If you wish to save more, you can also contribute after-tax contributions.

You can enroll in the Werfen Savings Plan by calling **1-800-922-9945** or logging on to www.rps.troweprice.com

*limits may increase for 2026 as the IRS announcement is pending.

Vesting

You are always 100% vested in your contributions. You will vest in the company match based on your years of services. Company contributions and earnings on them vest according to the following table:

Percent of years of company contributions service in which you're vested	
1 year	20%
2 year	40%
3 year	60%
4 year	80%
5 or more years	100%

A Year of Service is attained on the one-year anniversary of your dote of hire and ensuing anniversaries.

Company-Paid Benefits

Basic Life and AD&D Insurance

Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. Accidental death and dismemberment (AD&D) insurance provides an additional benefit if you lose your life, sight, hearing, speech, or limbs in an accident. Coverage is provided through **Prudential**.

- Werfen provides you with basic life insurance in the amount of 2x your annual salary up to $600,000.
- If you die as a result of an accident, your beneficiary will receive an additional benefit equal to the basic life insurance. For other covered losses, the amount of the benefit is a percentage of the AD&D insurance coverage amount.
- Evidence of good health is not required.
- Benefits begin to reduce at age 65.

Short-Term Disability Insurance administered through Prudential

100% Employer-Paid Short-Term Disability (STD)

STD coverage is intended to provide income during short-term disabilities beyond usual sick time but less than 26 weeks. After a 7-day elimination period, benefits payable on day 8, short-term disability pays 60% of earnings up to a maximum of $1,300 per week. (Buy-Up option for STD is available, see page 16).
For employees who work in a state with a statutory disability requirement, our policy will be reduced by any benefits paid by that policy or state plan. The following state plans are now private through Prudential: NY, NJ, MA, CT, CO, OR, MN. All other state statutory plans, employees will still go through their resident state. Please visit your state website to learn more. Benefit amounts may change annually. Employees are responsible for reviewing state statutory benefits to confirm if our plan will pay any additional amounts up to the maximum combined benefit of $1,300 per week.

Medical Benefits Abroad (MBA)

Werfen provides Medical Benefits Abroad (MBA) coverage through Cigna for full-time employees (20+ hours) traveling internationally on business. Dependents are not covered. The plan offers up to $500,000/year in medical benefits, $200,000 AD&D, and $250,000 for evacuation/repatriation, with no deductible and 100% coverage for eligible expenses, prescriptions, emergency dental, and pre-existing conditions. Crisis Assistance Plus (CAP) also supports emergencies such as terrorism, political threats, or natural disasters (excluding ransom). Coverage extends up to 7 days of personal travel during a business trip.

Health Advocate

Health Advocate is available 24/7/365 in multiple languages to help you make the best benefits decisions for you and your family. You can also visit their website at www.HealthAdvocate.com. Health Advocate is available to eligible employees but it also covers their spouses, dependent children, parents, and even parents-in-low.

Simple ways that Health Advocate can help you:

- Find the Right Doctor
- Schedule Appointments
- Assist in the Transfer of Medical
- Records Work with Insurance
- Companies
- Resolve claims issues
- Help with Eldercare
- Answer general questions about your benefits

Help is only a phone call away! Call **1-866-695-8622** today. Your Health Advocate benefit is being paid for by Werfen at no additional cost to you.

Employee Assistance Program (EAP)

Everyone experiences stress and challenges in life from time to time. Whether your concerns are big or small, the Employee Assistance Program (EAP) can help. This service is completely confidential and is available to all employees and immediate family members—**at no cost to you** offered through **Magellan**.
The EAP can assist with issues such as the below:

- Stress management
- Family problems
- Child care/parenting
- Legal/financial concerns
- Grief/loss
- Work-related issues
- Substance abuse

Visit https://member.magellanhealthcare.com/account-selection or call **1-800-523-5668**.

Business Travel Accident

Werfen provides coverage for all employees on business related travel under a Business Travel Accident (BTA) policy through **AIG**. You are automatically enrolled in this coverage at **no cost to you**. If you die due to an accident while traveling on company business this plan will pay a $250,000 benefit. Dismemberment benefits are also included.

Voluntary Benefits

Voluntary Life Insurance

You may also purchase additional coverage for yourself, your spouse, or your dependent children (up to age 26). Participation is voluntary, and **you pay 100% of the premiums** through **Prudential.** Rates can also be found in the ADP Portal.

Employee Life and AD&D Insurance

- Purchase coverage up to a maximum benefit of 1 to 5 times your annual salary up to $1,000,000 (not to exceed three times annual salary)
- Evidence of insurability required if you enroll after initial eligibility or if you elect a benefit greater than $500,000 (guarantee issue amount)
- Benefits begin to reduce when you reach age 65; coverage terminates at retirement

Spouse Life and AD&D Insurance

- Purchase coverage in $5,000 increments up to a maximum benefit of $250,000 (not to exceed employee life insurance amount)
- Evidence of insurability required if you enroll after initial eligibility or if you elect a benefit greater than $30,000 (guarantee issue amount)
- Coverage terminates at employee's age 70

Dependent Life and AD&D Insurance

- $10,000 benefit
- Evidence of insurability is not required

Evidence of Insurability (EOI)

Prudential requires you to show that you are in good health before they will agree to provide certain levels of coverage. This is called Evidence of Insurability (EOI).

- If you are enrolling for the first time after your initial eligibility period, any amount elected will be subject to EOI.
- EOI is required for any amount over the guarantee issue amount—$500,000 for employee, $30,000 for spouse.

Coverage that requires EOI will not be in effect until you receive approval from Prudential.

Tier	Monthly Rates Per $1,000 Employee/Spouse
<25	$0.064
25-29	$0.064
30-34	$0.080
35-39	$0.090
40-44	$0.127
45-49	$0.209
50-54	$0.373
55-59	$0.582
60-64	$0.900
65-69	$1.627
70+	$2.060
Child Life	$0.070

Voluntary AD&D Insurance

You may also purchase additional coverage for yourself, your spouse, or your dependent children (up to age 26). Participation is voluntary, and **you pay 100% of the premiums** through **Prudential**. Rates can also be found in the ADP Portal.

Employee AD&D Insurance

- Purchase coverage up to a maximum benefit of 1 to 5 times your annual salary up to $1,000,000 (not to exceed five times annual salary)
- Benefits begin to reduce when you reach age 65; coverage terminates at retirement

Spouse AD&D Insurance

- Purchase coverage in $5,000 increments up to a maximum benefit of $250,000 (not to exceed 50% of the employees AD&D insurance amount)

Dependent AD&D Insurance

- Increments of $1,000 up to $10,000 (not to exceed 50% of the employees AD&D insurance amount)

	Monthly Rates Per $1,000
Employee	$0.019
Spouse	$0.020
Child	$0.020

Voluntary Benefits Continued

Disability Insurance administered through Prudential

Disability insurance is a very important benefit that can provide you with income if you are sick, injured or having a baby and unable to work. If you do not have disability coverage now, you should consider adding it at this time. Because you pay the premium for the coverage, the benefit is available to you tax-free should you need to collect it. You pay the full cost of Short-Term and Long-Term Disability coverage.

Long-Term Disability (LTD)

LTD is intended to provide partial income replacement for extended disabilities over a longer period of time.

After a 26 week elimination period (during which you would receive short-term disability benefits if you elected it), pending approval, the long-term disability pion would pay 60% of pre-disability pay up to a maximum benefit amount of $10,000 per month.

Monthly Disability Rates

Tier	
Voluntary Long-Term Disability	Per $100 monthly earnings - $0.340

LTD Pre-existing condition limitations may apply

A pre-existing condition is a sickness or an injury for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or took prescribed drugs or medications prior to your effective date of coverage. If you suffer from a disability caused by, contributed to, or resulting from a pre-existing condition, your disability may not be covered.

Buy-Up Short-Term Disability (STD)

After a 7 day waiting period, 8th day benefits payable, short-term disability pays 60% of earnings up to a maximum of $2,000 per week.

If an employee is interesting in picking up additional short-term disability coverage, you have the option to elect a buy-up STD. This buy-up STD will bring their maximum benefit from $1,300 to $2,000.

Monthly Disability Rates

Tier	
Voluntary Buy-Up Short-Term Disability	Per $10 weekly benefit - $0.162

**Please refer to ADP for Bi-weekly Buy-Up STD and Voluntary LTD costs.*

Voluntary Benefits Continued

Accident Insurance

Accident Insurance through **Prudential** provides benefits to help cover the costs associated with unexpected bills due to covered accidents, regardless of any other insurance you have. If you purchase coverage and are hurt in a covered accident, you will receive a cash benefit for covered injuries that you may spend as you like.

Examples of covered situations:

- Broken bones
- Burns
- Torn ligaments
- Cuts repaired by stitches
- Eye injuries
- Ruptured discs
- Concussion injuries

This coverage includes benefits for treatments or procedures due to an accident. These include hospitalization, emergency room treatment, Xrays, and much more.

- Accident Coverage Type - Your accident coverage will cover injuries suffered when you are not on the job.
- Injury-Free Benefit - Pays $200 if a covered family is claim free for five years
- Rainy Day Fund - $300
- Yearly Wellness Benefit - Provides a $50 per year benefit for completing certain routine wellness screenings or procedures

Tier	Bi-Weekly: Accident Rates
Employee Only	$2.35
Employee + Spouse	$4.38
Employee + Child(ren)	$5.61
Family	$10.71

Hospital Indemnity Insurance

Hospital Indemnity Insurance through **Prudential** provides a fixed lump-sum payment that can help cover hospital expenses not covered by insurance, or to pay for expenses while you, your spouse/ domestic partner and/or dependents are in the hospital.

- The plan pays $1,000 (limit of 1 time per insured and 3 admissions per covered family) for the initial hospital admission, as well as $100 per day, for up to 15 days (one time per plan year), that an individual is hospitalized.
- Fully Portable
- Pre-Existing Condition Limitation: 3 month look back period, 12-month exclusion period.
- Dependent age limit – Childbirth to 26 years

Please note: This benefit is not payable for emergency room treatment, outpatient surgery or treatment, or a hospital stay of less than 20 hours in an observation unit, or when a charge for room and board is not made.

Tier	Bi-Weekly: Hospital Indemnity Rates
Employee Only	$4.14
Employee + Spouse	$8.43
Employee + Child(ren)	$5.17
Family	$11.03

Voluntary Benefits Continued

Critical Illness Coverage

There can be a lot of expenses associated with a critical illness, and a major medical plan may not cover them all. Critical Illness coverage with **Prudential** pays cash directly to you, the team member, upon a diagnosis of a covered critical illness. You may elect coverage with no pre-existing condition limitations. You must be enrolled in employee coverage before adding spouses or children to the plan.

Critical Illness Insurance – Employee, Spouse and Child(ren) coverage	
Employee	$10,000 Increments to $30,000
Spouse	$10,000 Increments to $30,000 max 100% EE
Child	$5,000 Increments to $15,000, max 50% of EE

**Spouse and Child(ren) coverage is dependent on enrollment in the Employee coverage.*
All amounts are guaranteed. Rates are age banded and available in ADP.

Aura Fraud & Identity Protection

Werfen offers an identity and fraud protection benefits. With **MetLife's partner Aura**, you'll have the option to enroll in a robust digital security plan to help protect you and your family from financial and identity fraud. With MetLife, you'll get full service, 24/7 fraud remediation, scan and cybercrime prevention, and much more! You can choose coverage for yourself or family coverage is available that also includes everyone in your household.

For Identity Protection call Aura directly at **1-844-931-2872.**

Tier	Protection	Protection Plus
Employee Only	$2.98	$3.90
Family	$5.05	$6.44

Home & Auto

Employees can take advantage of exclusive discounts and added protections with Home & Auto Insurance. Enjoy savings through special employee and automatic payment discounts, claim-free driving rewards, and enhanced coverage like roadside assistance, rental car damage protection, and no-deductible windshield repairs. Home coverage includes replacement cost options, access to a trusted contractor network, and ID protection services.

For Home & Auto call Farmers directly at **1-833-905-0408** or visit www.farmers.com/groupselect

MetLife Legal

During your lifetime, you may need legal help more often than you think. Getting married, buying or selling a home, starting a family, dealing with identity theft, sending your kids off to college or caring for aging parents are just some scenarios where our experienced attorneys can provide expert legal advice. With a legal plan, you get access to legal help for all of these issues and more.

- Wills & Trusts
- Real Estate Matters
- Bankruptcy
- Tax Audit Representation
- Traffic Defense
- Adoptions
- Divorce

Bi-Weekly Rate: $10.38
For Legal Protection call MetLife directly at **1-800-821-6400**.

Voluntary Benefits Continued

MetLife Pet Insurance

Why is pet insurance important?

Now more than ever, pets are playing a significant role in our lives, and it is important to keep them safe and healthy. Help make sure your furry family members are protected against unplanned vet expenses far covered accidents or illnesses with MetLife Pet Insurance.

- A small monthly payment can help you prepare for unexpected vet expenses down the road
- More than 6 in 10 pet owners said their pet has had an emergency medical Expense
- 24% of pet parents have credit cord or personal loan debt to cover pet health and vet costs
- Average annual cost far a routine vet visit is $212 for a dog and $160 for a cat; and average annual cost far a surgical vet visit is $426
- Pet insurance may not cover pre-existing conditions so there's no better time than now to protect your furry family members.

What's covered

- Accidental injuries Illnesses
- Exam fees
- Surgeries
- Medications
- Ultrasounds
- Hospital stays
- X-rays and diagnostic tests And much more!

How does MetLife pet insurance work

- You pay the full cost of the premium
- Select and enroll in the coverage that's best for you and your pet
- Download our mobile app
- Take your pet to the vet
- Pay the bill and send it with your claim to us via our mobile opp, online portal. email. fax or mail
- Receive reimbursement by check or direct deposit if the claim expense is covered under the policy

You must contact MetLife directly for a quote at **800.GETMETS**.

Pet Insurance – Figo

Figo, a pet healthcare plan that frees you from financial stress when choosing the best available veterinary care. Figo's plans cover unexpected illnesses and injuries to your dog or cat. If your pet becomes sick or injured, seek treatment from any licensed veterinarian in the US.

The plan covers Exam & Consultation Fees, Emergency & Hospitalization, Surgeries, Veterinary Specialists, Chronic Conditions, Cancer Treatments, Prescriptions, Imaging, Knee Conditions, Prosthetics & Orthopedics and Hip Dysplasia.

Premiums are based on an individual pet's age, gender, breed and zip code. Other factors that can affect the premium are the selected plan, reimbursement percentage, and deductible choices. All employees will receive up to a 10% employer group discount. You will be billed directly by Figo by ACH or Credit/Debit Card.

To obtain a quote and/or enroll:
https://bit.ly/3fHcA7U

To process claims, your Veterinarian needs to send Figo the last (two) 2 years of medical records including notes. Your veterinarian can email the records to the Figo Pet Parent's Pet Cloud directly using Your Personal Pet Cloud Email Address. The email address is located at the top of the page after the login screen from the Pet Parent's desktop or mobile. The Veterinarian can email the records to medicalrecords@insurefigo.com

You need to submit a formal claim for reimbursement.

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Werfen
180 Hartwell Road
Bedford, MA, 01730
United States

werfen.com

COMPLIANCE NOTICE TOOLKIT

Instrumentation Laboratory/Werfen

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THIS PAGE IS NOT DISTRIBUTED TO PARTICIPANTS

Hilb Group is pleased to provide this toolkit for furnishing the required notices and disclosures to your group health plan participants. Please review these instructions carefully so that you can ensure full compliance with the notice and disclosure requirements.

Most notices can be provided electronically to employees who have work-related computer access. This applies even if the employee is not able to print out a paper copy at the place where he or she has computer access, and even if the employee does not consent in writing to receive the documents electronically. However, prior written consent is required for electronic disclosures to employees who do not have work-related computer access. Additionally, a printed copy of these notices must be made available at no charge upon request to all employees.

If you use Employee Navigator or another similar benefits administration platform as an employee-facing enrollment tool, you can satisfy the distribution requirement by posting notices there, provided that you furnish a written notice to employees directing them to the website at the time the notices are posted, and describing the significance of the notices as well as the right to request a paper copy at no charge. The written notice may be provided via email.

Toolkit Item	Details	Action Required	Timing
Important Information About the Notice of Creditable Coverage (Not distributed to participants)	Description of the creditable coverage disclosure requirements for employers	Confirm whether your prescription drug coverage is creditable	Review before distributing Notice of Creditable Coverage to participants
Instructions for CMS Creditable Coverage Reporting (Not distributed to participants)	Plans that offer pharmacy benefits to Medicare-eligible individuals must submit online disclosure to CMS	Follow instructions to make required online disclosure	Annually, within 60 days after the beginning of the plan year (March 2nd for calendar year plans)
Medicare Part D Creditable or Non Creditable Coverage Notice	Notifies covered individuals whether employer-provided coverage is creditable	Notice must be distributed to participants	Annually, before October 15th (regardless of plan year) – if included with open enrollment materials, need not be sent again until next open enrollment
Health & Welfare Plan Participant Notices	Includes required annual notices to plan participants	Notices must be distributed to participants	Annually, typically with open enrollment materials
General Notice of COBRA Rights	Employers with 20+ employees in the preceding year are subject to COBRA	Notice must be distributed to participants **Only employers subject to COBRA must distribute*	Within 90 days after a participant becomes covered
Notice of Employee Rights Under FMLA	Employers with 50+ employees in the current or preceding year are subject to FMLA	Notice must be distributed to participants **Only employers subject to FMLA must distribute*	To new employees upon hire
Summary of Benefits and Coverage (SBC)	Standard summary of benefits, with examples of how plan will pay in specific circumstances	Obtain from carrier; most carriers *prepare* SBCs but require employer/plan sponsor to *provide* them to participants	With open enrollment materials and/or within 7 days after requested

Important Information About the Notice of Creditable Coverage

Employers with group health plans that provide prescription drug coverage to individuals who are eligible for Medicare must comply with certain disclosure requirements.

Group health plan sponsors must disclose to individuals who are eligible for Medicare Part D and to the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug coverage is at least as good as the Medicare Part D coverage – in other words, whether the employer's prescription drug coverage is "creditable." These disclosures must be provided on an annual basis.

There are no specific penalties for failure to comply with the Medicare Part D disclosure requirements. However, by not providing creditable coverage notices, employers may trigger adverse consequences for employees who do not enroll in Medicare Part D during their Initial Enrollment Period.

As a reminder: "Creditable" means the group health plan's expected paid claims for prescription drug coverage are at least as much as the expected paid claims under the standard Medicare Part D prescription drug plan. "Non-Creditable" means the employer plan coverage is not as good as Medicare Part D's prescription drug benefit.

BECAUSE THE PRESCRIPTION DRUG COVERAGE PROVIDED BY MOST EMPLOYER-SPONSORED GROUP HEALTH PLANS IS CREDITABLE,

THE ATTACHED NOTICE OF CREDITABLE COVERAGE HAS BEEN PREPARED WITH THE ASSUMPTION THAT THE PRESCRIPTION DRUG COVERAGE IS CREDITABLE.

CONFIRM WHETHER THE PRESCRIPTION DRUG COVERAGE IS CREDITABLE BEFORE PROVIDING THIS NOTICE TO PARTICIPANTS.

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Instructions for CMS Creditable Coverage Reporting

Employers sponsoring a plan offering pharmacy benefits to Medicare-eligible employees or former employees are required to do more than provide a Creditable or Non-Creditable Coverage Notice to those participants – a disclosure to the Centers for Medicare and Medicaid (CMS) is also required. If you are an employer who offers pharmacy benefits to Medicare- eligible individuals, you are required to submit online a creditable coverage disclosure form to CMS for each plan (only one disclosure is required if the plan year is the same for the entire company). The deadline is 60 days after the beginning of the plan year (that's March 2nd for calendar year plans). The good news is: it's really quite easy to do once you know the creditable status of your plan. Here's what you need to know in order to make your CMS Creditable Coverage Disclosure.

Disclosure Form Required Information

The online form is a basic fill-in-the-blank document that CMS predicts will take just minutes to complete. To speed up the process, gather the following information before you begin:

1. Name of entity offering coverage. This is your company name.
2. Federal ID or tax ID number.
3. Street address and phone number of company headquarters.
4. Information on whether the prescription drug coverage you offer is creditable or non-creditable.

Tips for Completing the Form

1. Find the form here: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm
2. Review the instructions and click the arrow at the bottom of the page.
3. Enter your company name, federal tax ID number, address, and phone number.
4. Select the type of coverage. The form offers a list of choices; you should select "GROUP HEALTH PLAN: Employer Sponsored Plan."
5. Select the creditable coverage statement that is true for the plan(s) you offer. The choices are:
   - All options offered are creditable.
   - All options offered are non-creditable.
   - There are some creditable and non-creditable options offered.
6. Once a choice is selected, you'll see a box with additional questions. The questions are specific to the creditable coverage statement selected in step 5.
   - Number of Medicare Part D eligible individuals covered (you can estimate this number)
   - Date of notice of creditable coverage. Enter the date on which you sent the notice of creditable coverage to your employees.
   - Change to a previous disclosure (the answer to this question is "no" for your initial disclosure).

1. Fill in the name, title, and email address of the company's authorized individual, and the date on which you are submitting the online form.
2. Click the arrow at the bottom of the page and you are done! On the next screen, you can download a PDF of your submission, which we recommend doing.

Employers who have previously failed to report will not be penalized. Non-compliance employers may receive additional requests for information, including data match requests, from CMS.

Medicare Part D Creditable Coverage Notice

Important Notice from Instrumentation Laboratory/Werfen 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 Instrumentation Laboratory/Werfen 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. Instrumentation Laboratory/Werfen has determined that the prescription drug coverage offered by your health 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 drug 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 current Instrumentation Laboratory/Werfen coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Instrumentation Laboratory/Werfen coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Instrumentation Laboratory/Werfen 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 be 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 the 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 below for further information. NOTE: you'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Instrumentation Laboratory/Werfen changes. You may also request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (penalty). You must give a copy of this notice to your Medicare-eligible dependents who are covered under the Instrumentation Laboratory/Werfen plan.

Date: 11/3/2025

Name of Entity/Sender: Instrumentation Laboratory/Werfen

Contact: Margie Daniell

Address: 180 Hartwell Rd

Bedford, MA 01730-2433

Phone Number: (781) 809-0399

2026 Health and Welfare Plan Participant Notices

Instrumentation Laboratory/Werfen

180 Hartwell Rd
Bedford, MA 01730-2433

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, such as a copayment, coinsurance, and/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 same service and might not count towards 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 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 <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

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

- 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 deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact your plan administrator for more information on your rights. The federal phone number for information and complaints is 1-800-985-3059.

Visit this website for more information about your rights under federal law:
https://www.cms.gov/nosurprises/consumers

State Balance Billing Laws & Protections

In addition to the federal balance billing protections, state protection laws may apply to you. Approximately 14 states have implemented broad surprise billing laws while many other states have laws that address certain issues related to surprise billing, such as a method for determining payment for emergency services. These state laws differ significantly in a variety of ways, including (1) the types of plans, items, services, and specialties to which the laws apply; (2) how the applicable out-of-network payment amount is determined; (3) the methodology used to resolve payment disputes; and (4) how they interact – and whether they are superseded by – federal law.

These state laws generally only apply to fully-insured plans, although self-insured plans may opt-in to state balance billing protections in some states. State balance billing laws have limited applicability to out-of-state providers. If providers or facilities are not covered under state law, disputes with those providers will be resolved under the federal No Surprises Act. Contact your state insurance department or your plan administrator for more information about whether and to what extent state balance billing laws and protections may apply.

Health Insurance Exchange Notice

Health Insurance Marketplace Notice Coverage Options and Your Health Coverage

Part A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance 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.

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if our employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're 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 9.5% (indexed annually) 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. 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% of such costs.

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. Also, this employer contribution – as well as your employee contribution to the cost of employer-sponsored 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.

How can I get more information?

For more information about the coverage offered by your employer, please check your summary plan description or contact:

180 Hartwell Rd
Bedford, MA 01730-2433
(781) 809-0399 - mdaniell@werfen.com

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

Part B: Information About Health Coverage Offered by Your Employer

Employer Name Instrumentation Laboratory/Werfen		Employer Identification Number (EIN) 02-0448199
Employer Address 180 Hartwell Rd		Employer Phone Number (781) 809-0399
City Bedford	State MA	ZIP 01730-2433
Who can we contact about employee health coverage at this job? Margie Daniell		
Phone Number (781) 809-0399		Email Address mdaniell@werfen.com

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

Notice of Special Enrollment Rights

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

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.
To request special enrollment or obtain more information, contact your plan administrator.

Notice of Privacy Practices

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plan recognizes your right to privacy in matters related to the disclosure of health-related information. The Notice of Privacy Practices *(provided in the plan certificate booklet)* details the steps your plan has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this notice is available to you at any time, free of charge, by request through your health plan.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made with respect to mental health or substance use disorder benefits, please contact your plan administrator at Instrumentation Laboratory/Werfen.

Women's Health and Cancer Rights Act (WHCRA) Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance you will be subject to depends on the coverage provided by your health plan.

Michelle's Law Notice

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

Newborns' and Mothers' Health Protection Act Notice

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 of the 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).

Genetic Information Nondiscrimination Act (GINA) Disclosure

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	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: 1-800-403-0864 Member Services Phone: 1-800-457- 4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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 HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792- 4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.as px Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?languag e=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: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1- 800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855- 632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1- 800-992-0900	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	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711) CHIP Premium Assistance Phone: 609-631-2392	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855- 4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844- 854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888- 365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: Apply for Medicaid Health Insurance Premium Payment Program (HIPP) | Commonwealth of Pennsylvania Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250- 8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp- programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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.

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.

USERRA Notice
Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer'
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service,

Then an employer may not deny you:

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment

Because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

A. Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health coverage for you and your dependents for up to 24 months while in the military.

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

B. Enforcement

The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on UERRRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed online at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

General Notice of COBRA Rights

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Margie Daniell
180 Hartwell Rd
Bedford,MA 01730-2433
mdaniell@werfen.com

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA continuation coverage?

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

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Margie Daniell
180 Hartwell Rd
Bedford, MA 01730-2433
(781) 809-0399
mdaniell@werfen.com

General FMLA Notice

Employee Rights Under the Family and Medical Leave Act

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

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

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

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.

For additional information or to file a complaint:
1-866-4-USWAGE
1-866-487-9243 TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor – Wage and Hour Division