Nason Mechanical Systems
Employee Benefits Guide

For Plan Year
September 1, 2023 – August 31, 2024

An overview of the wide array of benefits provided by Nason Mechanical Systems to help you enjoy increased well-being and financial security

CROSS INSURANCE

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Welcome

Benefits for September 1, 2023 – August 31, 2024

OUR EMPLOYEES ARE OUR MOST VALUABLE ASSET.

That's why Nason Mechanical Systems strives to provide you and your family with a comprehensive benefits package. We want you to pick the best benefits for you and your family. We've put together this Benefit Guide for open enrollment and for new employees hired during the year.

Open enrollment is an important time - it is a short period each year when you can make changes to your benefits. The IRS allows employees to select certain benefits through pre-tax salary reductions, which lowers taxes and saves money. Because of these tax savings, after your initial benefits selection at the time you are hired, the IRS allows you to make changes only during an open enrollment period, unless you experience a qualified status change. Since this is your one opportunity to enroll in or make changes to your benefits this year, please carefully consider your anticipated needs for the upcoming plan year. Elections you make during open enrollment will be **effective on September 1, 2023**.

This Guide outlines the different benefits Nason Mechanical Systems offers, so you can identify which offerings are best for you and your family. The Guide also provides definitions for important terms, contact information for each of the carriers, as well as some important annual notices you should be aware of.

Nason Mechanical Systems continues to support a culture of health and wellness, with a work environment and benefits to help support healthy lifestyles, decrease the risk of disease, and improve your quality of life.

This Benefits Guide includes summary descriptions of Nason Mechanical Systems' benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This Guide and plan summaries do not constitute a contract of employment and benefits described in this Guide may be changed by the employer.

This Guide is for illustrative purposes only and is not a legal contract, contract of employment or guarantee of coverage. Any benefits payable will be subject to the terms and conditions of the insurance policy issued by the insurance company and relevant plan document.

Contacts

Benefits for September 1, 2023 – August 31, 2024

If you have questions, or need more information, please do not hesitate to contact Michele Byras or your dedicated broker representatives at Cross Insurance.

Michele Bryas
194 Merrow Rd., Auburn, ME
Phone: 207-782-0727
email: mbyras@nasonmechanical.com

Your contact for daily claims and benefits questions:

Deb Turcotte, Sr. Acct. Service Rep.
150 Mill St. 4th Floor, Lewiston, ME
Phone: 207-330-3037
FAX: 207-333-3007
email: deb.turcotte@crossagency.com

In Deb's absence, please contact:

Kate Cornelio, Account Manager
150 Mill St. 4th Floor, Lewiston, ME
Phone Number: 207-330-3036
FAX: 207-333-3007
email: kate.Cornelio@crossagency.com

Carriers

Plan Type	Carrier	Website	Phone Number
Medical and Prescription Drug	**Aetna**	www.aetna.com	1-800-872-3862
Dental	**Lincoln Financial**	www.lincolnfinancial.com	1-800-423-2765
Vision	**Aetna**	www.aetna.com	1-877-973-3238
Life & AD&D	**Lincoln Financial**	www.lincolnfinancial.com	1-800-423-2765
Short Term Disability	**Lincoln Financial**	www.lincolnfinancial.com	1-800-423-2765
Long Term Disability	**Lincoln Financial**	www.lincolnfinancial.com	1-800-423-2765

Eligibility and Enrollment

Benefits for September 1, 2023 – August 31, 2024

Who Is Eligible?

All eligible employees may elect to enroll in the benefit program during our annual open enrollment period, or when you first become eligible. The minimum required hours you must work to be eligible, as well as the waiting periods before you can enroll yourself and eligible family members may be different for different types of coverage:

Coverage	Minimum Weekly Hours	Waiting Period for New Hires or Newly Eligible	Eligible Family
Medical and Prescription Drug	24	1st of the month following 60 days of active employment	Employee, Domestic Partner/Spouse and Children
Dental	24	1st of the month following 60 days of active employment	Employee, Domestic Partner/Spouse and Children
Vision	24	1st of the month following 60 days of active employment	Employee, Domestic Partner/Spouse and Children
Life/AD&D	24	1st of the month following 60 days of active employment	Employee
Life/AD&D – Voluntary	24	1st of the month following60 days of active employment	Employee, Spouse and Children
Short Term Disability	24	1st of the month following 60 days of active employment	Employee
Long-Term Disability	24	1st of the month following 60 days of active employment	Employee

How to Enroll During Open Enrollment

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes. Once all your information is up to date, it's time to make your benefit elections. The decisions you make during Open Enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When Your Enrollment Choices Are Effective

The benefits you choose during Open Enrollment will become **effective on September 1, 2023.**. For newly hired or newly eligible employees, coverage will begin using the waiting period schedule above.

How to Make Changes During the Plan Year – Qualifying Events

Unless you experience a life-changing "Qualifying Event," you cannot make changes to your benefits until the next Open Enrollment Period. Qualifying Events may include things like: (1) marriage, divorce, or legal separation; (2) birth or adoption of a child; (3) death of spouse, child, or other qualified dependent; (4) residence change in certain instances; (5) change in a child's dependent status; (6) change in employment status or a change in coverage under another employer-sponsored plan; (7) a COBRA event; (8) Family Medical Leave Act (FMLA) leave; or (9) entitlement to Medicare or Medicaid.

If you have a Qualifying Event, in most cases changes must be made within 30 days of the event, or you will need to wait until the next Open Enrollment.

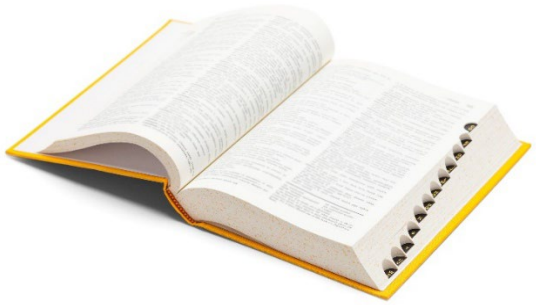
Medical

Benefits for September 1, 2023 – August 31, 2024

Key Terms to Remember

Annual Deductible

The amount you have to pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).



Annual Out-of-Pocket Maximum

This is the total amount you can pay out-of-pocket each calendar year before the plan pays 100% of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible*, copays, and coinsurance.

Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share (a percentage) of the allowed amount charged for a service and is generally billed to you after the health insurance company reconciles the bill with the provider.

Plan Type

Point of Service Plan (POS) – A Plan where there is a network of doctors, hospitals and other health care providers. You generally receive higher benefits when you go to a network health care provider. The Aetna AFA Health Care POS Plans are a Preferred Provider Organization Plan. These Plans provides benefits for covered services from health care providers in the Aetna AFA POS Network or outside the Network. Generally, the highest level of benefits is available when care is provided by in-network doctors and a lower level of benefits is available when care is provided by out-of-network doctors.

Medical (continued)

Benefits for September 1, 2023 – August 31, 2024

Preventive Care

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and to incorporate healthy habits into your lifestyle. Some examples include: getting regular physical examinations; mammograms; and immunizations. Through the plan offered by Nason Mechanical Systems, all covered individuals and family members are **eligible to receive routine wellness services like these at no cost - all copays, coinsurance, and deductibles are waived.**

Which Preventive Care Services Are Covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act compliant plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plan offered for 2023:

"An ounce of prevention is worth a pound of cure"

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence
- Depression Screening
- Blood Pressure Screening

Medical (continued)

Benefits for September 1, 2023 – August 31, 2024

Who Is Eligible and When?

Employees working 24 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Nason Mechanical Systems offers the **Aetna AFA POSII Plan**.

Summary of Coverage and Employee Contribution

Benefit	Aetna AFA POS II 3500 Deductible Plan	
	In-Network – You Pay	**Out-of-Network – You Pay**
Annual Contract Deductible (Individual/Family)	$3,500 Individual/$7,000 Family	$7,000 Individual/$21,000 Family
Annual Contract Out-of-Pocket Maximum (Individual/Family)	$7,000 Individual/$14,000 Family	$17,000 Individual/$51,000 Family
Coinsurance Percentage	20%	50%
PCP Office Visit		
Preventive Care (annual physical and preventive tests)	No Charge	Deductible, then 50%
Sick Care	$35 Copay	Deductible, then 50%
Specialist Office Visit	$75 Copay	Deductible, then 50%
Diagnostic Lab and X-ray	Deductible, then 20%	Deductible, then 50%
Advanced Radiology or Imaging Examples: MRI, CT, PET	Deductible, then 20%	Deductible, then 50%
Emergency Care		
Emergency Room	Deductible, then $300 Copay, then 20%	
Emergency Transportation	Deductible, then 20%	
Urgent Care (Convenience Care Clinic or Urgent Care Center)	$75 Copay	Deductible, then 50%
Inpatient Hospitalization	Deductible, then 20%	Deductible, then 50%
Outpatient Surgery	Deductible, then 20%	Deductible, then 50%
PT, OT, Speech & Chiropractic Care (60 Visit limit combined)	Deductible, then $75 Copay	Deductible, then 50%
Durable Medical Equipment	Deductible, then 50%	Deductible, then 50%
Hospice Care	Deductible, then 20%	Deductible, then 50%
In-Network	**30-Day Supply Retail Tier/ 90-Day Supply Mail Order Tier**	
Tier 2 – Preferred Brand Name	$3 / $10 Copay (30 day) $6 / $20 Copay (90 Day)	
Tier 3 – Non-Preferred Brand Name	$50 Copay (30 Day) $100 Copay (90 Day)	
Tier 3 – Preferred Specialty Rx	$80 Copay (30 Day) $160 (90 Day)	
Tier 4 – Non-Preferred Specialty Rx	20% Coinsurance up to $250 Maximum	
	40% Coinsurance up to $500 Maximum	

Weekly Employee Contribution				
	Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Family - Employee, Spouse/DP + Child(ren)
$3500 POSII Plan	$0.00	$80.60	$63.48	$93.00

Refer to your Medical Plan documentation for more information.

Medical (continued)

Benefits for September 1, 2023 – August 31, 2024

Who Is Eligible and When?

Employees working 24 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible..

Benefits You Receive

Nason Mechanical Systems offers the **Aetna AFA POSII Plan**.

Summary of Coverage and Employee Contribution

Benefit	Aetna AFA POS II 2000 Deductible Plan	
	In-Network – You Pay	**Out-of-Network – You Pay**
Annual Contract Deductible (Individual/Family)	$2,000 Individual/$4,000 Family	$4,000 Individual/$12,000 Family
Annual Contract Out-of-Pocket Maximum (Individual/Family)	$6,000 Individual/$12,000 Family	$14,000 Individual/$42,000 Family
Coinsurance Percentage	20%	50%
PCP Office Visit		
Preventive Care (annual physical and preventive tests)	No Charge	Deductible, then 50%
Sick Care	$25 Copay	Deductible, then 50%
Specialist Office Visit	$75 Copay	Deductible, then 50%
Diagnostic Lab and X-ray	Deductible, then 20%	Deductible, then 50%
Advanced Radiology or Imaging Examples: MRI, CT, PET	Deductible, then 20%	Deductible, then 50%
Emergency Care		
Emergency Room	Deductible, then $300 Copay, then 20%	
Emergency Transportation	Deductible, then 20%	
Urgent Care (Convenience Care Clinic or Urgent Care Center)	$75 Copay	Deductible, then 50%
Inpatient Hospitalization	Deductible, then 20%	Deductible, then 50%
Outpatient Surgery	Deductible, then 20%	Deductible, then 50%
PT, OT, Speech & Chiropractic Care (60 Visit limit combined)	Deductible, then $75 Copay	Deductible, then 50%
Durable Medical Equipment	Deductible, then $75 Copay	Deductible, then 50%
Hospice Care	Deductible, then 20%	Deductible, then 50%
In-Network	**30-Day Supply Retail Tier/ 90-Day Supply Mail Order Tier**	
Tier 2 – Preferred Brand Name	$3 / $10 Copay (30 day) $6 / $20 Copay (90 Day)	
Tier 3 – Non-Preferred Brand Name	$50 Copay (30 Day) $100 Copay (90 Day)	
Tier 3 – Preferred Specialty Rx	$80 Copay (30 Day) $160 (90 Day)	
Tier 4 – Non-Preferred Specialty Rx	20% Coinsurance up to $250 Maximum	
	40% Coinsurance up to $500 Maximum	

Weekly Employee Contribution				
	Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Family - Employee, Spouse/DP + Child(ren)
$2000 POSII Plan	$13.44	$114.69	$101.02	$152.22

Refer to your Medical Plan documentation for more information.

Dental

Benefits for September 1, 2023 – August 31, 2024

Who is Eligible and When?

Employees working 24 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Nason Mechanical Systems offers a **Dental Plan** you can purchase from **Lincoln Financial Insurance Company**.

Summaries of Coverage and Employee Payroll Deduction

Lincoln Financial Dental Passive PPO	In-Network	Out-of-Network
Calendar Year Deductible (Individual/Family) – Does not apply to Preventive/Diagnostic or Basic Care	$50/$150	$50/$150
Calendar Year Maximum Benefit – Preventive/Diagnostic, Basic and Major Care Combined Per Person *(Subject to Annual Maximum Rollover of $400 up to a total of $1,200 in additional benefits)*	$2,000	$2,000
Preventive and Diagnostic Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%

Dental Weekly Employee Payroll Deduction				
	Employee Only	Employee + Spouse/DP	Employee + Children	Family - Employee, Spouse/DP + Child(ren)
Lincoln Dental Plan	$2.86	$6.06	$6.67	$9.87

Refer to your Dental Plan documentation for more information.

Vision

Benefits for September 1, 2023 – August 31, 2024

Who is Eligible and When?

Employees working 24 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Summary of Coverage and Employee Payroll Deduction

Plan Features	Aetna Vision Plan	
	In-Network	**Out-of-Network**
	Your Cost	**Plan Pays Up To**
Vision Exam – every calendar year	$10 Copay	$25
Frames– every calendar year	$0 Copay, $130 Allowance, 20% Off Balance over $130	$65
Lenses– every calendar year		
Single	$25 Copay	$10
Bifocal	$25 Copay	$25
Trifocal	$25 Copay	$55
Lenticular	$25 Copay	$25
Contacts– every calendar year		
Conventional	$130 Allowance, additional 15% off Balance	$90
Disposable	$130 Allowance	$104
Medically Necessary	$0 Copay	$200

Vision Weekly Employee Payroll Deduction				
	Employee Only	Employee + Spouse/DP	Employee + Children	Family - Employee, Spouse/DP + Child(ren)
Aetna Vision Plan	$.85	$1.62	$1.70	$2.50

Refer to your Vision Plan documentation for more information.

Life - Basic

Benefits for September 1, 2023 – August 31, 2024

Who is Eligible and When?

Employees working 24 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

At no cost to you, **Nason Mechanical Systems** offers you employer-sponsored **Group Life and Accidental Death and Dismemberment (AD&D) insurance** from Lincoln Financial. As long as you are eligible, you are automatically enrolled and can receive coverage of $10,000 without having to answer any questions about your health. This is referred to as the Guarantee Issue amount. The AD&D insurance amount is also $10,000. This insurance can help provide for your family if something happens to you. You must choose a beneficiary or beneficiaries - the person(s) or entity you name who will receive the proceeds from your life or AD&D insurance in the event of your death or injury.

Benefits are summarized below.

Summary of Coverage

Plan Features	Basic Life – [Carrier Name]
Employee Benefit Amount	$10,000
AD&D Benefit Amount	$10,000
Guarantee Issue Amount	$10,000
The following shows how much benefits are reduced at certain ages – coverage is available if you are still employed at Nason Mechanical Systems	
Age Reduction	**Benefits Available**
Age 70	65%
Age 75	50%

Refer to your Life and AD&D Plan documentation for more information.

Voluntary Life

Benefits for September 1, 2023 – August 31, 2024

Who is Eligible and When?

Employees working 24 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Nason Mechanical Systems offers you the chance to buy employer-sponsored **Voluntary Group Life/AD&D** from **Lincoln Financial**. As long as you purchase coverage when you are first eligible as a new hire, you can buy coverage for yourself up to $300,000 in $10,000 increments. You can purchase coverage without answering any questions about your health. This is referred to as the Guarantee Issue Amount and is listed below. To purchase coverage after your initial eligibility or that exceeds the Guarantee Issue Amount, you need to provide evidence of insurability to Lincoln Financial. You must choose a beneficiary or beneficiaries - the person(s) or entity who will receive the proceeds from your Life/AD&D insurance if you die or are injured. You can also buy coverage for family members. Benefits are summarized below.

Summary of Coverage

Employee - Plan Features	Voluntary Life/AD&D – Lincoln Financial
Employee Benefit Amount	Up to $300,000 in $10,000 Increments]
Guarantee Issue Amount	$80,000
Age Reduction	**Benefits Available if still employed at Nason Mechanical Systems :** Age 70: 65%, Age 75: 50%
Spouse/Domestic Partner - Plan Features	**Voluntary Life/AD&D – Lincoln Financial**
Spouse Benefit Amount	Up to $100,000 in $5,000 Increments
Guarantee Issue Amount	$10,000
Age Reduction	**Benefits Available if employee is still employed at Nason Mechanical Systems:** Age 70: 65%, Age 75: 50%
Child(ren) - Plan Features	**Voluntary Life/AD&D – Lincoln Financial**
Child(ren) Benefit Amount (up to Age 26)	$10,000 in $2,000 Increments
Guarantee Issue Amount	$10,000

If you buy Voluntary Life Insurance, the weekly cost will be based on employee's age and the amount of coverage purchased.

Refer to your Life/AD&D Plan documentation for more information

Short-Term / Long-Term Disability

Benefits for September 1, 2023 – August 31, 2024

Who is Eligible and When?

Employees working 24 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Nason Mechanical Systems provides to you **Short Term Disability at** no cost. Your employer offers you the opportunity to purchase **Long Term Disability insurance** from **Lincoln Financial.** If you become disabled from a non-work-related injury or illness, disability income benefits will provide a partial replacement of lost income.

Summary of Coverage

Plan Features	Short -Term Disability – Lincoln Financial
Benefits Begin Accident Sickness	 1st Day 8th Day
Weekly Benefit	**$1,000 maximum** not to exceed 60% of your weekly earnings
Benefits Duration	Up to 90 days if you enroll in voluntary Long-Term Disability / 180 Days if you do not enroll in Voluntary Long-Term Disability

Plan Features	Long- Term Disability – Lincoln Financial
Benefits Begin	On the 90th day
Weekly Benefit	**$8,000 maximum** not to exceed 60% of your monthly salary
Benefits Duration	To age 65 ADEA
Mental Health Benefit Duration	24 Months unless hospital confined
Pre-existing Condition Limitation	Disability caused or contributed to by a pre-existing condition (a condition or symptom for which you consulted a doctor, were treated or took prescription drugs in the 3 months before coverage became effective) is not covered in the first 12-months after your enrollment in the plan.

If you purchase LTD Insurance, the weekly cost will be based on your age and the amount of coverage you purchase.

Refer to your STD/LTD Plan documentation for more information.

Legal Notices

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman'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:

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

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan. If you would like more information on WHCRA benefits, please contact your health plan administrator at 207-782-0727.

HIPAA Notice of Privacy Practices

The Plan's HIPAA Notice of Privacy Practices is available upon request. To obtain a copy of the Plan's HIPAA Notice of Privacy Practices, please contact the HR Department. For more information on the Plan's privacy policies or your rights under HIPAA, contact Michele Byras at 207-782-0727.

HIPAA Special Enrollment Rights

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Nason Mechanical Systems' health plan under "special enrollment provisions" briefly described below.

- Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Nason Mechanical Systems' health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after your or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under Nason Mechanical Systems' health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in Nason Mechanical Systems' health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the Plan Administrator at 207-782-0727 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan descriptions or insurance contract.

Legal Notices

Important Notice From Nason Mechanical Systems 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 Nason Mechanical Systems 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. Nason Mechanical Systems has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage through Nason Mechanical Systems may be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop Nason Mechanical Systems' medical plan with prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back at a later date.

Legal Notices

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 Nason Mechanical Systems and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent 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 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further 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 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week.

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

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

Date: September 1, 2023
Contact: Michele Byras – Financial Manager
Name of Entity/Sender: Harry E. Nason, Inc. dba Nason Mechanical Systems
Phone Number: 207-782-0727

Legal Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. 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)	Website: Health Insurance Premium Payment (HIPP) Program 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

Legal Notices

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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	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/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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

Legal Notices

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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp 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

Legal Notices

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 toward your 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 are 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 the provider or facility can bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 balanced billed for these post-stabilization services.

Certain states have enacted balance billing protections for patients receiving emergency services. For example, New Hampshire, Maine, Massachusetts and Vermont all have laws protecting patients from balance billings. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

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 may 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 never 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.**

Legal Notices

State law prohibitions against balance billing may also apply. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally 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 believe you've been wrongly billed, you may contact your insurance carrier by calling the number on your insurance card. You may also contact the state insurance regulator or the No Surprises helpdesk at 1-800-985-3059.

Visit *https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act* for more information about your rights under federal law.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Legal Notices

Notice Regarding Health Insurance Marketplace Coverage Options

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2023 and ends December 15, 2023 for coverage starting as early as January 1, 2024.

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 your 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. For Plan Years beginning in 2023, if the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% 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.[1]

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 employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Michele Byras at 207-782-0727.

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.

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

Legal Notices

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Harry E. Nason, Inc. dba Nason Mechanical Systems		4. Employer Identification Number (EIN) 01-0126470
5. Employer address 194 Merrow Rd		6. Employer phone number 207-782-0727
7. City Auburn	8. State ME	9. ZIP code 04210
10. Who can we contact about employee health coverage at this job? Michele Byras		
11. Phone number (if different from above)	12. Email address mbyras@nasonmechanical.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

■ Some employees. Eligible employees are:

Full Time Employees working 30 or more hours per week

- With respect to dependents:

■ We do offer coverage. Eligible dependents are:

Spouse or Domestic Partner, Dependent Children to age 26

☐ We do not offer coverage.

■ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**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 mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

Legal Notices

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 [*choose and enter appropriate information:* must pay *or* aren't required to 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.

Legal Notices

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;
- *[add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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: Michele Byras.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Legal Notices

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Michele Byras, 207-782-0727.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

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