ERWIN ELECTRIC

Proven Ability & Exceptional Service



BENEFIT GUIDE

December 1, 2026 – November 30, 2027

CONTENTS & CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

HOW TO ENROLL IN BENEFITS

WWW.EMPLOYEENAVIGATOR.COM
COMPANY ID: ERWINELECTRIC

HUMAN RESOURCES

Lauren Valenti
813-210-9804
hr@erwinelectric.com

BROKER

M.E. Wilson Company
Katie Miller
813-984-3602
kmiller@mewilson.com

MEDICAL

UnitedHealthcare
866-414-1959
www.myuhc.com

DENTAL AND VISION

UnitedHealthcare
DHMO network: Exclusive Network Dental Plan-National
DPPO network: National Options PPO 20
866-414-1959
www.myuhc.com

EMPLOYER PAID AND VOLUNTARY LIFE

Guardian (Policy # 00088914)
800-541-7846
www.guardiananytime.com

DISABILITY AND SUPPLEMENTAL BENEFITS

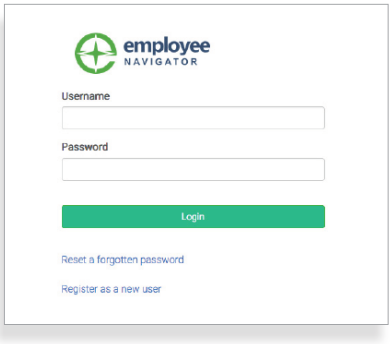
Guardian (Policy # 00088914)
800-541-7846
www.guardiananytime.com

LEGAL AND EMPLOYEE ASSISTANCE PROGRAM (EAP)

EAP: CompPsych
855-239-0743 (24/7/365)
www.guidanceresource.com

HOW TO ENROLL

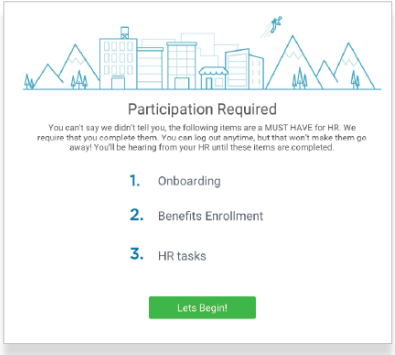
Company Code: erwinelectric



Step 1: Log In

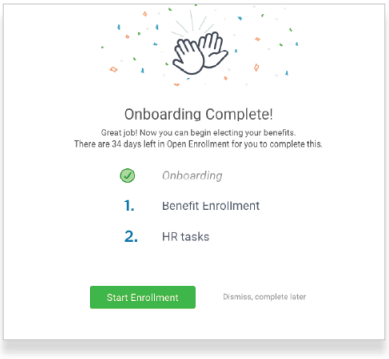
Go to www.employeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.
- **For Login Assistance:** Please call GIS Benefits - 866-400-7771



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

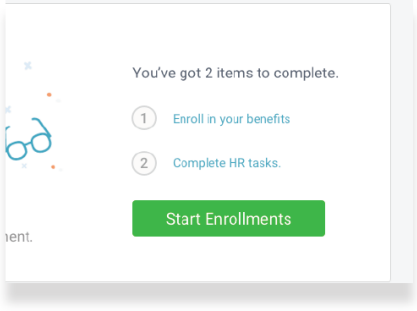


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP

if you hit "**Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**



Step 4: Start Enrollments

After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

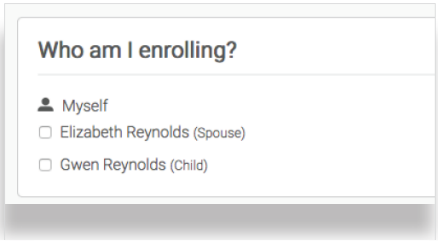
TIP

Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

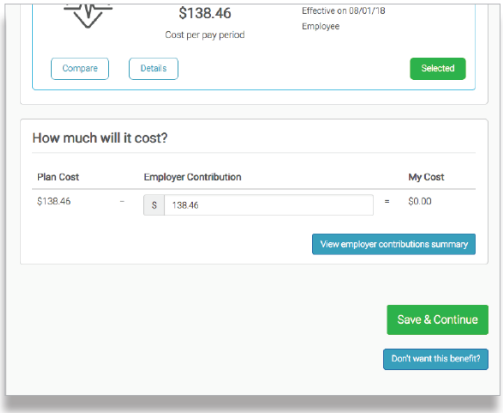
HOW TO ENROLL

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**



Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

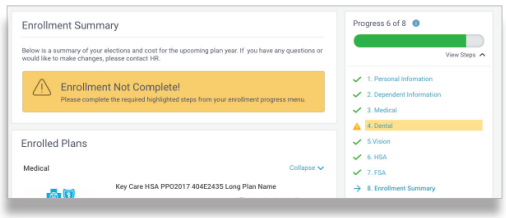


Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.



Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

YOUR BENEFITS PLAN

Erwin Electric offers a variety of benefits allowing you the opportunity to customize a benefits package that meets your personal needs.

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

Benefit	Who pays the cost?
Medical Insurance	Erwin Electric pays for 50% of the employee cost of coverage for each of the 4 plans offered.
Dental Insurance	You may elect dental coverage for yourself and your eligible dependents on a voluntary basis and you will be responsible for the cost.
Vision Insurance	You may elect vision coverage for yourself and your eligible dependents on a voluntary basis and you will be responsible for the cost.
Employer Paid Life	Erwin Electric pays 100% for employees.
Disability and Supplemental Plans	You may elect disability coverage for yourself and will pay the entire cost. Supplemental coverage is available for you and your eligible dependents on a voluntary basis and you will be responsible for the cost

ELIGIBILITY

All Regular full-time employees are eligible to join the Erwin Electric Benefits Plan on the 90th day of full-time employment. Regular full-time employees are those working 30+ hours per week. You may also enroll your dependents in the Benefits Plan when you enroll.

Eligible dependents include:

- Your legal spouse
- Your natural children, step-children living with you, legally adopted children and any other children for whom you have legal guardianship, who are:
  - Under 26 years of age;
  - A Dependent must:
    - Be unmarried and not have dependents of his or her own; AND
    - Be a resident of Florida or a student; AND
    - Not have coverage of their own, or covered under any other plan; AND
    - Not entitled to benefits under Medicare



WHEN CAN YOU ENROLL?

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

- After completing your initial eligibility period;
- During the annual open enrollment period;
- Within 30 days of a qualified family-status change.

If you do not enroll at one of the above times, you must wait for the next annual open enrollment period.

CHOOSING YOUR BENEFITS

You must actively choose any benefit that you pay for, or share in the cost with Erwin Electric .

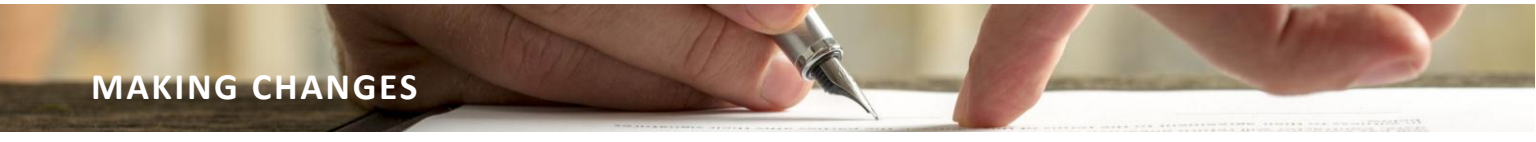
Your part of the cost is automatically taken out of your paycheck. There are two ways that the money can be taken out:

- BEFORE YOUR TAXES ARE CALCULATED – medical, dental, vision
- AFTER YOUR TAXES ARE CALCULATED – voluntary life/ accidental death & dismemberment, disability and voluntary products

WHY DO I PAY FOR BENEFITS WITH BEFORE-TAX MONEY?

There is a definite advantage to paying for some benefits with before-tax money:

Taking the money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.



MAKING CHANGES

Generally, you can only change your benefit choices during the annual benefits enrollment period. However, you may be able to change your benefit choices during the plan year if you have a change in status including:

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

If you fail to notify Human Resources within 30 days of a family status change, you will be required to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

WHEN COVERAGE ENDS

Coverage will stop on the last day of the month in which employment with the company ends.

KEY BENEFIT TERMS

COBRA – A Federal law that allows workers and dependents who lose their medical, dental, or vision coverage to continue any of these coverages for a specified length of time by electing and paying for continuation benefits.
Copayment – A flat fee that you pay for medical services, regardless of the actual amount charged by your doctor or another provider. This generally applies to physicians' office visits and prescription drugs.
Deductible – The amount you pay toward medical and dental expenses each year before the plan begins paying benefits.
Out of Pocket Maximum – The maximum amount you will pay in deductibles, copayments and coinsurance during the year.

Erwin Electric offers four medical plans through United Healthcare. To find participating providers go to www.myuhc.com and click on "Find a Doctor", choose the appropriate network based on the plan (**NHP** or **Choice**). Then, narrow down your search based on location and provider type. The chart below provides a brief overview of the medical plans.

United Healthcare

	Plan 1 *NHP EZDN*	***Plan 2*** *EZAN*	***Plan 3*** *EY9D*	***Plan 4*** *H.S.A EY66*
	NHP	***Choice***	***Choice***	***Choice***
IN-NETWORK				
Plan Year / Contract Year Basis	Calendar Year	Calendar Year	Calendar Year	Calendar Year
Deductible (Individual / Family)	$4,000 / $8,000	$5,000 / $10,000	$2,000 / $4,000	$2,500 / $5,000
Maximum Out-of-Pocket (Individual / Family)	$7,500 / $15,000	$6,600 / $13,200	$6,000 / $12,000	$2,500 / $5,000
Out-of-Pocket Max Includes	Deductible, Coinsurance, & Copays	Deductible, Coinsurance, & Copays	Deductible, Coinsurance, & Copays	Deductible, Coinsurance, & Copays
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Coinsurance	60% / 40%	70% / 30%	80% / 20%	100% / 0%
Routine Preventive Services Wellness / Immunizations Mammography / Colonoscopy	Covered 100%	Covered 100%	Covered 100%	Covered 100%
FACILITY VISITS				
Primary Doctor Required?	**Yes**	No	No	No
Primary Care Visits	**Designated**: $25 Copay **Network**: 40%, after deductible	$30 Copay	$25 Copay	Deductible
Specialist Visits	**Designated**: $75 Copay **Network**: 40%, after deductible	$80 Copay	$50 Copay	Deductible
Inpatient Hospital	$500 Copay + 40% Coinsurance after Deductible	30% Coinsurance, after Deductible	20% Coinsurance after Deductible	Deductible
Outpatient Hospital Surgery	$350 Copay, then 40% Coinsurance after Deductible	30% Coinsurance, after Deductible	20% Coinsurance after Deductible	Deductible
Emergency Room	$350 Copay + 40% Coinsurance after Deductible	$500 Copay	$350 Copay	Deductible
Urgent Care	$50 Copay	$100 Copay	$75 Copay	Deductible
OUTPATIENT DIAGNOSTIC SERVICES				
Lab Services (Freestanding Lab)	40% Coinsurance after Deductible	**Designated Network**: 30% coinsurance after Deductible, **Network**: 50% coinsurance after Deductible	**Designated**: Covered 100% **Network**: 50% Coinsurance	Deductible
X-Ray Services (Freestanding Lab)	40% Coinsurance after deductible	30% coinsurance after Deductible	**Designated**: Covered 100% **Network**: 50% Coinsurance	Deductible
Complex Diagnostic	**Designated Network**: $250 Copay + 40% Coinsurance after Deductible, **Network**: $500 Copay + 40% Coinsurance after Deductible	**Designated Network**: $300 Copay, after Deductible **Network**: 50% coinsurance after Deductible	**Designated**: $400 Copay **Network**: $750 Copay	Deductible
PRESCRIPTIONS				
Retail (30-day supply)	$10 / $35 / $70	$10 / $35 / $70	$10 / $35 / $70	Deductible
Mail Order (90-day supply)	2.5x retail	2.5x retail	2.5x retail	Deductible
OUT-OF-NETWORK	**Not Available**			

This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. If the below illustration of benefits conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your exact description of services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Plan 1 NHP EZDN	Employee Weekly Contribution
Employee Only	$ 57.57
Employee + Spouse	$216.47
Employee + Child(ren)	$163.51
Family	$310.90

Plan 2 Choice EZAN	Employee Weekly Contribution
Employee Only	$ 79.92
Employee + Spouse	$300.48
Employee + Child(ren)	$226.97
Family	$431.55

Plan 3 Choice EY9D	Employee Weekly Contribution
Employee Only	$ 87.38
Employee + Spouse	$328.56
Employee + Child(ren)	$248.18
Family	$471.87

Plan 4 Choice H.S.A EY66	Employee Weekly Contribution
Employee Only	$ 88.54
Employee + Spouse	$332.90
Employee + Child(ren)	$251.45
Family	$478.10

KNOW BEFORE YOU GO

Teladoc	Convenience Care	Doctor's Office	Urgent Care	ER
Access telehealth services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when where and how it works best for you.	Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The best place to go for routine or preventive care, to keep track of medications, or for a referral to see a specialist.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to the nearest emergency room.
› Colds and flu › Rashes › Sore throats › Headaches › Stomachaches › Fever › Allergies › UTIs and more	› Colds and flu › Rashes or skin conditions › Sore throats, earaches, sinus pain › Minor cuts or burns › Pregnancy testing › Vaccines	› General health issues › Preventive care › Routine checkups › Immunizations and screenings	› Minor cuts, sprains, burns, rashes › Chronic lower back pain › Minor respiratory symptoms › Fever	› Sudden numbness, weakness › Bleeding › Chest pain › Head injury/major trauma

TELEMEDICINE

TELADOC®

Telemedicine allow you to see and talk to a doctor from a mobile device or computer 24/7 without an appointment. A majority of visits take between 10-15 minutes, and telemedicine is a part of your health benefits.

As part of a telemedicine visit, doctors can diagnose and treat a vast range of non-emergency medical conditions and provide services such as writing a prescription, if needed. This includes:

Common conditions treated (but not limited to):

- Eye/ear infections
- Bronchitis
- Sinus infections
- Headaches/migraines
- Rash/skin infections
- Allergies
- Cold/Flu
- Stomachache/diarrhea
- Urinary tract infections

Talk to a doctor anytime

Teladoc.com 1-800-Teladoc (835-2362) | Download the app

Erwin Electric offers dental coverage through United Healthcare (UHC). To search in-network providers, visit www.myuhc.com and search in the network listed per plan below. The Dental PPO Plans allow you to use in-network or out-of-network benefits. If out-of-network dentists are used, you will be responsible for paying the difference between UHC's allowed amount and what the dentist may charge, also known as "balance billing". The charts below provides a brief overview of the plans.

United Healthcare	Dental			
	Base DHMO Network: **Exclusive Network Dental Plan-National**		**HIGH PPO** Network: **National Options PPO 20**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network***
Calendar Year Deductible				
Individual	None	None	$50	$50
Family	None	None	$150	$150
Annual Maximum (maximum amount UHC will pay for covered services per person, per year)				
Per Covered Person	Unlimited	N/A	$5,000	
Preventive Services				
Exams Cleanings Fluoride X-Rays Sealants	Refer to Fee Schedule	None	Covered in full, no deductible	Covered 100%, no deductible
Basic Services				
Amalgam Fillings Extractions - Single Tooth	Refer to Fee Schedule	None	Covered 80% after deductible	Covered 80% after deductible
Major Services				
Crowns Bridges Dentures	Refer to Fee Schedule	None	Covered 50% after deductible	Covered 50% after deductible
Endo & Perio				
Endodontics (Root Canal) Periodontics (Gum Disease)	Refer to Fee Schedule	None	Basic Service Covered 80% after deductible	Basic Service Covered 80% after deductible
Orthodontia (Adults & Children)				
Lifetime maximum	Refer to Fee Schedule	None	50% $1,500	

Employee Cost Weekly	Base DHMO Dental Plan	High PPO Dental Plan
Employee Only	$3.25	$7.53
Employee + Spouse	$6.50	$15.05
Employee + Child(ren)	$8.45	$18.39
Family	$11.37	$27.36

Erwin Electric offers vision coverage through United Healthcare (UHC). The UHC vision network consists of optometrists, ophthalmologist opticians and optical retailers. You have the option of visiting any provider, however by choosing a participating provider, you receive the highest level of benefits.

	Vision UHC Network	
	In-Network	**Out-of-Network**
Routine Eye Exams	**Every 12 months**	
	$10 copay	Reimbursed up to $50
Lenses*	**Every 12 months**	
Single Bifocal Trifocal	$25 copay	Reimbursed up to $48 Reimbursed up to $67 Reimbursed up to $86
Frames	**Every 12 months**	
	$150 allowance + 30% off the overage	Reimbursed up to $48
Contact Lenses	**Every 12 months**	
Elective	$25 copay provides a $150 allowance	Reimbursed up to $105
Medically Necessary	Covered in Full (less applicable copay)	Reimbursed up to $210

- Covered lenses include single vision, bifocal, trifocal and lenticular.
- Lenses, Frames & Contacts are limited to either one pair of contacts or frames/lenses per calendar year.

Employee Cost Weekly	**With** Medical Coverage Election	Without Medical Coverage Election
Employee Only	$0.81	$1.62
Employee + Spouse	$2.48	$3.29
Employee + Child(ren)	$2.91	$3.72
Family	$4.79	$5.60

BASIC LIFE

Erwin Electric provides all full-time employees working 30 or more hours per week a basic life insurance coverage through a group plan. The chart below provides an overview of the plan.

Basic Life Insurance	Guardian
Employee Only	$10,000 Basic Life/AD&D **The Basic Life insurance is paid 100% by Erwin Electric .**
Benefit Reduction Schedule	At age 65, benefits reduce by 35% of original amount. At age 70, benefits reduce by 60% of the original amount. At age 75, benefits reduce by 75% of the original amount. At age 85, benefits reduce by 85% of the original amount.

VOLUNTARY LIFE INSURANCE

Erwin Electric provides all full-time employees working 30 or more hours per week the opportunity to enroll in voluntary life for you and your eligible dependents. The chart below provides an overview of the plan.

Voluntary Life and Accidental Death and Dismemberment	Guardian
Employee Life and AD&D Limit	Increments of $10,000 up to a maximum of $300,000
Employee Guarantee Issue	$200,000
Age Reduction	35% at age 65, 60% a age 70, 75% at age 75, 85% at age 80
Spouse Life and AD&D Limit	$250,000, not to exceed 100% of employee election
Spouse Guarantee Issue	$25,000
Child Life and AD&D Amount	$1,000 - $10,000 (Not to exceed 100% of employee election)
Child Guarantee Issue	$10,000

SHORT TERM DISABILITY

Erwin Electric provides all full-time employees working 30 or more hours per week the opportunity to enroll in voluntary short-term disability.. The chart below provides an overview of the plan.

Short Term Disability	Guardian
Benefit Pays	60% of Base Salary
Maximum Benefit	$1,000 Per Week
Benefits Begin	Day 8 (Sickness or Injury)
Maximum Benefit Period	13 Weeks
Evidence of Insurability	Not Required (Newly eligible employees)
Pre-Existing	A pre-existing condition includes any condition for which an employee, in the three-month period prior to coverage under this plan, consults with a physician, receives treatment, or takes prescribed drugs.
Basis of Payment	Base Salary

ACCIDENT

Erwin Electric provides all full-time employees working 30 or more hours per week the opportunity to enroll in accident coverage for you and your eligible dependents. The chart below provides an overview of the plan.

Accident	Guardian
Accidental Death & Dismemberment	Employee: $20,000 Spouse: $10,000 Child(ren): $5,000
Ambulance (Air/Ground)	$1,000 / $200
Concussion	$200
Dislocations (Surgical or Non-Surgical)	Up to $5,000
Cuts / Lacerations	Up to $400
Fractures (Closed or Open)	Up to $6,000
Hospital Admission (Non-ICU / ICU) Confinement (Non-ICU / ICU)	$1,000 / $2,000 $250 per day / $500 per Day
Wellness Benefit	**$50**

HOSPITAL

Erwin Electric provides all full-time employees working 30 or more hours per week the opportunity to enroll in hospital coverage for you and your eligible dependents. The chart below provides an overview of the plan

Hospital	Option 1	Option 2
Hospital Admission (Non-ICU / ICU)	$1,000 / $2,000	$1,500 / $3,000
Hospital Confinement (Non-ICU / ICU) (30-Day Consecutive Days Per Year)	$100 / $200	$200 / $400
Wellness Benefit	Not Included	Not Included
Pre-Existing	No Pre-Existing	No-Prexisting

CRITICAL ILLNESS

Erwin Electric provides all full-time employees working 30 or more hours per week the opportunity to enroll in critical illness coverage for you and your eligible dependents. The chart below provides an overview of the plan.

Critical Illness	Coverage
Benefit Election Amount	$10,000 or $20,000
Guarantee Issue	$20,000
Spouse Benefit	Not to Exceed 50% of Employee Amount
Spouse Guarantee Issue	$10,000
Child Benefit	Not to Exceed 50% of Employee Amount
Child Guarantee Issue	All Child Amounts are Guaranteed
Pre-Existing	No Pre-Existing
Wellness Benefit	$50

LEGAL

Legal issues occur throughout life, when you're are getting married, buying a home, becoming a caregiver or handling financial matters like debt or tax audits. Dealing with these matters can be costly and time consuming, taking you away from work and impacting your overall well-being.

MetLife Legal Plan provides you with the cost-effective, multi-channel access to legal help you may need to easily handle costly legal matters in your life—helping you to feel more financially and emotionally secure.

MetLife | Legal Plans

Telephone and office consultations, demand letters and document review on **unlimited number** of personal legal matters

Over 18,000 attorneys in all 50 states and many U.S. territories who have an average of 25 years of experience and are subject to a comprehensive set of criteria

Best-in-class digital experience to find attorneys and complete estate planning

We're focused on providing **exceptional customer service** and are appropriately staffed for peak call volume

EMPLOYEE ASSISTANCE PROGRAM (EAP)

ComPsych GuidanceResources Worldwide | Guardian

Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych® GuidanceResources® program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small.

Services:

Confidential Emotional Support
3 face-to-face or virtual sessions per person, per issue, per year
- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work and Lifestyle Support
- Child, elder and pet care
- Moving and relocation
- Shelter and government assistance

Legal Guidance
- Divorce, adoption and family law
- Wills, trusts and estate planning
- Free consultation and discounted local representation

Financial Resources
- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Digital Support
- Connect to counseling, work-life support or other services
- Tap into an array of articles, podcasts, videos, slideshows
- Improve your skills with On-Demand trainings

Online Will Preparation
- Quickly and easily complete a will on your computer with EstateGuidance®
- Specify guardians, trustees and property division
- Provide funeral and burial instructions

Wellness Support
Flexible 3-5 coaching session model
- Make positive lifestyle changes with health coaching
- Improve your nutrition, exercise habits, weight loss efforts
- Get help with smoking cessation, back care, resiliency and more

24/7 Live Assistance:
Call: (855) 239.0743
TRS: Dial 711

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: Guardian

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

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

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

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

SECTION 111

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

MICHELLE'S LAW

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

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

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

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES [CONT]

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

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

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

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

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

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

III. **No intimidating or retaliatory acts**

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

IV. **No Waiver**

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

PATIENT PROTECTION:

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

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

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

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

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

Erwin Electric
Human Resources | 813-855-0048
13817 Monroes Business Park, Tampa, FL 33635

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information at the top of this page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts • If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

Our Uses and Disclosures How do we typically use or share your health information? We typically use or share your health information in the following ways.		
Help manage the health care treatment you receive	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.	Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	Example: We use health information about you to develop better services for you
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	Example: We share information about you with your dental plan to coordinate payment for your dental work
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

Our Responsibilities
• We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it. • We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Changes to the Terms of This Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. Effective 12/01/2026
This Notice of Privacy Practices applies to the following organizations. Erwin Electric

Model Wellness Program Disclosure:

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

Disclosure of Grandfathered Status:

Erwin Electric believes this medical is NOT a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that medical plans may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator in Human Resources. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

REQUIRED ANNUAL EMPLOYEE DISCLOSURE NOTICES

MEDICARE PART D

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

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

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

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

When can you join a Medicare Drug Plan?

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

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

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

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

If you decide to join a Medicare drug plan and drop your current coverage with **Erwin Electric** , be aware that you and your dependents will be able to get this coverage back.

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

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

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

your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information (see contact information below). NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through Erwin Electric changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

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

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

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

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: December 1, 2026
Name of Entity/Sender: Erwin Electric , Inc.
Contact--Position/Office: Human Resources
Phone Number: 813-855-0048

GENERAL NOTICE OF COBRA RIGHTS
[CONTINUATION OF COVERAGE RIGHTS UNDER COBRA]

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

GENERAL NOTICE OF COBRA RIGHTS [CONTINUED]

How is COBRA continuation coverage provided?

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

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

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

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

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

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

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

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

MODEL SPECIAL ENROLLMENT NOTICE:

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 [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2027)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **Lauren Valenti at 813-855-0048 x224**

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

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 Erwin Electric	4. Employer Identification Number (EIN) 59-3490070	
5. Employer address 13817 Monroe Business Park	6. Employer phone number 813-855-0048 x224	
7. City Tampa	8. State FL	9. ZIP code 33635
10. Who can we contact about employee health coverage at this job? Lauren Valenti		
11. Phone number (if different from above)	12. Email address hr@erwinelectric.com	

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

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

  [X] All employees. Eligible employees are:

  Employees who work at least 30 hours per week.

  [ ] Some employees. Eligible employees are:

- With respect to dependents:

  [X] We do offer coverage. Eligible dependents are:

  Your Legal Spouse. Your married or unmarried natural children, step-children living with you, legally adopted children and any other children for whom you have legal guardianship, who are under 26 years of age. A dependent who is older than 26 years of age, but less than 30 years of age may be eligible for medical benefits if the dependent is:
  - unmarried and not have dependents of his or her own; AND
  - Be a resident of Florida or a student; AND
  - Not have coverage of their own, or covered under any other plan; AND
  - Not entitled to benefits under Medicare

  [ ] We do not offer coverage.

[X] 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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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.

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 a deductible. You may have other 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" 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.

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 may 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 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.

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 deductibles 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 (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 No Surprises Help Desk at **(800) 985-3059.** Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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, 2026. 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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ 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	ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
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	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: https://dss.mo.gov/mhd/hipp Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

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

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

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

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.



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

Presented by:

M.E. WILSON
Risk Management • Insurance • Benefits • Bonds