ELECTRIC THERMAL SOLUTIONS

CHROMALOX Advanced Thermal Technologies · Vulcanic · THERMOCOAX · DUREX Technologies

2025 Benefits Guide

This publication contains important information about your employee benefit program.

Please read thoroughly.

Table of Contents

Welcome to Your 2025 Benefits Guide

Plan Year: January 1, 2025 through December 31, 2025

Electric Thermal Solutions is pleased to present your Employee Benefits for 2025. This Benefits Guide will help you to better understand your benefit options and make great decisions regarding your coverage.

The benefit elections you make during Open Enrollment will be effective January 1, 2025 and will last until December 31, 2025. Be sure you plan accordingly! If you don't enroll within your specified time period, you forfeit the opportunity to make any benefit changes until the next plan year, unless you have a qualifying life event. Be sure you make wise decisions. Specific questions can be answered by the insurance Summary Plan Descriptions (SPDs).

What's New in 2025?

- Medical will remain with BCBS of SC. We will offer three plans; PPO $1500, HDHP $1650 and HDHP $2500
  - HDHP 1650: the deductible increase to $1650 (individual) and $3,300 (family), is required in accordance with updated IRS guidelines.
- NEW—Electric Thermal Solutions will put $500 into your HSA for single and $1,000 for family if you choose one of the two HDHP offerings.
  - Funds will be distributed in two payments, January and July (subject to change).
- Health Savings Account (HSA)—increase in annual plan contribution limits (only eligible if enrolled in HDHP Plan):
  - Employee only: $4,300
  - Employee + spouse, child(ren), family: $8,550
- Flexible Spending Accounts (FSA)—increase in annual plan contribution limits to $3,300.
- FSA and Dependent Daycare Account Rollover in 2024. Any account balance remaining at the end of 2024 will be rolled over for use in 2025 up to $640.

Who is Eligible

If you are a Electric Thermal Solutions full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. You and your eligible dependents are eligible for medical, dental, and vision coverage. Eligible dependents generally include your spouse and dependent children until age 26. You will be required to prove your dependents are eligible dependents under the plan.

How to Enroll

The first step to enroll in your benefits is to review this Benefits Guide. Once you make your selections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

When to Enroll

New Hires can enroll within 31 days of your hire date. All benefits will begin on your first day of full-time status.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of a spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status. Changes must be made within 31 days of the event. See page 50 for more details.

Helpful Definitions

In network—Providers that have contracted with a network to provide covered services at a negotiated rate (i.e.,—hospitals, doctors, pharmacies, durable medical equipment suppliers, etc.)

Out of Network—Providers that have not contracted for reimbursement at a negotiated rate.

Copayment—A Specified amount of money you pay each time certain covered services are preformed (i.e.,—office visit, prescription, inpatient treatment, etc.)

Coinsurance—A specified percentage share in which you and the plan pay toward the cost of covered services. Usually, you have to meet your deductible before coinsurance kicks in.

Deductible—Each year you must meet a plan year deductible. This means you must pay a certain amount of money towards covered expenses before the coinsurance kicks in. Coinsurance and Benefit Year Deductibles which apply to the Out-of-Network Out-of-Pocket Maximums shall also contribute to the In-Network Out-of-Pocket Maximums.

Out-of-Pocket Maximum—Once you meet the out of pocket limit (by paying your part of the coinsurance), the plan pays 100% of any further covered medical expenses that you incur for the remainder of the plan year.

BenManage Enrollment Instructions

Instructions

Welcome to the **Employee Self Service for Benefits** screen.

www.spiraxsarcobenefits.com/ETS

- Login=SSN, PW= last 4 digits of SSN plus two-digit birth year

To get started, click on either **Start Open Enrollment, Start New Employee Enrollment** or **Life Change Event** button on menu below.

As you proceed through the benefit categories (Medical, Dental, etc.), review the provider, pricing and coverage type that best meets your family's needs. Note that there are options to compare plan pricing and features to assist you with your selections.

Once you have decided on a plan, click on the "select" checkbox next to the plan. Note that you do have the option to waive plan coverage and can modify your selections up to final submit on confirm selections tab.

After you have selected your plan, if you have chosen a plan that requires a dependent (e.g. Employee plus Family) you will need to define those dependents. In most cases your dependents have already been added to the options for you. If not, you will want to have your dependent(s) contact, SSN and birthday information available as you complete this section.

NOTE: You must complete the Confirmation Selection tab and submit prior to your selections to be considered for activation.

Call Center Enrollment Instructions

If you would rather speak with a benefit counselor to complete the enrollment process you can reach the Electric Thermal Solutions enrollment center from 8 AM to 5 PM CT, Monday through Friday at **803.573.2350**. The benefit counselors will provide an overview of the benefits being offered to you and answer any benefit related questions that you may have. They will also fully complete the benefit enrollment process on your behalf if you provide them the authorization to do so.

Your information will be forwarded to the HR Department for review and approval. You can always return to view your status of current benefits as needed or prompt a request for change should you experience a "Life Change Event" outside of the open enrollment period.

Please contact HR for questions or issues.

Confirm and Submit

Thank you for selecting (or waiving) your new benefit plans. Please take a moment to review the plans and coverage levels. Select the **Previous** option on the menu below to make any changes up to finalization.

Note: If you waive your health and welfare coverage for any benefits, you will not be able to enroll back into the plan(s) until the next Open Enrollment date unless you have a qualifying **Life Change Event**.

If you are satisfied with your selection, please add/identify your dependents that are to be included on your plan (if applicable). Once you have identified your dependents, you will be able to use the "submit request" option to finalize and submit your selections.

The HR Department will review your submittal and contact you should we have any additional questions. Thank you.

Enrollment Acknowledgment

If you wish to make additional changes, click on **"decline"** and you will return to the option menu.

Click on **"accept"** if you are satisfied with your selections and wish to proceed with the submittal process.

Note that you will not be enrolled in new plans until you complete this selection and acceptance process. Contract your HR Department should you have any questions regarding this process.

True and complete acknowledgment: The answers I have provided throughout this benefit submission are to the best of my knowledge and belief, true, and complete.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization any time upon written notice unless I have chosen to use pretax deductions.

You can review the status of your benefits at any time by going to **My Account > My Benefits > Review Benefit**.

Medical Coverage

Blue Cross Blue Shield (BCBS)

Blue Cross Blue Shield is our exclusive medical healthcare provider. You have the choice of three plans. Each option offers you the ability to choose the benefit plan that best meets your benefit and budgetary needs.

It is important to remember that we are all healthcare consumers with the power to make informed decisions about the service we receive. The medical care and prescription drugs that we utilize have direct impact on the cost of the company's health insurance.

You can locate a physician by contacting Member Services or by logging into the BCBS website at **www.southcarolinablues.com.**

BlueCare on Demand—Powered by MDLIVE

BCBS offers BlueCare on Demand. This service allows you access to a doctor when it's not an emergency, but you need urgent attention. BlueCare on Demand is there 24/7 to assist with:

- Common Cold
- Flu Like Symptoms
- Pink Eye
- Strep Throat
- Ear Ache

Use a smart phone, tablet, or personal computer for easy access—no matter where you are! Download the app and create an account today.

Access BlueCare on Demand through your My Health Toolkit account: Visit **www.southcarolinablues.com**.

Medical and Prescription Benefits at a Glance

	PPO		HDHP 1650		HDHP 2500	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Schedule of Benefits						
Benefit Period	January 1st through December 31st					
Dependent Age Limit	Up to age 26 (coverage goes through the end of the month in which the dependent turns 26)					
Lifetime Maximum	Unlimited					
Enrollment & Qualifying Life Events	Coverage is elected during annual open enrollment or within 31 days of a qualifying life event					
Annual Deductible						
Employee (EE) Only	$1,500	$1,500	$1,650	$4,000	$2,500	$5,000
EE + Spouse/Child(ren)/ Family	$3,000	$3,000	$3,300	$8,000	$5,000	$10,000
Annual Out-of-Pocket Maximum (Includes Deductible)						
EE Only	$3,200	$4,600	$3,000	$8,000	$5,000	$10,000
EE + Spouse/Child(ren)/ Family	$6,400	$9,200	$6,000	$16,000	$10,000	$20,000
Medical Benefits						
Coinsurance	80% after ded.	60% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Emergency room visit	$500 then coinsurance		80% after ded.	60% after ded.	80% after ded.	60% after ded.
Inpatient stay	80% after ded.	60% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Outpatient Therapy	80% after ded.	60% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Physician Office Visit (PCP)	$25	60% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Specialist Office visit	$40	60% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Preventative	100% covered		100% covered		100% covered	
Urgent care center	$40	60% after ded.	80% after ded.	60% after ded.	80% after ded.	60% after ded.
Prescription Drug Retail Prescription Copay (30-Day Supply)						
Generic	$5	Ded. then coinsurance	80% after ded.	In network only	80% after ded.	In network only
Brand	$45	Ded. then coinsurance	80% after ded.	In network only	80% after ded.	In network only
Non-Formulary	$75	Ded. then coinsurance	80% after ded.	In network only	80% after ded.	In network only
Specialty	$75	Ded. then coinsurance	80% after ded.	In network only	80% after ded.	In network only
Mail-Order Prescription Copay (90-Day Supply)						
Generic	$10 copay	Ded. then coinsurance	80% after ded.	In network only	80% after ded.	In network only
Formulary	$90	Ded. then coinsurance	80% after ded.	In network only	80% after ded.	In network only
Non-Formulary	$150	Ded. then coinsurance	80% after ded.	In network only	80% after ded.	In network only
Specialty	85% after deductible	Ded. then coinsurance	80% after ded.	In network only	80% after ded.	In network only

While every effort has been made to ensure the accuracy of this chart, in the event of any discrepancy, the legal documents, policies, or certificates of coverage pertaining to the various benefits will prevail. This summary is not intended to be a complete benefit description. *Refer to the Summary Plan Description for a detailed overview of benefits offered

BCBS Mail Order Prescriptions

As a BCBS customer, you'll have access to OptumRx's Mail Service Pharmacy. Please call OptumRx Home Delivery Customer Care at **855.811.2218** or visit My Health Toolkit with any questions.

You'll Enjoy

- Easy refills—up to a 90-day supply means fewer refills
- 24 hour, toll free hotline to speak to registered pharmacists about medication questions
- Convenient Internet and refill-by-phone services to order your refills any time, any day
- Helpful order updates and refill reminders, by e-mail, phone, or text

Getting Started

Members can call OptumRx Home Delivery to enroll in its FastStart service. The representative will contact their doctors for their prescriptions. They'll need their member ID number, the name of their drug, doctor's name and phone number and their shipping address. They will also need to provide a credit card number to pay for their mail-order prescription, along with the expiration date for the card they use.

Prescription Refills

After you get your initial prescription, you may request a refill on the Internet, by phone or by mail. Have your prescription refill form with your prescription number close by when you reorder. For Internet refills, go to My Health Toolkit and click on the link to OptumRx. You may also call OptumRx Customer Care toll free at **855.811.2218** to refill your prescription by phone. If there are no refills available, OptumRx will call your doctor for authorization to refill your prescription(s). If your prescription is out of refills, please allow extra time to process your order.

Automatic Refills

Your medication will be refilled automatically if you sign up for the Optum automatic refill program on its website or by phone. After you receive your first mail-service prescription, go to your MyHealth Toolkit portal or call OptumRx toll free at **855.811.2218**. If you don't sign up for the automatic refill program, you'll need to request your refills each time you're ready for them, either on the OptumRx's website, by phone or by mailing in your refill form to OptumRx.

Medical Deductions

Monthly Contributions

	HDHP 1650 Employee	HDHP 1650 Employer	HDHP 2500 Employee	HDHP 2500 Employer	PPO 1500 Employee	PPO 1500 Employer
Individual	$148.06	$547.52	$109.03	$555.46	$202.58	$530.76
EE + Child(ren)	$365.56	$1,177.55	$271.80	$1,193.02	$489.35	$1,133.89
EE + Spouse	$312.55	$1,077.44	$248.08	$1,098.17	$423.58	$1,044.25
Family	$586.49	$1,911.48	$440.25	$1,905.27	$831.37	$1,798.06

Employee benefits represent a significant cost to Electric Thermal Solutions and we take great pride in providing a competitive and comprehensive benefits program for our employees and your families.

Electric Thermal Solutions shares in the majority of the costs of our benefit plans. Our goals are getting you more engaged in maintaining your health; improving chronic disease management; reducing the cost of benefits; improving utilization of preventive services; incorporating incentive programs to increase utilization of wellness/health promotion programs; and education efforts to help you manage your healthcare finances.

Medical Plan Cost Comparison Examples

Profile 1—Cam, Low Utilizer (Employee-Only Coverage)

Cam is a low utilizer of healthcare. In this example, his care consists of one annual physical, an office visit for an illness, and three prescriptions.

	HDHP 1650	HDHP 2500	Traditional PPO
Deductible to be Satisfied	$1,650	$2,500	$1,500
Out-of-Pocket Max to be Satisfied	$3,000	$5,000	$3,200
Employer Account Funding	$500	$500	$0
Cam's Services	Cost of Care	Cost of Care	Cost of Care
1 Preventive Physical Exam (Assumes $125 Office Visit Charge)	$0	$0	$0
1 PCP Visits (Assumes $125 Office Visit Charge)	$125	$125	$25
2 Generic Non-Preventive Retail Prescriptions (Assumes $30 Total Cost/30-day Rx)	$60	$60	$10
1 Brand Non-Preferred Retail Prescriptions (Assumes $200 Total Cost/30-day Rx)	$200	$200	$75
Totals	Cost of Care	Cost of Care	Cost of Care
Out-of-Pocket Expenses	$385	$385	$110
Expenses Covered by Account Funding	$385	$385	$0
Net Out-of-Pocket	$0	$0	$110
Annual Payroll Contributions	$1,777	$1,308	$2,431
Total	**$1,777**	**$1,308**	**$2,541**

Profile 2—Steve, High Utilizer (Employee-Only Coverage)

Steve is a high utilizer of healthcare and is managing a complex heart condition. His care consists of regular visits with his primary care physician and cardiologist. He had one surgical procedure and takes medication on an ongoing basis to manage his condition.

	HDHP 1650	HDHP 2500	Traditional PPO
Deductible to be Satisfied	$1,650	$2,500	$1,500
Out-of-Pocket Max to be Satisfied	$3,000	$5,000	$3,200
Employer Account Funding	$500	$500	$0
Steve's Services	Cost of Care	Cost of Care	Cost of Care
1 Preventive Physical Exam (Assumes $125 Office Visit Charge)	$0	$0	$0
4 Sick Visits With Primary Care Physician (Assumes $125 Office Visit Charge)	$500	$500	$100
1 Inpatient Procedure (Assumes $5,000 Charge)	$1,920	$2,600	$2,120
8 Specialist Visits With Cardiologist (Assumes $350 Per Office Visit Charge)	$560	$560	$320
12 Preferred Brand Retail Prescriptions (Assumes $100 Cost/30-Day Rx)	$20	$240	$110
Totals	Cost of Care	Cost of Care	Cost of Care
Out of-Pocket Expenses	$3,000	$3,900	$3,080
Expenses Covered by Account Funding	$500	$500	N/A
Net Out-of-Pocket	$2,500	$3,400	$3,080
Annual Payroll Contributions	$1,777	$1,308	$2,431
Total	**$4,277**	**$4,708**	**$5,511**

Profile 3—Jeff, Highest Utilizer (Employee-Only Coverage)

Jeff is a high utilizer of healthcare and is managing a complex heart condition. His care consists of regular visits with his primary care physician and cardiologist. He had two surgical procedures and takes medication on an ongoing basis to manage his condition.

	HDHP 1650	HDHP 2500	Traditional PPO
Deductible to be Satisfied	$1,650	$2,500	$1,500
Out-of-Pocket Max to be Satisfied	$3,000	$5,000	$3,200
Employer Account Funding	$500	$500	$0
Steve's Services	Cost of Care	Cost of Care	Cost of Care
1 Preventive Physical Exam (Assumes $125 Office Visit Charge)	$0	$0	$0
8 Sick Visits With Primary Care Physician (Assumes $125 Office Visit Charge)	$1,000	$1,000	$200
Inpatient Procedure (Assumes $5,000 Charge)	$1,520	$2,200	$2,040
12 Specialist Visits With Cardiologist (Assumes $350 Per Office Visit Charge)	$480	$840	$480
Inpatient Procedure (Assumes $4,000)	$0	$800	$430
12 Preferred Brand Retail Prescriptions (Assumes $100 Cost/30-Day Rx)	$0	$160	$0
Totals	Cost of Care	Cost of Care	Cost of Care
Out of-Pocket Expenses	$3,000	$5,000	$3,200
Expenses Covered by Account Funding	$500	$500	N/A
Net Out-of-Pocket	$2,500	$4,500	$3,200
Annual Payroll Contributions	$1,777	$1,308	$2,431
Total	**$4,277**	**$5,808**	**$5,631**

Working Spouse Provision

Employees who enroll a spouse who is otherwise eligible to participate in a health plan offered by their own employer will be subject to an additional deduction of $250 per month. When electing the tier of Employee + Spouse or Family, the surcharge is automatically built into your payroll deductions unless you attest that your spouse does not have other coverage available.

The purpose of the Spousal Surcharge is to financially encourage all employees' spouses to enroll in their own employer's medical insurance regardless of whether or not they receive an incentive from their employers to not enroll. When an employed spouse enrolls in his or her own employer's medical insurance, the spouse's medical costs are appropriately shifted to his or her own employer. Accordingly, the surcharge reduces the extent to which Electric Thermal Solutions and our employees subsidize the healthcare expenses of other employers.

When enrolling a spouse online the employee attests to the following: I understand that if my spouse's group insurance status changes, it's my responsibility to update the portal and to notify the HR Department within 30 days of such change. Any false statements or elections as it relates to spouse health insurance information shall be considered grounds for disciplinary action which may include potential termination. Attestation is done through the employee portal during the enrollment process.

Enrolling a Spouse or Child

If enrolling a spouse or child on your Electric Thermal Solutions coverage you are required to provide proof of their dependent status regardless of the time of year it is done. All submitted copies must be legible. Black out all confidential information such as financial data and Social Security numbers. Do not submit original documents as they will not be returned.

Spouse

(Provide Document 1 AND Document 2 Below)

One of the following documents:

- Valid legal or religious marriage certificate (employees married within the last 6 months do not need to provide second document)
- Presently valid state-issued certificate, declaration, or registration of common law or informal marriage (in applicable states)
- Legal household/family registry, must show spousal relationship (this is only acceptable if you were married outside of the US and do not have a marriage certificate)

AND

- Your Federal 1040 or State income tax return from the current or previous year, indicating if married filing jointly or married filing separately; financial information should be redacted

OR

- One of the following documents dated within the last 12 months:
  - Utility bill
  - Document from a bank account or financial information
  - Insurance document such as homeowner, renter, or automobile
  - Mortgage document or current lease
  - Valid vehicle registration

Child

(Provide Any One of the Options Below)

- Your Federal 1040 or Sate income tax return, which must list your dependent with relationship as daughter, son, or child
- Child's legal or hospital birth certificate or affidavit of parentage
- Legal household/family registry, must show relationship (this is only acceptable if you were married outside of the US and do not have a marriage certificate)
- Final divorce decree, parental custody agreement, or Qualified Medical Child Support Order (QMCSO)
- Legal adoption, guardianship, or legal custody papers
- Also required to prove the relationship between you and your stepchild—if you are an employee providing documentation for a child of your legal spouse (or domestic partner), you must include the required documents listed for Spouse or Domestic Partner, even if you do not currently cover your spouse (or domestic partner)

* Stepchild—You must provide a combination of documents that demonstrate your step-parent status by proving your relationship to the parent of the child (your spouse) and proving the relationship between your spouse and that child. For example, your marriage certificate to your spouse and your stepchild's birth certificate listing your spouse as their parent.

** Disabled Adult Child—You must have an approved Disabled Dependent Certification form on file with the respective insurance company in which they are enrolled.

Cannot Locate A Document?

If you cannot locate a record such as a marriage license or birth certificate you can order through VitalChek by visiting their website at **https://www.vitalchek.com**. VitalChek's Express Certificate Service provides a convenient way for you to order these documents online—quickly, affordable, and with added security to ensure your documents are safe. Trust VitalChek when you need to replace one of your life's most vital records—birth certificate, death certificate, marriage record, or divorce record.

Identification Card

Your identification card is one of the most important cards you carry. Providers will accept it when you need covered services. It contains information about your coverage that will help with the fast and accurate processing of any claims.

Notes

1. Identification cards feature the name of the policyholder only. Any dependents who have coverage under this policy (for example, a spouse or child) can still use the ID card, even though it only shows the policyholder's name.
2. Alpha Prefix—is the first three characters of the "Member ID," and identifies your group. A group number does not appear on the identification card.
3. If Optum is the PBM (via the National Alliance contract), RXBin, RXGRP, and Plan Code apply across entire population.
4. Copays (if applicable) do not appear on Identification cards.
5. Single members receive one card, family tiers receive four cards and other tiers of coverage receive two. Additional cards can be ordered via My Health Toolkit® or through Customer Service at **800.922.1185**.
6. Call **844.206.0620** to confirm receipt of your card and get insurance updates delivered straight to your mobile device. Calling is not mandatory. Card will be active as of effective date.

Your ID cards will arrive in an envelope.

BCBS—My Health Tool Kit

These BCBS programs and services can help you make the most of your medical plan.

BCBS offers numerous tools to make it easy to manage and track your medical claims, search for in-network providers, and much more! Please review the information below to learn more about BCBS and their online tools!

Access to SouthCarolinaBlues.com and My Health Toolkit:

- Learn more about your plan, and the coverage an programs that come with it
- View claim history and account transactions; print claim forms
- Find information and estimate costs for medical procedures and treatments
- Compare hospitals by number of procedures performed, patients' average length of stay and cost

Make South Carolina Blues your personal health place:

Enjoy a simple way to personalize, organize and access your important plan information. Register on My Health Toolkit on **www.SouthCarolinaBlues.com**. Once you do, you can login anytime, anywhere to:

- Find doctors and compare cost and quality ratings
- Review your coverage
- Manage and track claims
- Access temporary ID cards and find out how to order new ones
- Track your account balances and deductibles
- Find health information and resources
- Browse member perks and discounts
- Compare hospital quality

Download the My Health Toolkit App! With the app you can:

- Use your digital ID card wherever, whenever
- Check the status of your claims fast
- See what's covered by your health plan
- Find a local provider who's right for you

BCBS Member Perks

BCBS offers discounts on a variety of products and services to enhance your quality of life. Think of them as special perks just for being Blue! Please note that these services are not covered under your regular health plan benefits. Visit **www.southcarolinablues.com**, and select Member Perks.

Discounts are available on items such as:

- Hearing screenings
- Hair restoration
- Eyewear
- Lasik services
- Weight loss programs
- Allergy relief products
- Massage therapy
- Fitness centers
- Diet and supplement advisers
- Chiropractic services
- And more!

Blue365 Program

Register today at **www.blue365deals.com** to start receiving your discounts!

What it Offers

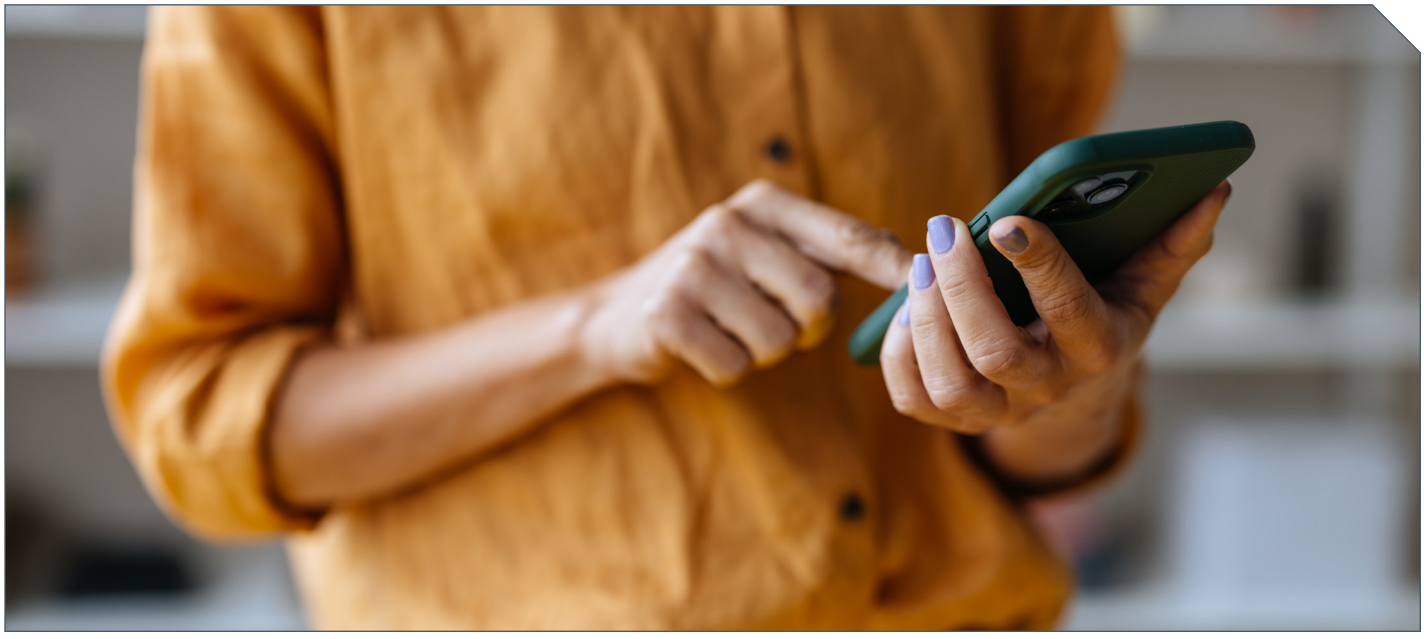
Deals on products and services to help keep you happy and healthy. The Blue365 program is sponsored by participating Blue companies. Members can receive regular updates on available deals via email.

How it Works

Register free online. Then browse the current deals in these categories: fitness, personal care, healthy eating, financial health, lifestyle, and wellness.

Two Ways to Save

Some deals give you a coupon code that can be applied to a purchase on a vendor's website, or provide a discounted option. Others take you directly to a vendor's website to make a discounted purchase or enroll in a special discount program.



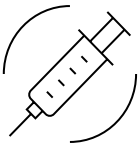
Avoid a Scare with Preventive Care

Did you know in-network preventive care is FREE to you if you are covered under one of our health plans? An in-network preventive care visit won't cost you a penny, and it could help you live longer and healthier.

What is Preventive Care?

Preventive care helps evaluate your current health status and can help detect health problems early—before any signs or symptoms have appeared. Through regular preventive exams and screenings, you and your doctor(s) can work together to manage your overall health. Preventive care includes the following:

Wellness checkups are a great way to see your primary care doctor regularly to make sure you are getting the correct health screenings and vaccines based on your age and health status.



Vaccines are needed by kids and adults alike to help prevent illnesses, such as flu and whooping cough.

Screening tests, such as lab work and colonoscopies, can help detect conditions like a diabetes, high cholesterol, or certain kinds of cancer.

Make Sure Your Visit is Free

When you schedule an appointment, make it known you are interested in getting free preventive care only and want to be informed if any services aren't free preventive care.

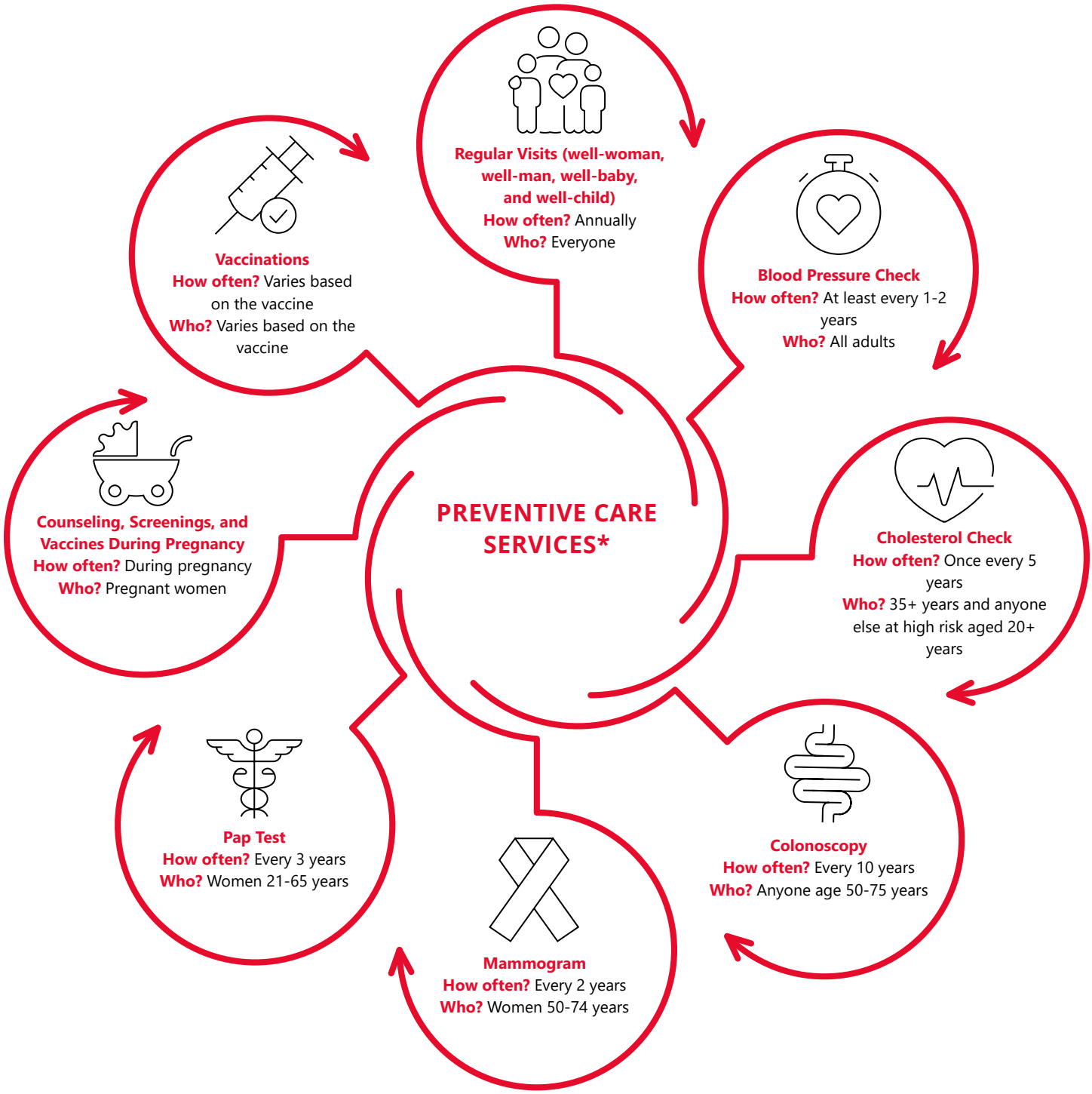
If there is a diagnosis, medical condition, or additional testing/treatment involved in your visit, it will likely not be coded a preventive visit, and you will incur a charge.

Over 100,000 lives could be saved each year if everyone in the United States received the recommended clinical preventive care!*

Don't delay! Call your doctor and schedule your family's preventive care visit today!

* CDC estimate

Preventive Care Services



Where Should You Go for Care?

When you find yourself injured or ill, you can save time and money by thinking about the BEST place to get care. Of course, if your condition is life threatening, call an ambulance or go to the ER. If it can wait, take a look at the lists below and consider these tips.

$ Telehealth

For a minor illness, you might try BlueCare on Demand. It's one of the least expensive options, and it's available 24/7.

$$ Your Doctor

Your first stop—during business hours—is your regular doctor, if available. Whether you choose a telehealth or in-person visit, your provider knows you and is best equipped to provide personalized care. You'll pay less when you choose an in-network doctor.

$$$ Retail Clinic

These are a good option for minor illnesses and injuries when your doctor isn't available. They cost a bit less than urgent care centers, but they aren't equipped to stitch you up or take X-rays. Wait times are usually 30 minutes or less.

$$$ Urgent Care

An urgent care center may be your next step. They can run simple tests, take X-rays, and treat cuts and sprains. They typically get patients in and out in about an hour, and many visits cost around $150.

$$$$ Emergency Room

The emergency room is always the best place for treating a life-threatening condition. But think twice—or three times—before using it for a minor illness or injury. The cost is a lot higher—usually $1,000 or more—and the wait times are often quite long.

Choose the Right Option for Your Condition

 YOUR DOCTOR	 TELEHEALTH	 URGENT CARE	 EMERGENCY ROOM
▶ Checkups and physicals ▶ Common illnesses ▶ Flu shots and other vaccines ▶ Skin conditions ▶ Uncontrolled blood pressure ▶ Health advice ▶ Medication refills or changes ▶ Referrals to specialists ▶ Routine tests ▶ Your regular medical concerns	▶ Back pain ▶ Coughs ▶ Diarrhea ▶ Headache ▶ Heartburn ▶ Red eye ▶ Sinus problems ▶ Urinary problems ▶ Vaginal discharge	▶ Allergic reactions ▶ Animal or insect bites ▶ Acute back pain or injury ▶ Asthma ▶ Bad colds or flu ▶ Cuts requiring stitches (urgent care) ▶ Earaches ▶ Eye infections or irritations ▶ Mild fevers ▶ Minor burns ▶ Nausea, vomiting and diarrhea ▶ Rashes ▶ Sore throats ▶ Sprains or strains ▶ Suspected broken bones (urgent care) ▶ Urinary problems	▶ Suspected broken bones ▶ Coughing or vomiting blood ▶ Chest pain ▶ Difficulty speaking ▶ Head or eye injuries ▶ Dehydration ▶ Poisoning or overdoses ▶ Severe stomach pain ▶ Signs of a stroke: numbing or weakness of limbs, facial drooping, difficulty speaking ▶ Shortness of breath ▶ Urgent lab tests ▶ Loss of consciousness ▶ Uncontrolled bleeding

Meet "Consumerism Connie"

Takeaways: "Know Before You Go" time investment can help achieve higher quality outcome and save money!

Her Story

Consumerism Connie's doctor, Conrad, recommended a hip replacement surgery. Connie's first inclination was to have the procedure done within Dr. Conrad's health system, Centerville City Care Center, that she and the doctor have been part of for decades. But, being the cost-conscious consumer that Connie is (she loves a bargain!), she also wants quality care, and conducts due diligence/ research on her proposed procedure.

After logging-in to BCBS's website (**www.southcarolinablues.com**), Connie uses the Care & Cost Finder tool to review alternatives, ratings, and pricing, much like a consumer does. A review of her findings is summarized below.

TOP FOUR "CONSUMERISM" TAKEAWAYS

1. **Choice**—There were four in-network options where Connie could have the procedure done.
2. **Convenience**—All 4 options were only 1.1-3.8 miles away.
3. **Cost**—Total estimated cost ranged from $33.0K-41.4K, although she would hit her OOP maximum regardless.
4. **Quality**—Average star rating ranges from 3.0 to 4.0.

Health Saving Account (HSA)

Flores HSA Mobile App

At Flores, our goal is to help you Own Your Health. Flores Accounts Mobile is all about giving you the tools to take control and better manage your health accounts. Safe and secure, Flores Accounts Mobile offers real-time access for all your account needs, 24 hours a day, seven days a week. It's simple, intuitive, and convenient. For assistance please contact the Client Assistance Center at **800.532.3327**.

Features and Benefits

- Simple and secure login
- Check account balances
- View account activity
- Review and verify IRS-qualified medical expenses
- Make a payment from your account
- File claims with receipt images
- Enter and track expenses
- Easy access to the Client Assistance Center

To Get Started, Follow These Three Simple Steps

- Create your username and password by registering on the HSA website **www.flores247.com**
- Download Flores Account Mobile App
- Log in to Flores Account and start managing your account on the go

Download Flores Mobile today

Download on the App Store

GET IT ON Google Play

What are My Options at Electric Thermal Solutions?

Health Care Spending Account

You can use the tax-free money in your account to reimburse yourself for:

- Eligible expenses not paid by your medical and dental coverage, and
- Out-of-pocket expenses, such as deductibles and co-payments.
- NOTE: If you are enrolled in the HDHP and elect an FSA, you will be enrolled in a limited purpose FSA which can be used to reimburse dental and vision claims only.
- You can find examples of eligible and ineligible expenses in the list below. For a complete list of eligible expenses, you can review IRS Publication 502, which is available from your local Internal Revenue Service Office or by downloading a copy from **www.irs.gov**.

Eligible Expenses	Ineligible Expenses
Deductibles and copayments not paid by other medical, dental or vision insurance	Elective cosmetic surgery, such as liposuction, hair transplants, electrolysis and face-lifts
Hearing aids and batteries	Custodial care in an institution
Contact solutions	Automobile insurance premiums
Smoking cessation aides	Health club dues, YMCA dues, steam baths, etc.

The Health Care Spending Account may be right for you if you and your eligible dependents typically have predictable out-of-pocket medical or dental expenses during the year.

How to Use Your HSA

It's easy to manage your Health Savings Account (HSA) online. Access real-time account balances, transaction history and statements, as well as track your expenses online. Sign up for online banking today.

- **Mobile App—**Use your iOS (iPhone, iPod Touch, iPad) or Android-powered device to check available balances in your account and view HSA transaction details, save and store receipts using your device's camera, receive account balances and configurable alerts via text message, and access customer service contact information.
- **Dashboard—**Use this tool to track your healthcare expenses, submit and retain receipts and claims from multiple insurance and financial account providers. Also view expenses by provider, category, and more.

How to Deposit Funds into your HSA—To maximize HSA tax and savings benefits, begin funding your account as soon as you can. You can even rollover funds from a previous HSA. Flores offers several convenient methods for making contributions to your HSA:

- **Payroll Deductions—**Flores will facilitate recurring pre-tax payroll deductions. Log into your BenManage account to update your HSA contribution anytime throughout the year.
- **Online Transfers—**On the Flores website, you can transfer funds from an external bank account, such as a personal checking or savings account, to your HSA.
- **Check—**Mail your personal check and completed Contribution Form to: Flores, PO Box 939, Sheboygan, WI 53082

How to Pay for Healthcare Expenses from your HSA—Whether you want to reimburse yourself for an IRS-Qualified medical expense paid out-of-pocket or you want to pay directly from your HSA, Flores offer multiple options for accessing your funds:

- **Health Benefits Debit Card—**Your HSA funds are loaded onto your Flores MasterCard. Simply swipe your card as credit to pull the funds from your HSA account to pay the provider directly.
- **Pay My Provider**—You can also transfer your HSA funds directly to a provider. Through your HSA portal at **www.flores247.com**, choose the Bill Pay option in the My Accounts dropdown. Select Bill Pay and then Pay Someone Else to send payment once, weekly, or monthly.
- **Online Transfers—**You can transfer your HSA funds into your checking/savings account or send yourself a check. Through your HSA portal at **www.flores247.com**, choose the Bill Pay option in the My Accounts dropdown. Select Bill Pay and then Pay Me to then reimburse yourself via direct deposit or check.

If you choose the Health Savings Account (HSA), the government allows you to set aside pre-tax money into a separate checking account at the bank. You can use the money for your deductibles if you wish or for other items related to Section 125 of the IRS Code, see IRS web-site for full listing.

To be able to contribute to an HSA after age 65, you must not enroll in Medicare. If you are not enrolled in Medicare and are otherwise HSA eligible, you can continue to contribute to an HSA after age 65.

You can put up to $4,300 (single) or $8,550 (family) for the 2025 plan year.

The contribution amounts are greater than the maximum deductibles. Participants over age 55 have an additional $1,000 catch up provision annually.

Electric Thermal Solutions will put money into your HSA account for you if you choose the HSA option.

For all current employees enrolling in Medical Coverage for the 2025 Benefit year, Electric Thermal Solutions will make a contribution to your HSA. Funds will be distributed on a pre-determined schedule in 2025.

Total Annual Employer Contribution	
Single	$500
Employee & Spouse	$1,000
Employee & Child(ren)	$1,000
Employee & Two or more	$1,000

Flexible Spending Account (FSA)

Flores

Flexible Spending Accounts (FSAs) are a tax-free way to pay healthcare, dependent care, and transit expenses that you would typically pay out-of-pocket on an after-tax basis. The money you set aside reduces your taxable income, which can save you money at tax season. You can participate in an FSA even if you are not enrolled in a medical plan.

Flexible Spending Accounts are administered by Flores. They are regulated by the IRS; therefore, certain restrictions and limits apply.

Limited Purpose HCFSA for High Deductible Health Plan Participants

If you are enrolled in a high deductible health plan, whether through Electric Thermal Solutions or another group health plan, IRS regulations limit the expenses for which you may be reimbursed under a HCFSA. You may, therefore, only participate in a Limited Purpose HCFSA for dental and vision expenses only. You can still use a Health Savings Account (separate account) to pay for eligible medical expenses and prescriptions.

Download Flores Mobile today

Download on the App Store

GET IT ON Google Play

Healthcare FSA

Healthcare FSAs are used to pay for eligible healthcare expenses such as copays, deductibles, dental, and vision expenses. You will be provided with a debit card you can use to draw money from the account to pay at the doctor's office or pharmacy. The IRS maximum contribution to the Healthcare FSA is $3,300.

Your Flexible Spending Account (FSA) elections are effective from January 1 through December 31. Our Healthcare FSA provides a 2½ month "grace period" during which Healthcare FSA funds from the prior year may be used for claims with a submission deadline of March 15. Claims for the Dependent Care FSA must be submitted by March 15.

Please plan your contributions carefully. Any money remaining in your accounts over $640 after the claim submission deadlines will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

FSAs and eligible expenses are regulated by the IRS. For a detailed list of eligible expenses, visit **www.irs.gov/publications** and search for Publication 502 or visit the WEX website.

Some examples of eligible healthcare expenses include:

- Office copays
- Prescription drugs
- Dental expenses, including orthodontia
- Vision care expenses, including laser eye surgery
- Chiropractic services
- Acupuncture
- Over-the-counter healthcare products accompanied by a doctor's prescription)

Dependent Care Spending Account

You can deposit up to $5,000 in your Dependent Care Spending Account. This account lets you set aside pre-tax dollars to pay dependent care expenses that are necessary in order for you (and your spouse, if you're married) to work or attend school full-time. You can find examples of eligible and ineligible expenses below.

Dependent care expenses will qualify for reimbursement if you meet these IRS requirements:

Eligible Expenses	Ineligible Expenses
Home or day care for dependent children under age 13.	Expenses for days you are not working.
Payments made to a licensed nursery day care or day care center for preschool children.	Child care services provided by another of your dependent children.
Home or day care for dependents of any age who are mentally or physically disabled and are unable to care for themselves.	Care for dependents who have an annual income of $1.
	Expenses you already claimed as deductions or credits on a federal or state income tax return.

- If you're married, both you and your spouse must be working. Spouses who don't work must be full-time students or incapable of caring for themselves.
- If you're married, the total annual amount you deposit can't be more than the lower of your income or your spouse's income.
- If you're single, your dependent day care expenses must be necessary for you to work. You may change your dependent care contribution during the plan year only if you have a change in family status.

The Dependent Care Spending Account may be right for you if you have day care expenses for an eligible dependent while you are at work.

Examples of How you Can Save

Sample employee makes $2,000 per month. This example shows an employee's net pay per month with and without the FSA:

Employee Paycheck Without the Plan	
Salary	$2,000
Insurance Premium	-$100
Health and Daycare Expenses	-$300
FICA, Federal, and State Taxes	-$500
Net Pay Without the Plan	**$1,100**

Employee Paycheck With the Plan	
Salary	$2,000
Insurance Premium	-$100
Health and Daycare Expenses	-$300
Adjusted Earnings	$1,600
FICA, Federal, and State Taxes	-$400
Net Pay With the Plan	**$1,200**

How to Submit a Claim

Flores Web Portal

You may scan your claim and upload it to our secure website or complete your claim detail online at **www.flores247.com**.

Flores Mobile Smartphone App

Use your phone's camera to take a picture of your documentation and upload. Download Flores Mobile through Apple Store or Google Play.

Mail Claims

Claims Processing
PO Box 31397
Charlotte, NC 28231

Please keep in mind, certified mail will need to be sent to our physical address at 2013 West Morehead Street, Suite B, Charlotte, NC 28208.

Fax Claims

704.335.0818 or **800.726.9982**

All receipts for reimbursement must include the following:

- Date of Service
- Description of Service
- Out-of-Pocket Cost
- Provider Name
- Patient Name

How to Upload a Claim on www.flores247.com

Step One: Log in to **www.flores247.com** using your Participant ID or Username and password. Tip: Your Participant ID will be on any correspondence you have received from Flores.

Step Two: Click "File a new Health Care or Dependent Care Flexible Spending Account Claim." Hit "Next."

Step Three: If you have completed a hard copy claim form and scanned it into your computer, click "Already Completed" to upload your document. If you have not already completed a claim form, fill in your claim detail and hit "Next."

Step Four: Click "Choose File" and choose the file on your computer that contains your scanned documentation that is required to process your claim. Repeat until all documents are attached. Click "Submit" to finalize your claim.

Tip: Update your email or subscribe to SMS notifications in the Settings tab to receive email or text updates on your claim!

PO Box 31397, Charlotte, NC 28231
800.532.3327
flores247.com

Reimbursement for Orthodontia Expenses

Only proof of payment will be required for future claim submissions. Orthodontia will be reimbursable as you pay it, meaning that the payment can only be reimbursed from the plan year in which the payment was made. If you have any questions about reimbursement for orthodontia, you can call an account manager at **800.532.3327**.

The Difference Between an HSA and FSA

Health Savings Accounts (HSA) and Healthcare Flexible Spending Accounts (FSA) are both tax-advantaged accounts available through our benefits program. We created this chart below to illustrate the similarities and differences to help you pick which one is best for you:

	Health Savings Account (HSA)	Healthcare Flexible Spending Account (FSA)
Eligibility Requirements	You must be a full-time employee who works a minimum of 30 hours per week and is enrolled in the HSA plan.	You must be a full-time employee who works a minimum of 30 hours per week and is not enrolled in the HSA plan or any HSA. You do not have to be enrolled in a medical plan to contribute.
Eligible Expenses	Qualifying out-of-pocket healthcare expenses for you and your dependents include deductibles, copays, prescriptions, and glasses/contacts.	
Contribution Limits**	Contribute up to $4,300 for employee only coverage and up to $8,550 for family coverage in 2025. If you are age 55 or older, you may contribute an additional catch-up contribution of $1,000.	You may contribute up to $3,300 in 2025.
Changing Contributions	You can change how much you contribute to the account at any point during the year.	You can only change how much you contribute during annual enrollment or if you experience a Qualifying Life Event.
When Can Expenses be Incurred?	Expenses can be incurred any time after you have established your HSA and have started funding it.	Expenses can be incurred between January 1 and December 31 of the plan year.
Claim Deadlines	You can reimburse yourself any time for past medical expenses as long as the expense was incurred after your HSA was opened and you have funds in your HSA.	You have until March 31 to submit receipts for expenses incurred during the previous plan year.
Rollover	Unused balances roll over into the next year.	Up to $640 of unused funds can be rolled over into the next plan year. **You will forfeit any additional unused funds.**
Connection to Employer	You keep your HSA even if you change jobs or retire.	In most cases, you'll lose your FSA with a job change unless you are eligible for FSA continuation through COBRA.
Effect on Taxes	Contributions are tax-deductible, but can also be taken out of your pay pre-tax. Growth and distributions are tax-free.	Contributions are pre-tax and distributions are untaxed.
How Do I Pay for Expenses?	Use your account debit card to automatically pay for qualified expenses at the point of service. You may also submit claims for reimbursement.	
Usage	Balance can be used during the plan year or anytime in the future, including retirement.	Full balance is available upon start of plan year.
Vendor Information	Flores **800.532.3327** **www.flores247.com**	

Dental

Guardian Insurance

Electric Thermal Solutions has a preferred list of dentists with Guardian, see **www.guardianlife.com** to find a local dentist in the Guardian network. If you use these providers you will have "contract protection" that a dentist cannot charge you over reasonable and customary charges. If you do not use the network, the dental plan will continue to pay the scheduled amounts.

- **Diagnostic and Preventive Care** (Core Plan and High Plan) are services that are provided on a routine basis. These include oral exams and cleanings, dental x-rays, fluoride application and sealants for dependent children under the age of 15, space maintainers and basic emergency care of an acute condition.
- **Restorative Services** (Core Plan and High Plan) include medically necessary anesthesia, fillings, endodontic, gum and bone surgeries, simple extractions, biopsies and consultations by a specialist when referred by the attending dentist.
- **Major Restorative Services** (Core Plan and High Plan only) include crowns, bridgework, dental implants, dentures and repair of these items.
- **Orthodontic Services** (High Plan only) include orthodontic appliances (braces), active treatment including banding and subsequent retention treatment.

Dental Benefits	High Plan	Core Plan
Annual Deductible	$0	$0
Coverage A—Diagnostic and Preventive Services	100% of allowable charges	100% of allowable charges
Coverage B—Basic and Restorative Services	100% of allowable charges	100% of allowable charges
Coverage C—Major Dental Services	75% of allowable charges	50% of allowable charges
Coverage D—Orthodontics	50% of allowable charges	NONE
Benefit Maximum:		
Coverage's A, B, & C—EMPLOYEE	$2,000 annually	$2,000 annually
A & B Only		
Coverage's A, B & C—DEPENDENTS	$2,000 annually	$2,000 annually
A&B Only		
Coverage D	$2,000 lifetime maximum	N/A

Monthly Employee Cost

	Employee Only	EE+Sp	EE+ Child(ren)	Family
High Plan	$27.36	$52.67	$45.79	$68.24
Core Plan	$7.26	$12.44	$17.12	$25.52

Vision

EyeMed

EYEMEDVISIONCARE.COM—INSIGHT NETWORK

Benefits Highlights	In Network	Out-of-Network Reimbursement
Eye Exam—Glasses or Contact Lenses—Once Every 12 Months	$10 copay	$50
Lenses—Once Every 12 Months		
Single	$20 copay	$42
Bifocal		$78
Trifocal		$130
Lenses Treatment—Unlimited		
UV Coating	$15	
Tint	$15	
Standard Scratch Resistant Coating	$15	
Standard Polycarbonate (age 26+)	$40	
Standard Anti-Reflective Coating	$45	$36
Standard Progressive	$75	$140
Other Add-Ons and Services	20% off retail price	
Frames—Once Every 24 Months Up To $150 Retail Value	Covered in full; 20% off balance after $150	$120
Contact Lenses—Medically Necessary—Once Every 12 Months	Covered in full	$210
Contact Lenses—Conventional Elective— Once Every 12 Months In Lieu Of Lenses—Up To $150 Retail Value	Covered in full;15% off balance over $150	$150

Monthly Employee Cost

Single	$6.72
EE + Spouse	$12.77
EE + Child(ren)	$13.44
Full Family	$19.76

EYEMED MEMBERSHIP PERKS: PLUS PROVIDERS

This Plus Can Really Add Up

Your Inroads to Extra Benefits

It's the little extras that make life fun—the icing on the cake, the sauce on the steak, and of course, the cash you keep when you visit a PLUS Provider.

Choosing an in-network eye doctor already helps you save on annual exams, frames and other perks. But to save even more, visit a PLUS Provider. Getting more without paying more? Now, that's a benefit.

A Bigger Deal Is a Big Deal

Visit a PLUS Provider and you get access to a supersized set of benefits—for starters, try a $0 exam copay and more to spend on frames.* That's on top of everyday savings and other discounts from your EyeMed vision benefits.

* Frame allowance may vary by plan.

Look for the Plus Provider Mark

See exactly where you can boost your benefits on the Provider Locator at **eyemed.com**. With thousands of PLUS Providers across the country—retail, independent, and online—finding one nearby is a snap.

Simply Show Up and Save

All PLUS Provider perks are built right into your vision benefits—no promo codes, no coupons, no paperwork. Simple, streamlined, and stress-free.

Look for a PLUS Provider at eyemed.com (Insight Network)

YOUR PLUS PROVIDER BENEFITS

- $0 exam copay
- Extra cash to spend on frames

After Tax Choices

Guardian

Employer-Sponsored Life And Accidental Death & Dismemberment (AD&D) Insurance

	Hourly Employees	Salary Employees
Basic Life and AD&D Insurance	$25,000	2× base salary
Life and Accidental Death and Dismemberment (AD&D coverage)	$25,000	2× base salary
Life and AD&D Cost	Paid by Electric Thermal Solutions	Paid by Electric Thermal Solutions

- You will be taxed per pay period for the economic benefit of all life insurance amounts over $50,000 per Section 79 IRC

Designate a Beneficiary

You will need to designate a beneficiary for your life and AD&D coverage in the Employee Portal. If you choose, you may designate different beneficiary(ies) for each type of coverage (basic life and AD&D, supplemental life and AD&D). Your beneficiary for business travel accident insurance is the same as your beneficiary for your basic life insurance. You are the beneficiary for any dependent life insurance coverage you choose.

Evidence of Insurability (EOI)

Evidence of Insurability (EOI) is a statement of proof of your physical condition that you provide to the insurance company in certain situations as part of their acceptance of your insurance application. Generally, you will need to provide EOI if you are enrolling for supplemental life insurance coverage or dependent life insurance coverage after you first become eligible. Coverage is not effective until the EOI application has been approved.

If a new hire enrolls within their initial enrollment the premium should be deducted the first payday deductions are taken for the employee's enrollment. If they do not enroll for this coverage during their initial enrollment period, then they must be approved by the carrier to bind this coverage (EOI) before deductions are taken.

Additional Employee Life Insurance

- Increments of $10,000
- Minimum coverage is $10,000 and maximum coverage is up to $500,000.
- There is a guaranteed issue (GI) amount of $200,000 which means completion of medical questions is not required if you enroll within your initial enrollment (or subsequent open enrollments).
- This only applies to new coverage or coverage increases.
- An employee who already has additional life coverage can increase their volume by up to $50,000 without EOI during open enrollment as long as it remains at or below the GI amount
- Refer to the chart for the life only rates.
- Age based reductions when you are age 65 or older, your life insurance benefits will reduce to:
  - 65% of the life insurance benefit at age 65
  - 50% of the life insurance benefit at age 70
- Log into your **https://spiraxsarcobenefits.com/ETS/** account to enroll in this benefit.

Age Bands	Life only Rate per$1,000
Under Age 29	$0.06
30-34	$0.08
35-39	$0.10
40-44	$0.14
45-49	$0.21
50-54	$0.37
55-59	$0.63
60-64	$0.97
65-69	$1.86
70 and above	$3.02

Additional Spouse Life Insurance

- You can purchase Additional Spouse Life Insurance only if you purchase Additional Employee Life Insurance.
- You can select a minimum of $10,000 to $250,000 in $5,000 increments, not to exceed 100% of employee's amount.
- There is a guaranteed issue (GI) amount of $50,000 which means completion of medical questions is not required if your spouse enrolls within your initial enrollment (or subsequent open enrollments). This only applies to new coverage or coverage increases.
- Refer to the life only rate chart on page **35**. Spouse rate is based off the employee age bracket.
- Log into your **https://spiraxsarcobenefits.com/ETS/** account to enroll in this benefit.

Additional Child Life Insurance

- You may purchase a flat amount of $10,000 in Life Insurance only per dependent child.
- The cost is the same no matter how many children are to be insured on the plan.
- If you do not enroll for this coverage during your initial enrollment period or subsequent open enrollments, then you and/or your family will be required to answer health questions and be approved by the carrier to bind this coverage (EOI). Electric Thermal Solutions, Inc. will not deduct any premiums until you are approved by the carrier in this situation.
- Cost per Pay Period: $.78
- Log into your **https://spiraxsarcobenefits.com/ETS/** account to enroll in this benefit.

Disability

During paid STD leave, deductions for medical, dental, vision, and voluntary benefits will be made automatically. If the STD payment does not cover all benefit payments, the employee will be responsible for the difference. Existing employee and dependent medical, dental, vision, and life insurance will remain in force during the leave period as long as contributions are paid.

Group Health and Welfare Benefits are active for up to 13 weeks from the date the disability begins regardless of the length of the approved disability. After 13 weeks, the employee and eligible dependents may elect continuation of benefits under COBRA.

Continuation of Benefits

Electric Thermal Solutions offers salary continuation (income replacement) to full-time employees who are unable to work for more than 7 consecutive days due to a non-work-related illness or injury, or pregnancy. This short term disability (STD) benefit is not intended to cover absences less than 7 days. The first day an employee misses a scheduled workday is considered the first day of the 7-day waiting period. STD benefits are based upon base pay at the time of disability (excluding overtime and other pay). STD payments will be adjusted and integrated with other supplemental income (such as Social Security).

Benefit Payment

If recurrent periods of disability are due to the same or a related illness, injury, or pregnancy and are separated by less than a 12-month period, the eligible employee's time off is considered to be the same period of disability and is subject to the maximum term. The first day an employee misses a scheduled workday is considered the first day of the 7-day waiting period.

When an employee is receiving short term disability benefits, the employee will not be eligible to receive holiday pay; an employee will receive holiday pay when the return to work date is on a day in which a holiday occurs. An employee disabled and receiving short-term disability benefits will not be eligible to receive vacation pay. If an employee wishes to take vacation or PTO (if available), all hours should be scheduled prior to the commencement of short-term benefits. The employee is required to take an FMLA leave during a disability leave of absence, if applicable. Prior to returning to work, the Company requires that an employee present a medical certification of "fitness-to-return-to-work," as a condition to the restoration of employment.

If a period of disability is extended by a new cause while weekly benefits are payable, weekly benefits will continue subject to the following:

1. Weekly benefits will not continue beyond the end of the original maximum duration of benefits; and
2. The exclusions will apply to the new cause of disability.

Electric Thermal Solutions utilizes a third party administrator, Guardian, to provide Full Service Advice to Pay STD.

Medical Certification

The employee must provide medical certification of the disability that includes the starting and expected ending date of the disability. This certification must be submitted to the third-party administrator who provides full service advice on benefit qualification. The company reserves the right to request an examination, at the company's expense, by a physician of the company's choice.

Return to Work

Prior to returning to work, the Company requires that an employee submit a "fitness-to-return-to-work" clearance to Human Resources. In the event a change in Electric Thermal Solutions business circumstances requires a reduction in the workforce, the employee's status would be determined as if the employee had remained an active employee that was never on a leave of absence. Any disability caused or contributed to by an injury or illness in the course of employment covered by worker's compensation, occupational disease law, or similar legislation, is not covered under the provisions of the STD plan. Short term disability leave meeting the qualifying criteria will run concurrently with Family and Medical Leave. Both are administered through Guardian.

Qualifications (all must apply)
The employee has completed the mandatory seven (7) calendar days waiting period.
Actively at work at least 30 hours each week. At work will include regularly scheduled days off, holidays, or vacation days, so long as the employee is capable of active work on those days.
Employee is under the regular care of a physician.
The employee has provided Proof of Loss satisfactory to the Third Party Administrator, Mutual of Omaha Absence Pro.

	Hourly	Salary
Short Term Disability (STD)	Immediate eligibility 100% of base wages for up to 13 weeks	Immediate eligibility 100% of base salary for up to 26 weeks
Maximum Number of Weeks	13	26
Cost	Paid by Electric Thermal Solutions	Paid by Electric Thermal Solutions
Coverage	100%	100%
Details	The STD benefit may be paid for a maximum of 12 weeks per calendar year following a 7-day waiting period. The company will compensate the employee for the 7-day waiting period upon approval for disability.	The STD benefit may be paid for a maximum of 25 weeks per calendar year following a 7-day waiting period. The company will compensate the employee for the 7-day waiting period upon approval for disability.
Long Term Disability (LTD)	Not applicable	LTD coverage is offered to all salary employees in the amount of 60% of their January 1 base annual earnings to a maximum of $10,000 per month after 90 days of service. This amount may be offset by other Supplemental Income Benefits, such as Social Security. LTD insurance pays a benefit after an employee has been absent from work due to a non-work-related injury or illness for more than 26 consecutive weeks, and was eligible for 26 weeks of STD.
LTD Cost	Not applicable	Paid by Electric Thermal Solutions

Family Medical Leave

Family medical leave is administered by Guardian on behalf of the company. Employee FMLA requests will be approved and administered by Guardian to protect your benefits and ensure that qualified claims are filed.

FMLA provides up to 12 weeks of unpaid, job protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for Electric Thermal Solutions for at least one year and for 1,250 hours over the previous 12 months.

Reasons for Leave Under The FMLA

Unpaid leave may be granted for any of the following reasons:

- To care for your child after birth, or placement for adoption or foster care;
- To care for your spouse, son, daughter, or parent who has a serious health condition;
- For a serious health condition that makes you unable to perform your job
- Leave for "Qualifying Exigency"—would cover an employee or an employee's spouse, child or parent, who has received a call to support a qualifying Military operation
- Leave to care for an injured service member: the spouse, child, parent, or "next of kin" (defined as the "nearest blood relative") of a covered service member is entitled to leave, to care for the covered service member

Job Benefits and Protection

- For the duration of FMLA leave, Electric Thermal Solutions must maintain your health coverage under any "group health plan" on the same terms as if the employee had continued to work.
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

How Do I Request Leave Under the FMLA?

Contact Guardian by calling **888.889.2953** or log on to **https://g00056068.glicleavepro.com**

- Your information will be verified by a Benefit Specialist who will initiate the family medical leave process and answer any questions you may have.
- You will be notified of the status of your FMLA claim once it has been processed.
- Contact your Supervisor or Human Resources to report your absence according to site time off request guidelines. (See Employee Handbook).

Advance Notice and Medication Certification

You may be required to provide advance leave notice and medical certification. Taking leave may be denied if requirements are not met:

- Generally you must provide 30 days advance notice when the leave is foreseeable.
- Electric Thermal Solutions may require medical certification to support a request for leave due to a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness-for-duty report to return to work.

888.889.2953

https://g00056068.glicleavepro.com

Additional Voluntary Benefits

Guardian

Voluntary Accidental Death and Dismemberment Insurance (AD&D)

Voluntary Accidental Death and Dismemberment Insurance is available for you alone or for you and your eligible dependents under the Family Plan. If selected, the Plan provides additional worldwide protection 24 hours per day and 365 days per year against losses from covered accidents on or off the job whether on business, on vacation or at home.

Voluntary Accidental Death & Dismemberment (AD&D)

SINGLE PLAN	FAMILY PLAN
Specified increments of $10,000 up to a maximum of $500,000 not to exceed 5 times your (employee) annual compensation*	▶ You can select a minimum of $10,000 to $250,000 in $5,000 increments ▶ Child—$10,000

Annual compensation means an Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as commissions, bonuses and overtime pay, but not any other extra compensation. Commissions, bonuses and overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Log into your **https://spiraxsarcobenefits.com/ETS/** account to enroll in this benefit.

	Rates per $1,000
Employee	$0.02
Spouse	$0.02
Child(ren)	$0.02

Critical Illness

Guardian

With Critical Illness Insurance, you also get access to health care support services. You can talk with medical and claims experts about your medical coverage, benefits, diagnosis, and treatment options.

Helps Protect Your Finances From An Illness

When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

Helps Cover Related Expenses

While health plans may cover direct costs associated with a critical illness, you can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and copays.

Pays A Cash Benefit Directly to You

Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have. What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

Benefits (you can purchase this coverage at a group rate)	
For You	You can choose between **$10,000** and **$30,000** of coverage, in increments of $10,000. No medical questions asked.
For Your Spouse	If you elect coverage for yourself, you can choose between **$10,000** and **$30,000** of coverage, in increments of $10,000. No medical questions asked. Not to exceed 100% of employee coverage amount.
For Your Child(Ren)	If you elect coverage for yourself, your child is automatically covered at no additional cost at 50% of your elected amount.

What's Covered

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is the full list of conditions.

Covered conditions—The plan pays 100% of the benefit amount unless stated otherwise.		
Core conditions	Heart Attack R Stroke R—moderate 50% Stroke R—severe 100% Major Organ Failure (Heart, Liver, Pancreas, Lungs) R Coronary Artery Disease R—10% Coronary Artery	Disease w/Bypass R—50% Pacemaker R—10% Transient Ischemic Attack (TIA) R—10% Pulmonary Embolism R—30% Aneurysm R—10% Kidney Failure R
Cancer conditions	Invasive Cancer R Non-Invasive Cancer R—30% Skin Cancer—$250 BRCA1 or BRCA2	Mutation—30% Bone Marrow Failure R Benign Brain or Spinal Cord Tumor R
Other conditions	Addison's disease 30% Coma Loss of Hearing, Sight or Speech Permanent Paralysis Severe Burns Alzheimer's disease—early Stage 50% Alzheimer's disease—advanced Stage 100% ALS (Lou Gehrig's) Dementia—other causes 100% Huntington's disease 30%	Multiple Sclerosis (MS)—early Stage 50% Multiple Sclerosis (MS)—advanced Stage 100% Myasthenia Gravis 30% Parkinson's disease—early Stage 50% Parkinson's disease—advanced Stage 100% Crohn's disease 30% Epilepsy 10% Lupus 30% Ulcerative Colitis 30%
Childhood conditions applies to dependent children only	Autism Spectrum Disorder Cerebral Palsy Cleft Lip or Cleft Palate Clubfoot Congenital Heart Defect Cystic Fibrosis	Type 1 Diabetes Down Syndrome Hemophilia Multisystem Inflammatory Syndrome (MIS) Muscular Dystrophy Spina Bifida
Wellness screening benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

R = Recurrence Benefit available

Frequently Asked Questions

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 6 consecutive months treatment-free, have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table on the previous page are eligible for the recurrence benefit. Once a recurrence benefit has been paid, no additional benefit will be paid for that critical illness.

Do I need to answer any health questions to enroll?

You do not need to answer any health questions to enroll in Critical Illness Insurance, all policies are guarantee-issue with no health questions. If you do not elect coverage during this open enrollment, you can elect coverage during a qualifying life event or future annual enrollment with no health questions asked.

How do I file a critical illness claim?

If you have a diagnosis after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about your medical condition.

How do I get the Wellness Screening Benefit?

You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can also be downloaded from our website.

Can I receive benefits for more than one critical illness?

Yes. If you have two qualifying critical illness diagnoses, you will be paid for both. There is not a waiting period between diagnoses. You can only claim benefits once for each covered condition unless a recurrence benefit is payable.

Contributions are made with post-tax dollars so the benefit amount payable to you is not taxed.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your options.

Rates

Rates are effective as of January 1, 2025. The charts below shows possible coverage amounts and their monthly costs. Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Critical Illness

MONTHLY EMPLOYEE AMOUNT

Age	$10,000	$20,000	$30,000
<30	$4.10	$8.20	$12.30
30-39	$6.60	$13.20	$19.80
40-49	$13.00	$26.00	$39.00
50-59	$25.70	$51.40	$77.10
60-69	$43.60	$87.20	$130.80
70+	$73.40	$146.80	$220.20

MONTHLY SPOUSE AMOUNT

Age	$10,000	$20,000	$30,000
<30	$4.10	$8.20	$12.30
30-39	$6.60	$13.20	$19.80
40-49	$13.00	$26.00	$39.00
50-59	$25.70	$51.40	$77.10
60-69	$43.60	$87.20	$130.80
70+	$73.40	$146.80	$220.20

CHILD(REN)

Child(ren) will be offered 50% of the Employee's elected coverage amount automatically at no additional charge.

Critical Illness Fast Fact

Most heart attack victims are middle-aged or older; the risk of a heart attack climbs for men after age 45 and for women after age 55.

Accident Insurance

Guardian

Injuries occurring off the job can be protected with Guardian Accident Insurance. This plan is designed to pay cash directly to you, the employee. This additional cash support can be used to help pay any out-of-pocket expenses related to the injury. Payments are made tax free, to be used at your direction.

Wellness Benefit: $50 per insured Employee or Covered Dependent per year for completing routine wellness screenings.

Some Covered Benefits	Benefit Amount
Hospital Admission	$1,500
Daily Hospital Confinement (up to 365 days)	$300
Daily ICU Confinement (up to 15 days)	$600
Burns	up to $12,000
Ambulance (Ground/Air)	$200/$1,000
Torn Knee Cartilage	$500

Example: Broken Ankle	Benefit Amount
Emergency Room with X-Ray	$340
Broken Ankle, Closed Reduction (no surgery)	$2,000
Physical Therapy (10 sessions)	$350
Physician Follow-Up (per visit)	$50
Total Dollars Payable to Employee	**$2,740**

Accident Plan	Monthly Rates
Employee	$12.59
Employee + Spouse	$20.90
Employee + Child(ren)	$20.97
Family	$29.28

Hospital Indemnity Insurance

Guardian

Hospital Indemnity insurance with Guardian is designed to provide financial assistance for an event that results in a hospital confinement, to supplement your current coverage. Employees can use the benefit shown below, to meet any out-of-pocket expenses and extra bills that can occur. Benefits are paid directly to you, regardless of the actual cost of treatment. Below is an example of how a trip to the Hospital for childbirth would payout.

Covered Benefits	Benefit Amount
Hospital Admission Benefit (max 2 admissions combined with ICU)	$1,000
ICU Admission Benefit (paid if admitted directly to ICU)	$2,000
Daily Hospital Confinement (up to 30 days per year)	$200
Daily ICU Confinement (up to 30 days per year)	$400

Example: Childbirth with a 3 day stay	Benefit Amount
Hospital Admission Benefit	$1,000
Daily Hospital Confinement (starting day 2)	$200
Total Benefit Amount	**$1,400**

Hospital Indemnity Plan	Monthly Rates
Employee	$18.09
Employee + Spouse	$39.16
Employee + Child(ren)	$30.49
Employee + Family	$51.55

Global Employee Assistance Program (EAP)

The new group-wide EAP is available to every employee and their dependents around the world, in their local language and includes the services below:

- 24-hour counseling
- Legal and financial support
- 6 face-to-face (or virtual) counseling sessions
- Critical incident advice
- Online resources
- Management support

Follow the steps below to access EAP services directly through the website:

1. Go to **https://www.guidanceresources.com/**
2. Register using the organization Web ID: HealthAssuredEAP
3. Click on the flag or globe icon on the top right corner
4. Choose your country
5. Choose the service you require—you will be provided with a local number to call

Employee Hotline—Safecall

Safecall Is Your Personal 24-Hour Incident Reporting System

As an organization, we are committed to reducing fraud and unethical practices in the workplace and making it a safe and inclusive place to work, a commitment that is underpinned by our internal policies, procedures, and Code of Conduct already available to you. Failure to comply can have serious implications for our business and its reputation. We encourage you to raise any concerns you may have about potentially unethical conduct or illegal activity by:

- Reporting them to your line manager or
- Speaking to a senior manager or
- Calling Safecall

Safecall should be used when you do not wish to communicate directly with someone within the company. Safecall provides an independent, external reporting line where you can raise your concerns and be assured they will be fully addressed.

Each call is treated in complete confidence by trained Safecall staff who will summarize the content of the call and forward a confidential report for review and proper handling. Safecall will not disclose your name to anyone else if you wish to remain anonymous.

Independent Confidential Reporting Regarding:

- Accounting irregularities
- Theft
- Substance abuse
- Fraud
- Bribery and corruption
- Unethical conduct
- Industrial accidents
- Unfair labor practices
- Harassment
- Discrimination
- Anti-competitive behavior
- Environmental concerns
- Health and safety
- Price fixing
- Mistreatment
- And more!

You can contact Safecall at anytime and ask to speak to someone in your preferred language (over 40 are covered).

Ethics and Compliance Hotline

- Anonymous
- Confidential
- Easy to use
- Fast
- Always accessible
- Free

We're committed to helping you enjoy a safe, healthy, and friendly work environment. Use Safecall to report things that concern you and be heard. Let us know how you feel.

Confidential 24/7 Access!

www.safecall.co.uk/reports
866.901.3295

Making Changes to Your Benefits During the Year

The IRS requires elections made during the Annual Enrollment Period to be effective for the upcoming plan year January 1 through December 31. You may not change your benefit election after the annual enrollment period unless you experience a Qualifying Life Event.

You must update the portal within 30 days of your Qualifying Life Event and provide all required documentation. If you fail to update the portal with your Qualifying Life Event and do not provide documentation, you must wait until the next Annual Enrollment period to change your benefit elections.

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 30 days after the marriage, birth, adoption, or placement for adoption.

Type of Family Status Change	Required Documentation
	(In addition to one of the documents below you must provide the proper proof of spouse or dependent status from the list on the previous page, if applicable.)
Add or Lose Other Coverage Through Another Employer-Sponsored Plan	▶ Copy of employer letter with an effective date and the name of the dependent(s) who gained or lost coverage, or ▶ Copy of insurance letter with an effective date and the name of the dependent(s) who gained/lost coverage, or ▶ Copy of HIPAA Certificate of Creditable Coverage with the effective date and the name of dependent(s) who lost coverage, or ▶ Copy of insurance ID card with the effective date and the name of the dependent(s) who gained coverage
Add or Lose an Eligible Dependent Birth, Adoption, Placement of Adoption or Death of Spouse or Child	▶ Copy of birth certificate showing you as a parent, or ▶ Copy of adoption agreement, or ▶ Copy of court custody or guardianship documents, or ▶ Copy of the portion of the divorce degree showing the dependent, or ▶ Copy of Qualified Medical Court Support Order (QMCSO), or ▶ Copy of death certificate (if applicable)
Qualified Medical Child Support Order (for a dependent child)	▶ Copy of Qualified Medical Child Support Order (QMCSO)
Marriage, Divorce, Legal Separation or Annulment	▶ Copy of the legal documents with effective dates and name of dependent

401(k) Retirement

Employees are automatically enrolled in the 401(k) Retirement Plan in the first payroll following one month of service. The default deferral is 6% of your regular earnings. All new hires and employees have the option to "opt out" of the 401(k) at any time.

Vesting

Vesting refers to your "ownership" of your account. You are always 100% vested in your contributions (including any rollover/transfer contributions you have made to the Plan), plus any earnings generated on those contributions.

Save More Automatically With Auto Increase

Electric Thermal Solutions is ready to help you build your retirement nest egg more quickly with an automatic yearly increase of 1% effective January 1st of every year.

You can opt of this at any point by logging into Fidelity's NetBenefits at **www.netbenefits.com**.

That's All There Is to It!

The best part is that you'll barely notice a difference in your take-home pay, but you'll see a big difference in the amount you save for retirement over the long run. Of course, you can choose to adjust or stop your contributions at any time.

Consider rolling over prior retirement accounts to Fidelity Investments to streamline your savings and simplify your life.

Summary Plan Description

The above highlights represent only a brief overview of the Plan's features and do not constitute a legally binding document. Please refer to the Summary Plan Description for more information about the specific Plan provisions.

Your Contributions to the Plan

- You may choose to make the following contributions from 1% to 80% of your eligible pay.
  - Before tax contributions.
  - Roth after-tax contributions.
- An IRS dollar limit for 2025 (adjusted annually for inflation) also applies.
- You may elect to make a catch-up contribution, as long as you are age 50 or older by the end of the calendar year.
- Contributions cannot be determined to be catch-up contributions until the participant's regular pre-tax salary deferral contributions exceed an applicable limit under the plan. (These limits could include the 402(g) limit, the 415 limit, plan limits, or limits that apply to highly compensated employees as a result of the 401(k) ADP test or plan specific provisions).
- If you have an existing retirement plan account with a prior employer, you may transfer or roll over the account into the plan.
- You may stop your contributions at any time.
- You may increase or decrease the amount of your contributions at any time.

Employer Contributions

ETS is pleased to provide a competitive plan that includes a fixed contribution to your 401(k) calculated on your base salary **AND** a matching contribution of 50% of your first 6% of deferred pay (max 3% Company match).

Easy Access to Your Retirement Account

Your plan website is the first step for anything you want to know about your account. Use it to sign in to your account, find information about your retirement plan benefits, and learn more about saving for your future. Once you have signed in, you can review the current status of your account, make changes, and access tools to help you personalize your retirement strategy.

www.netbenefits.com

Set goals, track your progress and take control of your 401(k):

- Manage your overall finances
- Plan for expected and unexpected life events
- Get answers to our financial questions
- Change your contributions and investments

Get Loan Details

Loans from your vested account balance shall be made available to all qualifying participants on a reasonably equivalent basis. For further information please contact Fidelity Investments at **800.294.4015**.

CAPTRUST Financial Wellness and Participant Advice Services

CAPTRUST is an independent investment advisory firm that provides investment advice to the Spirax Sarco retirement plan and participants. CAPTRUST offers advice and financial planning services, while Fidelity remains the plan recordkeeper. CAPTRUST serves employees as a resource providing financial wellness, savings, and guidance. You may call CAPTRUST at **800.967.9948** to speak to a counselor, who will assist you with your investment questions and other financial inquiries you may have. CAPTRUST also provides a Retirement Blueprint financial plan to assist with your long-term financial needs. Counselors are available Monday to Thursday, 8:30 a.m. to 5:30 p.m., Friday 8:30 a.m. to 4 p.m. ET, or you can make an appointment online via **www.captrustatwork.com**.

Contact Information

Navigating through insurance options, medical plans and preferred networks can be confusing and overwhelming. Below are some helpful websites to make this process easier for you. The benefit website gives you access 24 hours a day to information about your benefits, from work or from home. It also makes it easy for you to obtain frequently used forms so you can keep your benefits information up to date. Take a minute to explore the website at the following address and see how it can make it easier for you to manage your benefits. Review benefit coverage, forms and Summary Plan Documents (SPDs) at: **https://spiraxsarcobenefits.com/ETS/**.

Please contact your local HR office if you need any assistance.

MEDICAL AND PRESCRIPTIONS

Blue Cross Blue Shield
800.922.1185
www.southcarolinablues.com

BlueCare on Demand
www.bluecareondemandsc.com/landing.htm

OptumRx Home Delivery
855.811.2218

HEALTH SAVINGS ACCOUNT (HSA)

Flores
800.532.3327
www.flores247.com

FLEXIBLE SPENDING ACCOUNT (FSA)

Flores
800.532.3327
www.flores247.com

DENTAL

Guardian
800.627.4200
www.guardianlife.com

VISION

EyeMed
www.eyemedvisioncare.com

LIFE AND AD&D, LONG TERM DISABILITY

Guardian
800.627.4200
www.guardianlife.com

FMLA/SHORT-TERM DISABILITY

Guardian
888.889.2953
www.guardiananytime.com

CRITICAL ILLNESS

Guardian
800.627.4200
www.guardianlife.com

HOSPITAL INDEMNITY

Guardian
800.627.4200
www.guardianlife.com

ACCIDENT

Guardian
800.627.4200
www.guardianlife.com

GLOBAL EAP

ComPsych
https://www.guidanceresources.com/
Register using the organization Web ID: HealthAssuredEAP

401(K)

Fidelity
800.294.4015
www.netbenefits.com

SAFECALL EMPLOYEE

HOTLINE
866.901.3295
www.safecall.co.uk/reports

Electric Thermal Solutions

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Electric Thermal Solutions About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM ELECTIRC THERMAL SOLUTIONS 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 Electric Thermal Solutions and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Electric Thermal Solutions has determined that the prescription drug coverage offered by the Electric Thermal Solutions Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Electric Thermal Solutions Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Electric Thermal Solutions Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Electric Thermal Solutions Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Electric Thermal Solutions prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 862-777-4449. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Electric Thermal Solutions changes. You also may request a copy.

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.

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 whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Plan Administrator
Contact—Position/Office:	Human Resources
Address:	103 Gamma Drive Pittsburgh, PA 15238

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

ELECTIRC THERMAL SOLUTIONS
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

These plans comprise what is called an "Affiliated Covered Entity," and are treated as a single plan for purposes of this notice and the privacy rules that require it. For purposes of this notice, we will refer to these plans as a single "Plan."

For the remainder of this notice, Electric Thermal Solutions is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its

representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to

the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right

to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

The Plan's Deputy Privacy Official(s) is/are:

Plan Administrator

Organized Health Care Arrangement Designation
The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.
The members of the Organized Health Care Arrangement are:

Effective Date
The effective date of this notice is: January 1, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

ELECTIRC THERMAL SOLUTIONS EMPLOYEE HEALTH CARE PLAN

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *60 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 *60 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Plan Administrator

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- 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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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**.

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

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Plan Administrator
103 Gamma Drive
Pittsburgh, PA 15238
412-967-3800

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

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Electric Thermal Solutions Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The Electric Thermal Solutions Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

PPO Plan	In-Network	Out-of-Network
Individual Deductible	$1,500	$1,500
Family Deductible	$3,000	$3,000
Coinsurance	20%	40%
HDHP 1650	In-Network	Out-of-Network
Individual Deductible	$1,650	$4,000
Family Deductible	$3,300	$8,000
Coinsurance	20%	40%

HDHP 2500	In-Network	Out-of-Network
Individual Deductible	$2,500	$5,000
Family Deductible	$5,000	$10,000
Coinsurance	0%	0%

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator.

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Plan Administrator.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Electric Thermal Solutions Wellness Program is a voluntary wellness program available to All employees regardless of enrollment. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Wellness Guide.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting at the plan administrator.

The information from the Biometric Screening and the Health Risk Assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Electric Thermal Solutions may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse and a doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator if you have questions or concerns regarding this notice, or about protections against discrimination and retaliation.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Electric Thermal Solutions. Wellness Program is a voluntary wellness program available to All employees regardless of enrollment. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Wellness Guide.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting at or .

The information from the Biometric Screening and the Health Risk Assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as . You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Electric Thermal Solutions. may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse and a doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother 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 newborns' 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

FEDERAL EARNED INCOME TAX CREDIT (EITC) NOTIFICATION

You may be eligible to receive the earned income tax credit from the federal government. The earned income tax credit is a refundable federal income tax credit for low-income working individuals and families. The earned income tax credit has no effect on certain welfare benefits. In most cases, earned income tax credit payments will not be used to determine eligibility for Medicaid, supplemental security income, food stamps, low-income housing or most temporary assistance for needy families payments. Even if you do not owe federal taxes, you must file a tax return to receive the earned income tax credit. Be sure to fill out the earned income tax credit form in the federal income tax return booklet. For information regarding your eligibility to receive the earned income tax credit, including information on how to obtain the IRS Notice 797, or any other necessary forms and instructions, contact the Internal Revenue Service.

INVITATION TO SELF-IDENTIFY DISABILITY STATUS

Per section 503 of IRS regulations regarding self-identification of disability status, we invite you to update your disability status at any time should your circumstances change. To do this please complete the Self-identify Disability Form located on the employee portal under the Forms Library and return to HR. Completion of this form is voluntary.

HEALTHCARE REFORM EXCHANGE NOTICE

Health Insurance Marketplace Coverage Options And Your Health Coverage

Part A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the 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, 2024 for coverage starting January 1, 2025.

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. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. 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.

What If I'm Losing Job-Based Insurance?

If you lose your job-based health insurance, you have two primary options for health insurance:

- Get an individual Marketplace plan. If you leave your job for any reason and lose your job-based coverage, you can choose to buy coverage from the Marketplace. This is true even if you leave your job outside the Marketplace open enrollment period beginning November 1st. By using the Marketplace, you'll learn whether you qualify for lower costs on your monthly premiums on private insurance or if you will qualify for lower out-of-pocket costs. Through the Marketplace you'll also learn whether you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).
- Get COBRA coverage. You may be able to keep your job-based plan through COBRA continuation coverage. COBRA is a federal law that may let you pay to keep yourself and your family on your employee health insurance for a limited time (usually 18 months) after your employment ends or you otherwise lose coverage. It is important
to note that not all health plan participants are entitled to COBRA coverage when they lose coverage. If you are eligible for COBRA and you buy COBRA continuation coverage, you won't be able to get any of the lower costs on premiums and out-of-pocket costs that people may get using the Marketplace. You'd also have to pay the full monthly premium, including any part of the premium that your employer had contributed.

If I Sign Up For Cobra Continuation Coverage, Can I Switch To Coverage In The Marketplace? What About If I Choose Marketplace Coverage And Want To Switch Back To Cobra Continuation Coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can terminate your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

How Can I Get More Information?

For more information about your coverage offered by your employer, please contact your Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. You can also call 1-800-318-2596 (TTY: 1-855-889-4325) 24 hours a day, 7 days a week.

Note: An employer-sponsored 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.

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

This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.

[Rev 10/17/24] CHROM 25BG 3806856.pdf