PROFESSIONAL PLASTICS

NON-CA EMPLOYEES

EMPLOYEE BENEFITS

Plans are effective January 1, 2026 through December 31, 2026

Benefits Website
professionalplastics.benefitsmap.com

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A HEALTHY YEAR STARTS HERE!

Making decisions about you and your family's health isn't always easy. But choosing your benefits can be simplified with this helpful guide to your 2026 healthcare options. Simply review the enclosed information and choose from the flexible benefit options that provide the right balance of cost and features for you and your family.

DON'T FORGET

In order to receive benefits, all eligible employees must satisfy the required waiting period, lasting until the first of the month after 60 days from your date of hire. Your Enrollment period is your one opportunity to review and/or elect the benefits you would like to participate in for the 2026 plan year, unless you experience a qualifying life event (i.e. birth, marriage, adoption, divorce). If any of these changes occur, it is your responsibility to alert Human Resources to make changes within 30 days of the date of the qualifying event.

Please review this guide and all materials provided carefully as you consider your benefit needs.

If you (and/or your dependents) have Medicare, or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. See page 13 for more details.

LETTER FROM DAVE KIETZKE & MARK CASEY

Professional Plastics Family,

Welcome to the 2026 Employee Benefits Enrollment Guide! As we begin our annual enrollment period, we want to take a moment to thank you for your continued dedication and commitment. Our people are our greatest strength, and investing in your health, well-being, and financial security remains a top priority.

We work hard to offer a benefits package that reflects the diverse needs of our team—one that not only supports you today, but also helps you plan confidently for the future. In this booklet, you'll find important information about your options, updates for the coming year, and resources to help you make informed decisions.

While there are no significant changes to the plan options, you may notice that the cost of some benefits has increased slightly this year. This is due to unavoidable renewal costs and market conditions. While we are not immune to these trends, we do our best to manage costs without compromising quality or reducing coverage.

Continuing our benefits through Anthem Blue Cross for the fourth consecutive year provides Team ProPlas with the best comprehensive choices while maintaining access to the doctors, specialists, and support services you already know and trust. It also means less disruption, fewer administrative changes, and more time focused on what matters: your care and peace of mind.

We encourage you to take the time to review your choices carefully, ask questions, and select the options that best fit your personal and family needs. In addition to medical, dental and vision coverage, there are a lot of supplemental elections included in this booklet for your consideration.

Thank you for everything you do. Here's to a healthy, successful year ahead—together.

Dave Kietzke
CEO & Chairman of the Board

Mark Casey
President – North America

2026 BENEFIT UPDATES

Medical Coverage - We are pleased to continue our partnership with Anthem Blue Cross as our Medical insurance carrier. Our plan options from last year will remain in place. See page 4 for an overview of the Medical plan.

Dental Coverage - We are continuing our partnership with Anthem Blue Cross with no plan changes from last year. See page 5 for an overview of the Dental plan.

Vision Coverage - We are continuing our partnership with Anthem Blue Cross with no plan changes from last year. See page 6 for an overview of the Vision plan.

Life and AD&D - We are continuing our partnership with Anthem Blue Cross/The Standard with no plan changes from last year. See page 7 for an overview of the Life and AD&D plan.

Flexible Spending Accounts (FSAs) - We will continue to offer our FSA plan options which allow you to set aside a portion of your earnings, before taxes, to pay for qualified medical or dependent care expenses. See page 8 for an overview of the FSA plan.

Disability - We are continuing our partnership with Anthem Blue Cross/The Standard with no plan changes from last year. See page 9 for an overview of the Disability plans.

Employee Assistance Program (EAP) - We will offer an EAP through Anthem Blue Cross with no plan changes from last year. See page 7 for an overview of the EAP plan.

Voluntary Worksite Plans - We are continuing our partnership with Anthem Blue Cross to offer Voluntary Accident, Critical Illness and Hospital Indemnity Insurance for extra protection.

Norton ID Theft - We are continuing our partnership with Norton ID Theft to give you all-in-one protection for your identity and devices. This program helps safeguard your personal information.

Pet Care Discount - We are continuing our partnership with United Pet Care. This program provides immediate savings on everything from check-ups to treatments for your pets.

MetLife Legal - We are continuing our partnership with MetLife. This program will provide access to help for a wide range of legal matters in your life.

Personify Health - We are continuing our wellness program with Personify Health to help make healthy choices, be well together, and inspire all of us to live better every day.

MEDICAL PLAN OPTIONS

	Anthem Prudent Buyer EPO	Anthem Solution PPO	
FEATURES	**In-Network (ONLY)**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$1,250 Individual $2,500 Family	$3,000 Individual $6,000 Family	
Physician Office Visits	$35 PCP / $50 Specialist	$30 PCP / $30 Specialist	50% after deductible
Preventive Care	No copay	No copay	50% after deductible
Inpatient Hospitalization	30% after deductible	$100 + 20% after deductible	$100 + 50% after deductible
Outpatient Hospitalization	30% after deductible	20% after deductible	50% after deductible
Emergency Room Visit	$150 copay + 30% after deductible	$100 copay + 20% after deductible	
Urgent Care	$50 copay	$30 copay	50% after deductible
Prescription Drugs Rx Deductible:	None	None	None
Tier 1: Generic **Tier 2: Brand** **Tier 3: Non-Formulary** **Tier 4: Specialty**	$10 / $30 copay $30 copay $60 copay 30% up to $250	$10 copay $35 copay $75 copay 30% up to $250	**Tiers 1-3:** in-network copay **Tier 4:** not covered
Out-of-Pocket Maximum (includes deductible)	$6,350 Individual / $12,700 Family (includes deductible)	$6,350 Individual / $12,700 Family (includes deductible)	$13,000 Individual / $26,000 Family (includes deductible)

Please refer to your carrier Summary(ies) of Benefits and Coverage (SBCs) for more detailed benefit information. Plan documents will govern.

ANTHEM: FINDING A MEDICAL PROVIDER

1. Go to www.anthem.com/ca/find-care/
2. Click on “Basic search as a guest”
3. Under “Select the type of plan or network”, select “Medical Plan or Network”
4. Under “Select the state where the plan or network is offered”, select “California”
5. Under “Select how you get health insurance”, select “Medical (Employer-Sponsored)”
6. Select a plan or network:
   - “National PPO (BlueCard PPO)” for the Anthem Prudent Buyer EPO Plan
   - “National PPO (BlueCard PPO)” for the Anthem Solutions PPO Plan

ANTHEM: FINDING A DENTAL PROVIDER

1. Go to www.anthem.com/ca/find-care/
2. Click on “Basic search as a guest”
3. Under “Select the type of plan or network”, select “Dental Plan or Network”
4. Under “Select the state where the plan or network is offered”, select “California”
5. Under “Select how you get health insurance”, select “Dental”
6. Select a plan or network:
   - “Dental Complete” for the Anthem Dental PPO Plan

DENTAL PLAN OPTIONS

	Anthem Low PPO		Anthem High PPO	
FEATURES	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Maximum	$1,000		$1,500	
Calendar Year Deductible Waived for Preventive?	$50/$150 Yes	$100/$300 No	$50/$150 Yes	$50/$150 Yes
Office Visit	N/A	N/A	N/A	N/A
Preventive & Diagnostic - (Oral exams, Cleanings, X-rays)	20% deductible waived	30% after deductible	No charge deductible waived	20% deductible waived
Basic - (Fillings, Oral surgery)	20% after deductible	40% after deductible	20% after deductible	20% after deductible
Major - (Crowns, Dentures)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Endodontics - (Root canals)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Periodontics - (Gingivectomy, per tooth, per quadrant)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontics	Not covered		Not covered	

VISION PLAN

	Anthem Vision Plan	
	In-Network (Blue View Vision)	**Out-of-Network Reimbursement**
Exams - Every 12 months	$10 copay	Up to $42 allowance
Lenses - Every 12 months		
Single Lenses	$25 copay	Up to $40 allowance
Bifocals	$25 copay	Up to $60 allowance
Trifocals	$25 copay	Up to $80 allowance
Frames - Every 24 months	$130 allowance + 20% off balance	Up to $45 allowance
Contacts (in lieu of glasses) - Every 12 months		
Contacts - Medically Necessary	No charge after lenses copay	Up to $210 allowance
Contacts - Elective (disposable)	$130 materials allowance	Up to $105 allowance

ANTHEM: FINDING A VISION PROVIDER

1. Go to www.anthem.com/ca/find-care/
2. Click on “Basic search as a guest”
3. Under “Select the type of plan or network”, select “Vision Plan or Network”
4. Under “Select the state where the plan or network is offered”, select “California”
5. Under “Select how you get health insurance”, select “Vision”
6. Select a plan or network:
   - “Blue View Vision” for the Anthem Blue View Vision Plan

LIFE AND AD&D INSURANCE

Basic Life and AD&D Insurance

You are automatically eligible for Basic Life and Accidental Death & Dismemberment (AD&D) insurance benefits in the amount of $25,000. This benefit is paid in full by Professional Plastics. The coverage amount decreases to 65% at age 65, and 50% at age 70.

Voluntary Life Insurance

You can elect to purchase additional Voluntary Life insurance for yourself, your spouse and dependent children. Rates for employees and spouses are based on the amount of coverage and age. The coverage amount decreases to 65% at age 65 and 50% at age 70. You can elect to purchase coverage:

- For you in $10,000 increments up to $200,000 or 5x annual earnings (whichever is less). Guaranteed issue amount of $100,000.
- For your spouse in $5,000 increments not exceeding 50% of the employee benefit to a maximum of $100,000. Spouse guaranteed issue amount of $10,000.
- For your children in increments of $2,000, not exceeding 50% of the employee benefit to a maximum of $10,000. Guaranteed issue amount of $10,000.

	Voluntary Life Monthly Premium	
Age	**Employee Cost per $1,000**	**Spouse Cost per $1,000**
Under 30	$0.07	$0.07
30-34	$0.08	$0.08
35-39	$0.10	$0.10
40-44	$0.16	$0.16
45-49	$0.25	$0.25
50-54	$0.39	$0.39
55-59	$0.67	$0.67
60-64	$1.09	$1.09
65+	$1.75	$1.75
Child(ren) Voluntary Life	$0.16 per $1,000	

PREMIUM CALCULATION EXAMPLE

For a 40-year-old employee, the monthly cost for $100,000 of coverage would be $16.00 a month ($100,000 x $0.16/1,000). The cost of your coverage will be divided equally among pay periods and deducted from your paycheck.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Professional Plastics is pleased to offer all benefit-eligible employees the chance to participate in Flexible Spending Accounts (FSAs) through IGOE.

FSAs allow employees to make certain purchases, such as medical or dental expenses, on a pre-tax basis. When you participate in an FSA plan via salary reduction, you reduce your federal, FICA, Social Security and Medicare taxes and increase your take-home pay. The money that is deposited into your FSA comes straight out of your gross pay, therefore reducing your taxes. We offer two FSA options: a Health Care FSA and a Dependent Care FSA. By funding an FSA with pre-tax dollars, you can increase your net income by lowering your taxes.

THE HEALTH CARE FSA

With the Professional Plastics Health Care FSA, you can set aside the annual IRS maximum on a pre-tax basis to pay expenses you know you will incur, such as medical and dental plan deductibles, copays, vision care expenses (including LASIK eye surgery) and other out-of-pocket health and dental care expenses. The IRS has even ruled that you can set aside pre-tax dollars to pay for over-the-counter medications, such as aspirin, other pain relievers, heartburn medications, allergy relief and more.

The Health Care FSA also includes a “roll over” provision, which allows you to roll over dollars up to the IRS maximum of unused funds from your healthcare account into the new plan year.

THE DEPENDENT CARE FSA

With the Dependent Care FSA, you can set aside up to $7,500 each year to pay for dependent care expenses you incur in order to work (if you’re married but filing separately, federal regulations limit the use of a Dependent Care FSA to $3,750 each year).

Keep in mind with the Dependent Care FSA, you have a grace period that allows you to get reimbursed for expenses occurring after the 2026 plan year ends. You can incur eligible dependent care expenses until March 15, 2027, as long as you submit all claims no later than March 31, 2027. These claims will be billed against your 2026 account balance.

LONG-TERM DISABILITY

Long-Term Disability (LTD) coverage is designed to replace a portion of your earnings if you are unable to work due to injury or illness. If approved, the benefit is 60% of your salary to a maximum of $5,000 a month, following a 90-day waiting period.

	Voluntary LTD Monthly Premium
Age	Employee Cost per $100 of Monthly Salary
Under 25	$0.18
25-29	$0.21
30-34	$0.23
35-39	$0.34
40-44	$0.55
45-49	$0.96
50-54	$1.40
55-59	$1.58
60-99	$1.13

VOLUNTARY WORKSITE BENEFITS

ACCIDENT

Accident insurance helps cover everyday expenses such as rent, mortgage, groceries and transportation while you recover from an accident. The plan covers from the initial emergency room treatment, hospital confinement, to follow-up visits.

HOSPITAL INDEMNITY

Hospital Indemnity helps cover expenses for things like emergency room and doctor's visits as well as transportation and ambulance costs. Benefits are predetermined and are paid regardless of any other insurance policies you may have.

CRITICAL ILLNESS

The Critical Illness plan helps with the treatment costs of covered critical illnesses, such as a heart attack or stroke that your medical plan may not cover. More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs.

With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) - giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses. Log into PlanSource to view the cost of this plan based on the level of coverage desired.

SHORT-TERM DISABILITY

Short-Term Disability (STD) coverage is designed to replace a portion of your earnings if you are unable to work for a short period of time due to injury or illness. If approved, the benefit is 60% of your weekly salary to a maximum of $840 a week, following a 7-day waiting period.

	Voluntary STD Monthly Premium
Age	Employee Cost per $10 of Weekly Benefit
Under 25	$0.422
25-29	$0.455
30-34	$0.433
35-39	$0.385
40-44	$0.462
45-49	$0.415
50-54	$0.502
55-59	$0.601
60-64	$0.720
65+	$0.792

NORTON ID THEFT

Identity – Monitors for fraudulent use of your personal info and works to resolve identity theft issues.

Home and Family – Helps you manage your kids' activities online so that they can explore, learn, and enjoy their connected world safely.

Device Security – Gives you protection against malware threats, including spyware and ransomware.

Privacy Monitor – Helps reduce the public exposure of your personal information.

Cost – Individual: $5.30, Family: $10.14 per pay period.

EMPLOYEE ASSISTANCE PROGRAM

The EAP offers no-cost, 100% confidential assistance with every day issues such as: relationship and parenting issues, child and elder care needs, emotional and stress-related issues, conflicts at home or work, alcohol and drug dependencies, and health and wellness issues. Call and set up face-to-face counseling sessions or talk with a licensed counselor by phone or video chat. To contact the EAP, call (**888) 209-7840** or log in to **www.carelonwellbeing.com/ resourceadvisor.**

UNITED PET CARE

The pet care discount program through United Pet Care puts an end to deductibles and frustrating claim forms that traditional pet insurance requires. As a United Pet Care member, you simply take your pet to a vet or a provider contracted with United Pet Care as often as you need, and instantly save 20-50% on everything from check-ups, vaccines, skin treatments, and surgeries.

For more details and to enroll, call **(888) 781-6622** or visit **www.unitedpetcare.com**.

METLIFE LEGAL PLANS

MetLife's quality legal assistance helps you reduce your out-of-pocket costs while providing you with multi-channel access to legal help, assisting you with legal matters with a large network of attorneys and resources online.

Log in to **www.members.legalplans.com** or call **(800) 821-6400** for assistance to review your coverages, select an attorney, and schedule an appointment.

CONTACT INFORMATION

	Contact Information			
Benefit Plan	**Company**	**Contact**	**Website/Email**	**Plan Number**
Medical	Anthem	(800) 888-8288	www.anthem.com	L04099
Dental	Anthem	(877) 567-1804	www.anthem.com	L04099
Vision	Anthem	(866) 723-0515	www.anthem.com	L04099
Life/AD&D	Standard	(800) 552-2137	www.standard.com	L04099
Disability	Standard	(800) 232-0113	www.standard.com	L04099
Supplemental Insurance (Accident/Hospital/Critical Illness)	Anthem	(800) 604-4381	www.anthem.com	L04099
Pet Discount Program	United Pet Care	(888) 781-6622	www.unitedpetcare.com	00001493
Legal Assistance	MetLife	(800) 821-6400	www.members.legalplans.com	5386746
Employee Assistance Program	Standard	(888) 209-7840	www.carelonwellbeing.com/ resourceadvisor	L04099
Flexible Spending Accounts	IGOE	(800) 633-8818 option #1	www.goigoe.com Login code: IGOPROPLA	ProPlas

PLAN COSTS *(per pay period)*

	2024 Deductions	2025 Deductions	2026 Deductions
Plan	**Anthem Prudent Buyer EPO**		
Employee Only	$76.63	$76.63	$94.27
Employee + Spouse	$172.59	$172.59	$207.39
Employee + Child(ren)	$140.60	$140.60	$169.68
Employee + Family	$244.55	$244.55	$292.23
Plan	**Anthem Solution PPO**		
Employee Only	$90.13	$90.13	$110.18
Employee + Spouse	$202.28	$202.28	$242.40
Employee + Child(ren)	$164.90	$164.90	$198.33
Employee + Family	$286.40	$286.40	$341.56
Plan	**Anthem Dental PPO High Option**		
Employee Only	$12.98	$14.05	$14.62
Employee + Spouse	$26.30	$28.47	$29.61
Employee + Child(ren)	$29.18	$31.59	$32.85
Employee + Family	$42.60	$46.11	$47.96
Plan	**Anthem Dental PPO Low Option**		
Employee Only	$10.11	$10.95	$11.39
Employee + Spouse	$20.47	$22.16	$23.05
Employee + Child(ren)	$22.70	$24.57	$25.56
Employee + Family	$33.09	$35.82	$37.25
Plan	**Anthem Vision**		
Employee	$3.21	$3.21	$3.21
Employee + 1	$4.98	$4.98	$4.98
Employee + 2 or more	$7.90	$7.90	$7.90

IMPORTANT NOTICES AND DISCLOSURES

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998—IMPORTANT NOTICE

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

HIPAA PRIVACY NOTICE—IMPORTANT NOTICE ABOUT YOUR HEALTH INFORMATION

The HIPAA Notice of Privacy Practices applies to protected health information associated with the group health plan provided to our employees, employee's dependents and, as applicable, retired employees. The Notice describes that Professional Plastics may use and disclose protected health information to carry out payment and healthcare operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of protected health information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning protected health information. We are required to abide by the terms of the Notice so long as it remains in effect. We reserve the right to change the terms of the Notice as necessary and to make the new Notice effective for all protected health information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders covered by the group health plan. Copies of our current Notice may be obtained by contacting:

Joe Daigneault
Professional Plastics, Inc.
1810 E. Valencia Drive, Fullerton, CA 92831
Phone Number: (714) 866-7857

PATIENT PROTECTION DISCLOSURE

Anthem health plan generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem at (800) 888-8288.

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

You do not need prior authorization from Anthem or any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem at (800) 888-8288.

NEWBORNS' AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining for yourself or your dependent (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependent's other coverage). However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing towards the other coverage). Note: if the change is due to Medicaid/CHIP eligibility, there is a 60-day window for Medicaid/CHIP eligibility changes only.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

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

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

You're protected from balance billing for:

Emergency services - If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as

copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

MEDICARE NOTICE OF CREDITABLE COVERAGE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or 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. Professional Plastics has determined that the prescription drug coverage offered by the Anthem medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

- If you decide to join a Medicare drug plan, your current Professional Plastics coverage may be affected.
- If you do decide to join a Medicare drug plan and drop your current Professional Plastics coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Professional Plastics and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Professional Plastics changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

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

Date: January 1, 2026
Name of Entity/Sender: Joe Daigneault
Phone Number: (714) 866-7857

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

Date : January 1, 2026 | Name of Entity/Sender: Joe Daigneault, (714) 866-7857

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-543-7669** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-692-7447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website:https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website:http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

The material in this benefits brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Consult the Summary Plan Descriptions to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plans. In case of a conflict between your plan documents and this information, the plan documents will govern. The availability of a plan or program may vary by geographic service area.

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