2026 Benefits

PRO TEC
BUILDING SERVICES

Here’s some important information you should know.

Kaiser Permanente HRA

Beginning on 1/1/2026, we will be offering Kaiser Permanente with an HRA to cover the first $1,250 ($2,500 for families) of your medical expenses. Just like in previous years you will have a debit card to use for these medically covered services.

If you enrolled in one of the HealthNet / Difference Card plans in 2025, you will no longer be using the MasterCard for your services. Your Difference Card MasterCard will no longer be active as of 1/1/2026, so you will need to make sure all of your claims are submitted before 12/31/2025.

The Kaiser Permanente HRA program is relatively easy to use so long as you follow these “golden rules”:

- Stay in network for all services and prescriptions
- Use your Kaiser Permanente HRA Debit Card to help pay for covered expenses

Humana Dental and Vision

We will be replacing HealthNet dental and Standard vision with Humana dental and vision.

Benefits for dental are improving as the annual maximum is increasing from $1,000 to $1,500. Your vision benefits are remaining as they are today.

Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices at the end of this document for more details.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide. The

benefits in this summary are effective 1/1/2026-12/31/2026.

Welcome to your 2026 benefits. Our benefits program provides you with the best in coverage that is simple and easy to use. We offer programs that protect your health, your money, your family, and help you find balance between your concerns at work and at home. We also know the value of understanding your coverage so you know how to get care, when you need it, at the lowest cost. With the information and tools in this guide and related resources, we hope to help you be well today and work toward a healthy and secure future.

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Who is eligible for benefits?

Employees

You are eligible for benefits if you are a full-time employee working 30 or more hours per week.

> IMPORTANT: Employees with variable hours and seasonal schedules may be considered eligible if they work on average 30 hours a week or 130 hours a month. ProTec Building Services measures hours worked based on the number of hours you work each month as required by the Affordable Care Act (ACA). Refer to Determining Eligibility later in this guide for details.

Eligible dependents

- Legally married spouse or domestic partner (including same-sex spouse)
- Natural, adopted, or step children up to age 26
- Tax dependents over age 26 who are disabled and dependent on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law

Family members such as parents, grandparents and siblings who are not your tax dependents as described above are not eligible for coverage. In addition, an employee of ProTec Building Services cannot be covered as both an employee and a dependent of another employee (for example, a spouse).

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period.

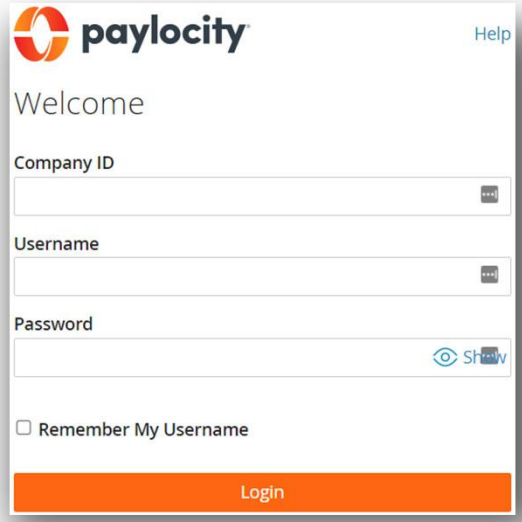
New hire coverage begins on the first of the month following 60 days of employment as long as you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

Changing your benefits

Outside of open enrollment, you may be able to add or remove dependents or change benefit options if you have a qualifying event in your life and submit your change within 30 days. Eligible events include:

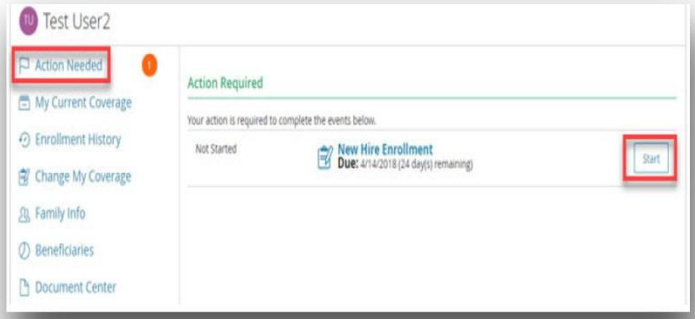
- change in legal marital status
- change in number of dependents or dependent eligibility status
- change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- change in residence that affects access to network providers
- change in your health coverage or your spouse's coverage due to your spouse's employment
- court order requiring coverage for your child
- "special enrollment" event under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan



Step 1: Log In

Login at access.paylocity.com

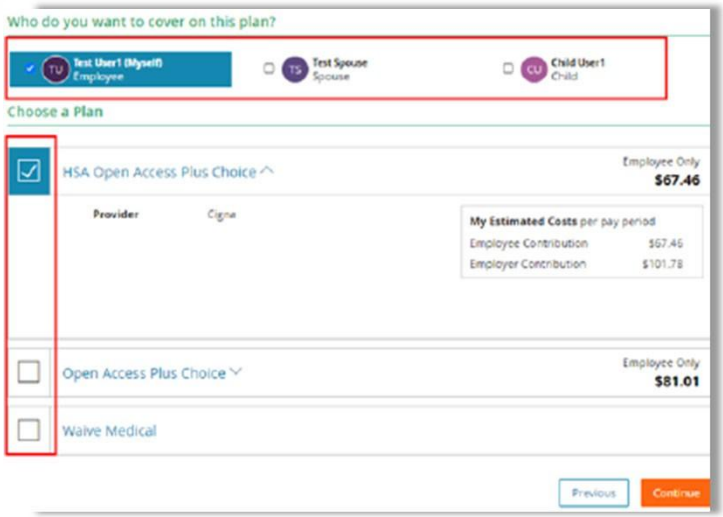
- Returning users: Log in with the username and password you selected. Click Reset a forgotten password.
- First time users: Click on your Registration Link in the email sent to you by your admin or Register as a new user. Create an account, and create your own username and password.



Step 2: Start Enrollments

Select **Action Needed** in the sidebar menu, This option only appears if an enrollment event is available.

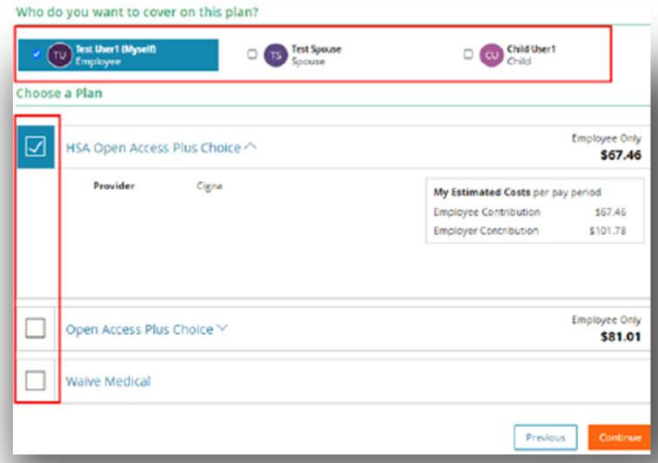
After clicking **Start Your Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.



Step 3: Benefit Elections

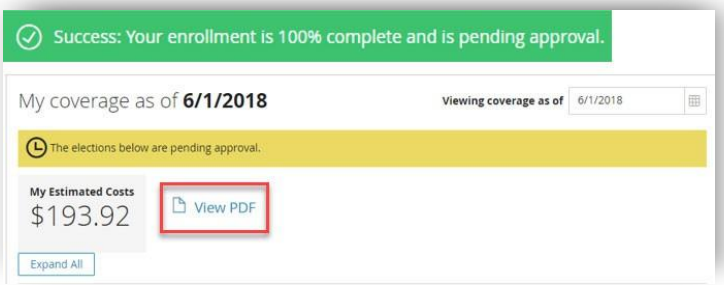
A. Select the dependents to cover. The system will calculate a coverage tier and cost based on the dependents selected.
B. Select the checkmark next to the appropriate **Plan** or **Waive** option
C. Select **Continue**

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



Step 4: Designate Beneficiaries

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



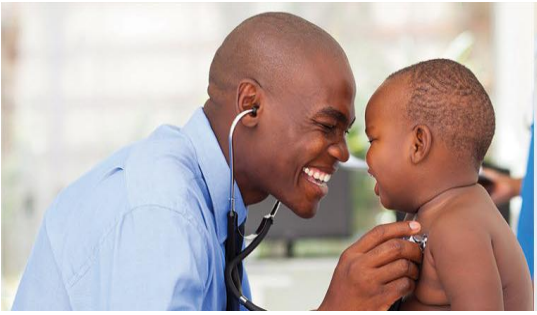
Step 5: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct, then click **Submit** to complete your enrollment. You can either print a summary of your elections for your records or login anytime throughout the year to view your benefits & summaries online.

TIP

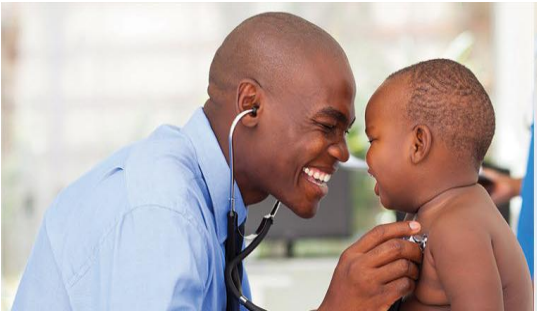
If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

You can login to review your benefits 24/7



Medical – HMO (CA Only)

	SIMNSA HMO In-network only	Kaiser Permanente HMO In-network only
Annual deductible	None	Individual: $3000 ($1,750 after HRA) Family: $6000 ($3,500 after HRA)
Annual out-of-pocket maximum	Individual: $6,350 Family: $12,700	Individual: $6,000 ($4,750 after HRA) Family: $12,000 ($9,500 after HRA)
Primary provider office visit	$5 copay	$40 copay
Specialist office visit	$5 copay	$50 copay
Chiropractic care	Not covered	Not Covered
Preventive care	No charge	No charge
Diagnostic lab and X-ray	No charge	$15 copay after Ded.
Urgent care	$25 copay	$40 copay
Emergency room	$250 copay (copay waived if admitted)	30% after Ded.
Hospitalization	No charge	30% after Ded.
Outpatient surgery	No charge	30% after Ded.
PRESCRIPTION DRUGS		
Annual deductible	None	None
Annual out-of-pocket maximum	None	None
Generic	Pharmacy: $5 copay Mail order: Not covered	Pharmacy: $15 Mail order: $30
Preferred brand	Pharmacy: $5 copay Mail order: Not covered	Pharmacy: $35 Mail order: $70
Non-preferred brand	Pharmacy: $5 copay Mail order: Not covered	Pharmacy: $35 Mail order: $70
Number of days' supply	Pharmacy: 30 days Mail order: Not covered	Pharmacy: 30 days Mail order: 100 days



Medical – PPO (Non-CA Only)

	Kaiser Permanente PPO In-Network	Out-of-Network
Annual deductible (deductibles do not cross apply)	Individual: $3,500 ($2,250 after HRA) Family: $7,000 ($5,500 after HRA)	Individual: $7,000 Family: $14,000
Annual out-of-pocket maximum (maximums do not cross apply)	Individual: $6,500 ($5,250 after HRA) Family: $13,000 ($10,500 after HRA)	Individual: $13,000 Family: $26,000
Primary provider office visit	$40 copay	50% after deductible
Specialist office visit	$40 copay	50% after deductible
Chiropractic care (20 visits per year)	Not Covered	50% after deductible
Preventive care	No charge	50% after deductible
Diagnostic lab and X-ray	30% after Ded.	50% after deductible
Urgent care	$60 copay	50% after deductible
Emergency room	$150 copay + 30% after deductible	$150 copay + 30% after deductible
Hospitalization	$500 copay + 30% after deductible	$1,000 copay + 30% after deductible
Outpatient surgery	$100 copay + 30% after deductible	$150 copay + 30% after deductible
PRESCRIPTION DRUGS		
Annual deductible	None	See SBC for out of network prescription benefits.
Annual out-of-pocket maximum	None	
Generic	Pharmacy / Mail Order: $15 / $30	
Preferred brand	Pharmacy / Mail Order: $40 / $80	
Non-preferred brand	Pharmacy / Mail Order: $40 / $80	
Number of days' supply	Pharmacy: 30 days / Mail order: 100 days	

Provider Search: Medical, Dental, Vision

Line of coverage	Carrier	Plans	Link
Medical	Kaiser Permanente	HMO – Kaiser Permanente	https://healthy.kaiserpermanente.org/doctors-locations
		PPO – Cigna PPO	https://hcpdirectory.cigna.com/web/public/consumer/directory/search
	SIMNSA	HMO	https://www.simnsaee.net/Expediente2010/CitasOnline/proveedores/frm_proveedores.aspx
Dental	Humana DHMO	Dental Liberty HMO	https://findcare.humana.com/
	SIMNSA	Dental	https://www.simnsaee.net/Expediente2010/CitasOnline/proveedores/frm_proveedores.aspx
	Humana PPO	Dental PPO/Traditional	https://findcare.humana.com/
Vision	Humana	Insight	https://findcare.humana.com/

Prescription drug savings

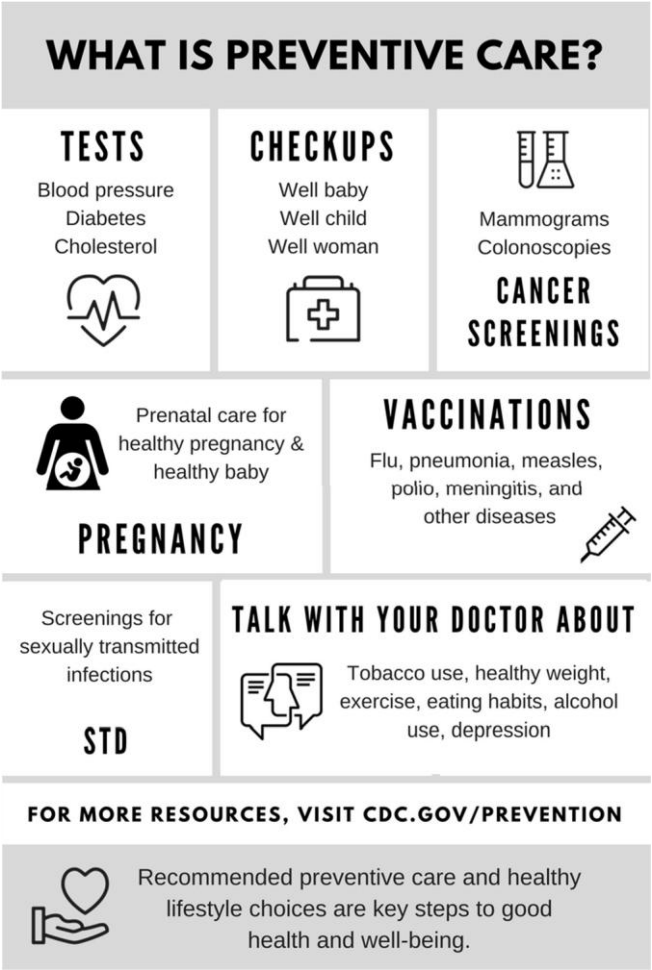
Are prescription drug costs breaking your budget?

A little research before you go to the pharmacy could result in huge savings. This is especially important in a high deductible health plan because you pay the full cost of prescription drugs until you meet your deductible.

	Insider tip	Rx expert!
	Your medical plan includes prescription drug coverage. You pay a different amount depending on the “tier” or class of drug.	GENERIC drugs are always the least expensive. Get in the habit of asking your doctor or pharmacist if there’s a generic alternative.
	A FORMULARY is a list of drugs that are preferred by the plan. Plans use formularies to encourage the most cost-effective drugs.	If a generic drug is not available, ask your doctor whether there is an effective brand name medication that is on the plan's preferred drug list.
	A PARTICIPATING PHARMACY (one that contracts with your medical plan) will usually offer the best price. You can find a participating (in-network) pharmacy on your plan’s website or by calling member services.	SHOP AROUND! Even within the same drugstore chain, you may find a better price at a different location. Your medical plan may have an online tool or app to compare prices. Or try websites like goodrx.com or lowestmed.com
	SPECIAL HANDLING REQUIRED? Your plan may require preauthorization (plan approval) or step therapy (trying certain drugs before others). Specialty drugs such as injectables may need to be purchased from a certain provider.	Talk with your doctor about your course of treatment and confirm whether your plan requires any special procedures. Before filling your prescription, verify that the pharmacy is in-network.
	You can get medicines that you take routinely by MAIL ORDER. Your doctor will need to authorize a 90-day supply. You can submit refills through a website or app, or by phone.	Compare your plan's mail-order copay and shipping costs against your local pharmacy price and/or other discount programs. If it's less expensive locally, ask if your doctor can write a 90-day prescription rather than a 30-day one.

Preventive care & you

Your body doesn't come with an owner's manual, but you have to take care of it to make sure it will keep running for a long time. An important part of self-care is getting preventive medical exams to check that you're staying healthy or to identify and treat diseases before they become serious.



Prevention is a habit

- Make healthy lifestyle choices —food, exercise, sleep, safety.
- Schedule an annual physical with your primary care doctor, and follow your doctor's recommendations.
- Set health and wellness goals and work towards them daily.

Know your numbers

Keep a record of your health screening dates and results so you can talk to your doctor about any changes.

- Date of last checkup
- Height and weight
- Blood pressure
- Cholesterol
- Immunizations and vaccines
- Other test results

What preventive care do you need?

Visit **healthfinder.gov** and enter your age and sex in the app to get a list of recommended preventive screenings for your stage in life. Talk to your doctor about which are appropriate for you.

Dental – HMO

Dental coverage provides periodic preventive care, and if there's a problem, helps with the cost of dental work.

	Humana HMO In-network only	SIMNSA Dental HMO In-network only
Annual deductible	Individual: None Family: None	Individual: None Family: None
Annual plan maximum	Individual: None Family: None	Individual: None Family: None
Diagnostic services	No charge	No charge (deductible waived)
Basic services		
Crown	$85 - $115 copay	$5 - $37 copay
Root canals	$30 - $105 copay	$30 - $50 copay
Periodontics	$0 - $250 copay	$7 - $36 copay
Orthodontia services		
Orthodontia	Adolescent: $1,550 copay Adult: $1,695 copay	Adolescent: $50 copay per visit Adult: $50 copay per visit
Dependent children	Covered	Covered
Adults and eligible full-time students	Covered	Covered
Lifetime maximum	N/A	N/A

The list above is only a summary of the benefits listed. For more information on cost and copays, please refer to the benefit summary.

Dental – PPO

	Humana Dental PPO	
	In-network	Out-of-Network*
Annual deductible	Individual: $50 Family: $150	Individual: $100 Family: $300
Annual plan maximum (Combined with out-of-network)	$1,500 per individual	$1,000 per individual
Diagnostic and preventive	No charge	You pay 0%
Basic services		
Fillings	You pay 10% after deductible	You pay 10% after deductible
Root canals	You pay 10% after deductible	You pay 10% after deductible
Periodontics	You pay 10% after deductible	You pay 10% after deductible
Major services	You pay 40% after deductible	You pay 40% after deductible
Orthodontia services		
Orthodontia	You pay 50%	You pay 50%
Dependent children	Covered	Covered
Adults and eligible full-time students	Covered	Covered
Lifetime maximum	$1,000 (combined with out-of-network)	$1,000 (combined with in-network)

Vision

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

	Humana Vision	
	In-network	Out-of-network
Frequency		
Examination	Every 12 months	
Frames	Every 24 months	
Eyeglass lenses	Every 12 months	
Contacts (elective)	Every 12 months	
Benefit		
Examination	$10 copay	Reimbursement up to $30
Materials	$25 copay	Reimbursement up to $25
Single vision lenses	No charge	Reimbursement up to $40
Bifocal lenses	No charge	Reimbursement up to $60
Trifocal lenses	No charge	Reimbursement up to $100
Frames	Allowance up to $150	Reimbursement up to $80
Contacts	Allowance up to $150	Reimbursement up to $128

Life and AD&D

Life insurance can fill a number of financial gaps for a family recovering from the death of a loved one. Without enough life insurance, many families have to reduce their standard of living after the loss of an income. Consider your current and future financial needs when evaluating how much coverage you need. The most common short and long-term financial needs include:

- Medical bills and funeral expenses
- Living expenses for the surviving family (housing, food, clothing, utilities, etc.)
- Large expenses, e.g., college education, or home mortgage
- Taxes and debts that need to be settled.

Make sure that you have named a beneficiary for your life insurance benefit, and update it if your family or marital status changes.

Company-provided coverage

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

The cost of coverage is paid in full by ProTec Building Services.

THE STANDARD LIFE AND AD&D

Basic Life	$25,000
Basic AD&D	$25,000

Voluntary coverage

Voluntary Life

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

THE STANDARD VOLUNTARY LIFE

Employee	Increments of $10,000 up to $300,000. Guaranteed issue is $100,000
Spouse	Increments of $5,00 up to $150,000. Guaranteed issue is $20,000
Child(ren)	Increments of $2,000 up to $10,000

If you select coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit an Evidence of Insurability (EOI) form with additional information about your health in order for the insurance company to approve this higher amount of coverage.

Voluntary benefits

ProTec Building Services offers these voluntary benefits (you pay the premium) to help you source and buy protection and services you may need for your family—at rates that may be more attractive than individual coverage. And you get the added convenience of paying through payroll deduction.

Accident insurance

Accident Insurance from Mutual of Omaha helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump- sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

If you are interested in this plan, you will find the rates via Paylocity

Critical illness insurance

Critical illness insurance from Mutual of Omaha can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Benefits can be used to help cover medical costs, transportation, child care, lost income, or costs associated with adjusting to life following a critical illness.

You choose a benefit amount that fits your paycheck. You can cover yourself and your family members if needed. If you are interested in this plan, you will find the rates via Paylocity.

Identity theft insurance

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft insurance from LifeLock helps protect your personal information through proactive monitoring, identity restoration, and resolution.

If you are interested in this plan, you will find the rates via Paylocity

Cost of coverage

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover.

Costs shown are semi-monthly (24/year):

Medical	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Kaiser Permanente HMO	$116.57	$482.81	$329.67	$635.94
Kaiser Permanente PPO (Non CA)	$133.33	$569.46	$381.13	$774.24

Medical	Employee Only	Employee + One		Employee + Family
SIMNSA HMO	$38.96	$125.66		$227.13

Dental	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Humana Dental HMO	$1.74	$4.99	$5.39	$9.05
Humana Dental PPO	$5.57	$18.57	$23.96	$40.09

Dental	Employee Only	Employee + One		Employee + Family
SIMNSA Dental HMO	$2.74	$7.85		$16.32

Vision	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse
Humana Vision	$2.82	$5.62	$6.08	$9.13

Voluntary Coverages

The cost for the following plans will be located in Paylocity:

- The Standard Voluntary Life
- Mutual of Omaha Critical Illness
- Mutual of Omaha Accident
- LifeLock Identity Theft

Plan Contacts

Plan type	Provider	Phone	Website	Policy#
Medical	Kaiser Permanente	(800) 581-8651	www.healthy.kaiserpermanente.org	
Medical	SIMNSA	(800) 556-1555	www.simnsa.com	234
Dental	Humana	(866) 427-7478	www.humana.com	
Vision	Humana	(866) 427-7478	www.humana.com	
Life and AD&D	The Standard	(800) 547-9515	www.standard.com	164837
Voluntary Life	The Standard	(800) 547-9515	www.standard.com	164837
Accident	Mutual of Omaha	(800) 228-7104	www.mutualofomaha.com	G000C8WW
Critical Illness	Mutual of Omaha	(800) 228-7104	www.mutualofomaha.com	G000C8WW
Identity Theft	Lifelock	(904) 354-8329	www.lifelock.com	
General Support	New City	(888) 786-5839	admin@newcityinsurance.com	

Determining eligibility

The information below explains in detail how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Monthly Measurement Method

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. ProTec Building Services uses the monthly measurement method to determine whether an employee meets this eligibility threshold.

Important plan notices & documents

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document:

Medicare Part D Notice	Describes options to access prescription drug coverage for Medicare eligible individuals
Women's Health and Cancer Rights Act	Describes benefits available to those that will or have undergone a mastectomy
Newborns' and Mothers' Health Protection Act	Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
HIPAA Notice of Special Enrollment Rights	Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
HIPAA Notice of Privacy Practices	Describes how health information about you may be used and disclosed
Notice of Choice of Providers	Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)	Describes availability of premium assistance for Medicaid eligible dependents

COBRA continuation coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Plan documents

Important documents for our health plan and retirement plan are available in Paylocity. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator or Human Resources 800-557-2217.

Summary Plan Descriptions

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- ProTec Building Services Health & Welfare Plan

Summary of Benefits and Coverage

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available in Paylocity.

- SIMNSA HMO
- Kaiser Permanente HMO
- Kaiser Permanente PPO

Statement of Material Modifications (SMM)

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the ProTec Building Services Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthlypremium.

2. ProTec Building Services has determined that the prescription drug coverage offered by the Health Net and SIMNSA 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 ProTec Building Services coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under ProTec Building Services is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your ProTec Building Services prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 ProTec Building Services 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 or call Jose Cortez at (619) 453-5991. 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 ProTec Building Services changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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:	11/17/2025
Name of Entity/Sender:	ProTec Building Services / Cecilia Gonzalez
Contact-Position/Office:	Human Resource Manager
Address:	10180 Willow Creek Road, San Diego, CA 92131
Phone Number:	(858) 569-1060

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in ProTec Building Services' health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in ProTec Building Services, health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in ProTec Building Services health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for ProTec Building Services describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Jose Cortez.

Notice of Choice of Providers

The SIMNSA Health Net SmartCare HMO, and Health Net Salud y Mas HMO generally requires 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, Health Net or SIMNSA designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact Health Net directly to change your HMO primary care provider. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Health Net or SIMNSA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in 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 Health Net for more information.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility-

ALABAMA Medicaid

Website: http://myalhipp.com/ Phone: 1-855-692-5447

ALASKA Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS Medicaid

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA

Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
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://www.colorado.gov/pacific/hcpf/child- health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance- buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecov ery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA Medicaid

Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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

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

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.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740 TTY: Maine relay 711

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth- premium-assistance-pa
Phone: 1-800-862-4840

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

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/oii/hipp.htm Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/ HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND Medicaid
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 and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid
Website: http://gethipptexas.com/ 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: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA Medicaid and CHIP
: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA Medicaid
Website: http://mywvhipp.com/ 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, 2021, 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

ProTec Building Services
Health Insurance Rate Sheet & Per Payroll Period Deductions
Effective: January 1, 2026 - December 31, 2026

CALIFORNIA – **Kaiser Permanente HMO**							
EE Only		**EE + Spouse**		**EE + Child(ren)**		**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**
$302.60	$116.57	$502.39	$482.81	$416.87	$329.67	$587.91	$635.94
NATIONWIDE (NON-CALIFORNIA) - **Health Net - PPO Non CA**							
EE Only		**EE + Spouse**		**EE + Child(ren)**		**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**
$443.76	$133.33	$794.75	$569.46	$641.77	$381.13	$931.27	$774.24
SAN DIEGO COUNTY - **SIMNSA HMO**							
EE Only		**EE + 1**				**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**		**EE Portion**		**ER Portion**	**EE Portion**
$90.90	$38.96	$128.05		$125.66		$171.54	$227.13
CALIFORNIA - **Humana Dental HMO**							
EE Only		**EE + Spouse**		**EE + Child(ren)**		**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**
$4.06	$1.74	$5.45	$4.99	$5.62	$5.39	$7.19	$9.05
NATIONWIDE - **Humana Dental PPO**							
EE Only		**EE + Spouse**		**EE + Child(ren)**		**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**
$12.99	$5.57	$18.56	$18.57	$20.87	$23.96	$27.79	$40.09
SAN DIEGO COUNTY - **SIMNSA Dental HMO**							
EE Only		**EE + 1**				**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**		**EE Portion**		**ER Portion**	**EE Portion**
$6.39	$2.74	$8.58		$7.85		$12.21	$16.32
NATIONWIDE - **Standard Vision**							
EE Only		**EE + Spouse**		**EE + Child(ren)**		**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**
$0.00	$2.82	$0.00	$5.62	$0.00	$6.08	$0.00	$9.13
NATIONWIDE - **Group Voluntary Accident**							
EE Only		**EE + Spouse**		**EE + Child(ren)**		**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**
$0.00	$4.81	$0.00	$7.35	$0.00	$9.38	$0.00	$13.18
NATIONWIDE - **Group Critical Illness - Custom GVCIP2**							
EE Only		**EE + Spouse**		**EE + Child(ren)**		**EE + Family**	
ER Portion	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**	**ER Portion**	**EE Portion**
$0.00	Multiple Choices	$0.00	Multiple Choices	$0.00	Multiple Choices	$0.00	Multiple Choices
NATIONWIDE - **LifeLock Benefit Elite**							
EE Only				**EE + Family**			
ER Portion		**EE Portion**		**ER Portion**		**EE Portion**	
$0.00		$4.25		$0.00		$8.49	