BENEFITS GUIDEBOOK

Kimray Benefits and Wellness Program

One of Kimray's Core Values is Strengthening the Family. That's why the benefits we offer our team members are designed to support the physical, emotional, and spiritual well-being of you and your family.

This booklet goes into those benefits programs in detail. From health and wellness programs to financial security, there are a wide range of options designed to meet your needs. We're here to help you thrive, both personally and professionally, alongside your family.

At Kimray, we believe that all people are equally and intrinsically valuable — but we're not all the same. That's one of the reasons we offer three health insurance plans. I hope you'll take the time to look over these plans, discuss them with your family, and decide which one is right for you.

Through our Wellness program, you and your spouse can significantly reduce the amount you pay monthly for your medical plan, just by taking part in one-time or ongoing opportunities to explore and experience different aspects of your well-being through our partners at Aduro.

Kimray's People & Culture team members are a resource you can use to find out more about these plans and the specifics of each one. I encourage you to reach out to them if you have any questions about our benefits.

Our Mission is Making a Difference in the Lives of Those We Serve, and I hope our Wellness offerings empower you to make a difference in the lives of your family and community.

Thomas Hill III
Kimray CEO

Benefit Basics

Since your benefit elections remain in effect for the entire plan year (January 1 — December 31), Kimray encourages you to review all benefit options and make the decision that is best for you and your family.

Eligibility for Benefits

Benefit Effective Date for New Hires

You are eligible to enroll in benefits as of your date of hire; they will become effective, anddeductions will begin the first of the month following your enrollment in the plan. (ex.: If you enroll in benefits February 14, your benefits and deductions will begin March 1.
If you are hired on February 1 and enroll in benefits same day, your first deduction will be in the month of February.)

***You have 31 days from date of hire to enroll in your benefits.**

Team Member

Full-time working at least 30 hours per week

Dependent

Spouse, dependent children covered to 26th birthday

Life Events

If you experience a qualified Life Event, you can request benefits change mid-year. The change must be requested within 31 days of the event, and it must be consistent with one of the following events:

- Change in status, which includes legal marital status, number of dependents, employment status, and dependent satisfies or ceases to satisfy eligibility
- Loss or gain of other coverage
- Dependent’s employer’s Open Enrollment
- Significant cost or coverage changes
- HIPAA special enrollment rights
- FMLA special requirements
- Changes due to a judgment, decree, or court order
- Entitlement to Medicare or Medicaid

Your Benefits and Your Costs

Kimray provides some benefits at no cost to you, some you pay for, and other benefit costs are shared between you and the company. This creates the best benefits program to fit your needs and your lifestyle.

Benefit	Who Pays	Tax Treatment
Medical/Prescription	Kimray and You	Pre-tax
Dental	Kimray and You	Pre-tax
Vision	You	Pre-tax
Health Savings Accounts	Kimray and You	Pre-tax
Flexible Spending Accounts	You	Pre-tax
Short Term Disability	Kimray	N/A
Long-Term Disability	Kimray	Pre-tax
Basic Life, Basic AD&D and Basic Dependent Life	Kimray	N/A
Supplemental Life and AD&D	You	Post-tax
Critical Illness	You	Post-tax
Group Accident	You	Post-tax
Pet Insurance	You	Post-tax

*** Please review the Notices at the end of this document for more information.**

Wellness Incentives

With the Kimray wellness outcomes-based program and portal through Aduro, you now have access to a variety of tools and resources to help you achieve a healthier, more productive, and balanced lifestyle.

Features through Aduro:

- Take an online Well-Being Assessment to help you understand many dimensions of your personal well-being.
- Participate in a variety of challenges and wellness initiatives.
- Unlock a customized wellness plan tailored to your goals and visions.
- Participate in community-based webinars and topics that interest you with a Health Performance Coach.

Wellness Incentive Design and Requirements:

- Level 1 – Motivated – (250 points): Earn $50 discount on your medical premium per plan member. *Must complete a biometric screening and Well-Being Assessment.
- Level 2 – Determined – (500 points): Earn an additional $50 discount on your medical premium per plan member.
- Level 3 – Thriving – (2,000 points): Earn a paid wellness day off.
    - If spouses are enrolled, their name will be put in for a raffle prize at the end of the year.

*If you are not enrolled in the Kimray medical plan, you are still eligible to participate in the wellness incentive plan. If you participate, you will receive a cash payout equal to the level that you have achieved in your wellness goals.

To begin your wellness initiative, log into the wellness portal at Aduro Web Platform (https://kimray.adurolife.com/enter-email).

Medical/Rx Coverage

Kimray offers three medical insurance plan options for you to choose from: a traditional PPO plan, a hybrid plan, and a high-deductible health plan paired with a matched health savings account. The following pages include a high-level plan summary of each.

For rates and how to earn wellness discounts please reference the benefits compare tool in Kronos or request from People and Culture.

Option 1–Blue Preferred PPO Plan

BLUE PREFERRED PPO PLAN		
Provider Network	Blue Cross and Blue Shield – Blue Preferred	
Benefit Period	Calendar Year - January 1 - December 31	
Lifetime Maximum	Unlimited	
	In-Network	**Out-of-Network**
Calendar Year Deductible (D) - In/Out of network deductibles update each other		
Individual	$500	$1,000
Family (team member plus one or more dependents) *Family deductible is embedded; therefore, the entire family deductible does not have to be met before claims begin to pay. Once an individual meets their individual deductible, claims for that individual will begin to pay.	$1,000	$2,000
Calendar Year Out–of–Pocket Expense Limit (OPX) – In/Out–of–Network limits:		
	The following items are not applied to this limit: • Reduction in benefits due to non-compliance with utilization management requirements • Charges that exceed the allowable charge	
Individual	$3,000 – Blue Preferred Network	$6,000
Family (team member plus one or more dependents) *Once an individual meets their OOP max, claims for that individual will begin to pay	$6,000 – Blue Preferred Network	$12,000
Coinsurance (C) - after deductible is met	80%- Blue Preferred	50% of allowed

Physician Services		
Physician Office Visit	$25 copay	50% of allowed after D
Specialist Office Visit	$25 copay	50% of allowed after D
Urgent Care Visit	$50 copay	50% of allowed after D
Preventive Care Includes benefits for routine physical exams, well child care, immunizations, routine diagnostic tests including, but notlimited to: PSA, Bone Density, Colonoscopy, Health Education and Counseling Services including, but not limited to: Smoking Cessation and Obesity	100%	50%
Routine Mammograms	100%	Covered at 100%
Immunizations Children under age 19	100%	Not Covered
Maternity	100%	50% of allowed after D
Medical/Surgical Services Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures and physician services	80% after D - Blue Preferred	50% of allowed after D
Prescription Drugs		
Generic	$10 retail / $25 mail order	In network co-pay plus 20% coinsurance
Brand Preferred	$25 retail / $62.50 mail order	In network co-pay plus 20% coinsurance
Brand Non-Preferred	$50 retail / $125 mail order	In network co-pay plus 20% coinsurance
Specialty	$150	In network co-pay plus 20% coinsurance
Hospital Services		
Inpatient Hospital Services Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice; room allowance based on hospital's most common semi-private room rate.	80% after D - Blue Preferred	50% of allowed after D
Precertification Penalty	$500	$500

Outpatient Hospital Services Coverage for services includes but is not limited to outpatient/ ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, diagnostic mammograms performed in a hospital or ambulatory surgical center. Routine services performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.	80% after D - Blue Preferred	50% of allowed after D
Outpatient Emergency Care (Emergency Room - Accident or Illness)	$150 per occurrence plus 80% of allowed after D (copay waived fortrue emergencies)	$150 per occurrence plus 80% of allowed after D (copay waived for true emergencies)
Mental Health and Chemical Dependency		
Mental Health and Chemical Dependency Treatment Services	See “Hospital Services”	
Additional Services		
Therapy Services Occupational, Physical, and Speech–25 visits combined per benefit period	80% after D- Blue Preferred	50% of allowed after D
Durable Medical Equipment andProsthetics	80% after D- Blue Preferred	50% of allowed after D
Home Health Care 30-visit annual maximum per benefit period	80% after D- Blue Preferred	50% of allowed after D
Hospice Requires precertification	80% after D- Blue Preferred	50% of allowed after D
Vision Services Limited to one annual routine exam	100%	Not covered
Hearing Benefits Routine hearing exams and hearing aids, excluding maintenance costs and batteries	100%, Limit of 2 devices per lifetime	

Option 2–Blue Preferred Hybrid Plan

BLUE PREFERRED PPO PLAN – INCLUDES MEMBERSHIP TO PRIMARY HEALTH PARTNERS*		
Provider Network	Blue Cross and Blue Shield – Blue Preferred	
Benefit Period	Calendar Year - January 1 - December 31	
Lifetime Maximum	Unlimited	
	In-Network	**Out-of-Network**
Calendar Year Deductible (D) - In/Out of network deductibles update each other		
Individual	$750	$2,000
Family (team member plus one or more dependents) *Family deductible is embedded; therefore, the entire family deductible does not have to be met before claims begin to pay. Once an individual meets their individual deductible, claims for that individual will begin to pay.	$1,500	$4,000
Calendar Year Out–of–Pocket Expense Limit (OPX) -Separate In/Out–of–Network limits:	The following items are not applied to this limit: • Reduction in benefits due to non-compliance with utilization management requirements • Charges that exceed the allowable charge	
Individual	$4,000 – Blue Preferred Network	$7,000
Family (team member plus one or more dependents) *Once an individual meets their OOP max, claims for that individual will begin to pay	$8,000 – Blue Preferred Network	$14,000
Coinsurance (C) - after deductible is met	80%	50% of allowed
Physician Services		
Physician Office Visit	$50 copay	50% of allowed after D
Specialist Office Visit	$50 copay	50% of allowed after D
Urgent Care Visit	$75 copay	50% of allowed after D
Preventive Care Includes benefits for routine physical exams, well child care, immunizations, routine diagnostic tests including, but not limited to: PSA, Bone Density, Colonoscopy, Health Education and Counseling Services including, but not limited to: Smoking Cessation and Obesity	100%	50%
Routine Mammograms	100%	Covered at 100%
Immunizations Children under age 19	100%	Not Covered
Maternity	100%	50% of allowed after D

Medical/Surgical Services Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures and physician services	80% after D - Blue Preferred	50% of allowed after D*
Prescription Drugs		
Generic	$10 retail / $25 mail order*	In network co-pay plus 20% coinsurance
Brand Preferred	$25 retail / $62.50 mail order*	In network co-pay plus 20% coinsurance
Brand Non-Preferred	$50 retail / $125 mail order*	In network co-pay plus 20% coinsurance
Specialty	$150*	In network co-pay plus 20% coinsurance
Hospital Services		
Inpatient Hospital Services Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice; room allowance based on hospital's most common semi-private room rate.	80% after D - Blue Preferred	50% of allowed after D
Precertification Penalty	$500	$500
Outpatient Hospital Services Coverage for services includes but is not limited to outpatient/ ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, diagnostic mammograms performed in a hospital or ambulatory surgical center. Routine services performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.	80% after D - Blue Preferred	50% of allowed after D
Outpatient Emergency Care (Emergency Room - Accident or Illness)	80% of allowed after D *Additional fee for non-emergent use	70% of allowed after D *Additional fee for non-emergent use
Mental Health and Chemical Dependency		
Mental Health and Chemical Dependency Treatment Services	See "Hospital Services"	

Additional Services		
Therapy Services Occupational, Physical, and Speech - 25 visits combined per benefit period	80% after D - Blue Preferred	50% of allowed after D
Durable Medical Equipment and Prosthetics	80% after D - Blue Preferred	50% of allowed after D
Home Health Care 30-visit annual maximum per benefit period	80% after D - Blue Preferred	50% of allowed after D
Hospice Requires precertification	80% after D - Blue Preferred	50% of allowed after D
Vision Services Limited to one annual routine exam	100%	Not covered
Hearing Benefits Routine hearing exams and hearing aids, excluding maintenance costs and batteries	100%, Limit of 2 devices perlifetime	

*All items marked with the asterisk will normally be billed through Primary Health Partners. There is no copay to see your doctor. Primary Health Partners also offers most medications at wholesale cost, which tends to be significantly less than retail pricing – even with insurance. See Primary Health Partners section for more information about benefits. See People & Culture for full details regarding Primary Health Partners.

This is a non-grandfathered health plan. This is not a contract. This benefit summary does not contain a complete list of benefits available to you, nor does it contain a complete listing of exclusions, limitations and conditions that apply to the benefits shown. Full information can be found in the Certificate of Benefits.

If there are any variances/differences in these high-level summaries, the SPD document supersedes the high-level summaries illustrated in this booklet.

Option 3–High Deductible Health Plan with HSA

Employer Funded HSA *(For those meeting eligibility requirements)*	**Dollar–for–Dollar match up to:** Individual - $750 Family (EE+1 or more): $1,500 See "Health Savings Account (HSA)" section for more information	
Program Basics		
Provider Network	BlueCross and BlueShield – Blue Preferred	
Benefit Period	Calendar Year - January 1 - December 31	
Lifetime Maximum	Unlimited	
	In-Network	**Out-of-Network**
Calendar Year Deductible (D) - In/Out update each other		
Individual	$1,650	$3,000
Family (team member plus one or more dependents) Entire family D must be met before benefits are available; Dmay be met by one individual or a combination of any two or more family members	$3,300	$6,000
Calendar Year Out–of–Pocket Expense Limit (OPX) Separate In/Out–of–Network limits: • Individual	The following items are not applied to this limit: • Reduction in benefits due to non-compliance with utilization management requirements • Charges that exceed the allowable charge $3,000	Unlimited
• Family (team member plus one or more dependents) The OPX limit may be met by any one individual or combination of any two or more family members	$6,000	Unlimited
Coinsurance (C) - after deductible is met	80%	50% of allowed
Prescription Drugs: • Generic • Brand Preferred • Brand Non-Preferred • Specialty	Copay after D: $10 retail / $25 mail order $25 retail / $62.50 mail order $50 retail / $125 mail order $150 Retail	Subject to D & C + 20%

Physician Services		
Physician Office Visit—Includes surgeries, therapies and certain diagnostic procedures performed in a physician's office.	80% after D	50% of allowed after D

Preventive Care—Includes benefits for routine physical exams, well child care, immunizations, routine diagnostic tests including, but not limited to: PSA, Bone Density, Colonoscopy, Routine Mammograms, Health Education and Counseling Services including, but not limited to: Smoking Cessation and Obesity	100%	50%
Maternity **Contact P&C for more information about the maternity benefit.*	100% after D*	50% of allowed after D
Medical/Surgical Services—Coveragefor surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures and physician services	80% after D	50% of allowed after D
Hospital Services		
Inpatient Hospital Services—Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice; room allowance based on hospital's most common semi- private room rate.	80% after D	50% of allowed after D
Precertification Penalty	$500	$500
Outpatient Hospital Services—Coverage for services includes but is not limited to outpatient/ ambulatory surgical procedures, x- ray, lab tests, chemotherapy, radiation therapy, renal dialysis, diagnostic mammograms performed in a hospital or ambulatory surgical center. Routine services performed inan in-network outpatient hospital setting are payable at 100%, no deductible will apply.	80% after D	50% of allowed after D
Outpatient Emergency Care (Emergency Room - Accident or Illness)	80% of allowed after D	80% of allowed after D
Mental Health and Chemical Dependency		
	See "Hospital Services"	

Additional Services		
Therapy Services Occupational and Physical and Speech—25 visits combined per benefit period	80% after D	50% of allowed after D
Durable Medical Equipment and Prosthetics	80% after D	50% of allowed after D
Home Health Care 30-visit annual maximum per benefit period	80% after D	50% of allowed after D
Hospice Requires precertification	80% after D	50% of allowed after D
Vision Services Limited to one annual routine exam	100%	Not covered
Hearing Benefits Routine hearing exams	100%	
Hearing aids–excluding maintenance costs and batteries	100% after D–Limit of 2 devices per lifetime	

Plan Comparison Chart

	Blue Preferred PPO	Hybrid Plan (includes Primary Health Partners)	High Deductible HealthPlan (HDHP)
Provider Network	Blue Cross Blue Shield Blue Preferred	Blue Cross Blue Shield Blue Preferred	Blue Cross Blue Shield Blue Preferred
Annual Deductible (In–network)	$500 (individual) $1,000 (family)	$750 (individual) $2,000 (family)	$1,650 (individual) $3,300 (family)
Annual Deductible (Out–of–network)	$1,000 (individual) $2,000 (family)	$1,500 (individual) $4,000 (family)	$3,000 (individual) $6,000 (family)
Annual Out of Pocket Maximum	**Blue Preferred Network:** $3,000 individual $6,000 family **Out-of-Network:** $6,000 individual $12,000 family	**Blue Preferred Network:** $4,000 individual $8,000family **Out-of-Network:** $7,000 individual $14,000 family	**Blue Preferred Network:** $3,000 (individual) $6,000 (family) **Out-of-Network:** No maximum
Co-Insurance (after deductible is met)	**In-Network:** 80% **Out-of-Network:** 50% of allowable charges	**In-Network:** 80% **Out-of-Network:** 50% of allowable charges	**In-Network:** 80% **Out-of-Network:** 50% of allowable charges
Prescription Drugs	No Deductible Applies:	Most drugs can be obtained through your Primary Health Partners location at wholesale cost. For prescriptions billed through Blue Cross, see prescription plan for traditional PPO plan.	Copay after deductible is met:
Generic	$10 retail / $25 mail order	$10 retail / $25 mail order	$10 retail / $25 mail order
Brand Preferred	$25 retail / $62.50 mail order	$25 retail / $62.50 mail order	$25 retail / $62.50 mail order
Brand Non-Preferred	$50 retail / $125 mail order	$50 retail / $125 mail order	$50 retail / $125 mail order
Specialty	$150 Retail	$150 Retail	$150 Retail
Physician Office Visit	$25 copay	PHP: $0 Copay PCP visits billed through BCBS: $25 Copay	In-Network: 80% after deductible is met Out-of-Network: 50% after deductible is met
Preventative Care	100%	100%	100%
Medical/Surgical Services Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments	In-Network: 80% afterdeductible is met - BluePreferred Out-of-Network: 50% after deductible is met	In-Network: 80% afterdeductible is met - BluePreferred Out-of-Network: 50% after deductible is met	In-Network: 80% afterdeductible is met Out-of-Network: 50% after deductible is met
Maternity	100% (deductible does not apply)	100% (deductible does not apply)	100% after deductible is met
Outpatient Emergency Care (Emergency Room – Accidentor Illness)	$150 per occurrence plus 80% of allowed charges after deductible (copay waived for true emergencies)	80% coinsurance after deductible has been met Non-Emergent Use of ER: $150 copay plus network coinsurance	In-Network: 80% afterdeductible is met Out-of-Network: 50% afterdeductible is met

BlueCross BlueShield of Oklahoma

Split Fill Program

Your Blue Cross and Blue Shield of Oklahoma plan may have a split fill program for certain medications. The medications in the program are those that are often harder to tolerate. The Split Fill Program can help lower your out-of-pocket costs while also limiting waste of unused medication.

A partial (“split”) fill lets you try the medication in a smaller amount first to make sure you can tolerate any potential side effects. You will get a split fill of your monthly prescription for up to three months. You can get a split fill if it is your first time taking the medication or you do not have claims history for the drug within the past 120 days. Your cost share (or copay) will be prorated. That way you only pay for how much medication is dispensed.

If you can tolerate the dosage and decide to continue treatment, you will be switched to a monthly fill. At that point, you will be responsible for the full applicable cost share, based on your benefits.

If you have questions, call the number on your BCBSOK member ID card.

Member Pay the Difference

Through Blue Cross and Blue Shield of Oklahoma (BCBSOK), your prescription drug benefit uses a Member Pay the Difference pharmacy benefit designed to encourage members to use medicines that have been shown to be safe and cost-effective.

How does Member Pay the Difference work?

When you fill a prescription through a contracting pharmacy for a covered brand name drug where a generic equivalent is available, you may pay more. You will pay the copay/ coinsurance amount plus the difference in cost between the brand drug and its generic equivalent.

This may apply even if your doctor writes “do not substitute” on your prescription.

GLP-1 New to Therapy

This program limits the member to a 30 day supply when they first fill a strength of a GLP-1. This reduces waste in instances when a member cannot tolerate the drug or might have to increase strength.

Dental Coverage

Dental Plan Coverage	
Provider Network	BlueCross BlueShield – Blue Care Dental
Benefit Period	Calendar Year: January 1 – December 31
Deductible	None
Annual Maximum Benefit	$2,500 per Covered Person for preventive, primary and major services combined
Orthodontic Services Lifetime Maximum	$2,500
Payable Amount of Allowable Changes	
Covered Services	All Dental Providers
Preventative Services	100%
Primary Services	100%
Major Services	50%
Orthodontic Services (up to age 23)	50%, $2,500 lifetime maximum

Vision Coverage

Vision Plan Coverage	
Provider Network	VSP Choice
Benefit Period	Calendar Year: January 1 – December 31
Benefit Frequency	Every 12 Months
Benefit	**Copay**
Well Vision Exam	$10
Prescription Glasses – Frames • $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance	$25
Prescription Glasses – Lenses • Single vision, lined bifocal, and lined trifocallenses • Polycarbonate lenses for dependent children	$25
Prescription Glasses – Lens Enhancements • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175
Contacts (instead of glasses) • $130 allowance for contacts; copay does notapply • Contact lens exam (fitting and evaluation)	Up to $60

Life and Disability Benefits

Short-Term Disability (STD)

Short Term Disability-UNUM	
Weekly Benefit	75% of weekly covered earnings, $1,000 maximum; 90-day waiting period; Employer Paid Benefit
Benefit Waiting Period	7 Calendar Days for Accident or Sickness
Maximum Benefit Duration	26 weeks Accident or Sickness (from benefit start date)
Pre-existing Conditions	No limit
Coverage Type	Non-occupational

Long-Term Disability (LTD)

Long Term Disability – UNUM- 90 day waiting period *Employer Paid Benefit*	
Core – Employer Paid	60% up to $5,000
Maximum Duration	Social Security Normal Retirement Age
Pre-existing Condition Limitation	3 months prior/12 months insured
Mental Illness/Substance Abuse Limitation	24-month Lifetime Limitation

Life Insurance and AD&D

Benefit	**Available Coverage**
Basic Life and Accidental Death and Dismemberment (AD&D) Insurance	1x Annual base wages rounded to the next higher 1,000; capped at $250,000
Age Reductions	To 65% at age 70, 50% at age 75
Spouse	$5,000
Child(ren)	14 days to 6 months = $200 6 months to age 26 years = $2,000
Voluntary Supplemental Life and Voluntary Team Members & Spouse Supplemental AD&D-UNUM *See online enrollment system for cost information*	
Team Member – Life & AD&D Benefit	• $10,000 units to the lesser of 5 times salary or $500,000 • Guarantee Issue is $300,000 • Age Reductions: To 65% at age 70, 50% at age 75
Spouse – Life AD&D Benefit	• $5,000 up to a maximum of $250,000 • Guarantee Issue is $50,000 • Age Reductions: To 65% at age 70, 50% at age 75
Child(ren) - Life AD&D Benefit	• 14 days to 6 months: $250 • 6 months to age 26 years: $10,000 • Guarantee Issue is $10,000

Statements of Health are required and must be approved by the carrier before coverage begins/increase takes effect:

- for all amounts if not enrolled when first eligible;
- for increases;
- at annual enrollment, then no statement of health is needed if the increase is only up to the maximum guaranteed issue. Amounts above the guaranteed issue will require statement of health. If during a change in status within 31 days of eligibility the employee applies for the first time (i.e. marriage) the employee will need to complete a statement of health. Spouse/Dep Child(ren) will be able to apply for up to the guaranteed issue without statement of health, amounts over the maximum guaranteed issue will require statement of health. Spouse/Dep Chil(ren) effective date will be delayed until employee is approved. If employee already has coverage and wants to increase then any amount requesting to be increased to will require statement of health. Spouse/Dep Child(ren) will be able to apply for up to the guaranteed issue without statement of health, amounts over the maximum guaranteed issue will require statement of health.
- for amounts elected over the Guarantee Issue for those enrolling when first eligible (will be enrolled for the GI amount on date eligible and the rest if/when approved).

Voluntary Supplemental Benefits- UNUM	
Benefit	Purpose of Coverage
Group Accident Insurance	To help individuals meet the out-of-pocket expenses and extra bills that follow an accidental injury.
Details of the plan can be found in the plan summary	
Group Critical Illness	To help individuals offset the financial effectsof a catastrophic illness with a lump sum benefit if an insured is diagnosed with a covered critical illness
Details of the plan can be found in the plan summary	

Pet Insurance

Pet Insurance- PetAssure	
Benefit	**Purpose of Coverage**
Pet Assure	Veterinary discount plan to save on in housemedical service such as office visits, vaccinations, dental procedures, and emergency visits
Cost	$8/month – one pet $11/month – unlimited number of pets
Pet Plus	Discount program on brand name prescriptionsand preventatives for pets such as flea and tickproducts, dietary foods, and heartworm prevention.
Cost	$3.75/month – one cat or dog $7.50/month – unlimited cats and dogs in your home

Health Savings Account (HSA)

Kimray is offering a Health Savings Account (HSA) to those team members who enroll in the High Deductible Health Plan (HDHP). For those eligible for the HSA, Kimray will match your HSA contributions dollar-for-dollar, up to $750 for those with the Individual Plan and $1,500 for those with the Family Plan (team member plus one or more dependents). Kimray will fund the HSA in semiannual installments (January and July).

What is a Health Savings Account?

A Health Savings Account (HSA) is a special account where you save money, tax-free, to cover certain healthcare costs. It works with an HSA-compatible health plan. With contributions that grow and earn interest over time, an HSA is to healthcare what a 401K is to retirement. With balances that rollover year-to-year, you'll have constant access to your HSA funds, and you'll never lose the money.

Where will the HSA funds be deposited?

HSABank is Kimray's provider for HSA accounts. Funds will be deposited into each participating team member's account.

Am I eligible for an HSA?

To be eligible you must be covered under an HSA-compatible health plan, not be enrolled in Medicare or other non-compatible plans, and not be claimed as a dependent on another person's tax return.

*To find out the current year IRS HSA contribution limits, visit www.irs.gov.

How do I contribute to my HSA?

There are several easy ways to put money into your HSA. Whichever method you choose, you can start contributing in as little as two days.

- Schedule transfers to or from your bank account through Internet Banking
- Make contributions through payroll deductions
- Send a check with a contribution form or deposit ticket
- Track your contributions online

How do I access the funds in my HSA?

Pay medical expenses or withdraw cash from an ATM with your HSA Bank Visa® debit card. You can also buy HSA Bank checks or pay medical expenses from your bank account and reimburse yourself through Internet Banking or by taking your debit card to any bank and requesting a cash advance for the exact amount that you are reimbursing.

Who do I contact with questions regarding my HSA?

HSA Bank at the number on the back of this booklet.

Flexible Spending Accounts (FSA)

Flexible Spending Account:

If you are enrolled in the HDHP with HSA, this is a Limited Purpose FSA and only Dental and Vision expenses are eligible. If you are enrolled in the Blue Options PPO or the Hybrid Plan, you are ineligible for the HSA, this is a Full FSA and can be used for Medical, Dental, and Vision expenses.

Grace Period:

You can submit claims for your previous plan year expenses through March 15 of the current plan year.

If your employment with Kimray ends during the plan year, you will be reimbursed for expenses incurred prior to your termination date if they are submitted for reimbursement within 30 days of termination. Remaining funds are forfeited unless COBRA is elected.

Dependent Care Spending Account:

$5,000 maximum ($2,500 maximum if married and filing separately—statutory requirement). No reimbursement for over-the-counter (OTC) medicines under the Health Care Flexible Spending Account.

U.S. Department of Health and
Human Services
Centers for Medicare & Medicaid
Services
www.cms.hhs.gov
1-866-444-EBSA (3272)

401(K) and Profit Sharing Plan

Kimray is excited to be a partner in helping you plan for your retirement. The plan helps you save and invest by offering:

- Automatic enrollment;
- Automatic annual savings increases;
- Before-tax and after-tax 401(k) saving options; and
- A wide range of investment options.

If you are a full-time team member, you are eligible to participate in the plan upon your date of hire. You will be enrolled in the plan automatically beginning with the first available payroll. You are always one-hundred (100) percent vested in the money in your retirement account; this includes money you contribute, money rolled-over, and company matched contributions and any investment earnings in those accounts.

Kimray Inc. may also make a discretionary profit-sharing contribution into the 401(k) Plan. The profit-sharing contribution will be an amount determined and authorized by Kimray Inc. for the plan year. For a given plan year, you will be eligible to share in any profit-sharing contribution if you complete 1,000 hours of service and are actively employed on the last day of the plan year, or if you retire, become disabled or die during the plan year. Vesting schedule:

**Refer to the 401(k)-summary plan description.*

Regular Profit Sharing Account	
Years Employed	Vested %
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6 or more	100%

Educational Assistance Programs

Kimray, Inc. (the “Company”) is committed to the continued growth and development of our workforce. The following Company-sponsored Tuition Assistance Program (“TAP”) encourages team members to continue their education by reimbursing team members for student loan payments and certain eligible expenses associated with coursework or programs from an accredited higher education institution or vocational-technical school. In order to best assist team members, the Company offers reimbursement for educational expenses under three different plans:

1. Qualified Educational Assistance Program,
2. Working Condition Fringe Benefit Program; and
3. Student Loan Reimbursement Program

Child Care Reimbursement

Full-time Kimray team members are eligible for child care reimbursement of up to $300 per child, per month. Per calendar year, each team member is eligible to be reimbursed up to a total of $5,000 pre tax and any eligible expenses after this dollar amount will be taxed. Eligible expenses include day care facilities, before/after school programs and/or care (through age 12), and nanny services. If you have alternative forms of childcare outside of those listed, you may meet with a member of the People & Culture team to discuss eligibility.

Adoption Benefit

If you are a regular, full-time team member, Kimray offers you adoption assistance that reimburses you up to a maximum of ten-thousand dollars ($10,000) per eligible child for qualified adoption expenses. The adopted child may not be the child of the team member’s spouse and must be under the age of eighteen (18) at the time a qualified adoption expense is paid or incurred.

Qualified adoption expenses include reasonable and necessary adoption fees, court costs, attorneys’ fees, and other expenses directly related to, and whose principal purpose is for the legal adoption of an eligible child, such as:

» Agency and placement fees;
» Travel expenses associated with the adoption (including transportation, lodging and meals);
» Medical expenses for the child not otherwise covered by insurance;
» Temporary foster care provided before placement of the child in your home;
» Immigration, immunization, and translation fees; and
» Court costs and legal fees.

You may apply for reimbursement of qualified adoption expenses upon placement of the eligible child in your home.

Applications of reimbursement must be made within six (6) months following the finalization of the adoption, and you are responsible for accurately reporting adoption reimbursement amounts to federal, state, and local tax authorities. Contact a member of the People & Culture Department for more information. Kimray will provide new parents paid leave in accordance to the maternity and paternity leave policy at the time of placement. For leave being requested for the placement of a foster child or placement of a child for adoption, please contact P&C.

Kimray Health & Welfare Plan
Health and Welfare
Benefits Annual Notice Packet

For the 2025 Plan Year

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:
Children's Health Insurance Program (CHIP) Notice
Women's Health and Cancer Rights Act (WHCRA) Notice
Newborns' Mothers Health Protection Act (NMHPA) Notice
USERRA Continuation
Genetic Information Nondiscrimination Act (GINA)
HIPAA Special Enrollment Rights Notice
Medicare Part D Creditable Coverage Notice
HIPAA Privacy Notice of Availability
HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice
ADA Wellness Program Notice
Family Medical Leave Act
Surprise Medical Bills
COBRA Continuation Coverage Notice

Should you have any questions regarding the content of the notices, please contact us at 405-525-6601.

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 page [7] for more details.

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website:Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htmPhone: 1-800-362-3002	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)

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 405-525-6601 for more information.

Newborns' And Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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).

USERRA Continuation

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under a group health plan by paying premiums in the manner specified by the Plan Sponsor.

If you do not elect to continue to participate in a group health plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA continuation coverage under a group health plan for up to the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds, subject to the rules that are set out in the applicable Plan features.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Genetic Information Nondiscrimination Act (GINA)

Gina prohibits group health plans from discriminating on the basis of genetic information. Genetic information is:

1. Information about an individual's genetic tests;
2. Genetic tests of an individual's family members; and
3. The manifestation of a disease or disorder of an individual's family members.

The group health plan may collect genetic information after initial enrollment, it may not do so in connection with the annual renewal process. The group health plan may not adjust premiums or increase contributions based on genetic information, nor request or require genetic testing or use genetic information for underwriting purposes.

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Kimray Health & Welfare Plan group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within "31 days" after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "31 days" after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact
Kimray People & Culture at 405-525-6601

Medicare Part D Creditable Coverage Notice

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan while enrolled in BCBS coverage as an active employee, please note that your BCBS coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in BCBS coverage as a former employee.

You may also choose to drop your BCBS coverage. If you do decide to join a Medicare drug plan and drop your current BCBS 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 BCBS 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 contact Kimray People & Culture at (405) 525-6601. **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 BCBS changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: September 30, 2024
Name of Entity/Sender: Kimray People & Culture
Address: 52 NW 42nd St. OK 73118
Phone Number: 405-525-6601

Availability of HIPAA Notice of Privacy Practices

Kimray's Health & Welfare Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Kimray People & Culture Department at 405-525-6601.

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [405-525-6601] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

ADA Wellness Program Notice

Notice Regarding Wellness Program

Kimray's wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for Glucose, HDL, LDL, Triglycerides, & total Cholesterol You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $50 discount on your medical premium per plan member for Level 1 – Motivated. Employees can earn an additional $50 discount on your medical premium per plan member for Level 2 – Determined. In addition, employees can earn a paid wellness day off for Level 3 – thriving. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentives based on the different level.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Kimray People & Culture at 405-525-6601.

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

Protections from Disclosure of Medical Information

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Kimray People & Culture at 405-525-6601.

Family Medical Leave Act

The Family and Medical Leave Act (FMLA) provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. It also requires that their group health benefits be maintained during the leave.
FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

Covered employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- for the birth and care of the newborn child of an employee;
- for placement with the employee of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when the employee is unable to work because of a serious health condition.

Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Whether an employee has worked the minimum 1,250 hours of service is determined according to FLSA principles for determining compensable hours or work.

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition.

Upon return from FMLA leave, an employee will be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. Group health insurance coverage for an employee on FMLA leave is maintained under the same terms and conditions as if the employee had not taken leave.

For additional information regarding your benefits under FMLA, please contact Kimray People & Culture at 405-525-6601.

Your Rights and Protection against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, federal law can provide some protection from surprise billing or balance billing.

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

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is usually more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Federal law provides some protection against balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility is supposed to bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). Federal law restricts the ability of the provider or facility to balance bill you for these emergency services. This includes services you may get after you’re in a 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, federal law restricts the ability of those providers to bill you more than 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 are not supposed to balance bill you, and they are not supposed to ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, federal law restricts the ability of out-of-network providers to balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network.

You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed by federal law, you also have the following protections:

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

The health plan cannot guaranty you won’t be balance billed.

These are only general statements of what the law requires. The terms of the health plan will always control, notwithstanding anything provided in this or any other notice or disclosure. The health plan does not make any guaranty or promise that balance billing protections will apply in any particular situation, and in no way is the health plan liable for any balance billed amount.

If you believe you’ve been wrongly billed, you may contact:

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

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

COBRA Continuation Coverage Notice

You are receiving this notice because you have recently become or may soon be covered under the Plan. This notice contains important information about your right to COBRA continuation coverage ("COBRA coverage"), which is a temporary extension of group health coverage under the Plan in certain circumstances when coverage would otherwise end. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

This notice is a summary only; it does not fully describe the COBRA coverage law or other rights or obligations under the Plan. For a more complete description of your rights and obligations concerning COBRA coverage, see the Plan's governing document(s) or contact the Kimray People & Culture department, whose contact information is below. The Plan provides no greater COBRA rights than what COBRA requires; nothing in this notice is intended to expand your rights beyond COBRA's requirements.

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

What Is COBRA Continuation Coverage?
COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event."

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of either one of the following qualifying events:

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

If you are the spouse of an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because of any of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

A person enrolled as an employee's dependent child will be entitled to elect COBRA coverage if he/she loses group health coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

After a qualifying event (and after any required notice is properly and timely provided to the Plan), COBRA requires that COBRA coverage be offered to each person who is a "qualified beneficiary." You, your spouse, and your

dependent children could become qualified beneficiaries entitled to elect COBRA coverage if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage.

Please note that domestic partners are not qualified beneficiaries for purposes of COBRA.

When is COBRA Coverage Available?
When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries.

You Must Give Notice of Some Qualifying Events
For all other qualifying events (including divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA coverage election will only be available if you notify the Plan in writing within 60 days after the later of (a) the date the qualifying event occurs or (b) the date on which the qualified beneficiary loses or would lose coverage under the terms of the Plan as a result of the qualifying event. If you do not timely and properly give notice, you and your dependents will lose any rights to elect COBRA continuation coverage. Contact the Plan to obtain the appropriate forms for this notice, including a description of any required information or documentation.

Electing COBRA Coverage
Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA continuation coverage on behalf of their children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA.

How Long Does COBRA Coverage Last?
COBRA coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of work hours. Certain qualifying events, or a second qualifying event during the initial period of coverage, (death of the employee, a covered employee’s divorce or legal separation, or losing eligibility as a child) may permit a beneficiary to receive up to 36 months of Plan group health coverage.

When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination of employment can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the initial qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination of employment or reduction in hours. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Plan's summary plan description.

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

1. Disability Extension of COBRA Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you properly notify
the Plan in a timely fashion, all qualified beneficiaries in your family may be entitled to receive up to an additional11 months of COBRA continuation coverage, for a total maximum of 29 months. This

extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the COBRA administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of: (a) the date of the Social Security Administration's disability determination; (b) the date of the covered employee's termination of employment or reduction of hours; or (c) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The COBRA administrator may require that notice be given on certain forms. Contact the COBRA administrator to obtain the proper forms**. If the Plan's and COBRA administrator's procedures are not followed or if the notice is not provided to the COBRA administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.**

2. Second Qualifying Event Extension of COBRA Coverage

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction in hours (including COBRA coverage during a disability extension period), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving COBRA coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.) This extension due to a second qualifying event is available only if you notify the COBRA administrator in writing of the second qualifying event within 60 days of the date of the second qualifying event.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If You Have Questions

Questions concerning your Plan or your COBRA rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Plan Administrator:
Kimray
C/O Kimray, People, & Culture
Department
52 NW 42nd St. OK 73118

COBRA Administrator:
P&A COBRA

Phone: 800-359-3921