The Power of
MARMON
Working Well Together

2023 Health & Well-Being Guide

MARMON U.S. BENEFITS AND MERP

EFFECTIVE JANUARY 1, 2023 THROUGH DECEMBER 31, 2023

Welcome

At Marmon, our success as a collection of more than 125 businesses hinges on the success of our people. For this reason, we offer a broad array of market-competitive benefits, designed to help you live well every day—and succeed at work and at home. Please read this guide carefully, as it includes important information about your 2023 benefit options.

Eligibility

After you complete your onboarding tasks in MPower, your enrollment event will be available and must be completed within 31 days of your hire date. Coverage is effective on your date of hire. Eligible family members include:

- Your legally married spouse
- Your registered domestic partner (RDP) and/or their children
- Your children who are your biological children, stepchildren, adopted children or children for whom you have legal custody (up to age 26). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

Choose Carefully!

Due to IRS regulations, you cannot change your elections after enrolling—unless you experience a qualifying life event during the year. Qualifying life events include marriage or divorce, birth, adoption or placement of a child, child reaching the maximum age limit, death of a dependent, loss of coverage under your spouse's/RDP's plan or when you gain access to state coverage under Medicaid or Children's Health Insurance Program (CHIP).

Making Changes

To make changes to your benefit elections, you must contact Human Resources **within 31 days of the qualified life event** (including newborns). Be prepared to show documentation of the event, such as a marriage license, birth certificate or divorce decree. If changes are not submitted within 31 days of a qualified life event, you must wait until the next Open Enrollment period to make election changes.

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Take Action:

Enroll on MPower within 31 days of your hire date!

Required Information—*When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the Company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.*

Note: The Medicare Part D Notice has been provided under separate cover and the following Annual Notices are provided at the end of this Guide: Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP), Women's Health and Cancer Rights Act of 1998 and Notice of Privacy Practices.

Health Care Benefits Support

You Get the VIP Treatment Through BCBS of Illinois!

Here at Marmon, we understand that navigating your health care and benefits alone can be frustrating—and with a Health Advocate, you don't have to! You and your family have 24/7 access to the Health Advocate service through your Blue Cross and Blue Shield of Illinois (BCBSIL) health plan. It's like having your own personal assistant who can answer your questions, cut through red tape and find you the help you need. Your Health Advocate team members are experts in Marmon's health plan and are here to help with:

- Providing answers to your benefit questions
- Finding where to go for care
- Helping you saving money on tests through Member Rewards
- Guiding you to the right provider to help with depression, stress, addiction and more
- Connecting you to a team of clinicians to help coordinate ongoing care for a new diagnosis
- Working with you and/or your providers to obtain the proper prior-authorization(s) for certain health tests and services
- And much more!

Get started by going to **myhealth.myevive.com** or downloading the MyEvive app on your mobile device. You can find information about resources and other Marmon benefits, including:

- Finding a provider
- Access Blue Access for Members to review medical and prescription drug benefits
- ConsumerMedical Second Opinion Support
- Diabetes and Hypertension Management through Livongo
- Virtual Visits with MDLIVE
- Ovia Fertility, Maternity and Parenting
- Prime Therapeutics
- Learn to Live, Digital Mental Health
- Member Rewards

Member Rewards: Your Health Advocate can help you earn cash rewards for making savvy health care choices when you use the Member Rewards program. Member Rewards is designed to help you save money on routine medical tests and services. When you're ready to schedule an appointment or procedure, go to **myhealth.myevive.com** and click on "Provider Finder with Member Rewards" to start shopping. You can also call your Health Advocate for help finding a rewards-eligible location or provider.

After you receive your procedure or service at your chosen reward-eligible location, a check will be mailed directly to your home once your claim is verified and paid. You can earn anywhere from $25 to $500 in cash rewards, depending on the location you choose! Eligible services include:

- MRIs, CTs and PET scans
- Mammograms
- Carpal tunnel
- Lab blood draws
- Ultrasound exam
- Colonoscopies
- Hip replacement
- Bariatric surgery
- And many more

The best part about having a Health Advocate is that you only have **ONE** phone number to call. So stop trying to do it all on your own and connect with your Health Advocate today!

Phone: (800) 318-4360

Live chat: Log in to **myevive.com**

To get started, visit **myhealth.myevive.com** or download the MyEvive mobile app. Enter your employer's name and click "Sign up now" on the following homepage. Enter your member ID number, full legal name, the last four digits of your Social Security number and your date of birth.

Medical Plans

The Company offers a choice of two medical plans administered by Blue Cross Blue Shield of Illinois (BCBSIL) and its broad national network of health care providers. Both plans provide comprehensive medical and prescription drug coverage with preventive care covered at 100%. The plans also offer many resources and tools to help you maintain a healthy lifestyle.

PPO Premier Plan

The Preferred Provider Organization (PPO) plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the BCBSIL national network. Coverage includes copays for office visits and coinsurance for prescription drugs, while other medical services may apply to the deductible (see page 5 for details). Participants in the PPO plan will meet their individual deductible before certain services are covered at the percentages allowed by the plan.

The PPO plan has an embedded deductible, which means each member of the family must meet their own individual deductible. Once a member in the embedded deductible family plan meets their deductible, coinsurance will kick in for that individual only.

HDHP Balanced Plan

The High-Deductible Health Plan (HDHP) also gives you the freedom to seek care from the provider of your choice. You will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the BCBSIL national network. In addition, the HDHP offers eligible participants a health savings account (HSA) that allows you to save pre-tax dollars[1] to pay for any qualified health care expenses as defined by the IRS, including **most out-of-pocket medical, prescription drug, dental and vision expenses**. For a complete list of qualified health care expenses, visit **www.irs.gov/pub/irs-pdf/p502.pdf**.

1. Tax free under federal tax law: state taxation rules may apply.

Here's how the HDHP works:

- If you enroll one or more family members, your aggregate deductible and coinsurance must meet the full FAMILY out-of-pocket maximum before the plan starts to pay covered services at 100 percent for any one individual.
- **Aggregate Deductible:** All covered medical and prescription drug expenses are applied to meet your deductible before the plan starts to pay at the coinsurance level. If you enroll one or more family members, all participants' covered expenses are combined to meet the family deductible. The deductible can be met by one or more participants.
- **Coinsurance:** Once you've met the plan's annual deductible, you are responsible for a percentage of your medical expenses, which is called coinsurance. For example, the plan may pay 80% and you may pay 20%.
- **Out-of-Pocket Maximum:** Once your deductible and coinsurance add up to the plan's annual out-of-pocket maximum, the plan will pay 100% of all covered services for all plan participants for the rest of the calendar year.

Spousal Surcharge

You will pay a surcharge if your spouse is enrolled under your Marmon plan when they are eligible for their own employer-sponsored plans and choose to be covered under Marmon's plan. This does not apply if your spouse works for a Marmon company. The surcharge is $200 per month for PPO plan participants and $150 per month for HDHP participants.

Note: Your spouse and dependents can only be covered under one Marmon plan.

Contact Blue Cross Blue Shield

Visit **www.bcbsil.com** or call (800) 458-6024 for medical benefits or (800) 423-1973 for prescription benefits.

Prime Therapeutics Retail Pharmacy

Prime Therapeutics offers easy access to retail pharmacies that handle a variety of prescriptions for treating common illnesses, from allergies to antibiotics. Visit in-network independent and chain pharmacies to find the medication you need at retail prices.

Express Scripts Home Delivery

Express Scripts offers support to treat long-term conditions, and its services include free shipping, a team of pharmacists ready to answer your questions, a mobile app for quick access to refill requests and more.

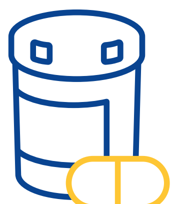
Once registered, you can place your orders online, by phone or via the mobile app. To set up your Express Scripts Pharmacy digital account, go to **www.esrx.com/BCBSIL** and click on "register," or call (833) 715-0942.

Accredo Specialty Pharmacy Services

Accredo provides the medication and 24/7 support you need to help manage complex health conditions. Its services include:

- A specialty-trained staff to answer your questions
- Digital tools, including refill reminders
- Free shipping with safe, on-time delivery

Visit **www.accredo.com/BCBSIL** to get started.



Medical Plans at a Glance

See the chart below for an overview of how services are covered under both plan options and what you pay for services after you meet the deductible. For complete coverage details, refer to the plan documents on MPower.

Key Medical Benefits	PPO Premier Plan BCBSIL PPO Network		HDHP Balanced Plan BCBSIL PPO Network	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (per calendar year)				
Individual / Family	$500 per individual; up to $1,500 family maximum	$1,000 per individual; up to $3,000 family maximum	$1,500 employee only / $3,000 aggregate if you have Spouse, Child(ren) or Family coverage	$1,500 employee only / $3,000 aggregate if you have Spouse, Child(ren) or Family coverage
Out-of-Pocket Maximum (including deductible; per calendar year)				
Individual / Family	$3,000 / $6,000	$6,000 / $12,000	$3,000 / $6,000	$6,000 / $12,000
Company Contribution to Your Health Savings Account (HSA) (Amount shown is per calendar year and prorated for new hires/newly eligible employees. Funds are deposited each quarter)				
Individual / Family	N/A		$750 / $1,500	
Covered Services				
Office Visits (physician/specialist)	$30 / $40 copay	40%*	20%*	40%*
Routine Preventive Care	No charge	Not covered	No charge	Not covered
Outpatient Diagnostic (lab/X-ray)	20%*	40%*	20%*	40%*
Chiropractic	20%* (up to 20 visits per year)	Not covered	20%* (up to 20 visits per year)	Not covered
Ambulance	20%*		20%*	
Emergency Room	$200 copay (waived if admitted), then 20%*		20%*	
Urgent Care Facility	$50 copay	40%*	20%*	40%*
Inpatient Hospital Stay	20%*	40%*	20%*	40%*
Outpatient Surgery	20%*	40%*	20%*	40%*
Telehealth (see page 6)	No charge	N/A	$48 copay	N/A
Prescription Drugs				
Tier 1: Generic	10%	10% (plus 25% of the remaining cost)	20%*	25% less 20%
Tier 2: Preferred	20%	20% (plus 25% of the remaining cost)		
Tier 3: Specialty/Non-Preferred	35%	35% (plus 25% of the remaining cost)		
Prescription Drug Out-of-Pocket Maximum	$1,000 per individual		Included in plan out-of-pocket max.	

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

***Benefits with an asterisk (*) require that the deductible be met before the plan begins to pay.**

To be eligible for the HSA, you must not have other health care coverage, or be covered through Medicare Part A or Part B or TRICARE programs. See the plan documents for full details. Employer contributions are based on your coverage in the plan as an active employee.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

To learn more about your medical plan options, watch the Understanding My Medical Plan Options video available on the My Benefits Dashboard in MPower.

Healthy Living

Marmon and Blue Cross and Blue Shield of Illinois (BCBSIL) offer the following resources and programs to help you stay well and inspire healthy living.

Blue Access for Members and the BCBSIL Mobile App

Blue Access for Members can help you find your next in-network health care provider, so you can make the most of your health benefits and savings. You can also check your claims, order ID cards and more. To start, go to **www.bcbsil.com/member** and sign up for the secure member website, Blue Access for Members. Find the "Log In" tab and click "Register Now." Use the information on your ID card to complete the process.

You can visit Blue Access for Members anytime you're on the go with the BCBSIL mobile app. To download the mobile app, text BCBSILAPP to 33633.

MDLIVE® Telehealth Program: BCBSIL

PPO plan participants have access to the confidential MDLIVE telehealth program at no cost. HDHP participants pay $48 per medical visit, which goes toward the plan deductible. Behavioral health visit fees vary based on treatment and provider.

MDLIVE connects you to board-certified doctors 24/7 via live chat on your computer or smartphone. Use MDLIVE to get advice on non-emergency health care issues, including:

- Allergies
- Earaches
- Insect bites
- Cold and flu
- Fever
- Nausea
- Diarrhea
- Headache
- Pink eye
- Mental health

Note: This is a confidential service.

Visit **www.mdlive.com/marmon** or call (800) 770-4622.

Mental Health: Learn to Live Program

Your mental health is just as important as your physical health, and likewise needs preventive care and maintenance. The Learn to Live program offers you access to self-guided modules that help to improve mental health wellness, focusing on:

- Depression
- Anxiety and panic attacks
- Substance use
- Insomnia
- Social anxiety
- Stress management

In addition to the self-guided modules, Learn to Live has an option to work one-on-one with a health coach to support you through your mental health journey.

The Learn to Live program is included through Blue Access for Members for employees and covered dependents (age 13 and older) at no cost. To register, visit **www.learntolive.com/welcome/BCBSIL** and enter code BETTERME. You can also use the login credentials you create for the BCBSIL mobile app.

Or, find the Learn to Live program through the Blue Access for Members portal—click the "Wellness" tab, then select "Digital Mental Health."

Wellness: Well onTarget

Well onTarget makes it easy to fit wellness into your schedule. You can use online trackers for sleep, blood pressure, cholesterol levels and more. Or, take online courses on topics like exercise and stress management. Through Well onTarget, you'll also have access to:

- The **Fitness Program** offers four different plans with flexible gym memberships and pay-as-you-go studio classes. Learn more and sign up by logging on to Blue Access for Members. In "Quick Links," click "Fitness Program."
- The **Blue Points system** will help keep you motivated—you'll earn points when you take part in healthy activities. Begin by completing your Health Assessment and you'll get a customized health report and earn 2,500 Blue Points. You can redeem your points through the online shopping mall.

Download the AlwaysOn® Wellness app to your phone today to explore the portal or visit **members.hcsc.net/wps/portal/wellontarget**.

Family Planning: Ovia Health

Ovia gives you access to family planning tools and step-by-step coaching for your journey through fertility, pregnancy and parenting. Get started by downloading one or all of the following apps on iTunes or Google Play: Ovia Fertility, Ovia Pregnancy and Ovia Parenting.

Diabetes and Hypertension Management: Livongo Programs

The Livongo® for Diabetes and Livongo® for Hypertension programs offer an advanced blood glucose meter or blood pressure monitor, plus the support you need 24 hours a day. Both programs are covered by your health plan at no cost to you. Call (800) 945-4355 to learn more or register at **welcome.livongo.com/Marmon** (registration code: MARMON).

Expert Medical Opinion: ConsumerMedical

ConsumerMedical is your health care decision tool. From minor health concerns to more complex issues, you and your family can get a second opinion on a medical diagnosis and treatment to decide which option is best for you, get help finding a doctor or hospital, find support to cope with a medical condition and more. Get more information by visiting **www.myconsumermedical.com** (use registration code: MARMON) or by calling (888) 361-3944.

Health Savings Account (HSA)

Enrollees in the HDHP may be eligible for an HSA. You and your employer may contribute to an HSA through pre-tax payroll deductions to help offset your annual deductible and pay for qualified health care expenses.

To be eligible for the HSA, you must be enrolled in the HDHP on the first of the month and must not have other health care coverage that is not a qualified HDHP, including the health care FSA, Medicare Part A or Part B or TRICARE programs. See the plan documents for full details. Employer contributions are based on your coverage in the plan as an active employee.

Triple-Tax Advantage

1. You contribute funds through pre-tax payroll deductions, which reduces the amount of taxable income—so less tax is withheld from your paycheck.
2. Funds grow tax free, and unused funds roll over year to year.
3. You can withdraw funds tax free to pay for qualified health care expenses—even for Medicare expenses in retirement!

Important: The HSA annual maximum contribution limits are shown below. The maximum limit includes both employee and employer contributions to the HSA.

HSA Contribution Limit	2023
Employee Only	$3,850
Family (employee + 1 or more)	$7,750
Catch-up (age 55+)	$1,000

For 2023, the Company will contribute to your HSA:

- $750 annually for employee-only coverage*
- $1,500 annually for family coverage (employee +1 or more)*

*Funds are deposited into your account each quarter. This is the company contribution for the 2023 calendar year; this amount is prorated for employees hired during 2023.

HSA Advantages

The HSA is an actual bank account and works differently than the FSA (see page 9 for FSA details). The money in the account is yours to spend or save, even if you change plans, leave the company or retire. Keep in mind that only the funds in the account are available for use.

You can use your HSA funds to pay for qualified medical, dental or vision expenses. You can also choose to let your account grow and use the funds for future health care expenses.

Funds used for health care expenses after retirement are always tax free, unlike 401(k) retirement funds, which are always taxable upon distribution. For this reason, it's wise to grow an HSA alongside your 401(k). When you reach and maintain a minimum threshold of $1,000, you can make investments to help your money grow tax free.

Qualified Expenses

Your HSA enables you to pay for the following qualified health care expenses on a tax-free basis:

- Copays, coinsurance and deductibles
- Dental and orthodontic expenses
- Smoking cessation programs
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Wheelchairs, crutches and other hardware
- Medicare/retiree health insurance premiums (excluding Medicare Supplement/Medigap insurance premiums) and COBRA premiums

For a full list of qualified expenses as defined by the IRS, visit **www.irs.gov/pub/irs-pdf/p502.pdf**.

Tips and Reminders

Here are some ways to make the most of your HSA:

- You can use the money in the account to pay for medical expenses for yourself and your tax-dependent family members—even if those dependents are not covered by your HSA medical plan.
- You can only use the funds available in your account—but you can always reimburse yourself later once you have accumulated funds in your account.
- A person making $45,000 a year can save more than $320 in taxes by putting $1,000 into an HSA for the year—that's less than $100 a month!

Contact HSA Bank

For more information, call (877) 848-0265 or visit **www.hsabank.com** (don't forget—you can add beneficiaries to your account on the site!).

Dental Plan

The Company offers a dental plan through Delta Dental, which encourages regular exams and cleanings by covering preventive care at 100% when using an in-network provider.

Dental Preferred Provider Organization (DPPO)

This plan offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a dentist who participates in the Delta Dental network.

The following is a high-level overview of the coverage available. **Coinsurance percentages shown in the below chart represent what plan members are responsible for paying.**

Key Dental Benefits	Delta Dental DPPO	
	In-Network	Out-of-Network[1]
Deductible (per calendar year)		
Per Individual	$50 per person, up to a maximum of $150 per family	
Benefit Maximum (per calendar year; preventive, basic and major services combined)		
Per Individual	$2,000	
Covered Services		
Preventive Services (Cleanings, exams, X-rays, etc.)	0%	
Basic Services (Fillings, oral surgery, periodontics, etc.)	10% after deductible	
Major Services (Crowns, dentures, bridges, implants, etc.)	50% after deductible	
Orthodontia (Child only)	50%, Lifetime Limit: $2,000	

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Contact Delta Dental

Visit **www.deltadentalil.com** or call (800) 323-1743.

Vision Plan

The Company offers vision coverage through Vision Service Plan (VSP).

The VSP vision plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the VSP network.

The following is a high-level overview of the coverage available.

Key Vision Benefits	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10 copay	Up to $45
Materials	$25 copay	N/A
Lenses (once every 12 months)	No charge after materials copay	
Single Vision		Up to $30
Bifocal		Up to $50
Trifocal		Up to $65
Frames (once every 24 months)	$175 allowance	Up to $70
Contact Lenses (once every 12 months; in lieu of glasses)	$175 allowance	Up to $105

Contact VSP

Visit **www.vsp.com** or call (800) 877-7195.

Flexible Spending Accounts

The Company provides the opportunity to participate in different flexible spending accounts (FSAs) administered through HSA Bank. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes. **Note: You must enroll each year to participate in the FSAs and/or carry over funds from the previous year.**

Health Care FSA*

The FSA contribution limit is $2,850. FSA funds may be used to cover qualified health care expenses incurred by you, your spouse and your children up to age 26. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Prescriptions
- Dental treatment
- Orthodontia
- Eye exams/eyeglasses
- LASIK eye surgery

For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p502.pdf. Participants will receive an FSA debit card, which you can use to pay your medical, dental or vision provider directly. You can also pay for expenses out-of-pocket, then submit a claim to HSA Bank for reimbursement. When submitting a claim, scan and upload your bills, Explanation of Benefits, prescriptions and/or receipts through your computer or HSA Bank's mobile app.

Note: Expenses incurred in 2023 must be submitted for reimbursement by the March 30, 2024, deadline. If you have health care FSA funds for which you have not incurred expenses in 2023, up to $610 will be rolled over to be used through December 31, 2024.

*HSA participants are not eligible to participate in the health care FSA.

Limited-Purpose Health Care FSA (for HSA participants)

If you are eligible for the HSA, you also have the option to enroll in a limited-purpose health care FSA. This type of FSA allows you to set aside additional pre-tax funds for eligible dental, orthodontia and vision expenses.

Participants will receive an FSA debit card, which you can use to pay your dental or vision provider directly. You can also pay for expenses out-of-pocket, then submit a claim to HSA Bank for reimbursement. When submitting a claim, scan and upload your bills, Explanation of Benefits, prescriptions and/or receipts through your computer or HSA Bank's mobile app.

Note: Expenses incurred in 2023 must be submitted for reimbursement by the March 30, 2024, deadline. If you have health care FSA funds for which you have not incurred expenses in 2023, up to $610 will be rolled over to be used through December 31, 2024.

Dependent Care FSA

You may contribute up to $5,000 (per family) to cover eligible dependent care expenses ($2,500 if you and your spouse file separate tax returns). Some eligible expenses include:

- Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers
- Care of a household member who is physically or mentally incapable of caring for themself and qualifies as your federal tax dependent

For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p503.pdf.

Note: Expenses incurred in 2023 must be submitted for reimbursement by the March 30, 2024, deadline. There is no rollover provision for the dependent care FSA.

Contact HSA Bank

Visit **www.hsabank.com** or call (877) 848-0265.

Life and AD&D Insurance

The Company provides eligible employees with a basic life and accidental death and dismemberment (AD&D) insurance program administered by Aflac. The Company provides this core benefit at no cost to you. You can add or update your beneficiaries on MPower when you enroll.

Basic Life/AD&D (Company-paid)

Benefit Amount	1 x your annual base salary

Voluntary Life/AD&D (Employee-paid)

Benefit Amount	
Employee	$10,000 increments up to $500,000
Spouse	$5,000 increments up to $250,000 (not to exceed 50% of employee election amount)
Child	$2,000 increments up to $10,000
Guaranteed Issue Amount	
Employee	$250,000
Spouse	$50,000
Child	$10,000

If you have previously waived coverage or would like to increase your voluntary life/AD&D benefit, you must complete an Evidence of Insurability (EOI) form.

Note: Voluntary life benefits are subject to age reduction.

Voluntary Life/AD&D Rates (Monthly)

Employee Age	Per $1,000 in Coverage	
	Employee/Spouse	Child
Up to 24	$0.095	$0.234
25-29	$0.095	
30-34	$0.115	
35-39	$0.125	
40-44	$0.150	
45-49	$0.217	
50-54	$0.320	
55-59	$0.489	
60-64	$0.695	
65-69	$1.305	
70-74	$2.095	
75+	$4.345	

Note: If you experience a birthday midway through the year that brings you up the next age tier, your rate will change accordingly.

Disability Insurance

The Company provides disability insurance at no cost to you. Disability coverage replaces part of your lost income when you become unable to work due to a covered injury or illness.

Short-Term Disability (Company-paid)	
Benefit Percentage	100% of pay (or 60% of pay on sliding scale based on your years of service, as shown in the table below)
When Benefits Begin	After 7th day of disability
Maximum Benefit Duration	25 weeks

Years of Service	# of weeks at full pay	# of weeks at 60% pay
Less than 1 year	8	17
1 year, but less than 2 years	8	17
2 years, but less than 3 years	8	17
3 years, but less than 4 years	8	17
4 years, but less than 5 years	10	15
5 years, but less than 6 years	12	13
6 years, but less than 7 years	14	11
7 years, but less than 8 years	16	9
8 years, but less than 9 years	18	7
9 years, but less than 10 years	22	3
10 years and over	25	0

Long-Term Disability (Company-paid)	
Benefit Percentage	60% of your annual base salary
Monthly Benefit Maximum	$20,000
When Benefits Begin	After 26 weeks of medically certified disability and recertification of ongoing disability
Maximum Benefit Duration	Social Security Normal Retirement Age

Visit MPower to add a beneficiary(s) to your coverage!

Marmon Employees’ Retirement Plan

You are eligible to participate in the Marmon Employees’ Retirement Plan (MERP), our 401(k) program for reaching your retirement goals. MERP offers flexibility, control and the right tools to help you prepare for your future. You save money on taxes by contributing pre-tax funds from your paycheck, and you get to decide how much of your salary you set aside—anywhere from 1% to 60% (within IRS limits). To help you start saving today, **Marmon matches 100% of your contributions up to 3%; Marmon will also match an additional 50% of the next 2% you contribute.** You are always fully vested in Marmon’s company match, meaning you own those contributions. The Company may also choose to make an additional discretionary contribution to eligible employees. For full details, see the plan document Marmon Employees’ Retirement Plan documents located on your My Benefits Dashboard on MPower.

2023 IRS Annual Contribution Limits	
Plan members under age 50	$22,500
Plan members who reach age 50+ during plan year	$7,500 ($30,000 total)

Roth 401(k) Option

You can enroll in a Roth 401(k) account through MERP. With a Roth 401(k), you contribute after-tax dollars to your retirement account. Those contributions, and any investment earnings, will then grow tax free.

You can determine if Roth account contributions are right for you with the Roth calculator on **www.empowermyretirement.com**.

Comparing Traditional and Roth Accounts

Roth accounts allow you to set aside taxable funds now, instead of at a later date when you may be in a higher tax bracket. Use the table below to help determine whether a traditional or Roth account is right for you and your family.

	Traditional Account	Roth Account
You invest	Pre-tax dollars	After-tax dollars
Investment Grows	Tax-deferred	
Income Limitation	No income limitation	No income limitation, unlike a Roth IRA
Withdrawals and Earnings	Certain requirements regarding distribution apply. For more information, refer to the MERP Summary Plan Description or contact Empower (formerly MassMutual).	Withdrawals of contributions and investment earnings are tax free if you are 59 ½ or older and have held the account for five years or more.
Annual Contribution Limits	Annual contribution limits are announced before each new year. In 2023, total combined pre-tax and Roth contributions to all qualified retirement plans are limited to $22,500 ($30,000 for employees age 50 and over).	
Employer Match, If Available	Made by your employer with pre-tax dollars to accumulate in the same account and be taxed as income at withdrawal.	Made by your employer with pre-tax dollars to accumulate in a separate account and be taxed as income at withdrawal.
When Changing Jobs	You can roll it into your new traditional retirement plan or an IRA.	You can roll it into a new Roth retirement plan or a Roth IRA.

Vesting

- Your contributions through payroll contributions are 100% vested at all times.
- The company’s match on those contributions is also 100% vested.
- Eligible employees can contribute to Marmon’s 401(k) plan up to the IRS limits using tax-deferred dollars. Marmon makes matching contributions of 100% on the first 3%, then 50% on the next 2% for a total, potential match of 4% of the employee’s eligible earnings. Additionally, each year the Company can elect to make a Retirement Contribution to the plan; this means all eligible employees receive this contribution regardless of their individual contribution levels.
- Retirement contributions made by Marmon are done annually. Employees are 100% vested at all times in salary deferrals and employer-matching contributions. Retirement contributions are subject to a five-year graded vesting schedule.

Contact Empower (formerly MassMutual)

Visit **www.empowermyretirement.com** or call (844) 465-4455.

Employee Assistance Program (EAP)

(Provided to employees and their dependents at no cost)

Life is full of challenges, and sometimes balancing it all can be difficult. We are pleased to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families.

The EAP can help with the following issues, among others:

- Mental health
- Relationships or marital conflicts
- Child and eldercare
- Substance abuse
- Grief and loss
- Legal or financial issues

EAP Benefits

- Assistance for you and your household members
- Up to three in-person sessions with a counselor per issue, per year, per individual
- Unlimited toll-free phone access and online resources

Contact LifeWorks:

Visit **www.login.lifeworks.com** or call (844) 246-7674 (username: **Marmon** | password: **eap**).

Contact Information

Coverage	Carrier	Phone #	Website/Email	Mobile App
Medical/ Prescription Drug	Blue Cross Blue Shield of Illinois	Health Advocacy Program: (800) 318-4360	**www.bcbsil.com**	Blue Cross and Blue Shield of Illinois
Rx Mail Order	Express Scripts Accredo		**www.esrx.com/BCBSIL** **www.accredo.com/BCBSIL**	Express Scripts
Telehealth	MDLIVE		**www.mdlive.com/marmon**	MDLIVE
Diabetes Management	Livongo		**get.livongo.com/Marmon/register**	Livongo
Hypertension				
Wellness	Well OnTarget		**members.hcsc.net/wps/portal/wellontarget**	AlwaysOn® Wellness
Expert Medical Guidance/Second Opinion	ConsumerMedical		**www.myconsumermedical.com** company code: MARMON	MyMedicalAlly
Dental	Delta Dental	(800) 323-1743	**www.deltadentalil.com**	Delta Dental Mobile
Vision	VSP	(800) 877-7195	**www.vsp.com**	VSP Vision Care on the Go
Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs) and Transit	HSA Bank	(877) 848-0265	**www.hsabank.com**	HSA Bank Mobile
401(k)	Empower	(844) 465-4455	**www.empowermyretirement.com**	Empower Retirement
Employee Assistance Program (EAP)	LifeWorks	(844) 246-7674	**www.login.lifeworks.com** username: **Marmon** password: **eap**	LifeWorks

Important Notices

CHIPRA/CHIP Notice
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, 2022. 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: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://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/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2

INDIANA - Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
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/masshealth/pa Phone: 1-800-862-4840 | TTY: (617) 886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 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

Important Notices

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/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: 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
Website: 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 and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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

Annual Notice of Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; prosthesis; treatment of physical complications of the mastectomy, including lymphodema. These benefits are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits under the plan. Call your plan administrator at (312) 845-5374 for more information.

Notice of Availability of HIPAA Notice of Privacy Practices

Marmon Holdings, Inc.
181 W. Madison, 39th Floor, Chicago, IL 60602
10/1/2022

To: Participants in the BCBS PPO Premier Plan, BCBS HDHP Balanced Plan, Delta Dental PPO Dental Plan, VSP Vision Plan, HSA Bank Flexible Spending Account, HSA Bank Health Savings Account, Aflac Life/AD&D, Aflac Short-Term Disability or Aflac Long-Term Disability plans

From: Melody Canak, Director, Benefits

Re: Availability of Notice of Privacy Practices

The If Yes, list all plan names here (each a "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 Melody Canak, Director, Benefits at 181 W. Madison, 39th Floor, Chicago, IL 60602, 312-845-5374, melody.canak@marmon.com.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2022 for coverage starting January 1, 2023.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.61% (for 2023) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you

Important Notices

may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact. Melody Canak, Director, Benefits at 181 W. Madison, 39th Floor, Chicago, IL 60602, 312-845-5374, melody.canak@marmon.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Part B (optional): Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Marmon Holdings, Inc.	**4. Employer Identification Number (EIN)** 36-3104690
5. Employer address, 7. City, 8. State, 9. Zip Code 181 W. Madison, 39th Floor, Chicago, IL 60602	**6. Employer phone number** 312-845-5374
10. Who can we contact about employee health coverage at this job? Melody Canak, Director, Benefits	
11. Phone number (if different from above) 312-845-5374	**12. Email address** melody.canak@marmon.com

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

As your employer, we offer a health plan to:

☒ All Full Time Employees
☐ Some Employees

With respect to dependents:

☒ We do offer coverage to eligible dependents.
☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment , coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

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

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

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

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

If you think you've been wrongly billed, contact:

Employee Benefits Security Administration
Department of Labor
200 Constitution Ave. NW
Washington, DC 20210
866-444-3272

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

DISCLAIMER: The material in this benefits brochure is for informational purposes only and is neither an offer of coverage nor medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between the plan documents and this information, the plan documents will always govern. **Annual Notices:** ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The Company will distribute all required notices annually.