2027 | All Employees

Benefits Guide



Inside

New this Year! 3
Contacts 4
Eligibility 5
Employee Contributions 6
Medical 7
Medical 8
Your Medical Plan: Fairos & SISCO 9
Healthcare Tips 11
Health Savings Account 12
Know Where to Go for Care 166
Employee Assistance Program 177
Vision 188
Dental 19
Life 20
Short-Term Disability 21
Supplemental Health 22
State & Federal Benefits Assistance 233
Discount Program 244
401(K) 255
Benefits On The Go 266
Benefit Terms 277
Havco Wood Products, LLC Hospitalization & Major Medical Plan: Important Disclosures & Notices .. 288

Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

Welcome

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

When to Enroll

- **Current Employees:** Open enrollment, which usually occurs in November, is your once-a-year opportunity to adjust benefit coverages and update any dependents. It's also a good time to review and update your beneficiaries on applicable policies.
- **New Hires:** Once eligible, you must complete your enrollment within 30 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.

Enroll online by scanning the QR Code!

Scan QR code or visit
https://bit.ly/HVC-E-G

- Access the self-service enrollment website at:
  You may use a computer or any mobile device.
- Username - Employee ID or full SSN
- Password is a 6-digit PIN consisting of the last 4 digits of your SSN followed by your 2-digit birth year.
  - For example, if your SSN is ###-##-4321 and your DOB is 08/06/1988, you would have a pin of 432188

Need Help?

Call BenManage: 314-827-0616 (Hours: 8:00 a.m. – 5:00 p.m. CST)

When to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Medicare Part D Notice: If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page 34-36 for details.

New this Year!

Benefit Highlights

Benefit changes take effect on **01/01/2027**.

Protect Your **Health**

- **Medical**: Moving to Fairos + (Reference Based Pricing) and Cigna (Buy Up Plan with Broad Network) with broader provider network access and slight adjustments to employee contributions.
- **Dental**: Coverage will continue to be offered through Delta Dental with no changes to employee rates and no major plan changes.
- **Vision:** Coverage will continue to be offered through UHC Vision with slight increase to employee rates and no major plan changes.

Protect Your **Family**

- **Employer-Provided Life/AD&D:** Havco provides 1x annual earnings rounded to the nearest thousand of coverage!
- **Voluntary Life/AD&D:** Provide financial security for your loved ones if you pass away. Health questions may be required to enroll.

Protect Your **Income**

- **Employer-Provided Short-Term Disability:** Havco provides income replacement in the event you are unable to work due to injury or illness to all hourly team members. Pre-existing condition limitations may apply.

Protect Your **Wallet**

- **Voluntary Accident, Critical Illness, and Hospital Indemnity:** Get cash benefits for non-work-related accidents, diagnoses such as cancer, stroke, or heart attack, or hospital stays including routine pregnancy. The Critical Illness plan includes a $100 wellness benefit that pays you for completing annual health screenings.
- **LifeTime Benefit Term Policy:** With Long Term Care rider.

How to Enroll:
Action Required!

To ensure you are covered appropriately, everyone is required to complete open enrollment between November 9 – November 20, 2026.

Enroll Online By Scanning the QR Code.

Scan QR code or visit
https://bit.ly/HVC-E-G

- Access the self-service enrollment website at:
  You may use a computer or any mobile device.
- Username - Employee ID or full SSN
- Password is a 6-digit PIN consisting of the last 4 digits of your SSN followed by your 2-digit birth year.
  - For example, if your SSN is ###-##-4321 and your DOB is 08/06/1988, you would have a pin of 432188

Need Help?

You can enroll over the phone with help from BenManage!

314-827-0616
(Hours: 8:00 a.m. – 5:00 p.m. CST)

Contacts

	Havco Benefits Contact			
Human Resource Contacts	HAVCO	Kristen Daniel	573-332-2522	kdaniel@havco.com
		Heather Minton – Missouri	573-334-6024 Ext.550	hminton@havco.com
		Quinn Satherlie - Tennessee	423-884-6641	qsatherlie@havco.com
BenManage	BenManage	314-827-0616	https://bit.ly/HVC-M-G	

Coverage	Carrier		Phone #	Website/Email
Medical	Cigna	Cigna.	1(800)- 997-1654.	https://www.cigna.com/individuals-families/member-guide/mycigna
Medical	Fairos +	FAIROS POWERED BY OccuNet	(833) 464-0290	https://fairos.com/members/login
Dental	Delta Dental	DELTA DENTAL	(800) 335-8266	https://members.deltadentalmo.com/login
Vision	UHC Vision	United Healthcare	(800) 638-3120	myuhcvision.com
Pharmacy	Optum	OPTUM	800-788-4863	optumrx.com
Health Savings Account	HSA Bank	hsabank	(800)-357-6246	hsabank.com
Life AD&D **Short Term Disability**	Renaissance	Renaissance BENEFITS	Customer Service: 800-894-4532 Claims: 844-368-6485	RenaissanceBenefits.com
Supplemental Insurance	Chubb	CHUBB	LifeTime Benefit Term: 855-241-9891 Accident, CI, & HI: 833-542-2013	chubb.com
Retirement/ 401(K)	Empower	EMPOWER RETIREMENT	855-756-4738	empower-retirement.com

Eligibility

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have 30 days from your initial start date to enroll in benefits.

- **Medical, Dental, Vision:** These coverages will take effect on the first of the month following 30 days of employment.
- **Other Coverages:*** All other coverages will take effect on the first of the month following 30 days of employment.

* **IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of "Eligible Dependents"

Medical, Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed.
- **Your dependent children under age 26**. This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page **20** for definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a "spouse", and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.

Making Changes

Internal Revenue Service (IRS) regulations stipulate that eligible employees may only make plan elections once a year. Elections are binding through December 31, 2025. The following qualifying life events are reasons you may change your benefit election during the plan year provided you inform Human Resources in writing within 30 days of the event date:

- Marriage
- Birth, adoption, or placement of a child for adoption
- Divorce or legal separation
- Termination or commencement of your spouse's coverage in general when coverage is maintained through your spouse's plan.
- Shift from part-time to full-time status (or vice versa) by you or your spouse
- Death of spouse or dependent
- Qualified Medical Support Order
- Change of Residence
- Becoming a U.S. Citizen Changes requested due to a "change of mind" cannot be allowed until the next open enrollment period.



Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your paycheck each week. Please contact Human Resources regarding any questions or concerns.

Medical	Fairos Copay Plan		Fairos HDHP Plan		Cigna Copay Plan		Cigna HDHP Plan	
	Wellness	Non-Wellness	Wellness	Non-Wellness	Wellness	Non-Wellness	Wellness	Non-wellness
Employee Only	$48.47	$70.28	$26.39	$38.27	$65.11	$94.41	$39.52	$57.31
Employee + Spouse	$97.95	$142.03	$53.28	$77.26	$131.22	$190.28	$80.11	$116.16
Employee + Child	$97.95	$142.03	$53.28	$77.26	$131.22	$190.28	$80.11	$116.16
Employee + Child(ren)	$131.31	$190.40	$64.42	$93.41	$177.08	$256.76	$102.92	$149.23
Family	$131.31	$190.40	$64.42	$93.41	$177.08	$256.76	$102.92	$149.23

Dental (Weekly Premiums)	Base Plan	Buy Up Plan
Employee Only	$1.75	$3.15
Family	$6.35	$11.00

Vision (Weekly Premiums)	
Employee Only	$1.49 *(+ $0.05 per Week)*
Employee + Spouse	$2.97 *(+ $0.08 per Week)*
Employee + Child(ren)	$3.16 *(+ $0.09 per Week)*
Family	$4.97 *(+ $0.13 per Week)*

Basic Life/AD&D **Short Term Disability**	Employer-provided
Voluntary Life/AD&D **Accident** **Critical Illness** **Hospital Indemnity**	To view your personalized rates, log in to BenManage.

Medical

Fairos



https://fairos.com/members/login
call (833) 464-0290

Medical	Fairos Copay Plan	Fairos HDHP Plan
	In-Network	In-Network
Annual Deductible		
Individual	$1,250	$3,500
Family	$2,500	$7,000
Coinsurance (Plan Pays/You Pay)	90% / 10%	100% / 0%
Annual Out-of-Pocket Maximum		
Individual	$2,500	$3,500
Family	$5,000	$7,000
Services	In-Network	In-Network
Preventive Care	Covered 100%	Covered 100%
Primary Care Office Visit	$10	0% after deductible
Specialist Office Visit	$10	0% after deductible
Urgent Care	$75	0% after deductible
Emergency Room	$200 before deductible $200 + 10% after deductible	0% after deductible
Hospitalization	10% after deductible	0% after deductible
Prescription Drugs		
Tier 1	$8	$0 after deductible
Tier 2	$25	$0 after deductible
Tier 3	$45	$0 after deductible
Tier 4	25%, max $200	$0 after deductible

Medical Weekly Cost	Fairos Copay Plan		Fairos HDHP Plan	
	Wellness	Non-Wellness	Wellness	Non- Wellness
Employee Only	$48.47	$70.28	$26.39	$38.27
Employee + Spouse	$97.95	$142.03	$53.28	$77.26
Employee + Child	$97.95	$142.03	$53.28	$77.26
Employee + Child(ren)	$131.31	$190.40	$64.42	$93.41
Family	$131.30	$190.40	$64.42	$93.41

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Medical

Cigna



Locate an in-network provider near you at https://www.cigna.com/individuals-families/member-guide/mycigna or call 1(800)- 997-1654.

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	Cigna Copay Plan		Cigna HDHP Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$2,500	$5,000	$7,000	$14,000
Family	$5,000	$10,000	$14,000	$28,000
Coinsurance (Plan Pays/You Pay)	70% /30%	50% / 50%	100% / 0%	50% / 50%
Annual Out-of-Pocket Maximum				
Individual	$5,000	$10,000	$7,000	$14,000
Family	$10,000	$20,000	$14,000	$28,000
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care	Covered 100%	Covered 100%	Covered 100%	
Primary Care Office Visit	$30	50% after deductible	0% after deductible	
Specialist Office Visit	$30	50% after deductible	0% after deductible	
Urgent Care	$100	50% after deductible	0% after deductible	
Emergency Room	$200 before deductible $200 + 30% after deductible		0% after deductible	
Hospitalization	30% after deductible	50% after deductible	0% after deductible	
Prescription Drugs				
Tier 1	$8		$0 after deductible	
Tier 2	$25		$0 after deductible	
Tier 3	$45		$0 after deductible	
Tier 4	25%, max $200		$0 after deductible	

Medical Weekly Cost	Cigna Copay Plan		Cigna HDHP Plan	
	Wellness	Non-Wellness	Wellness	Non- Wellness
Employee Only	$65.11	$94.41	$39.52	$57.31
Employee + Spouse	$131.22	$190.28	$80.11	$116.16
Employee + Child	$131.22	$190.28	$80.11	$116.16
Employee + Child(ren)	$177.08	$256.76	$102.92	$149.23
Family	$177.08	$256.76	$102.92	$149.23

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Your Medical Plan: Fairos & SISCO

Who are Fairos & SISCO?

Fairos will serve as your plan's Medical Open Access "Network." The Fairos Advocacy Team is available to answer any questions relating to your providers and plan acceptance as well as assist in resolving issues related to provider billing issues.

Fairos+ serves as your Health Plans Benefit Advocacy Service ready to assist all members and providers. Fairos+ will answer your benefit and eligibility questions as well as help guide you through finding providers and understanding your new Open Access health plan.

Sisco serves as your Health Plan Administrator, working closely with your employer to handle all administrative aspects of their plan. Sisco will be issuing your ID Cards, handling the Care Management aspects of your health care journey, processing your medical claims, and more.

What is Reference-Based Pricing?

- Reference-Based Pricing (RBP) is a cost-containment pricing model for healthcare services.
- RBP controls cost and promotes transparency in healthcare pricing.
- RBP sets a max limit on what the plan will pay for certain treatments or procedures.
- Providers are paid a fair percentage above a reference price, often based on Medicare rates.
- RBP plans offer an open network of providers to choose from.
- RBP ensures fair payments to providers.
- RBP reimburses around 50% above Medicare rates.

Member Experience

How to Access Physician Care:

- You are part of an open network for physician care.
- This means all hospital facilities are eligible to provide services to you and your dependents.
- If the front desk has any questions about your insurance that you are unable to answer, advise them to call Fairos+ at (833) 464-0290.

How to Access Hospital Care:

- You are part of an open network for hospital care.
- This means all hospital facilities are eligible to provide services to you and your dependents.
- If the front desk has any questions about your insurance that you are unable to answer, advise them to call Fairos+ at (833) 464-0290.

How to Pay Your Medical Bill:

- Compare the price of your medical bill to your Explanation of Benefits (EOB) before making any payment.
- You will receive your EOB in the mail.
- If the price of your medical bill matches your patient's responsibility on the EOB, you can pay the bill.
- If the price of your medical bill does not match your patient's responsibility on the EOB, this is a balance bill.

If You Receive a Balance Bill, Follow These Steps:

- Call Fairos+ at (833) 464-0290 to confirm you have a balance bill.
- You will be assigned a designated Fairos Advocate.
- You will have direct access to them via phone, the portal & email.
- You can track the status of your balance bill on the Fairos portal.
- Expect frequent updates from your Fairos Advocate at a minimum of every 15 calendar days until it's resolved.

What do I tell the provider if they do not recognize my insurance or Member ID card?

- Fairos is an open network that allows you to access the provider of your choice.
- They can call Fairos+ at (833) 464-0290 for any questions regarding your Fairos benefit plan.
- Fairos+'s number is on your Member ID Card.

What if my doctor or hospital has questions about my insurance plan?

- Your doctor or hospital should call Fairos+ at (833) 464-0290.
- Fairos+ will handle any questions regarding your benefit plan.

What happens if the provider requests payment at time of service?

- Confirm with the provider that they called Fairos+ to verify benefits.
- Any applicable co-pays will need to be paid at time of service.

What happens if the provider won't accept my insurance?

- Call Fairos+ at (833) 464-0290 for further assistance.

How do I find a provider that will accept my insurance?

- Fairos is an open network, meaning you can go to your provider of choice.
- If you're having difficulty finding a provider to accept your insurance, you can call Fairos+ at (833) 464-0290.
- Fairos+ will assist in finding an alternative provider that can provide the medical services you need.

Do you have a list of preferred Hospitals that I should visit?

- Members should call Fairos+ at (833) 464-0290 regarding where to access the best care experience.
- Once enrolled on the medical plan, members may also access a complete list of preferred providers by logging into the Fairos Member Portal or App.

Member Journey

How To Access Physician Care



1. Meet John
2. John needs to see a physician
3. His health plan participates in the PRIME Practitioner and Ancillary Only Network
4. PRIME is a Practitioner and Ancillary Only (P&A) Network of doctors John and his dependents can use
5. To find a provider, John calls Fairos+ at (833) 464-0290
6. When he arrives at the doctor's office, he shows his Member ID Card at the front desk
7. He receives treatment

How To Access Hospital Care



1. Meet John, a Fairos member
2. Havco Wood Products uses Fairos for hospital care
3. Fairos is an Open Access Network health plan
4. When John needs to visit a hospital
5. He can choose any hospital or physician he wants
6. He shows his Member ID Card at the front desk
7. He receives treatment
8. Days later, he gets a medical bill
9. He compares the medical bill and his EOB
10. If the bill matches the EOB, he pays it

99% of the time, the member journey ends here

11. If they don't match, he has a balance bill
12. John calls Fairos+ at (833) 464-0290
13. Fairos+ confirms his balance bill
14. John meets his Fairos Advocate
15. His Advocate sets him up on the Fairos portal and app
16. John receives frequent updates on his balance bill
17. Fairos settles his balance bill

Healthcare Tips

Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.

Provider The patient receives treatment. The doctor then sends the bill to the insurance company.	>	**In-Network Discount** Appropriate discount for using an in-network provider is applied.	>	**Bill** The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.
				v
Patient Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.	<	**Insurance Company Payments, Explanation of Benefits (EOB)** Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.		



Take advantage of preventive care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Health Savings Account

HSA Bank

Available to employees enrolled in the
Cigna HDHP Plan and the Fairos HDHP medical plans.

If you are enrolled in an HSA-qualified plan, you may be eligible to open a tax-free health savings account. To qualify, you cannot be covered by any health plan other than a high-deductible health plan (HDHP), and you cannot be enrolled in Medicare. The money in your HSA is carried over from year to year so you can budget for current and future expenses. Plus, you own the account so it's yours to keep even if you change jobs or retire.

Is an HSA Right for You?
www.cbmicrosite.com/video/hsa

HSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Coinsurance
- Other health-related expenses

2027 annual contribution limit	Individual	$4,500
	Family	$9,000
	Catch-up contribution (Age 55 or older)	$1,000
2027 annual employer contributions*	Individual	$600
	Family	$1,200
Rollover		Full Amount

* This amount applies to the IRS annual contribution limit.

All HSA contributions require an open and active account. Contributions cannot be made and are forfeited if no active account exists and cannot be paid later or in a different form.

Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or Human Resources to learn more.



Visit www.irs.gov and search for IRS Publication 502 to learn more about eligible expenses.

HSA Case Study

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

Year 1		→	Year 2	
HSA Balance	$1,000		HSA Balance	$1,850
Total Expenses: Prescription drugs: $150	- $150		**Total Expenses:** Office visit: $100 Prescription drugs: $200 Preventive care services: $0 (covered by insurance)	- $300
HSA Rollover to Year 2	$850		**HSA Rollover to Year 3**	$1,550

Since Justin did not spend all his HSA dollars in year 1, the remaining funds roll over.

Once again Justin did not spend all his HSA dollars, so they roll over to the next year.

Single Employee Coverage

Assumptions: Strategic Consult, In-Network Providers, and Max Rx Copay

$2,000 in Costs Example

Cost Assumptions:

4 - $100 Office Visits
1 - $500 ER Visit
1 - $500 ER Additional Costs
3 - $200 Urgent Care Visits

$2,000 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 1,372	$ 2,520	$ 2,055	$ 3,386
Deductible	$ 2,000	$ 500	$ 2,000	$ 500
Copay / Coinsurance	$ -	$ 465	$ -	$ 620
Health Savings Contribution	$ (600)	$ -	$ (600)	$ -
Total Cost to You	**$ 2,772**	**$ 3,485**	**$ 3,455**	**$ 4,506**

$3,500 in Costs Example

Cost Assumptions:

5 - $100 Office Visits
5 - $200 Specialist Visits
1 - $500 ER Visit
1 - $500 ER Additional Costs
5 - $200 Urgent Care Visits

$3,500 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 1,372	$ 2,520	$ 2,055	$ 3,386
Deductible	$ 3,500	$ 500	$ 3,500	$ 500
Copay / Coinsurance	$ -	$ 675	$ -	$ 1,000
Health Savings Contribution	$ (600)	$ -	$ (600)	$ -
Total Cost to You	**$ 4,272**	**$ 3,695**	**$ 4,955**	**$ 4,886**

$20,000 in Costs Example

Cost Assumptions:

5 - $100 Office Visits
1 - $16,250 Hospitalization
5 - $250 Specialty Office Visits
2 - $1000 Rx

$20,000 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 1,372	$ 2,520	$ 2,055	$ 3,386
Deductible	$ 3,500	$ 1,250	$ 7,000	$ 2,500
Copay / Coinsurance	$ -	$ 1,250	$ -	$ 2,500
Health Savings Contribution	$ (600)	$ -	$ (600)	$ -
Total Cost to You	**$ 4,272**	**$ 5,020**	**$ 8,455**	**$ 8,386**

Example

**Examples are for informational purposes only and should not be used alone when making election decisions. It is each employees' sole responsibilty to elect or forgo benefits based upon their individual circumstances.*

EE+Spouse / EE+Child Coverage

Assumptions: Strategic Consult, In-Network Providers, Max Rx Copay, & No Individual Deductibles Met

$5,000 in Costs Example

Cost Assumptions:
10 - $100 Office Visits
4 - $1000 Rx
$5,000 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 2,771	$ 5,093	$ 4,166	$ 6,823
Deductible	$ 5,000	$ -	$ 5,000	$ -
Copay / Coinsurance	$ -	$ 900	$ -	$ 1,100
Health Savings Contribution	$ (1,200)	$ -	$ (1,200)	$ -
Total Cost to You	**$ 6,571**	**$ 5,993**	**$ 7,966**	**$ 7,923**

$8,500 in Costs Example

Cost Assumptions:
5 - $100 Office Visits
5 - $200 Urgent Care Visits
2 - $500 ER Visits
2 - $500 ER Additional Costs
10 - $500 Rx
$8,500 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 2,771	$ 5,093	$ 4,166	$ 6,823
Deductible	$ 7,000	$ 1,000	$ 7,000	$ 1,000
Copay / Coinsurance	$ -	$ 2,825	$ -	$ 3,050
Health Savings Contribution	$ (1,200)	$ -	$ (1,200)	$ -
Total Cost to You	**$ 8,571**	**$ 8,918**	**$ 9,966**	**$ 10,873**

$35,000 in Costs Example

Cost Assumptions:
5 - $100 Office Visits
5 - $200 Urgent Care Visits
1 - $25,000 Hospitalization
10 - $250 Specialty Office Visits
12 - $500 Rx
$35,000 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 2,771	$ 5,093	$ 4,166	$ 6,823
Deductible	$ 7,000	$ 2,500	$ 14,000	$ 5,000
Copay / Coinsurance	$ -	$ 2,500	$ -	$ 5,000
Health Savings Contribution	$ (1,200)	$ -	$ (1,200)	$ -
Total Cost to You	**$ 8,571**	**$ 10,093**	**$ 16,966**	**$ 16,823**

Example

**Examples are for informational purposes only and should not be used alone when making election decisions. It is each employees' sole responsibilty to elect or forgo benefits based upon their individual circumstances.*

EE+Children / Family Coverage

Assumptions: Strategic Consult, In-Network Providers, Max Rx Copay, & No Individual Deductibles Met

$7,000 in Costs Example

Cost Assumptions:
10 - $100 Office Visits
6 - $1000 Rx
$7,000 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 3,350	$ 6,828	$ 5,352	$ 9,208
Deductible	$ 7,000	$ -	$ 7,000	$ -
Copay / Coinsurance	$ -	$ 1,300	$ -	$ 1,500
Health Savings Contribution	$ (1,200)	$ -	$ (1,200)	$ -
Total Cost to You	**$ 9,150**	**$ 8,128**	**$ 11,152**	**$ 10,708**

$15,000 in Costs Example

Cost Assumptions:
4 - $100 Office Visits
1 - $14,000 Hospitalization
3 - $200 Urgent Care Visits
$15,000 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 3,350	$ 6,828	$ 5,352	$ 9,208
Deductible	$ 7,000	$ 2,500	$ 14,000	$ 5,000
Copay / Coinsurance	$ -	$ 1,415	$ -	$ 3,120
Health Savings Contribution	$ (1,200)	$ -	$ (1,200)	$ -
Total Cost to You	**$ 9,150**	**$ 10,743**	**$ 18,152**	**$ 17,328**

$30,000 in Costs Example

Cost Assumptions:
10 - $100 Office Visits
5 - $200 Urgent Care Visits
2 - $10,000 Hospitalizations
8 - $1000 Rx
$30,000 Total Costs

	Fairos - HDHP	Fairos - Copay	Cigna - HDHP	Cigna - Copay
Annual Premium	$ 3,350	$ 6,828	$ 5,352	$ 9,208
Deductible	$ 7,000	$ 2,500	$ 14,000	$ 5,000
Copay / Coinsurance	$ -	$ 2,500	$ -	$ 5,000
Health Savings Contribution	$ (1,200)	$ -	$ (1,200)	$ -
Total Cost to You	**$ 9,150**	**$ 11,828**	**$ 18,152**	**$ 19,208**

Example

**Examples are for informational purposes only and should not be used alone when making election decisions. It is each employees' sole responsibilty to elect or forgo benefits based upon their individual circumstances.*

Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room ($$$$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Poisoning



Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Urgent Care ($$$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office ($$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.



Employee Assistance Program

H&H Health Associates

Available to all employees.

Life. Just when you think you've got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you and your family find solutions and peace of mind. In-Person, Video, Phone, Chat, and Messaging connection options!

Confidential Support

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

Contact information:

800-832-8302

info@hhhealthassociates.com

Vision

UHC

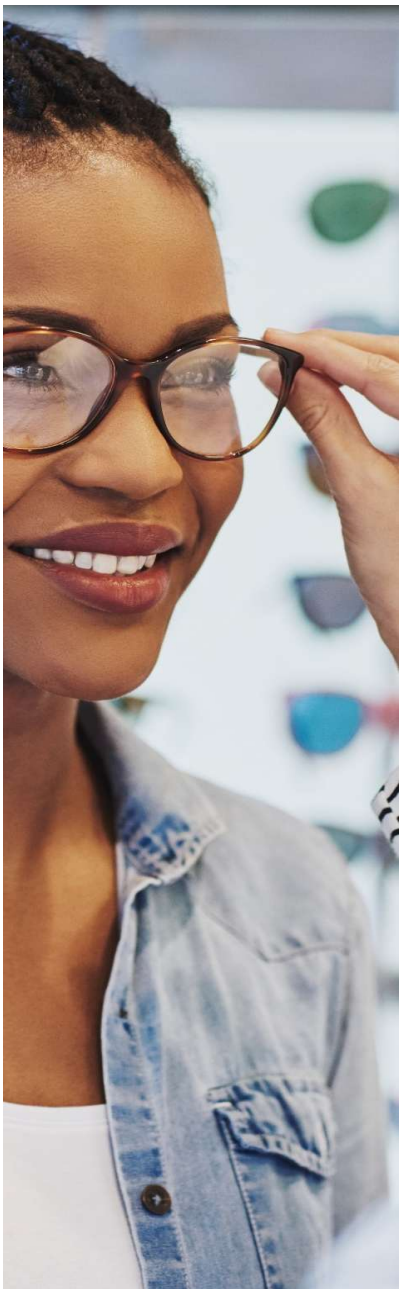
Vision	In-Network	Out-of-Network Allowance
Exam	$10 copay	Up to $40
Lenses	Single Vision: $25 copay Bifocal: $25 copay Trifocal: $25 copay Lenticular: $25 copay Progressive: $25 copay	Up to $40 Up to $60 Up to $80 Up to $80 Up to $60
Frames	$150 allowance 30% discount applied to amount over allowance	Up to $45
Contact Lenses	Copay: $25 copay Fit & Follow-up: $40 allowance Elective: $150 allowance Medically Necessary: Covered in full after copay	N/A Up to $0 Up to $125 Up to $210

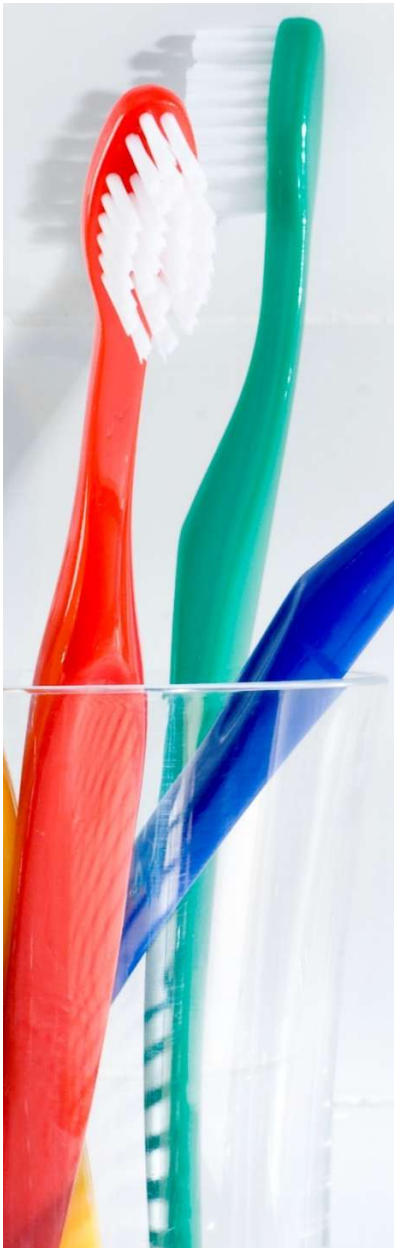
Frequencies	
Exams	1 per 12 months
Lenses or Contacts	1 per 12 months (Contacts in lieu of glasses)
Frames	1 per 12 months

Vision Cost	Weekly Premiums
Employee Only	$1.54
Employee + Spouse	$3.05
Employee + Child(ren)	$3.25
Family	$4.97

Locate an in-network provider near you at myuhcvision.com or call (800) 638-3120

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.





Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Locate an in-network provider near you at deltadentalmo.com or call Toll-Free: 800-392-1167 Local: 314-656-3000.

Dental

Delta Dental

Dental	Base Plan	Buy-Up Plan
	In-Network	In-Network
Annual Deductible	$50 per individual $150 per family	$50 per individual $150 per family
Annual Benefit Maximum	$1,500	$1,500
Lifetime Orthodontia Maximum	Not covered	50% up to $1,500 Lifetime Maximum
Plan Pays		
Preventive Care (Deductible waived)	100% Covered	100% Covered
Basic • Restorative services (fillings) • Periodontics—treatment for disease of the gums and bone supporting the teeth • Endodontics—root canal filling and pulpal therapy • Simple and surgical extractions • Oral surgery • General anesthesia in conjunction with covered surgical procedures • Brush biopsy	20% after deductible	20% after deductible
Major • Prosthetics: bridges and dentures; a replacement will be covered only once in 5 years • Crowns, inlays, and onlays, once in 5 years	Not covered	50% after deductible
Orthodontia	Not covered	50% up to $1,500 Lifetime Maximum

Dental Weekly Cost	Base Plan	Buy-Up Plan
Employee Only	$1.75	$3.15
Family	$6.35	$11.00

Life

Renaissance

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D	
Benefit Amount	**Employee:** 1x employee annual salary **Spousal Coverage**: $5,000 **Dependent Children**: $2,500
Benefit Cost	Employer-provided

Voluntary Term Life/AD&D	
Benefit Amount	**Employee:** Up to $500,000 **Spouse:** Up to $250,000^ (Up to 50% of employee's benefit) **Child(ren):** Up to $10,000^
Guaranteed Issue Amount[A]	**Employee:** $200,000 **Spouse:** $30,000 **Child(ren):** $10,000
Benefit Cost	To view your personalized rates, log in to RenaissanceBenefits.com

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of the effective date. Please refer to the policy certificate or HR for more details.

Definition of "Eligible Dependents"
It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.



Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

* The value of employer-funded life insurance benefits in excess of $50,000 is

^ Dependent elections require employee enrollment and may be limited by employee volume.

A If you enroll when first eligible, you may receive up to the listed amount without having to answer medical questions.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.



Short-Term Disability

Renaissance Benefits

For hourly employees

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Protecting your income is important! That is why you will be automatically enrolled in short-term disability coverage once eligible. To opt-out, please contact Human Resources.

Short-Term Disability	
Benefit Amount	Replaces 60% of earnings, up to a $650 benefit per week
Benefit Begins	Injury: after 8 days Illness: after 8 days
Benefit Duration	Up to 13 weeks

Short-term disability excludes work-related injury or illness.

Short-Term Disability Cost	Employer Provided

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Statutory Benefits Offset:
Your short-term disability benefit will be reduced by benefits from State Disability/Paid Family & Medical Leave for which you may be eligible.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.



Supplemental Health

Chubb

The following benefits may protect your financial security in the event of an unexpected medical expense. You can use the payments however you like including out-of-pocket costs related to your care or even daily living expenses.

Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Hospital Indemnity

Helps cover the cost of hospital stays—including pregnancy and childbirth.

Get paid for taking care of your health!

If you are enrolled in Critical Illness coverage, you can receive a wellness benefit payment each year when you have a qualifying screening or test.

LifeTime Benefit with Long Term Care Benefits

Chubb's LifeTime Benefit Term's innovative design provides lifetime guarantees at a fraction of the cost. And flexibility allows you to customize benefits for Long Term Care and double the benefit amount.

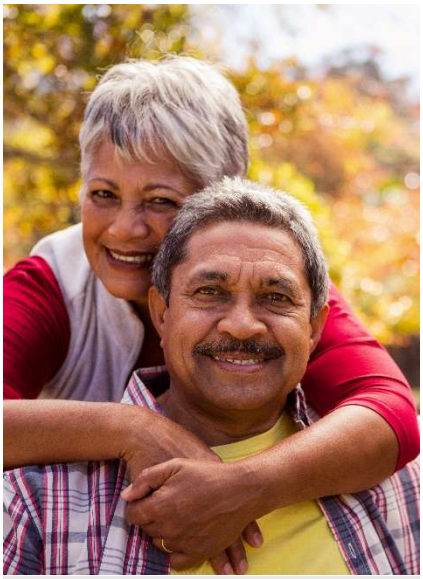
Long term care is expensive, and LifeTime Benefit term can help. It pays death benefits in advance for home health care, assisted living, adult day care and nursing home care.

Supplemental Health Cost	To view your personalized rates, log in to https://chubb.benselect.com/enroll/Login.aspx?Path=havco

Actively-at-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at the time of the effective date. Please refer to the policy certificate or HR for more details.

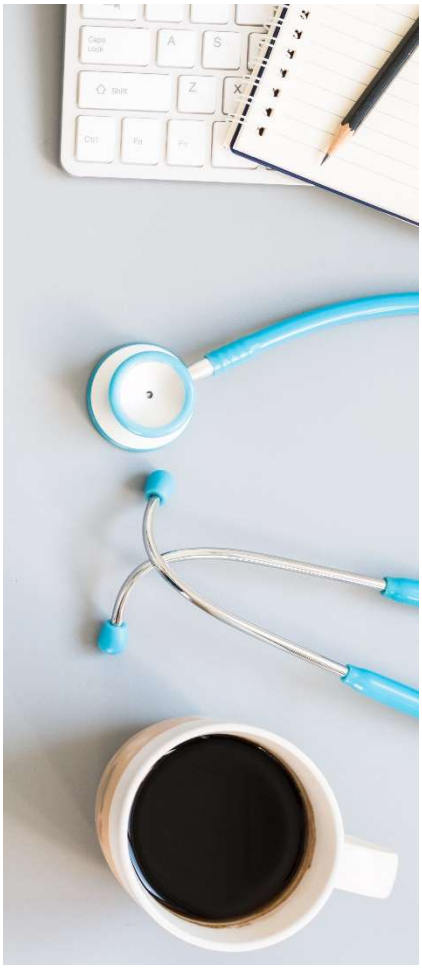
Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.



Schedule a consultation today!

(877) 837-4196

www.fedlogicgroup.com
services@fedlogicgroup.com



State & Federal Benefits Assistance

FEDlogic

We have partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members.

The service is free, unlimited, and confidential!

Get help navigating resources that you may be eligible for, such as:

- Medicare
- Medicaid
- Disability
- Social Security Retirement
- Child Benefits
- Widow Benefits
- Veterans Benefits
- Supplemental Security Income (SSI)
- Healthcare.gov (COBRA alternatives)
- End Stage Renal Disease
- ALS (Lou Gehrig's Disease)
- Cancer or Terminal Illness

Here's how it works:

① **Make a phone consultation appointment.**

Call to schedule time with a federal and state benefits expert. Invite your family to join. Calls typically last an hour.

② **Tell us your story, ask questions, and learn.**

Experts will listen to your story and understand your needs, then empower you with unbiased information so you can make the best decisions for your situation.

③ **If qualified, get enrolled.**

Once you feel confident with the information, experts will walk you through the application and approval process.

④ **Enjoy peace of mind.**

Now you know you have access to assistance programs created for situations like this.

Discount Program

PerkSpot through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Discount Program			
Shop for a Variety of Coupons & Deals from these Categories:	Apparel Auto Buying Automotive Beauty & Fragrance Books, Movies, & Music Business Perks Cell Phones Education Electronics Financial Wellness Flowers & Gifts Food Health & Wellness Hobbies & Creative Arts	Home & Garden Home Services Insurance & Protection Services Jewelry & Watches Movie Tickets Office & Business Pets Real Estate & Moving Services Sports & Outdoors Tickets & Entertainment Toys, Kids & Babies Travel	
Popular Discounted Brands*	Avis Canon Casper Columbia	Dell Enterprise Holiday Inn	Home Chef HP Ray-Ban
Benefit Cost	Included in our partnership with Cottingham & Butler		

* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at https://cottinghambutler.perkspot.com.



Unlock discounts for you and your family!

Visit: https://cottinghambutler.perkspot.com

If prompted to find your community, select our PerkSpot partner: **Cottingham and Butler**.

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers

Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alerts: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category
- Local Discounts: shop by location

401(K) Match

Empower Retirement

Havco offers a 401(k) Match program through Empower Retirement.

401(k) Match	
Contribution Amounts	401(k) provision allowing employees to make elected tax deferred contributions up to 50% of salary amount, limited to $25,500* per year. Individuals age 50 and older may contribute an additional $8,500* per year. *Projected IRS limits, IRS has not finalized next year as of print date.
Company Match	Havco matches employee contributions in accordance with the following schedule: • 100% match up to 3% of employee's salary • 50% match of the next 2% of employee's salary
Company Contribution	Havco may make an annual discretionary contribution based on company profitability

Investments are self-directed.

Empower Retirement is the Third Party Administrator.
Call 855-756-4738 or visit empower-retirement.com for more information.



Benefits On The Go

24/7 online access to benefits and service. Register today with Optum Rx, Delta Dental, Chubb, Renaissance Benefits, and Empower Retirement to:

- Review and print coverage levels, deductibles, maximums, and age limits
- Verify eligibility
- Order or print ID cards
- View Explanation of Benefits (EOB)
- Get answers to frequently asked questions

OPTUM

Scan here to go to OptumRx.com

Delta Dental

Register by visiting deltadentalmo.com/members/register or by downloading the mobile app.

CHUBB

Visit chubb.com or download the mobile app to register your account. Download the mobile app by texting “CHUBBMOBILE” to 24833 (CHUBB).

Empower

Visit participant.empower-retirement.com or download the Empower Retirement app to register your account.

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Havco Wood Products, LLC Hospitalization & Major Medical Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

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

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2026. V8. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

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

ALASKA – Medicaid
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
Health Insurance Premium Payment (HIPP) Program
Website: https://www.dhcs.ca.gov/services/health-insurance-premiumpayment-program-cost-avoidance/
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+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

ILLINOIS – Medicaid
Illinois Medicaid Premium Assistance Information
Medicaid Application Website:
https://abe.illinois.gov
HIPP Hotline Number: 217-524-8268
HIPP Email: mhfs.boc.hipp@illinois.gov

INDIANA – Medicaid
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)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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://accessnebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/
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)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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)

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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
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
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://bms.wv.gov/
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, 2026, 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 ❖

Patient Protection Notice

If the Havco Wood Products, LLC Hospitalization & Major Medical Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 10.22% of household income for the plan year beginning in 2027, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

* 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% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)
If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices
This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Havco Wood Products, LLC Hospitalization & Major Medical Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

a. Your past, present, or future physical or mental health or condition;
b. The provision of health care to you; or
c. The past, present, or future payment for the provision of health care to you.

We are required by law to:

a. maintain the privacy of your PHI;
b. provide you with certain rights with respect to your PHI;
c. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
d. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient:

1. For Treatment: When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. For example, we might disclose information about you with physicians who are treating you.

2. For Payment: We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

3. For Health Care Operations: We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

4. To Plan Sponsors: For the purpose of administering the plan, we may disclose PHI to certain employees of the Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

5. To Business Associates: We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI by entering into a Business Associate Agreement with us.

6. Substance Use Disorder (SUD) Treatment Information: Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

7. As Required by Law: We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

8. Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

9. Threats to Health or Safety: We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

10. Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

11. Law Enforcement Purposes: We may disclose your PHI if asked to do so by a law-enforcement official:

a. in response to a court order, subpoena, warrant, summons, or similar process;
b. to identify or locate a suspect, fugitive, material witness, or missing person;
c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
d. about a death that we believe may be the result of criminal conduct; and
e. about criminal conduct.

12. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, we may release PHI to identify a deceased person or to determine a cause of death or other duties as authorized by law.

13. Organ or Tissue Donation: If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

14. Military and National Security: If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

15. Workers' Compensation: We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

16. Treatment Alternatives or Health-Related Benefits and Services: We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

17. Government Required Disclosures: We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Authorizations: Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient:

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Inspect and Copy: You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if possible. If we cannot agree on an electronic form and format, or you request a paper copy, we will provide you with a paper copy. We may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

To inspect and copy your PHI, you must submit your request in writing. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. There may be a charge for the cost of providing lists beyond the last 12-month period.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. Your request must specify how or where you wish to be contacted, but you do not have to provide a reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Right to be Notified of a Breach: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Contact Information and Complaints: If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact Havco, 3200 E Outer Rd, Scott City, MO 63780, United States, 573-332-2541.

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us. ❖

Important Notice from Havco Wood Products, LLC Hospitalization & Major Medical Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Havco 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. Havco has determined that the prescription drug coverage offered by the Havco 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, your current Havco coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Havco coverage, be aware that you and your dependents will 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 Havco and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about this Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Havco 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: October 30, 2026
Name of Entity/Sender: Havco
Contact--Position/Office: Human Resources
Address: 3200 E Outer Rd, Scott City, MO 63780, United States
Phone Number: 573-332-2541 ❖

Important Notice from Havco Wood Products, LLC Hospitalization & Major Medical Plan about Your Prescription Drug Coverage and Medicare (Non-Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Havco 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Havco Wood Products, LLC Hospitalization & Major Medical Plan has determined that the prescription drug coverage offered by Havco is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Havco Wood Products, LLC Hospitalization & Major Medical Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Havco. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with Havco, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Havco Wood Products, LLC Hospitalization & Major Medical Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under the Havco Wood Products, LLC Hospitalization & Major Medical Plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Havco coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Havco coverage, be aware that you and your dependents will be able to get this coverage back.

For More Information about this Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Havco 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).

Date: October 30, 2026
Name of Entity/Sender: Havco
Contact--Position/Office: Human Resources
Address: 3200 E Outer Rd, Scott City, MO 63780, United States
Phone Number: 573-332-2541 ❖