COMANCO

SAFETY ★ QUALITY ★ SERVICE

2022 Benefits Guide

WELCOME

COMANCO is pleased to present our employee benefits program, designed specifically to benefit you, effective March 1, 2022.

COMANCO strives to provide its employees with a comprehensive, valuable benefits program offering the flexibility to customize benefits to meet your needs both now and in the future. We continue to make every effort to target the best quality benefit plans for our staff and your families.

We are proud to announce that your medical rates will continue to remain the same, with no increase. We will also continue to offer our medical plan with the current medical carrier, United Healthcare. We will offer the UHC Choice medical plan with no changes to the plan. Details about the medical plan can be found on page 6.

Guardian will continue to be the dental carrier. Superior Vision will continue to be the vision carrier. Details can be found on pages 10-11.

Mutual of Omaha will continue to be the carrier on Basic Life/AD&D, Voluntary Life/AD&D, Short-Term Disability, Voluntary Accident, and Voluntary Critical Illness coverage. Details can be found on pages 12-16.

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BENEFITS OVERVIEW

Below is a brief description of each benefit offered to COMANCO employees for the plan year March 1, 2022 - February 28, 2023.

Medical
Medical coverage is offered through **UnitedHealthcare.**

Dental
Dental coverage is offered through **Guardian**.

Vision
Vision coverage is offered through **Superior Vision.**

Basic Life and AD&D
Life insurance and accidental death & dismemberment coverage is provided to all full-time, benefit-eligible employees in the amount of $15,000. COMANCO provides this coverage through **Mutual of Omaha.**

Voluntary Life
You will have the opportunity to purchase voluntary life coverage for yourself and your dependents. Coverage is offered through **Mutual of Omaha.**

Short-Term Disability
COMANCO provides short-term disability through **Mutual of Omaha**.
You also have a Short-Term Disability Buy-Up Option, which allows you to purchase an increased benefit.

401(k)
COMANCO automatically enrolls you into the **VOYA** 401(k) Retirement Plan and provides matching funds.

Employee Assistance Program
An Employee Assistance Program is available through **UnitedHealthcare**.

Voluntary Critical Illness and Voluntary Accident
Voluntary supplemental benefits are available for purchase through **Mutual of Omaha**.

We encourage you to take the time to review the benefit plans described in this guide and to choose the best options for you and your family.

If you have questions regarding any of the above benefits or the enrollment process, please contact your dedicated BenefitsVIP team at 866.293.9736 or email solutions@benefitsvip.com.
Monday—Friday, 8:30am—8:00pm (EST).

ENROLLING IN YOUR BENEFITS

COMANCO utilizes an online website for benefits administration. Before you enroll, you must review all benefit information to determine which plans will best fit you and your family's needs.

If you choose to cover dependents on any benefit plan, you will be required to list their information. You also need to name a beneficiary with their information. The social security number and date of birth of all dependents and beneficiaries must be entered into the system to proceed through the enrollment process. Please gather this information before beginning the process. If you do not have this information, the system will not allow you to make any elections

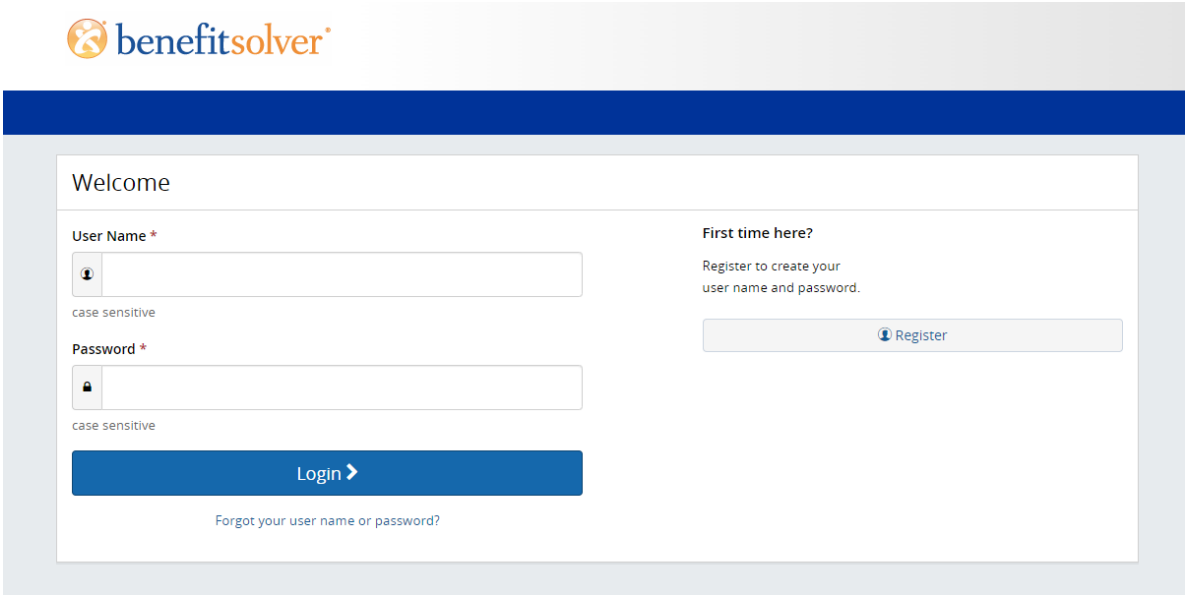
OPTIONS TO ENROLL

Once you decide which benefits you want to elect and have gathered all dependent and beneficiary information, you are ready to enroll.

Option 1: Log onto the enrollment website at www.benefitsolver.com
- If you are a first-time user, click on 'Register' to set up your username, password, and security questions.
- The 'Company Key' is **benefits** (case sensitive).

Option 2: Call 1-877-936-3774

BenefitsVIP can answer all Open Enrollment and benefits questions. Please contact BenefitsVIP for more information. Additional information on page 19.



FORGOT YOUR PASSWORD?

1. Visit www.benefitsolver.com and click on the 'Forgot your password' link.
2. Enter your social security number, company key, and date of birth.
3. Answer your security phrase.
4. Enter and confirm your new password, then click 'Continue' to return to the login page.

www.benefitsolver.com or call 877.936.3774

WELLNESS CREDIT

COMANCO employees who participate in our Medical Plan must complete the Annual Wellness Physical exam if you want to maintain the Wellness discount rate for your medical insurance in 2022.

ANNUAL PHYSICAL:
If your spouse is on the medical plan, we need their completed 2022 Annual Physical Form to maintain your Wellness discount rate. Many of our COMANCO employees who participate in the Medical Plan still need to complete their physical exam. Please contact Human Resources to verify that we have your completed physical form on file. *Children on the plan are not required to take the annual physical.*

REMEMBER: We require the completed Wellness Physical form only. Please do not send us any results!

If you have any questions or need help finding a clinic or a doctor:
1. Call United Healthcare at 1-866-844-4864
2. Visit www.myuhc.com or
3. Log in to the **UnitedHealthcare® App** on your mobile device. More details on page 8.

FAQ's

I completed my last physical in December 2021. If I take my next physical before December 2022, will I be charged for my 2022 physical since it has not been an entire year between the two physicals?

- No. You are eligible for ONE Annual Wellness Physical per calendar year under the Preventative Care Plan. Therefore, there is no charge if you go to an in-network, primary care physician's office to complete your Wellness physical.

Do I need to get a blood test?

- Yes. Your physician will review your results with you. Completing this exam is preventative healthcare and the reason you maintain your eligibility for the Wellness Discount for the following year.

MEDICAL BENEFITS

UnitedHealthcare®

IMPORTANT INFORMATION ABOUT YOUR PLAN

It is important to note the UnitedHealthcare® Choice medical plan offers IN-NETWORK BENEFITS ONLY

You MUST verify your provider participates in United's network before your visit, or you will not have coverage.

Searching for Providers:
You may search for in-network providers by accessing the website www.myuhc.com

- Click on "Find a Provider"
- Select a Directory
- Click on 'Employer and Individual Plans"
- Click on 'Choice'
- Enter your location and other search criteria

Once you are enrolled in the plan, be sure to register on www.myuhc.com so you can receive personalized benefit information.

The Pharmacy Network is changing to the UHC Broad National Network.
Both Walgreens and CVS are now in-network pharmacies.

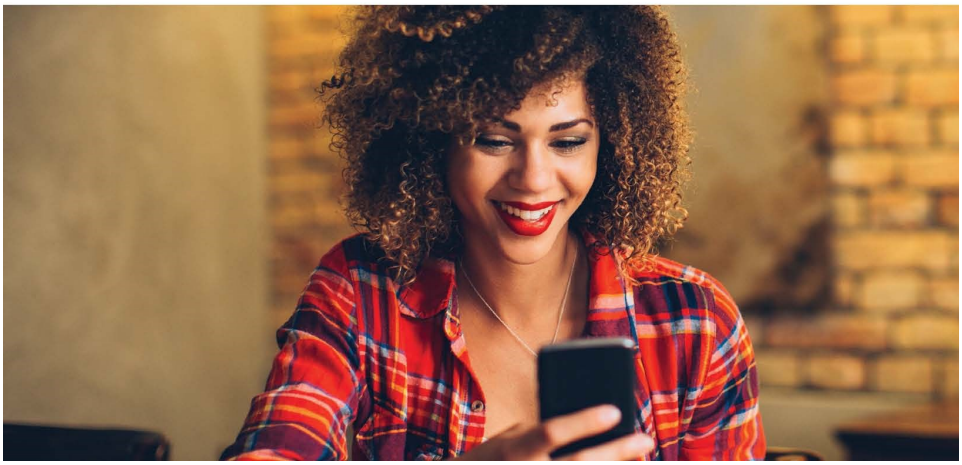
It is always recommended that you contact UHC to verify your local pharmacy is in-network.

UHC CHOICE PLAN

BENEFIT	IN-NETWORK
Annual Deductible per Calendar Year (January 1st - December 31st)	**Individual:** $1,500 **Family:** $3,000
Out-of-Pocket Maximum per Calendar Year (January 1st - December 31st)	**Individual:** $5,000 **Family:** $10,000
Preventive Care Adult Preventive Care, Adult Annual Physical Exam and Well-Child Care	No Charge
Outpatient Care Primary care physician office visits Specialist office visits Virtual Visits Outpatient facility surgery	 $35 Copayment $50 Copayment $0 Copayment Deductible, then 20%
Outpatient Lab & X-Ray Initial visit and all subsequent visits	Deductible, then 20%
Inpatient Hospital stay	Deductible, then 20%
Emergency Care Ambulance when medically necessary At hospital emergency room Urgent Care	 Deductible, then 20% $350 Copayment $50 Copayment
Maternity Care Prenatal and Postnatal care Hospital services for mother and child	 $35 Copayment Deductible, then 20%
Mental Health Inpatient Outpatient	 Deductible, then 20% $35 Copayment
Prescription Drugs **Retail Pharmacy** (31 day supply) Tier 1 / Tier 2 / Tier 3 Tier 4 **Mail Order** (90 day supply) Tier 1 / Tier 2 / Tier 3 Tier 4	 $10 / $35 / $75 **$250 Deductible**, then $125 Copay $25 / $87.50 / $187.50 **$250 Deductible**, then $312.50 Copay

Weekly Contributions	**Premium Rate***	**Value Rate**
Employee Only	$20.00	$54.57
Employee + Spouse	$90.00	$162.59
Employee + Children	$84.92	$145.49
Employee + Family	$165.00	$270.43

VIRTUAL VISITS



With Virtual Visits, it's easy to video chat with a doctor 24/7—whenever, wherever.

Whether you're at work, home, traveling, you name it—a Virtual Visit allows you to talk with a doctor by video 24/7. If needed, a Virtual Visit doctor can treat and prescribe* medication for everyday illnesses like the flu, sinus infections, cough, and more.

And, with a UnitedHealthcare plan, your cost is **$0** **

To get started, sign in at **myuhc.com/virtualvisits** or download the UnitedHealthcare® app.

In addition to all the great things you can do on **myuhc.com®** or the UnitedHealthcare® app, you can now talk to a doctor as well. There are no additional accounts to set up or apps to download.

Virtual Visits may save you time and money.

An estimated 25% of ER visits could be treated with a Virtual Visit —bringing a potential $1,700 cost down to just $0.***

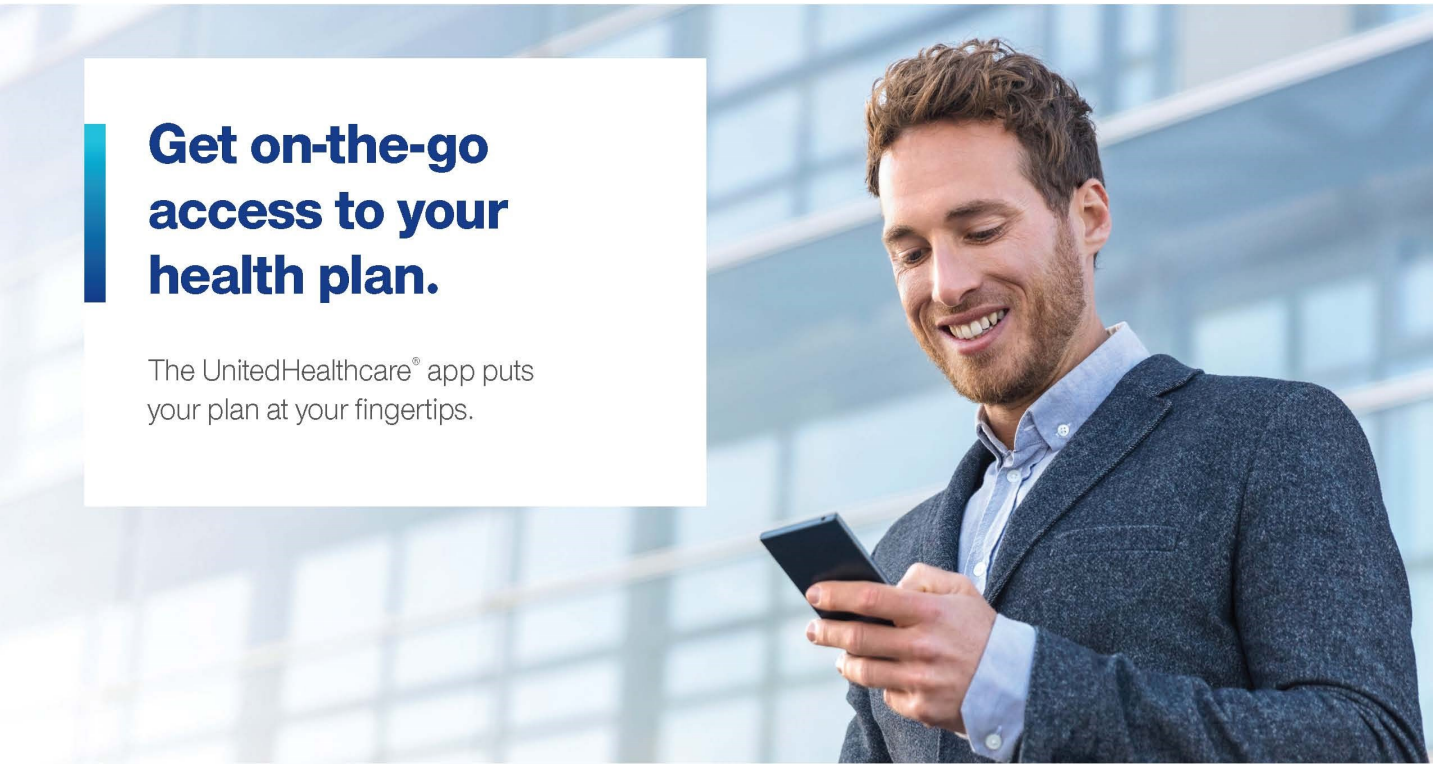
Quality care when and where you need it.

Use a Virtual Visit for everyday medical conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- And more

* Certain prescriptions may not be available, and other restrictions may apply. **The Designated Virtual Visit Provider's reduced rate for a virtual visit is subject to change at any time. *** UnitedHealthcare data: based on analysis of 2016 UnitedHealthcare ER claim volumes, where ER visits are low acuity and could be treated in a Virtual Visit, primary care physician, or urgent/convenient care setting. The UnitedHealthcare® app is available for download for iPhone® or AndroidTM. iPhone is a registered trademark of Apple, Inc. Android is a trademark of Google LLC. Virtual visits are not an insurance product, health care provider, or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. Insurance coverage provided by or through United Healthcare Insurance Company and its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage is provided by or through a UnitedHealthcare company.

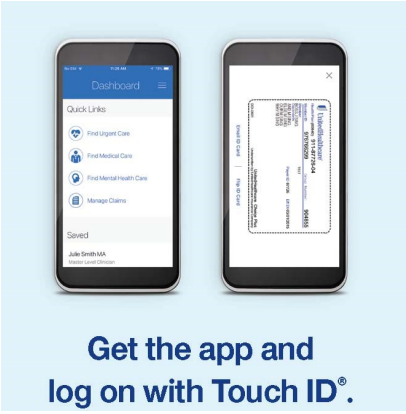
UNITEDHEALTHCARE MOBILE APP



The app has you covered.

When you're out and about, you can do everything from managing your plan to getting convenient care. Just download the app to:

- Find nearby care options in your network.
- Estimate costs.
- Video chat with a doctor 24/7.
- View and share your health plan ID card.
- See your claim details and view progress toward your deductible.



Get the app and log on with Touch ID®.

Get the app and log on with Touch ID®.

The UnitedHealthcare app is available for download for iPhone® or Android™.

GET IT ON Google Play

Download on the App Store

PHARMACY BENEFITS

Learn About your Prescription Drug Benefits

What is the difference between brand-name and generic medications?
Generic medications contain the same active ingredients as brand medications but often cost less. Once the patent of a brand-name medication ends, the FDA can approve a generic version with the same active ingredients. Generic medications must meet the strict FDA brand medication standards for quality, strength, and purity. Sometimes the same company that makes a brand-name medication also makes a generic version.

What if my doctor writes me a brand-name prescription?
The next time your doctor gives you a prescription for a brand-name medication, ask if a generic equivalent or lower-cost option is available and if it might be right for you. Generic medications are usually your lowest cost option, but not always.

What is a Prescription Drug List or PDL?
A Prescription Drug List, or PDL, is a list that places commonly prescribed medications for certain conditions into 'tiers'. This list includes brand and generic prescription medications approved by the FDA.

What are the tiers, and what do they mean?
Prescription medications are placed into tiers, and each tier is assigned to a cost. Using lower-tier medications can help you pay your lowest out-of-pocket cost. In the chart below, the overall value indicates the medications' effectiveness, safety, cost, and availability of alternative medications to treat the same or similar medical condition(s).

Drug Tier	What it means	Helpful Tips
Tier 1	Lower -Cost Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included	Use Tier 1 drugs for the lowest out-of-pocket costs.
Tiers 2 & 3	Mid-range Cost Medications that provide good overall value. A mix of brand-name and generic drugs.	Use Tier 2 or Tier 3 drugs, instead of Tier 4, to help reduce your out-of-pocket costs.
Tier 4	Highest-Cost Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics	Many Tier 4 drugs have lower-cost options in Tier 1, 2, or 3. Ask your doctor if they could work for you.

Services to Help you Save

Mail-order services: For medications you regularly take, choosing home delivery can save money. Filling a three-month prescription through mail-order costs less than refilling your prescription monthly at a retail pharmacy.

Specialty medications: Specialty medications are high-cost and may be used to treat rare or complex conditions, and are managed through the Specialty Pharmacy Program. If you are taking a specialty medication, visit www.myuhc.com, for personalized support and assistance in finding lower-cost options.

Medication pricing tool: With myuhc.com you can search and compare prescription medication costs and see costs based on your specific plan. You can also find lower-cost alternative medications.

DENTAL BENEFITS

GUARDIAN®

Need Help Finding an In-Network Provider?

Follow the steps below to locate a participating dental provider:

Step 1: Go to www.guardianlife.com

STEP 2: Under "Connect with us" select "Find a provider"

STEP 3: Select "PPO" plan and enter your location and search criteria

If you have any additional questions, please call Guardian at 800.541.7846

Dental Coverage

The Guardian Dental Plan is designed to allow you to seek care from the dentist of your choice. Please remember, you will incur lower out-of-pocket costs if you utilize in-network providers because of the negotiated discount rates.

If you choose to use an out-of-network provider, your reimbursement will be based upon 'Usual and Customary' (U&C) at the 90th percentile. This means you will be responsible for your co-insurance AND any charges above 90% of the U&C rate for each service rendered.

DENTALGUARD PREFERRED

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible per Calendar Year (January 1st - December 31st)		**Individual:** $50 **Family:** $150
Annual Benefit Maximum per Calendar Year (January 1st - December 31st)		$1,500
Diagnostic & Preventive Services Preventive Procedures which included, but are not limited to: Periodic Oral Examinations, X-Rays, Routine Cleaning Frequency and limitations may apply	100% No Deductible	100% of U&C No Deductible
Basic Services Procedures which included, but are not limited to: Fillings; Extractions; Oral Surgery; Endodontics; Periodontics; Periodontal Surgery; Anesthesia; Consultations;	90% after Deductible	80% of U&C after Deductible
Major Services Procedures which included, but are not limited to: Bridge and Dentures; Crowns, Inlays, Onlays	60% after Deductible	50% of U&C after Deductible

Weekly Contributions	
Employee Only	$2.40
Employee + Spouse	$8.10
Employee + Children	$6.80
Employee + Family	$14.20

VISION BENEFITS

Vision Coverage

Properly caring for your eyesight is of the utmost importance. As part of keeping up with maintaining your overall health, routine eye exams should be scheduled regularly. Without coverage, an exam and prescription glasses can cost $300 or more.

With Superior Vision coverage, the same exam, and prescription glasses might only cost $25 - you'll save!

SUPERIOR NATIONAL NETWORK PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	$10 copay	$10 copay and reimbursed up to $33
Materials (Frames and Lenses)	$15 copay	$15 copay
Frequency		
Exam	1 per plan year	1 per plan year
Lenses	1 per 2 plan years	1 per 2 plan years
Frames	1 per plan year	1 per plan year
Contact Lenses	1 allowance per plan year	1 allowance per plan year
Frames	$150 retail allowance	Reimbursed up to $70
Lenses		Reimbursed up to:
Single Vision Lenses	Covered in full	$28
Bifocal Vision Lenses	Covered in full	$40
Trifocal Vision Lenses	Covered in full	$53
Lenticular Vision Lenses	Covered in full	$84
Polycarbonate—children to age 19	Covered in full	Not covered
Photochromic Lenses		
Contact Lenses		
(In lieu of lenses & frames)		
Medically Necessary	Covered in full	Reimbursed up to $210
Elective Contact Lenses	$135 retail allowance	Reimbursed up to $100

Weekly Contributions	
Employee Only	$1.56
Employee + Spouse	$3.12
Employee + Children	$3.31
Employee + Family	$5.21

SUPERIOR VISION
See yourself healthy.

Need Help Finding an In-Network Provider?

Follow the steps below to locate a provider participating with Superior Vision:

Step 1: Go to www.superiorvision.com

Step 2: Click on 'Find an eye care professional' on the top left of the home screen

Step 3: Choose your location

Step 4: Choose your coverage type 'Insurance through your employer'

Step 5: Select 'Superior National' as the network

If you have additional questions, please call Benefits VIP at 866.293.9736

BASIC LIFE/AD&D

VALUE-ADDED SERVICES:

Travel Assistance: This program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.

Will Prep: Mutual of Omaha partners with Willing® to offer employees an online Will Prep tool. In just a few clicks, you can complete a customized plan to protect your family and property.

To get started, visit www.willprepservices.com

Hearing Discount Program: This program provides you and your family discounted hearing products, including hearing aids and batteries.

Call 888.534.1747 or visit www.amplifonusa.com/mutualofomaha.

EMPLOYER PAID LIFE AND AD&D

COMANCO provides all full-time, benefit-eligible employees with Basic Life/AD&D coverage through Mutual of Omaha.

Coverage amount: $15,000

- Age Reduction: Basic Life/AD&D benefits are reduced to 65% at age 70, and to 45% at age 75.
- Accelerated Death Benefit: 75% of $15,000, not to exceed $11,250. If you are diagnosed with a terminal illness, and your life expectancy is less than 12 months, you can receive a portion of your life benefit. Upon your passing, the remaining balance of the benefit will then be paid to your beneficiaries.

Make Sure to Update Your Beneficiary Information NOW!!

A beneficiary is a person or entity you name in a life insurance policy to receive the death benefit.

You can name:

- One person
- Two or more people
- The trustee of a trust you have set up
- Your estate

If a beneficiary is not added, the death benefit will be paid to your estate.

Two 'levels' of beneficiaries:

Your Life Insurance Policy should have both 'primary' and 'contingent' beneficiaries. The primary beneficiary receives the death benefit upon your passing if they are found. Contingent beneficiaries receive the death benefit if the primary beneficiary is not found. If no primary or contingent beneficiaries are found, the death benefit will be paid to your estate.

As part of naming beneficiaries, you should identify them clearly and include their Social Security numbers. This will make it easier for the life insurance company to find them, and it will make it less likely that disputes will arise regarding the death benefits.

VOLUNTARY LIFE/AD&D

Voluntary Life and AD&D

In addition to the Basic Life/AD&D insurance, employees have the option to elect voluntary coverage through Mutual of Omaha.

COVERAGE GUIDELINES			
	Minimum	**Guarantee Issue**	**Maximum**
For You	$10,000	7 times annual salary, up to $100,000	7 times annual salary, up to $500,000
Spouse	$5,000	100% of employees benefit, up to $30,000	100% of employees benefit, up to $100,000
Children	$10,000	$10,000	10,000

If you are ***newly eligible,*** you may elect seven (7) times your annual salary up to $100,000 for yourself and 100% of your elected amount up to $30,000 for your spouse without medical underwriting. Any elections over these amounts will require an Evidence of Insurability (EOI) form to be completed.

At Annual Enrollment:
If you previously waived this coverage and now wish to enroll, you and your spouse, if electing coverage, must complete an Evidence of Insurability form.

If you are currently enrolled and your coverage amount is less than the guarantee issue limit, you may increase your amount by one $10,000 without completing an EOI. Any request for an increase over the guarantee issue limit will require an EOI to be completed. Any increase in spousal insurance will require an EOI.

How to calculate your supplemental Life/AD&D deduction

Example: an employee who is 47 years old elected $100,000 in coverage

$100,000 / 1,000 = 100

100 x 0.057 (see rate chart) = $5.70 cost per week

$5.70 x 52 = $296.40 per year

Things to remember:

- Your spouse's rate is based on your age
- You pay just one payroll deduction for child coverage, no matter how many children are covered
- Benefits reduce to 65% at age 70, and to 45% at age 75
- Coverage is available for children 14 days to 26 years
- You must enroll in coverage to elect coverage for your dependents
- Spouse coverage terminates when the employee attains age 70
- Payroll deductions may vary due to rounding

WEEKLY VOLUNTARY LIFE/AD&D RATE TABLE	
<30	$0.022
30-34	$0.027
35-39	$0.029
40-44	$0.039
45-49	$0.057
50-54	$0.087
55-59	$0.131
60-64	$0.195
65-69	$0.309
70+	$0.576

SHORT-TERM DISABILITY

Short-term Disability

COMANCO provides all benefit-eligible employees with Short-Term Disability coverage at no cost to you. This coverage is designed to replace a portion of your income should you become unable to work due to a non-work-related injury or sickness. A summary of the plan is outlined in the chart below. Please refer to your Mutual of Omaha summary for additional details, including limitations and exclusions.
NOTE: CA, NY, NJ, and RI residents have State-mandated STD rates.

Short–Term Disability	
Income Benefit	40% of your weekly income to a maximum of $250
Elimination Period	Benefits begin on the 8th day of a nonwork-related accident or illness
Benefit Duration	You may receive benefits for up to 13 weeks if you continue to be disabled and are unable to work

Buy-Up Option

You may purchase additional Short-Term Disability coverage through Mutual of Omaha as follows:

Short–Term Disability Buy–Up Option	
Income Benefit	60% of your weekly income to a maximum of $1,000
Elimination Period	Benefits begin on the 8th day of a nonwork-related accident or illness
Benefit Duration	You may receive benefits for up to 13 weeks if you continue to be disabled and are unable to work
Pre-Existing Condition Exclusion	Under this plan, the pre-existing condition is 3/12, which means any condition you receive medical attention for in the three months before your effective date of coverage that results in a disability during the first 12 months of coverage would not be covered.
Rate	$0.17 per $10 of Weekly Benefit
Evidence of Insurability (EOI)	If you did not elect this coverage when you were first eligible, you would be required to complete an EOI form submitted to Mutual of Omaha. New Hires electing when they are first eligible for coverage do not need to complete the EOI form.

How to calculate your buy-up Short-Term Disability:

Employee earns $500 per week

$500 x 60% = $300 weekly benefit

$300 / $10 (of weekly benefit) = $30

$30 x $.17 = $5.10 monthly or $1.18 per paycheck (52 pay periods)

VOLUNTARY ACCIDENT

Voluntary Accident

COMANCO provides the option to purchase Accident coverage through Mutual of Omaha to all full-time benefit-eligible employees. This insurance offers financial protection by paying a cash benefit if you or your insured dependent are injured due to a covered accident. Unless otherwise stated, the benefit amount payable is the same for you and your insured dependent (s). A summary of the plan is outlined in the chart below.
Accident benefits pay in addition to other insurance, and can be used to help cover gaps in health insurance or other expenses if the unexpected happens.

Plan Information	Information/Amounts
Coverage Type	Non-occupational coverage (**Off-job only**)
Express Benefit	$150
Portability	Included

Benefits	Amounts
Initial Care & Emergency - Most treatment / service required within 72 hours of accident; Once per accident per insured person	
Emergency Room	$250
Urgent Care Center	$175
Initial Physician Office Visit	$150
Ambulance (Ground/Air)	$600 Ground / $2,000 Air
Specified Injuries	
Fractures (Surgical / Non-surgical)	Up to $6,000/Up to $3,000
Dislocations (Surgical / Non-surgical)	Up to $9,000/Up to $4,500
Lacerations	Up to $800
Burns	Up to $15,000
Dental	Up to $300
Hospital, Surgical & Diagnostic	
Admission	$2,000
Daily Confinement (Up to 365 days per accident)	$500 per day
ICU Confinement (Up to 15 days per accident)	$1,000 per day
Follow-Up Care—Treatment / service required within 365 days of accident	
Physician Follow-Up Visit	$75; Up to 6 per accident
Therapy Services	$50; Up to 6 per accident

COVERAGE TIER	WEEKLY PREMIUM AMOUNT
Employee	$2.77 ($0.39 per day)
Employee + Spouse	$3.92 ($0.56 per day)
Employee + Children	$5.54 ($0.79 per day)
Employee + Family	$7.15 ($1.02 per day)

VOLUNTARY CRITICAL ILLNESS

Voluntary Critical Illness

COMANCO provides the option to purchase Critical Illness coverage through Mutual of Omaha to all full-time benefit-eligible employees. This insurance offers financial protection by paying a cash benefit if you or your insured dependent are diagnosed with a covered illness. The chart below is a summary of the benefits. Please refer to the Mutual of Omaha contract for more details.

VOLUNTARY CRITICAL ILLNESS EMPLOYEE OR SPOUSE WEEKLY PREMIUM RATES		
Age	$10,000	$20,000
0-29	$.92	$1.85
30-39	$1.85	$3.69
40-49	$4.62	$9.23
50-59	$8.08	$16.15
60-69	$16.15	$32.31
70+	$32.31	$64.62

Benefit Category	Condition	Percent of CI Principal Sum
Heart/ Circulatory	Heart Attack, Heart Transplant, Stroke	100%
	Heart Valve Surgery, Coronary Artery Bypass, Aortic Surgery	25%
Organ	Major Organ Transplant/Placement on UNOS List, End-Stage Renal Failure	100%
	Acute Respiratory Distress Syndrome (ARDS)	25%
Cancer	Cancer (Invasive)	100%
	Bone Marrow Transplant	50%
	Carcinoma In Situ, Benign Brain Tumor	25%

Coverage Guidelines			
	Minimum	Guarantee Issue	Maximum
For You Elect in $10,000 increments	$10,000	$20,000	$20,000
Spouse Elect in $10,000 increments	$10,000	$20,000	100% of employees Principal Sum, up to $20,000
Children *benefit for each child	N/A	$5,000	25% of employee's Principal CI Sum, up to $5,000

The pre-existing condition under this plan is 12/12, which means any condition you receive medical attention for in the 12 months before your effective date of coverage that results in a disability during the first 12 months of coverage would not be covered. If coverage was not elected when you were first eligible, you would be required to complete an evidence of insurability form.

EMPLOYEE ASSISTANCE PROGRAM

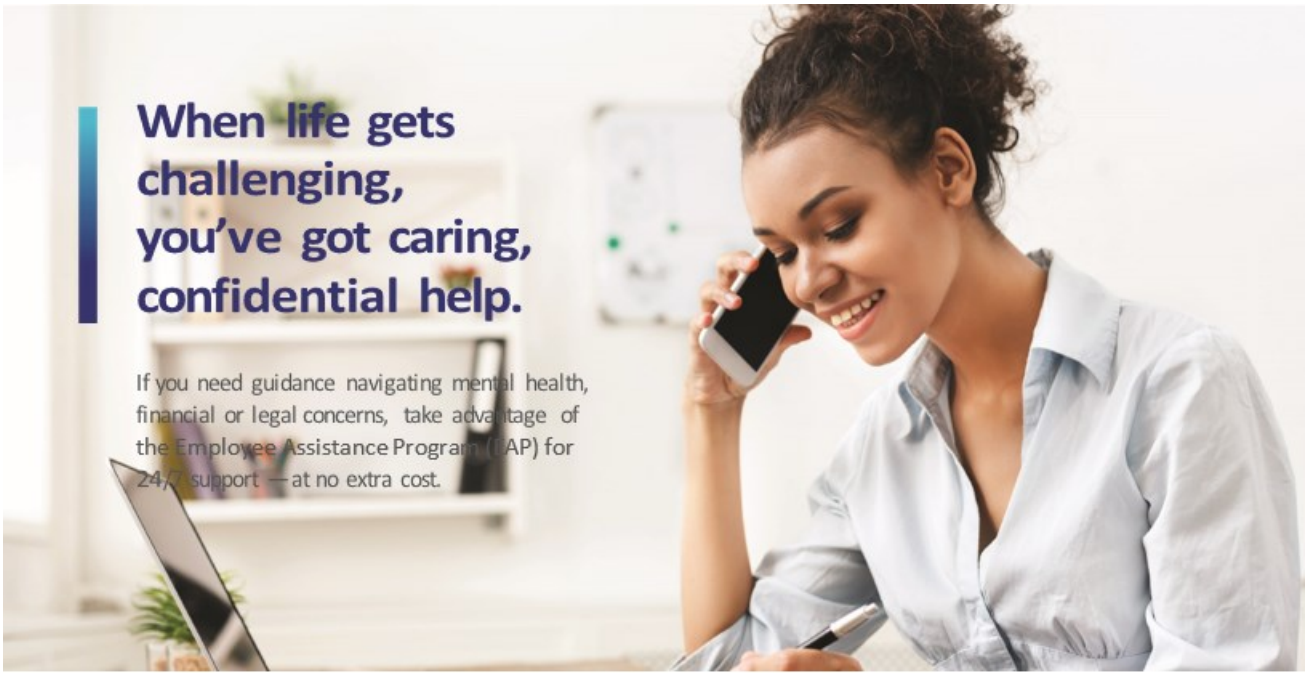
It's good to know you're not alone.

Reaching out to an EAP consultant is a good first step. They're trained to understand your concerns so they can connect you with the consultant or service best able to help you:

- Address depression, anxiety or substance use issues.
- Improve relationships at home or work.
- Manage stress.
- Work through emotional issues or grief.
- Assistance with legal and financial concerns.

One call puts you in touch with a clinician, counselor, mediator, lawyer or financial adviser who could help change your life for the better.

Resources | Employee Assistance Program



Call the member phone number on your health plan ID card and ask to speak to an EAP consultant. Or, contact EAP directly 24/7 at 1-888-887-4114.

UnitedHealthcare®

The material provided through this program is for informational purposes only. EAP staff cannot diagnose problems or suggest treatment. EAP is not a substitute for your doctor's care. Employees are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. EAP is not an insurance program and may be discontinued at any time. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

401(K)RETIREMENT PLAN

VOYA 401(K) RETIREMENT PLAN

COMANCO offers a Company match and an automatic enrollment feature to employees under the COMANCO 401(k) Plan. All new employees, 18 years of age and over, will be automatically enrolled in the 401(k) plan in the first quarter that follows six months of service.

COMANCO matches employee contributions of up to 6% at 50% of the employee contribution and 15% for employee contributions over 6%.

You may choose to contribute any amount from your weekly salary, and that amount will reduce your taxable income through a salary deferral. Your total salary deferral for 2022 may not be more than $20,500. Employees age 50 and over who have met the plan limit for deferrals may contribute an additional $6,500 as a catch-up contribution. Please see Human Resources if you would like to contribute a catch-up deferral. IRS regulations may also limit your maximum deferral percentage and dollar amount.

You may increase or decrease your salary deferral amount or stop making contributions at any time by calling Voya at 800-584-6001.

Your contributions to the plan are fully vested. Once you complete six years of service, you will be fully vested in the matching contributions made by COMANCO. Fully vested means that the contributions, along with any investment gain or loss, belong to you, and you will not lose them should you leave employment with COMANCO.

You decide where to invest your contributions and the company's matching contributions in the plan's professionally managed investment funds. Investment elections can be changed at any time by accessing your online account at www.voyaretirementplans.com or by calling Customer Service at 800-584-6001.

Example:
You earn $500.00/week and contribute 10% = $50
6% is $30 - COMANCO 50% match is $15.00
Remaining $20 - COMANCO 15% match is $3.00
Total COMANCO match is $18.00/wk

COMANCO's Contribution
1-Year (52 paychecks) $18 x 52 = $936 additional money in your account

Help starts here

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefit advocates is ready to help you and your family members resolve your benefits issues.

Let BeneftisVIP help you and your family with:

- Benefits questions
- ID card requests
- Claims resolution
- Prescription issues
- Provider network questions
- ...and much more!

For service that's confidential and responsive, contact:

866.293.9736

Monday - Friday,
8:30am—8:00pm (ET)
solutions@benefitsvip.com
Fax: 856-996-2775

QUESTIONS ANSWERED HERE:

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefits plans and answer benefits questions, and can quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day, and all calls adhere to privacy best practices.

BenefitsVIP®
Help starts here.

WEBSITE

Stay informed with the latest health news, biometric tools, calculators, and information at benefitsvip.com.

BLOG

HealthDiscovery.org is a lifestyle blog with wellness articles, tips, quizzes, recipes, and more!

DISCLOSURES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

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

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.
Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
- The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

DISCLOSURES

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).
If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility –
ALABAMA: Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

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

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

CALIFORNIA: Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO: Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/childhealth-plan-plus
CHP+ Customer Service:
1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-Program
HIBI Customer Service: 1-855-692-6442

FLORIDA: Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268
GEORGIA: Medicaid
Website: https://medicaid.georgia.gov/health-insurancepremium-payment-program-hipp
Phone: 678-564-1162 ext 2131
INDIANA: Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864
IOWA: Medicaid
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562
KANSAS: Medicaid
Website: https:/www.kancare.ks.gov/
Phone: 1-800-792-4884
KENTUCKY:
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA: Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

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

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

MINNESOTA: Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI: Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA: Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA: Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA: Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE: Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY: Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392 CHIP Website: http:/www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK: Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831
NORTH CAROLINA: Medicaid
Website: https://dma.ncdhhs.gov
Phone: 919-855-4100
NORTH DAKOTA: Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825
OKLAHOMA: Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON: Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
PENNSYLVANIA: Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx HIPP-Program.aspx
Phone: 1-800-692-7462
RHODE ISLAND: Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA: Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820
SOUTH DAKOTA: Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059
TEXAS: Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493
UTAH: Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

DISCLOSURES

VERMONT: Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA: Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

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

WEST VIRGINIA: Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN: Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING: Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:
U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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