COMANCO

SAFETY ★ QUALITY ★ SERVICE

2026 Benefits Guide

WELCOME

COMANCO is excited to introduce our updated employee benefits program, effective March 1, 2026. This program is thoughtfully designed to provide you with valuable options that meet your needs today and in the future.

We are committed to offering a comprehensive and flexible benefits package, allowing you to tailor your coverage to best support yourself and your family.

We are pleased to announce that medical rates will remain unchanged, with no increase. COMANCO will continue partnering with United Healthcare to offer the UHC Choice medical plan, which remains unchanged. For more details, please refer to page 6.

Additionally, Guardian will remain our dental insurance provider, and Superior Vision will continue as our vision insurance provider. More information on these plans is available on pages 12–13.

Mutual of Omaha will also continue to provide coverage for Basic Life/AD&D, Voluntary Life/AD&D, Short-Term Disability, Voluntary Accident, and Voluntary Critical Illness benefits. You can find more details about these plans on pages 14–18.

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BENEFITS OVERVIEW

Below is a summary of the benefits available to COMANCO employees for the plan year:
March 1, 2026 - February 28, 2027

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
COMANCO provides life insurance and accidental death & dismemberment (AD&D) coverage to all full-time, benefit-eligible employees. Coverage is valued at $15,000 and is provided through **Mutual of Omaha.**

Voluntary Life
You can purchase additional life insurance coverage for yourself and your dependents. This voluntary coverage is also offered through **Mutual of Omaha.**

Short-Term Disability
COMANCO provides short-term disability insurance through **Mutual of Omaha**. You also have the option to enhance your coverage with a Short-Term Disability Buy-Up Option, allowing you to increase your benefit .

Voluntary Critical Illness and Voluntary Accident
COMANCO offers voluntary supplemental benefits, including critical illness and accident insurance, available for purchase through **Mutual of Omaha**.

Employee Assistance Program
An Employee Assistance Program is available to you through **UnitedHealthcare**, offering support and resources for various personal and professional needs.

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

We encourage you to carefully review the benefit plans outlined in this guide to select the options that best meet the needs of you and your family .

If you have any questions about the benefits or the enrollment process, please contact your dedicated BenefitsVIP team by calling **866.293.9736** or email **solutions@benefitsvip.com.**
The team is available to assist you Monday through Friday, from **8:30 AM to 8:00 PM (EST)**.

ENROLLING IN YOUR BENEFITS

COMANCO uses an online platform for benefits administration. Before enrolling, please review all benefit details to determine which plans best suit the needs of you and your family.

If you plan to cover dependents under any benefit plan, you must provide their information. Additionally, you'll need to designate a beneficiary and enter their details. **To complete the enrollment process, the system requires the Social Security numbers and dates of birth for all dependents and beneficiaries**. Please gather this information in advance, as the system will not allow you to proceed without it.

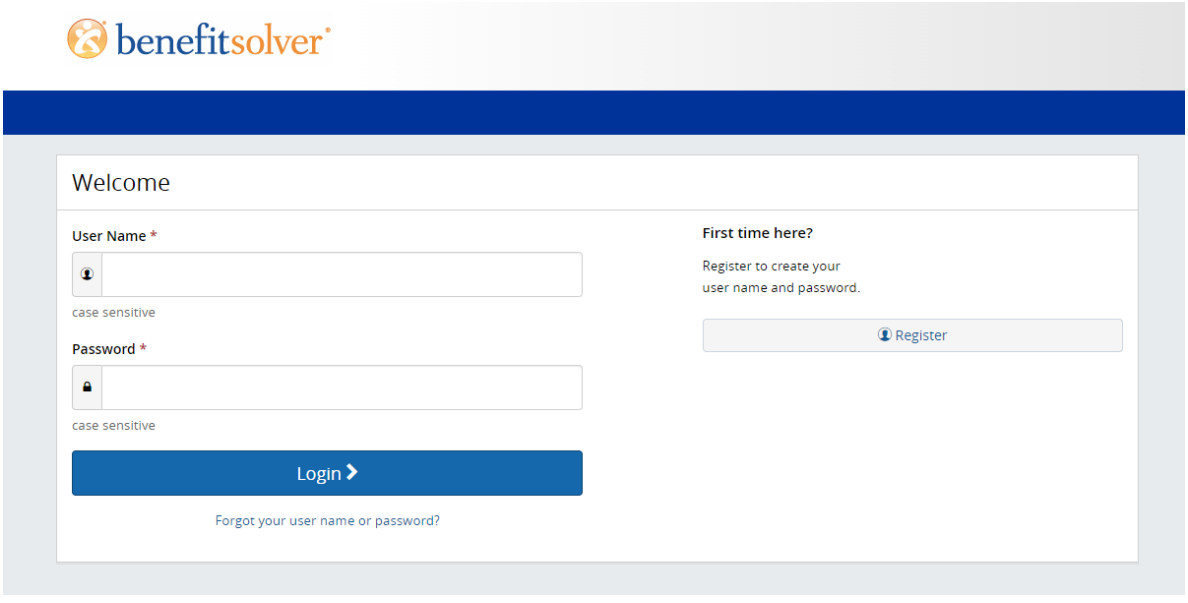
ENROLLMENT OPTIONS:

Once you've decided on your benefit elections and collected all necessary dependent and beneficiary information, you're ready to enroll.

Option 1: Log onto the enrollment website at **www.benefitsolver.com**
- First-time users: Click 'Register' to create your username, password, and security questions.
- The 'Company Key' is **ssbenefits** (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 21.



FORGOT YOUR PASSWORD?

1. Visit **www.benefitsolver.com** and click on the 'Trouble Logging In?' link.
2. Enter your social security number, date of birth and zip code.
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 participating in our Medical Plan must complete an Annual Wellness Physical Exam to maintain the Wellness Discount Rate for medical insurance in 2026.

ANNUAL PHYSICAL REQUIREMENTS:

- Employees: Ensure your completed 2026 Annual Physical Form is submitted to maintain your discount.
- Spouses: If your spouse is covered under the Medical Plan, their completed 2026 Annual Physical Form is also required.
- Children: Dependents are not required to complete the annual physical.

IMPORTANT: We only require the completed Wellness Physical Form—please do not send test results. Please contact Human Resources to confirm that we have your completed physical form on file.

NEED HELP?

If you have questions or need assistance finding a clinic or 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 10.

FREQUENTLY ASKED QUESTIONS (FAQS)

Q: I completed my last physical in December 2025. If I schedule my next physical before December 2026, will I be charged since it hasn't been a full year?
A: No. You are eligible for one Annual Wellness Physical per calendar year under the Preventative Care Plan. There is no charge as long as you visit an in-network primary care physician.

Q: Do I need to get a blood test?
A: Yes. Your physician will review the results with you. Completing this exam ensures you remain eligible for the Wellness Discount in the following year.

MEDICAL BENEFITS

IMPORTANT INFORMATION ABOUT YOUR PLAN

The UnitedHealthcare® Choice Medical Plan provides **IN-NETWORK BENEFITS ONLY**

To ensure coverage, you must verify that your provider participates in UnitedHealthcare's network before your visit.

How to Search for In-Network Providers:

1. Visit www.myuhc.com
2. Click on **"Find a Provider."**
3. Select a directory.
4. Choose **"Employer and Individual Plans."**
5. Select **"Choice."**
6. Enter your location and any other search criteria.

Once enrolled, register on www.myuhc.com to access personalized benefit information.

Pharmacy Network

The pharmacy network for this plan is the **UHC Broad National Network.**

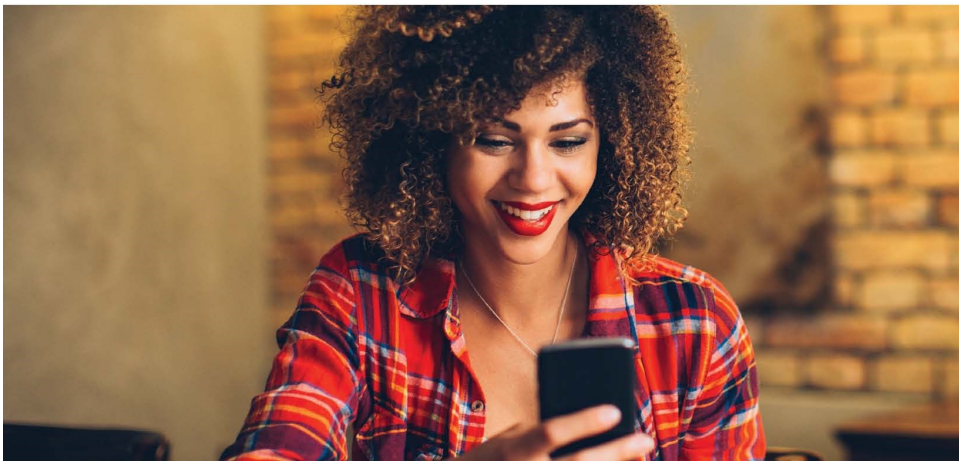
- Both **Walgreens** and **CVS** are in-network pharmacies.
- It's recommended to contact UHC to confirm that your local pharmacy is in-network.

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 24/7 Virtual Visits (myuhc.com/virtualvisits) 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.

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

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.***

* 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 DIGITAL RESOURCES

Go digital, get more out of your health plan benefits

Digital tools to keep you connected

Your personalized digital tools—the **UnitedHealthcare app** and myuhc.com– give you access to resources designed to help you:

- View benefit info, claim details and account balances
- Find quality providers through Smart Choice search results that are personalized to your preferences
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care

Register once to access both tools

Start by opening the **UnitedHealthcare App** or going to myuhc.com and then:

- Tap **Review Now** on the app, or select **Register** on the website
- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication — then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

Now that you're registered, you'll be able to manage your plan all year long.

PHARMACY BENEFITS

Understanding Your Prescription Drug Benefits

What's the Difference Between Brand-Name and Generic Medications?

- **Generic medications** contain the same active ingredients as brand-name medications but typically cost less.
- Once the patent for a brand-name medication expires, the FDA can approve a generic version with the same active ingredients.
- Generic medications must meet the FDA's strict standards for quality, strength, and purity.
- Fun fact: Sometimes, the same company that makes the brand-name medication also produces its generic version.

What if My Doctor Prescribes a Brand-Name Medication?

The next time your doctor prescribes a brand-name medication, ask if a **generic equivalent** or a **lower-cost alternative** is available and appropriate for you.

- Generic medications are often your most affordable option—but not always. Discuss with your doctor to find the best fit.

What Is a Prescription Drug List (PDL)?

A Prescription Drug List (PDL) organizes commonly prescribed medications into tiers based on their cost and value. This list includes FDA-approved brand-name and generic medications.

Understanding Drug Tiers?

Medications are placed into tiers, each tied to specific costs. Choosing medications in lower tiers can reduce your out-of-pocket expenses

Drug Tier	What it means	Helpful Tips
Tier 1	**Lower -Cost** Medications with the highest overall value (mostly generics, some brand-name).	Use Tier 1 drugs for the **lowest out-of-pocket costs**.
Tiers 2 & 3	**Mid-range Cost** Medications offering good overall value (a mix of brand-name and generic).	Opt for Tier 2 or 3 drugs instead of Tier 4 to help reduce costs.
Tier 4	**Highest-Cost** Highest-cost medications with the lowest overall value (mostly brand-name, some generics).	Ask your doctor about lower-cost alternatives in Tiers 1, 2, or 3.

Services to Help you Save

Mail-order Services: For medications you take regularly, home delivery through mail-order can save money. A three-month supply via mail-order typically costs less than monthly refills at a retail pharmacy.

Specialty Medications: High-cost medications for rare or complex conditions are managed through the Specialty Pharmacy Program. Visit www.myuhc.com for personalized support and assistance in exploring lower-cost options.

Medication Pricing Tool: On myuhc.com, you can search and compare prescription costs, see prices based on your specific plan, and find lower-cost alternatives.

DENTAL BENEFITS

GUARDIAN®

Need Help Finding an In-Network Provider?

Follow the steps below to locate a participating dental provider:

1: Go to www.guardianlife.com

2: Click "Find a dentist" on the top of the page

3: Under "Dental benefits bought through your workplace" click "Find a Dentist"

4: Select "**PPO: DentalGuard Preferred**" as the plan type. Enter your location information to find in-network Dentists in your area

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

You can also download the Guardian Mobile App from the App Store and Google Play.

GET IT ON Google play

Download on the App Store

Dental Coverage

The **Guardian Dental Plan** allows you the flexibility to choose any dentist for your care. However, you can save on out-of-pocket costs by selecting **in-network providers**, who offer services at negotiated discount rates .

If you decide to visit an **out-of-network provider**, your reimbursement will be based on the **Usual and Customary (U&C)** rate at the 90th percentile. This means you'll be responsible for:

- Your co-insurance, and
- Any charges that exceed 90% of the U&C rate for the services provided.

For the most cost-effective care, consider using in-network dentists whenever possible.

DENTALGUARD PREFERRED

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible per Calendar Year (January 1st - December 31st) **Family Deductible is $50 per person, up to a maximum of $150 per family*	**Individual:** $50 ***Family:** Up to $150	**Individual:** $50 ***Family:** Up to $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, Prophylaxis 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; Simple Extractions; Endodontics; Periodontics; Periodontal Surgery; Anesthesia;	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

Caring for your eyesight is essential to maintaining your overall health. Routine eye exams should be a regular part of your wellness plan. Without vision coverage, the cost of an eye exam and prescription glasses can exceed $300.

With **Superior Vision** coverage, you could pay as little as **$25** for the same exam and prescription glasses—saving you hundreds!

SUPERIOR NATIONAL ensures quality vision care while keeping costs affordable.

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 plan year	1 per plan year
Frames	1 per 2 plan years	1 per 2 plan years
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
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:

1: Go to www.superiorvision.com

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

3: Choose your location

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

5: Select '**Superior National**' as the network

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

BASIC LIFE/AD&D

Employer Paid Life and AD&D

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

VALUE-ADDED SERVICES:

Travel Assistance: This benefit provides support for your travels, whether you're over 100 miles from home or traveling internationally.

Will Prep: Through a partnership with Willing®, Mutual of Omaha offers an online tool to help you create a customized will, protecting your family and property.

To get started, visit www.willprepservices.com

Registration Code: Mutualwills

Hearing Discount Program: You and your family can access discounted hearing products, including hearing aids and batteries, through this program.

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

Coverage Details

- **Coverage Amount:** $15,000
- **Age Reduction**: Benefits are reduced to 65% at age 70 and to 45% at age 75.
- **Accelerated Death Benefit**: You may receive up to 75% of the $15,000 benefit (not exceeding $11,250) if diagnosed with a terminal illness and given a life expectancy of less than 12 months. The remaining balance will be paid to your beneficiaries upon your passing.

Update Your Beneficiary Information Today!

A beneficiary is the person or entity you designate to receive your life insurance benefits.

Who Can Be a Beneficiary?

- **A person:** One individual or multiple individuals
- **A trust:** The trustee of a trust you've established
- **Your estate:** If no beneficiaries are designated, the benefit will go to your estate

Beneficiary Levels:

Primary Beneficiary: The individual or entity that will receive the death benefit upon your passing.
Contingent Beneficiary: Receives the death benefit if the primary beneficiary is not found or unable to accept it.

If neither primary nor contingent beneficiaries are named, the death benefit will be paid to your estate.

Important Tips:

- Clearly identify your beneficiaries and include their Social Security numbers to avoid delays or disputes.
- Keep your beneficiary information up to date to ensure your life insurance benefits are distributed according to your wishes.

VOLUNTARY LIFE/AD&D

Voluntary Life and AD&D

In addition to the Basic Life/AD&D insurance, employees have the option to elect additional 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 can elect coverage for yourself up to 7 **times your annual salary** or $100,000, and for your spouse, up to 100% **of your elected coverage amount**, or **$30,000, without medical underwriting**. Any elections exceeding these amounts will require you to complete an Evidence **of Insurability (EOI) f**orm.

At Annual Enrollment:

- If you previously waived coverage and now wish to enroll, both you and your spouse (if enrolling) must submit an EOI form.
- If you are currently enrolled and your coverage amount is below the guarantee issue limit, you may increase your coverage by one $10,000 increment without completing an EOI. Any increase over the guarantee issue limit, or any increase in spousal coverage, will require an EOI form.

How to calculate your supplemental Life/AD&D deduction

Example: An employee, 47 years old, elects $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 only one payroll deduction for child coverage, regardless of the number of children covered.
- Benefits reduce to 65% at age 70 and 45% at age 75.
- Coverage is available for children aged 14 days to 26 years.
- You must enroll in coverage to elect coverage for your dependents.
- Spouse coverage ends when the employee reaches age 70.
- Payroll deductions may vary slightly 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 (STD) coverage at no cost. This coverage replaces a portion of your income if you're unable to work due to a **non-work-related injury or illness**. Below is a summary of the plan; for additional details, including limitations and exclusions, please refer to your **Mutual of Omaha** summary.
Note: Residents of CA, NY, NJ, and RI have **State-mandated STD rates**.

Standard Short-Term Disability Plan	
Income Benefit	40% of your weekly income, up to $250
Elimination Period	Benefits begin on the **8th day** of a nonwork-related accident or illness
Benefit Duration	Up to **13 weeks**, as long as you remain disabled and 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, up to $1,000
Elimination Period	Benefits begin on the **8th day** of a nonwork-related accident or illness
Benefit Duration	Up to **13 weeks**, as long as you remain disabled and unable to work
Pre-Existing Condition Exclusion	A 3/12 exclusion applies. This means any condition you received medical attention for in the **three months prior** to your effective coverage date is excluded from coverage for the **first 12 months.**
Rate	$0.20 per $10 of Weekly Benefit
Evidence of Insurability (EOI)	If you did not elect this coverage when first eligible, you must submit an EOI form to Mutual of Omaha. New hires electing coverage when first eligible do not need to complete the EOI.

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 Coverage

COMANCO offers all **full-time benefit-eligible employees** the option to purchase **Accident coverage** through **Mutual of Omaha**. This insurance provides financial protection by paying a cash benefit if you or your insured dependent are injured in a covered accident.
Unless otherwise specified, the benefit amount for you and your insured dependent(s) is the same. Below is a summary of the plan.

Accident benefits are paid in addition to other insurance and can help cover gaps in health insurance or other expenses if the unexpected occurs.

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 COVERAGE

COMANCO offers all **full-time benefit-eligible employees** the option to purchase Critical Illness coverage through **Mutual of Omaha**. This insurance provides financial protection by paying a cash benefit if you or your insured dependent is diagnosed with a covered illness.

The chart below summarizes 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

Pre-existing Condition Exclusion: Under this plan, the pre-existing condition clause is 12/12, meaning any condition you received medical attention for in the 12 months prior to your coverage's effective date that leads to a disability within the first 12 months of coverage will not be covered.

If you did not elect this coverage when you were first eligible, you will need to complete an **Evidence of Insurability (EOI)** form.

EMPLOYEE ASSISTANCE PROGRAM

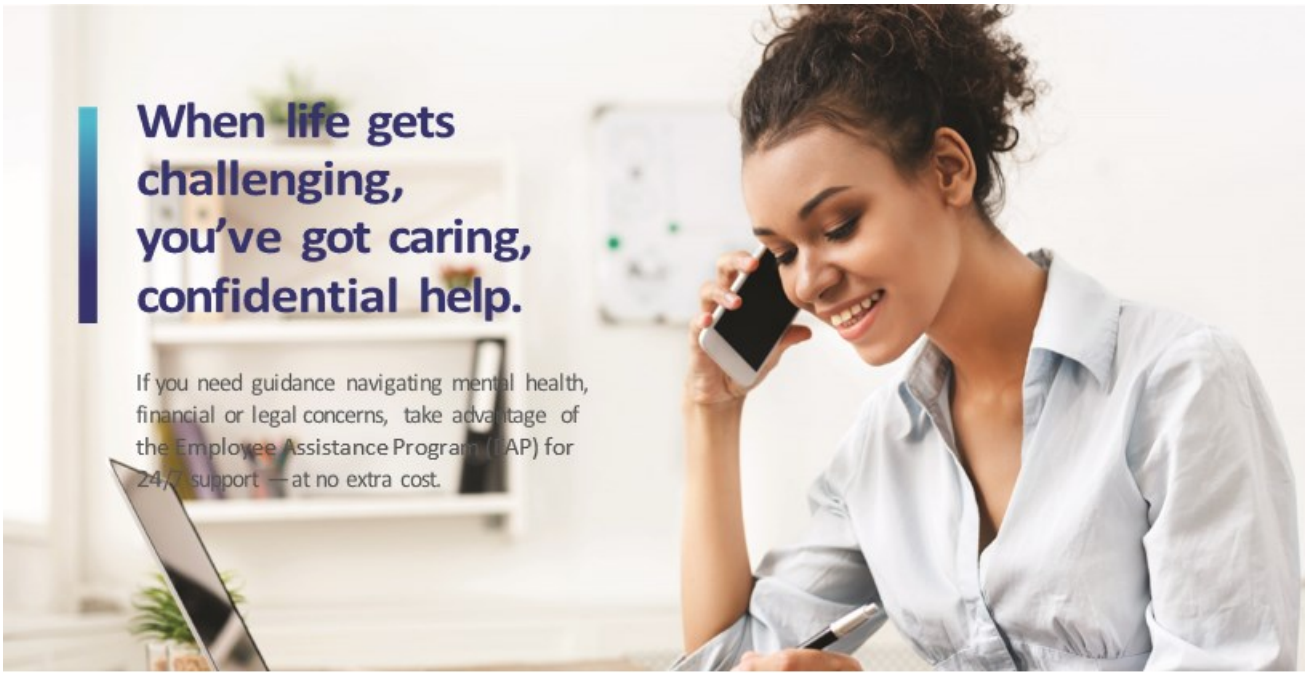
It's good to know you're not alone.

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 automatic enrollment feature for employees in the COMANCO 401(k) Plan. All new employees, 18 years of age or older, will be automatically enrolled in the 401(k) plan during the first quarter after completing six months of service.

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

You may choose to contribute any amount from your weekly salary, and that amount will reduce your taxable income through salary deferral. The maximum salary deferral for 2026 is $24,500. Employees aged 50 and over can contribute an additional **$8,000** as a **catch-up contribution** once the plan limit for deferrals is met. Please contact **Human Resources** if you wish to make a catch-up deferral. Note that IRS regulations may also limit your maximum deferral percentage and dollar amount.

You can adjust or stop your salary deferrals at any time by contacting **800-584-6001**.

Vesting: Your contributions are fully vested. After six years of service, you will be fully vested in the matching contributions made by COMANCO. **Fully vested** means the contributions, including any investment gains or losses, belong to you, and you will retain them even if you leave COMANCO.

You control how your contributions, as well as the company's matching contributions, are invested within the plan's professionally managed investment funds. You can change your investment elections at any time through your online account at www.voyaretirementplans.com or by calling **Customer Service at 800-584-6001 .**

Example:
If you earn **$500/week** and contribute **10%** ($50):

- The first **6%** ($30) gets a **50% match** from COMANCO, which is **$15**.
- The remaining **$20** gets a **15%** match from COMANCO, which is **$3**.
- **Total COMANCO match: $18/week.**

In **one year** (52 paychecks):

- **$18 x 52 = $936** in additional contributions to your account.

Roth 401(k) Contributions

Effective for the 2026 Plan Year, the Plan will accept Roth 401(k) elective deferrals. Roth contributions are made on an after-tax basis, meaning your contributions are subject to income tax at the time they are made. However, Roth 401(k) contributions are not taxed when distributed from the Plan. Employees may choose to make pre-tax contributions, Roth contributions, or a combination of both, subject to IRS limits.
For more information about Roth 401(k) deferrals or to take advantage of this new option, please contact Human Resources.

HELP STARTS HERE

BenefitsVIP is a comprehensive, one-stop contact center staffed by experienced professionals. Your dedicated team of employee benefit advocates is ready to assist you and your family members with any benefits-related concerns .

Let **BenefitsVIP** help you with:

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

For **confidential** and **responsive** service, contact :

866.293.9736

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

QUESTIONS ANSWERED HERE:

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates are experts in your benefits plans. They will promptly answer your questions and help resolve claims and eligibility issues. Most inquiries are resolved on the same day, and all calls are handled with strict adherence to privacy best practices.

BenefitsVIP

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.

SPECIAL ENROLLMENT RIGHTS CHIPRA – CHILDREN'S HEALTH INSURANCE PLAN

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.

You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

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.

NO SURPRISES ACT

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

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

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

PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH

DISCLOSURES

INSURANCE PROGRAM (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.
If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

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

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

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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

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

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

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

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

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

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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 and CHIP
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

DISCLOSURES

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
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://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone:304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

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

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

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

OMB Control Number 1210-0137
(expires 1/31/2026)

NOTES

CORPORATE SYNERGIES®