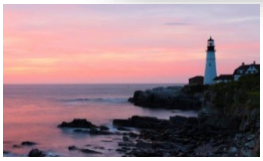
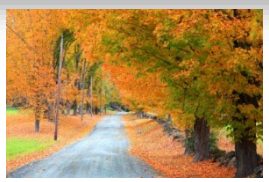




Spectrum Enterprises, Inc.

December 1, 2024 – November 30, 2025
Employee Benefit Guide

An overview of the wide array of benefits provided by Spectrum Enterprises, Inc. to help you enjoy increased well-being and financial security.

Prepared by Cross Insurance for Spectrum Enterprises, Inc.

Table Of Contents

Benefits for December 1, 2024 – November 30, 2025

Table of Contents

Welcome

Benefits for December 1, 2024 – November 30, 2025

Welcome

OUR EMPLOYEES ARE OUR MOST VALUABLE ASSET.

That's why Spectrum Enterprises, Inc. strives to provide you and your family with a comprehensive benefits package. We want you to pick the best benefits for you and your family. We've put together this Benefit Guide for annual enrollment and for new employees hired during the year.

Annual enrollment is an important time - it is a short period each year when you can make changes to your benefits. The IRS allows employees to select certain benefits through pre-tax salary reductions, which lowers taxes and saves money. Because of these tax savings, after your initial benefits selection at time you're hired, the IRS allows you to make changes only during an annual enrollment period, unless you experience a qualified status change. Since this is your one opportunity to enroll in or make changes to your benefits this year, please carefully consider your anticipated needs for the upcoming plan year. Elections you make during annual enrollment will be **effective on December 1, 2024.**

This Guide outlines the different benefits Spectrum Enterprises, Inc. offers, so you can identify which offerings are best for you and your family. The Guide also provides definitions for important terms, contact information for each of the carriers, as well as some important annual notices you should be aware of. This Benefit Guide includes summary descriptions of Spectrum Enterprises' benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This Guide and plan summaries do not constitute a contract of employment and benefits described in this Guide may be changed by the employer.

Contacts

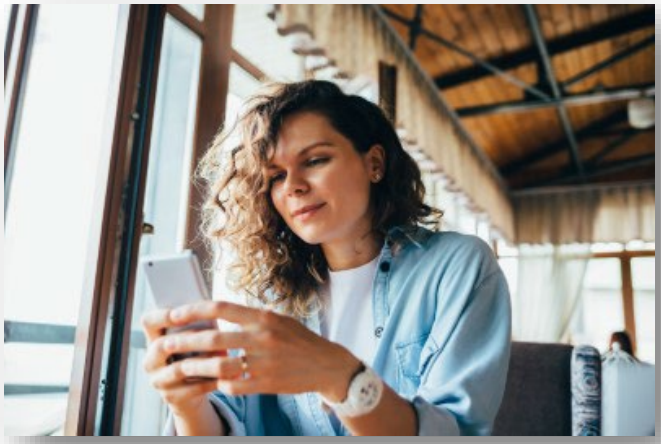
Benefits for December 1, 2024 – November 30, 2025

Contacts

If you have questions or need more information please do not hesitate to contact your Spectrum Enterprises, Inc. Human Resources Representative or our dedicated broker representatives at Cross Insurance.

Val Smith, CPA, MST
Director of Accounting and Benefits
75 John Roberts Road Suite 2C
South Portland, ME 04106
207-805-0038
vsmith@spectrumlihtc.com

Andy Bowden
Chief Financial Officer
75 John Roberts Road Suite 2C
South Portland, ME 04106
207-767-8000 Ext. 203
abowden@spectrumlihtc.com



Your contact for daily claims and benefits questions:

AJ Dickey, Account Service Representative
2367 Congress Street
Portland, Maine 04102
Phone: 207-523-2415
Fax: 207-828-8907
Alexander.Dickey@crossagency.com

In AJ's absence, please contact:

Gabriel Marchese, Account Executive
2367 Congress Street
Portland, Maine 04102
Phone: 207-523-2453
Fax: 207-828-8907
Gabriel.Marchese@crossagency.com

Contacts (continued)

Benefits for December 1, 2024 – November 30, 2025

Contacts

If you need to reach a carrier for the Spectrum Enterprises, Inc. employee benefit plan, these are the contacts.

Plan Type	Carrier	Website	Phone Number
Medical	Aetna	www.aetna.com	888-802-3862
Dental	Delta	www.nedelta.com	800-832-5700
Vision	Delta	www.nedelta.com	800-537-1715
Health Reimbursement Account	Flores	http://www.flores247.com/	800-532-3327
Flexible Spending Account	Flores	http://www.flores247.com/	800-532-3327
Life and AD&D	Principal	https://www.principal.com	800-245-1522
Short-Term Disability	Principal	https://www.principal.com	800-245-1522
Long-Term Disability	Principal	https://www.principal.com	800-245-1522
Employee Assistance Program	Principal	https://www.principal.com	800-245-1522

Eligibility and Enrollment

Benefits for December 1, 2024 – November 30, 2025

Eligibility & Enrollment

Who Is Eligible?

All eligible employees may elect to enroll in the benefit program during our annual enrollment period, or when you first become eligible. The minimum required hours you must work to be eligible, as well as the waiting periods before you can enroll yourself and eligible family members may be different for different types of coverage:

Coverage	Minimum Weekly Hours	Waiting Period	Eligible Family
Medical	30	1st of the month following 30 days	Employee, Domestic Partner/Spouse and Children
FSA/HSA	30	1st of the month following 30 days	Employee, Domestic Partner/Spouse and Children
Dental and Vision	20	1st of the month following 30 days	Employee, Domestic Partner/Spouse and Children
Life/AD&D – Basic	20	1st of the month following 30 days	Employee
Life/AD&D – Voluntary	20	1st of the month following 30 days	Employee, Domestic Partner/Spouse and Children
STD and LTD Disability	20	1st of the month following 30 days	Employee
EAP	20	1st of the month following 30 days	Employee and Household Family Members

How to Enroll or Make Changes During Annual Enrollment

If you are ready to enroll or make changes to your selections, the first step is to review your current benefits. Verify all your personal information and make any updates. Once all your information is up-to-date, it's time to make your benefit elections. The decisions you make during annual enrollment last for the plan year (unless you have a "Qualifying Event") and can have a big impact on your life and finances, so it is important to weigh your options carefully.

When Your Enrollment Choices Are Effective

The benefits you choose during annual enrollment will become **effective on December 1, 2024.** For newly hired or newly eligible employees, coverage will begin using the waiting period schedule above.

How to Make Changes – Qualifying Events

Unless you experience a life-changing "Qualifying Event," you cannot make changes to your benefits until the next annual enrollment Period. Qualifying Events may include things like: (1) marriage, divorce, or legal separation; (2) birth or adoption of a child; (3) death of spouse, child, or other qualified dependent; (4) residence change in certain instances; (5) change in a child's dependent status; (6) change in employment status or a change in coverage under another employer-sponsored plan; (7) a COBRA event; (8) Family Medical Leave Act (FMLA) leave; or (9) entitlement to Medicare or Medicaid.

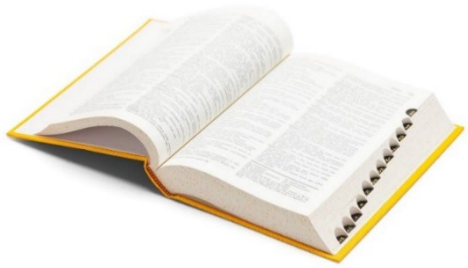
If you have a Qualifying Event, in most cases changes must be made within 30 days of the event, or you will need to wait until the next annual enrollment.

Medical

Benefits for December 1, 2024 – November 30, 2025

Medical

Key Terms to Remember



Annual Deductible

The amount you have to pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

Annual Out-of-Pocket Maximum

This is the total amount you can pay out-of-pocket each calendar year before the plan pays 100% of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible*, copays, and coinsurance.

*Except for Grandfathered medical plans

Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share (a percentage) of the allowed amount charged for a service and is generally billed to you after the health insurance company reconciles the bill with the provider.

Plan Types

High Deductible Health Plan (HDHP) - A plan that has higher annual deductibles in exchange for lower premiums. The **AFA CPOSII 3500 HSA, AFA CPOSII 6000 HSA, and AFA CPOSII 5500 HSA** plans are HDHPs, and you can set up a Health Savings Account (HSA) to accompany these plans.

Point of Service (POS) - A network of doctors, hospitals, and other health care providers that usually requires you to select a Primary Care Physician (PCP) who coordinates your care. You generally receive higher benefits when your PCP coordinates your care and lower benefits when you see an out-of-network provider and have not been referred by your PCP. In a medical emergency, network and coordination requirements do not apply. The **AFA CPOSII 3500 HSA, AFA CPOSII 5500 HSA, AFA CPOSII 6000 HSA and AFA CPOSII 8150** are POS plans.

Medical (continued)

Benefits for December 1, 2024 – November 30, 2025

Medical

Preventive Care

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and to incorporate healthy habits into your lifestyle. Some examples include: getting regular physical examinations; mammograms; and immunizations. Through the plans offered by Spectrum Enterprises, Inc., all covered individuals and family members are **eligible to receive routine wellness services like these at no cost - all copays, coinsurance, and deductibles are waived.**

Which Preventive Care Services Are Covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act compliant plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered:

"An ounce of prevention is worth a pound of cure"

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence
- Depression Screening
- Blood Pressure Screening

Medical (continued)

Benefits for December 1, 2024 – November 30, 2025

Medical

Who Is Eligible and When?

Employees working 30 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 30 days from date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Spectrum Enterprises Inc. offers the AFA CPOSII 8150 100/50 IntRx CY V24 from Aetna.

Summary of Coverage and Employee Contribution

Plan Features	AFA CPOSII 8150 100/50 IntRx CY V24	
	IN-NETWORK	OUT-OF-NETWORK
Deductible (Ind/Family)	$8,150 / $16,300	$25,000 / $75,000
Out-of-Pocket Maximum (Ind/Family)	$8,150 / $16,300	$50,000 / $150,000
Coinsurance Percentage	0%	50%
PCP Office Visits		
-Preventive Care	$0 Copay	50% after Deductible
-Sick Care	$0 Copay	50% after Deductible
Specialist Office Visits	0% after Deductible	50% after Deductible
Labs/Diagnostic & Imaging Services	0% after Deductible	50% after Deductible
Emergency Room Care	0% after Deductible	
Urgent Care	$0 Copay	50% after Deductible
Inpatient Hospital Care	0% after Deductible	50% after Deductible
Chiropractic Care (60 Visit Limit)	0% after Deductible	50% after Deductible
Physical, Speech and Occupational Therapy (60 Visit Limit)	0% after Deductible	50% after Deductible
Prescription Drugs (Rx)*		
1 – Generic Drugs	Tier 1: $0 Copay	Tier 1: 50% after Deductible
2 – Preferred Brand Drugs	Tier 2: 0% after Deductible	Tier 2: 50% after Deductible
3 - Non-Preferred Generic & Brand Drugs	Tier 3: 0% after Deductible	Tier 3: 50% after Deductible
4 - Preferred Specialty Drugs	Tier 4: 0% after Deductible	Tier 4: Not Covered
5 - Non-Preferred Specialty Drugs	Tier 5: 0% after Deductible	Tier 5: Not Covered

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Bi-Weekly Employee Contribution			
Employee Only	Employee + Spouse	Employee + Child(ren)	Family
$0	$385.22	$315.18	$700.43

Refer to your Medical plan documentation for more information.

Medical (continued)

Benefits for December 1, 2024 – November 30, 2025

Medical

Who Is Eligible and When?

Employees working 30 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 30 days from date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Spectrum Enterprises Inc. offers the AFA CPOSII 6000 HSA 70/50 E CY V24 ISL30 from Aetna.

Summary of Coverage and Employee Contribution

Plan Features	AFA CPOSII 6000 HSA 70/50 E CY V24 ISL30	
	IN-NETWORK	OUT-OF-NETWORK
Deductible (Ind/Family)	$6,000 / $12,000	$10,000 / $30,000
Out-of-Pocket Maximum (Ind/Family)	$7,500 / $15,000	$20,000 / $60,000
Coinsurance Percentage	30%	50%
PCP Office Visits **-Preventive Care** **-Sick Care**	 $0 Copay $35 Copay after Deductible	 50% after Deductible 50% after Deductible
Specialist Office Visits	$75 Copay after Deductible	50% after Deductible
Labs/Diagnostic & Imaging Services	30% after Deductible	50% after Deductible
Emergency Room Care	30% after Deductible	
Urgent Care	30% after Deductible	50% after Deductible
Inpatient Hospital Care	30% after Deductible	50% after Deductible
Chiropractic Care (60 Visit Limit)	$75 Copay after Deductible	50% after Deductible
Physical, Speech and Occupational Therapy (60 Visit Limit)	$75 Copay after Deductible	50% after Deductible
Prescription Drugs (Rx)* 1 – Generic Drugs 2 – Preferred Brand Drugs 3 - Non-Preferred Generic & Brand Drugs 4 - Preferred Specialty Drugs 5 - Non-Preferred Specialty Drugs	Tier 1a: $3 Copay after Deductible Tier 1: $10 Copay after Deductible Tier 2: $50 Copay after Deductible Tier 3: $100 Copay after Deductible Tier 4: 20% up to $250 after Deductible Tier 5: 40 % up to $500 after Deductible	Tier 1: 50% after Deductible Tier 2: 50% after Deductible Tier 3: 50% after Deductible Tier 4: Not Covered Tier 5: Not Covered

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Bi-Weekly Employee Contribution			
Employee Only	Employee + Spouse	Employee + Child(ren)	Family
$28.23	$446.27	$370.25	$788.31

Refer to your Medical plan documentation for more information.

Medical (continued)

Benefits for December 1, 2024 – November 30, 2025

Medical

Who Is Eligible and When?

Employees working 30 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 30 days from date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Spectrum Enterprises Inc. offers the AFA CPOSII 5500 HSA 80/50 E CY V24 ISL30 from Aetna.

Summary of Coverage and Employee Contribution

Plan Features	AFA CPOSII 5500 HSA 80/50 E CY V24 ISL30	
	IN-NETWORK	OUT-OF-NETWORK
Deductible (Ind/Family)	$5,500 / $11,000	$10,000 / $30,000
Out-of-Pocket Maximum (Ind/Family)	$7,500 / $15,000	$20,000 / $60,000
Coinsurance Percentage	20%	50%
PCP Office Visits **-Preventive Care** **-Sick Care**	 $0 Copay $35 Copay after Deductible	 50% after Deductible 50% after Deductible
Specialist Office Visits	$75 Copay after Deductible	50% after Deductible
Labs/Diagnostic & Imaging Services	20% after Deductible	50% after Deductible
Emergency Room Care	20% after Deductible	
Urgent Care	20% after Deductible	50% after Deductible
Inpatient Hospital Care	20% after Deductible	50% after Deductible
Chiropractic Care (60 Visit Limit)	$75 Copay after Deductible	50% after Deductible
Physical, Speech and Occupational Therapy (60 Visit Limit)	$75 Copay after Deductible	50% after Deductible
Prescription Drugs (Rx)* 1 – Generic Drugs 2 – Preferred Brand Drugs 3 - Non-Preferred Generic & Brand Drugs 4 - Preferred Specialty Drugs 5 - Non-Preferred Specialty Drugs	Tier 1a: $3 Copay after Deductible Tier 1: $10 Copay after Deductible Tier 2: $50 Copay after Deductible Tier 3: $100 Copay after Deductible Tier 4: 20% up to $250 after Deductible Tier 5: 40 % up to $500 after Deductible	Tier 1: 50% after Deductible Tier 2: 50% after Deductible Tier 3: 50% after Deductible Tier 4: Not Covered Tier 5: Not Covered

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Bi-Weekly Employee Contribution			
Employee Only	Employee + Spouse	Employee + Child(ren)	Family
$35.30	$461.56	$384.04	$810.34

Refer to your Medical plan documentation for more information.

Medical (continued)

Benefits for December 1, 2024 – November 30, 2025

Medical

Who Is Eligible and When?

Employees working 30 or more hours per week are eligible to enroll. New employees are eligible on the first day of the month following 30 days from date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Spectrum Enterprises Inc. offers the AFA CPOSII 3500 HSA 80/50 E CY V24 ISL30 from Aetna.

Summary of Coverage and Employee Contribution

Plan Features	AFA CPOSII 3500 HSA 80/50 E CY V24 ISL30	
	IN-NETWORK	OUT-OF-NETWORK
Deductible (Ind/Family)	$3,500 / $7,000	$10,000 / $30,000
Out-of-Pocket Maximum (Ind/Family)	$6,000 / $12,000	$20,000 / $60,000
Coinsurance Percentage	20%	50%
PCP Office Visits **-Preventive Care** **-Sick Care**	 $0 Copay $35 Copay after Deductible	 50% after Deductible 50% after Deductible
Specialist Office Visits	$75 Copay after Deductible	50% after Deductible
Labs/Diagnostic & Imaging Services	20% after Deductible	50% after Deductible
Emergency Room Care	20% after Deductible	
Urgent Care	20% after Deductible	50% after Deductible
Inpatient Hospital Care	20% after Deductible	50% after Deductible
Chiropractic Care (60 Visit Limit)	$75 Copay after Deductible	50% after Deductible
Physical, Speech and Occupational Therapy (60 Visit Limit)	$75 Copay after Deductible	50% after Deductible
Prescription Drugs (Rx)* 1 – Generic Drugs 2 – Preferred Brand Drugs 3 - Non-Preferred Generic & Brand Drugs 4 - Preferred Specialty Drugs 5 - Non-Preferred Specialty Drugs	Tier 1a: $3 Copay after Deductible Tier 1: $10 Copay after Deductible Tier 2: $50 Copay after Deductible Tier 3: $100 Copay after Deductible Tier 4: 20% up to $250 after Deductible Tier 5: 40 % up to $500 after Deductible	Tier 1: 50% after Deductible Tier 2: 50% after Deductible Tier 3: 50% after Deductible Tier 4: Not Covered Tier 5: Not Covered

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Bi-Weekly Employee Contribution			
Employee Only	Employee + Spouse	Employee + Child(ren)	Family
$91.69	$583.50	$494.06	$985.91

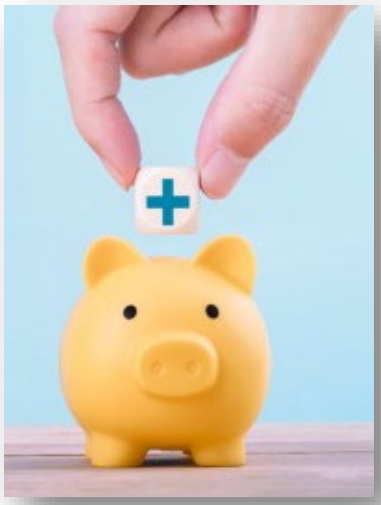
Refer to your Medical plan documentation for more information.

Health Reimbursement Account (HRA)

Benefits for December 1, 2024 – November 30, 2025

Who Is Eligible and When?

Benefits are available to all eligible employees who enroll in the medical insurance through Spectrum Enterprises.



Benefits You Receive

Spectrum Enterprises, Inc. offers a Health Reimbursement Account (HRA) with **Flores.** This is how an HRA works:

- Spectrum Enterprises, Inc. sets up an HRA for each participant.
- You don't contribute any money to your HRA account; the HRA account is funded entirely by Spectrum Enterprises, Inc..
- Each plan year, Spectrum Enterprises, Inc. contributes a specified amount to each participant's HRA. The funds are used toward eligible HRA expenses.

How Do I Benefit from an HRA?

HRAs benefit everyone – single individuals and families. You will appreciate your HRA because you don't pay taxes on the money in your account or your reimbursed expenses.

What Expenses Are Covered Under an HRA?

Only eligible expenses can be reimbursed under your HRA. These expenses are defined by IRS rules and by the Spectrum Enterprises, Inc. plan. In this case, your HRA is used to help meet your calendar year deductible under the medical plan. For 2024/2025, Spectrum Enterprises, Inc. is contributing $5,150 for individual/$10,300 for family coverage.

Here is How the HRA Plan Shares Expenses with You		
Out-of-Pocket Maximum:	**You Pay the First:**	**HRA Pays the next:**
S: $6,000 / $7,500 / $7,500 / $8,150	$1,650	$5,150
F: $12,000 / $15,000 / $15,000 / $16,300*	$3,300	$10,300

**Health Plan Maximum & HRA benefits are capped at the Single Plan level for individuals who are part of a Family Plan.*

Health Savings Account (HSA)

Benefits for December 1, 2024 – November 30, 2025

Who Is Eligible and When?

When you are enrolled in the **AFA CPOSII 3500 HSA, AFA CPOSII 5500 HSA and AFA CPOSII 6000 HSA** medical plans, **Spectrum Enterprises, Inc.** offers you an employer-sponsored Health Savings Account (HSA). With an HSA, employees can save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany High Deductible Health Plans (HDHPs).

How Do I Benefit from an HSA?

The main purpose of this account is to offset the cost of a qualifying HDHP and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement. This is a "portable" account. You own your HSA! It's included in your employee benefits package, but after you set up your account, it's yours to keep, even if you change jobs or retire.

Why Is It a Good Idea to Have an HSA?

HSAs benefit everyone who is eligible to have this account – single individuals, families, and soon-to-be retirees. You save money on taxes in three ways:

- **Tax-free deposits** – The money you contribute to your HSA isn't taxed (up to the IRS annual limit).
- **Tax-free earnings** – Your interest and any investment earnings grow tax-free.
- **Tax-free withdrawals** – The money used toward eligible health care expenses isn't taxed – now or in the future.

Setting aside pre-tax dollars into your HSA means you pay fewer taxes and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket. For example, if you are in the 30 percent tax bracket, you can save $30 on every $100 spent on eligible health care expenses.

HSA funds roll over from year to year and accumulate in your account. There is no "use-it-or-lose-it" rule with HSAs, and you decide how and when to use your HSA funds, which can be used for eligible expenses you have now, in the future, or during retirement. And when you have a certain balance in your HSA, investment opportunities are available.

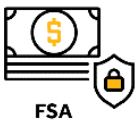
What Expenses are Covered Under an HSA and How Much Can I Contribute?

Once your HSA is established, you can contribute to your account up to a total of $4,300 if you have individual coverage and $8,550 if you have family coverage in 2025. Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum. You can then use your HSA dollars tax-free to pay for eligible health care expenses. You save money on expenses you're already paying for, such as doctors' office visits, prescription drugs, and much more. Best of all, you decide how and when to use your HSA dollars.

Refer to your HSA documentation for more information.

Flexible Spending Account (FSA)

Benefits for December 1, 2024 – November 30, 2025



Who Is Eligible and When?

Benefits are available to employees working 30 or more hours per week. New employees are eligible for benefits on the first day of the month following 30 days from the date of hire/eligibility.

Benefits You Receive

Spectrum Enterprises, Inc. offers employer-sponsored FSAs from **Flores**, where employees can save pre-tax dollars to pay for qualified health care expenses.

Benefits of an FSA Include

- **It saves you money.** Allows you put aside money tax-free that can be used for qualified expenses.
- **It's a tax-saver.** Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It's flexible.** You can use your FSA funds at any time during the year, even if it's the beginning of the year.

Summary of Accounts and Qualified Expenses

General Purpose Health Care FSA – For Health Care Expenses

Money you put in your FSA health care reimbursement account can pay for qualified expenses not covered by insurance that are listed below.

For this year, you can deposit up to $3,200 in your General Purpose Health Care FSA. You can carry over up to $640 of your unused FSA amounts to the next year.

Health Care FSA Eligible Expenses

- Medical expenses: copays, coinsurance, and deductibles
- Dental expenses: exams, cleanings, x- rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services: physical therapy, chiropractic care, and acupuncture
- Prescription drugs and insulin
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.

Voluntary Dental

Benefits for December 1, 2024 – November 30, 2025

Dental

Who is Eligible and When?

Benefits are available for purchase to employees working 30 or more hours per week. New employees are eligible for benefits on the first day of the month following 30 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment** are eligible.

Benefits You Receive

Spectrum Enterprises offers a Dental Plan you can purchase from Northeast Delta Dental.

Summary of Coverage and Employee Payroll Deduction

Delta Dental Plan	In-Network
One Time Deductible (Per Person/Family (Applies ONLY to Basic and Major Restorative Services)	$50/$150
A - Diagnostic and Preventive Services	100%
B - Basic Restorative Services	70%
C - Major Restorative Services *(6 Month Waiting Period)*	50%
Calendar Year Maximum	$1,500
D - Orthodontic Services *(6 Month Waiting Period)*	50%
Lifetime Maximum for Orthodontic Services	$1,250

A - Diagnostic/Preventive Services	B - Basic Restorative Services	C- Major Restorative Services	D - Orthodontic Services
Diagnostic: Oral Evaluations Bitewing x-rays **Preventive:** Full-mouth/Panoramic x-rays Cleanings Fluoride Sealants, to age 18 Space Maintainers	Fillings Extractions Root Canal Therapy Scaling and root planning Incision and draining of abscess Simple extractions Surgical removal of erupted or impacted tooth	Inlays/Onlays Crowns/Crown Repair Full & partial dentures Pontics Denture repair Anesthesia	Correction of malposed (crooked) teeth for dependent children up to age 20

Bi-Weekly Employee Contribution		
Employee Only	Employee + 1	Employee + 2 or More
$18.43	$33.76	$58.91

Refer to your Dental plan documentation for more information.

Voluntary Vision

Benefits for December 1, 2024 – November 30, 2025

Vision

Who is Eligible and When?

Benefits are available for purchase to employees working 30 or more hours per week. New employees are eligible for benefits on the first day of the month following 30 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment** are eligible.

Benefits You Receive

Spectrum Enterprises offers a Vision Plan you can purchase from Delta Vision.

Summary of Coverage and Employee Payroll Deduction

Plan Features	Delta Vision
	Delta Vision Network
	In-Network
	Your Cost
Vision Exam – every 12 months	$10 Copay
Frames– every 12 months	$150 Allowance, 20% off Balance over $130
Lenses– Standard - every 12 months	
Single	$25 Copay
Bifocal	$25 Copay
Trifocal	$25 Copay
Lenticular	$25 Copay
Lens Options	
UV Coating/Tint	$15 Copay for each
Standard Polycarbonate	$40 Copay
Standard Anti-reflective Coating	$45 Copay
Standard Progressive	$90 Copay
Premium Progressive	$90 Copay, 20% off retail price less $150 Allowance
Contact Lens Fit and Follow-up – Standard Lenses	$40 Copay
Contact Lens Fit and Follow-up – Premium Lenses	10% Discount off Retail Price
Contacts– every 12 months	
Conventional	$150 Allowance, 15% off Balance You Pay over $150
Disposable	$150 Allowance
Medically Necessary	$0 Copay
Laser Vision Correction	15% off Retail Price or 5% off Promotional Price

Bi-Weekly Employee Contribution		
Employee Only	Employee + 1	Employee + 2 or More
$3.17	$5.43	$9.72

Refer to your Vision plan documentation for more information.

Life - Basic

Benefits for December 1, 2024 – November 30, 2025

Life

Who is Eligible and When?

Benefits are available to employees working 20 or more hours per week. New employees are eligible for benefits on the first day of the month following 30 days from the date of hire/eligibility.

Benefits You Receive

At no cost to you, **Spectrum Enterprises, Inc.** offers you employer-sponsored Group Life and Accidental Death and Dismemberment (AD&D) insurance from Principal. As long as you are eligible, you are automatically enrolled and can receive coverage of 100% of your annual salary, rounded to the next higher $1,000 without having to answer any questions about your health. This is referred to as the Guarantee Issue Amount. The AD&D insurance amount is also 100% of your annual salary, rounded to the next higher $1,000. This insurance can help provide for your family if something happens to you. You must choose a beneficiary or beneficiaries - the person(s) or entity you name who will receive the proceeds from your life or AD&D insurance in the event of your death or injury.

Benefits are summarized below.

Summary of Coverage

Plan Features	Basic Life – Principal
Employee Benefit Amount	100% of your annual salary up to $400,000
AD&D Benefit Amount	100% of your annual salary up to $400,000
Guarantee Issue Amount	$200,000
The following shows how much benefits are reduced at certain ages – coverage is available if you are still employed at Spectrum Enterprises, Inc.	
Age Reduction	**Benefits Available**
Age 65	65%
Age 70	50%

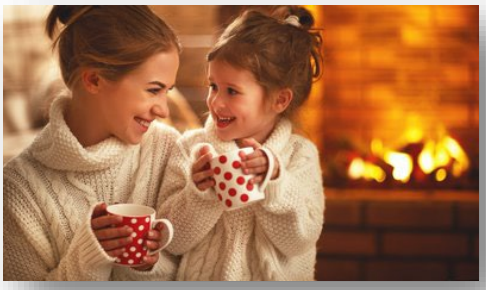
Refer to your Life and AD&D plan documentation for more information.

Voluntary Life

Benefits for December 1, 2024 – November 30, 2025

Life

Who is Eligible and When?



Benefits are available to employees working 20 or more hours per week. New employees are eligible for benefits on the first day of the month following 30 days from the date of hire/eligibility.
Family members listed in **Eligibility and Enrollment** are eligible.

Benefits You Receive

Spectrum Enterprises, Inc. offers you employer-sponsored Group Life and Accidental Death and Dismemberment (AD&D) insurance from Principal. As long as you purchase coverage when you are first eligible as a new hire, you can buy coverage of up to $300,000 in $10,000 increments without having to answer any questions about your health. This is referred to as the Guarantee Issue Amount. The AD&D insurance amount is the same as the Life amount. To purchase coverage after your initial eligibility or that exceeds the Guarantee Issue Amount, you need to provide evidence of insurability to Principal. This insurance can help provide for your family if something happens to you. You must choose a beneficiary or beneficiaries - the person(s) or entity you name who will receive the proceeds from your Life or AD&D insurance in the event of your death or injury.

Coverage can also be purchased for family members. Benefits are summarized below.

Summary of Coverage

Employee - Plan Features	Voluntary Life – Principal
Employee Life Benefit Amount	Up to $300,000 in $10,000 Increments
AD&D Benefit Amount	Same as Life
Guarantee Issue Amount	$100,000
The following shows the percentage of benefits available to you as you reach certain ages – coverage is available if you are still employed at Spectrum Enterprises, Inc.	
Age	**Benefits Available**
Age 65	65%
Age 70	50%
Spouse - Plan Features	**Voluntary Life – Principal**
Spouse Life Benefit Amount	100% of the Employee Insured Amount up to $100,000 in $5,000 Increments
AD&D Benefit Amount	Same as Life
Guarantee Issue Amount	$25,000
Age Reduction	Benefits Will Be Reduced by 35% When Employee Reaches Age 65
Child(ren) - Plan Features	**Voluntary Life – Principal**
Child(ren) Benefit Amount	$10,000

Employee Payroll Deduction

The amount deducted from your pay depends on the amount of Voluntary Life insurance you buy.

Refer to your Life and AD&D plan documentation for more information.

Disability

Benefits for December 1, 2024 – November 30, 2025

Disability

Who is Eligible and When?

For Short-Term (STD) and Long-Term Disability (LTD) insurance, benefits are available to employees working 20 or more hours per week. New employees are eligible for benefits on the first day of the month following 30 days from the date of hire/eligibility.

Benefits You Receive

At no cost to you, **Spectrum Enterprises, Inc.** offers you employer-sponsored STD and LTD insurance from **Principal**. If you become disabled from a non-work-related injury or illness, disability income benefits will provide a partial replacement of lost income.

Summaries of Coverage

Plan Features	Short-Term Disability – Principal	
Benefits Begin **Accident** **Sickness**	8th Day 8th Day	
Weekly Benefit	Benefit Amount	60% of your weekly earnings
	Maximum	$2,500 per week
Benefits Duration	Up to 12 weeks	

Plan Features	Long-Term Disability - Principal	
Benefits Begin **Accident** **Sickness**	91st Day 91st Day	
Monthly Benefit	Benefit Amount	60% of your monthly earnings
	Maximum	$5,000 per month
Benefits Duration	To your Social Security Normal Retirement Age (SSNRA)	
Pre-existing Limitation Exclusion	No benefits are available for disability caused by or contributed to by a pre-existing condition for which you were treated or had symptoms in the 3 months prior to beginning coverage for the first 12 months of coverage	

Refer to your Disability plan documentation for more information.

Employee Assistance Program (EAP)

Benefits for December 1, 2024 – November 30, 2025

EAP

Who is Eligible and When?

At no cost to you, the EAP is available to all employees working 20 or more hours per week participating in the insurance program with Principal. New employees are eligible on the first of the month following 30 days from date of eligibility. If you participate in the Life and AD&D Insurance, Long-Term Disability Insurance or Short-Term Disability Insurance, you are eligible for the Employee Assistance Program and you do not need to enroll separately.

What You Receive

The EAP is a completely confidential program that can help you or an immediate family member in your household deal with life challenges such as divorce, death in the family, anxiety or depression, work issues, or financial difficulties through counseling or referrals.

Travel Assistance

If you have life or disability insurance through Principal, you are also eligible for travel assistance from AXA Assistance USA. You, your spouse or domestic partner and your dependent children]have access to 24 hour assistance if an emergency arises. Just call the emergency phone number for help with travel, medical, legal matters, emergency medical evacuations and other matters when you're traveling. Please note that this assistance is not insurance.

Legal Notices

Women's Health and Cancer Rights Act Enrollment Notice

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

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

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan. If you would like more information on WHCRA benefits, please contact your health plan administrator at 207-805-0038.

HIPAA Notice of Privacy Practices

The Plan's HIPAA Notice of Privacy Practices is available upon request. To obtain a copy of the Plan's HIPAA Notice of Privacy Practices, please contact the HR Department. For more information on the Plan's privacy policies or your rights under HIPAA, contact Val Smith at 207-805-0038.

HIPAA Special Enrollment Rights

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Spectrum Enterprises, Inc.'s health plan under "special enrollment provisions" briefly described below.

- Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Spectrum Enterprises, Inc.'s health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after your or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under Spectrum Enterprises, Inc.'s health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in Spectrum Enterprises, Inc.'s health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the Plan Administrator at 207-805-0038 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan descriptions or insurance contract.

Legal Notices (continued)

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about the prescription drug coverage offered by Spectrum Enterprises, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Spectrum Enterprises, Inc. offers the following health plan options:

- AFA CPOSII 8150 100/50 IntRX CY V24 ISL30
- AFA CPOSII 5500 HSA 80/50 E CY V24 ISL30
- AFA CPOSII 3500 HSA 80/50 E CY V24 ISL30
- AFA CPOSII 6000 HSA 70/50 E CY V24 ISL30

Depending on the plan you choose, it may pay out as much as standard Medicare prescription drug coverage pays, which is called **Creditable Coverage.** If the plan you choose is NOT expected to pay out as much as standard Medicare prescription drug coverage pays, it is considered **Non-Creditable Coverage**.

Spectrum Enterprises, Inc. has determined that the prescription drug coverage offered by the following plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. The following plans provide **Creditable Coverage**:

- AFA CPOSII 8150 100/50 IntRX CY V24 ISL30
- AFA CPOSII 3500 HSA 80/50 E CY V24 ISL30

Spectrum Enterprises, Inc. has determined that the prescription drug coverage offered by the following plan(s) is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, the following plans provide **Non-Creditable Coverage**:

- AFA CPOSII 6000 HSA 70/50 E CY V24 ISL30
- AFA CPOSII 5500 HSA 80/50 E CY V24 ISL30

If you choose a plan that provides **Creditable Coverage,** you will **not** pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you choose a Plan that provides **Non-Creditable Coverage**, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Non-Creditable Coverage plan(s) listed above. **If you choose a Non-Creditable Coverage plan and you do not enroll in a Medicare Part D prescription drug plan, you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

There are some other important things you need to know about these offerings and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. If your existing coverage is **Creditable Coverage**, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
3. If your existing coverage is **Non-Creditable Coverage**, you can choose to enroll in a Plan providing Creditable Coverage or you can keep your existing coverage. Your decision about which Plan to enroll in and about Medicare prescription drug coverage may affect how much you pay for Medicare prescription drug coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area and the potential penalty for failing to enroll.

Legal Notices (continued)

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and **each year from October 15th to December 7th**. However, if you lose or drop your coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should know that if you drop or lose your creditable prescription drug coverage and don't join a Medicare drug plan within 63 continuous days after your current creditable coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Spectrum Enterprises, Inc. coverage will likely not be affected. You can keep this coverage if you elect Medicare Part D and the plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Spectrum Enterprises, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

For More Information About This Notice or Your Current Prescription Drug Coverage. . .
Contact the person listed below for further information. NOTE: You'll get a creditable coverage notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Spectrum Enterprises, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage.
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

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

Legal Notices (continued)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

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

Legal Notices (continued)

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

Legal Notices (continued)

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website:https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select; https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Legal Notices (continued)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, 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 healthcare provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or a deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a healthcare 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 states have enacted balance billing protections for patients receiving emergency services. For example, New Hampshire, Maine, Massachusetts, and Vermont all have laws protecting patients from balance billings. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

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.

Legal Notices (continued)

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.

State law prohibitions against balance billing may also apply. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

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

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

If you think you've been wrongly billed, contact your insurance carrier by calling the number on your insurance card. You may also contact your state insurance regulator or the No Surprises helpdesk at 1-800-985-3059.

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

Newborns' and Mothers' Health Protection Act of 1996

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).

Employee Benefits and Remote Work

To the extent that Spectrum Enterprises, Inc. permits remote work, you must notify Human Resources of your remote work location and any changes to that location, *especially* if that location is in another state. Different states have specific requirements such as workers compensation, state and local taxes, and state paid family leave requirements. Failing to provide Human Resources with accurate information may result in state-imposed fines or other adverse consequences. Please contact Val Smith at 207-805-0038 with any questions or updates.

Legal Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. For Plan Years beginning in 2025, if your share of the premium cost of all plans offered to you through your employment is more than 9.02%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution–as well as your employee contribution to employment-based coverage–is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

[1]Indexed annually.

[2]An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Legal Notices (continued)

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Val Smith at 207-805-0038.

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

Legal Notices (continued)

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Spectrum Enterprises, Inc.		4. Employer Identification Number (EIN) 01-0540652
5. Employer address 75 Jon Roberts Road Suite 2C		6. Employer phone number 207-767-8000
7. City Portland	8. State ME	9. ZIP code 04106
10. Who can we contact about employee health coverage at this job? Val Smith		
11. Phone number (if different from above) 207-805-0038	12. Email address vsmith@spectrumlihtc.com	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

All Eligible staff regularly working 32 hours or more per week

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse, Domestic Partner, Children – as defined in official Plan Documents

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

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Benefits Brought to You by:

Spectrum Enterprises, Inc.

Benefits Brokered by:

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