

2025-2026 Benefits Guide



T.M. Cobb Company

Alexis Cash

Benefits Specialist

alexisc@tmcobb.com

Office: 951.248.2407

500 Palmyrita Avenue, Riverside, CA 92507

Inside This Guide

- Benefits Overview 2
- Medical Benefits..... 3
- Dental Benefits..... 4
- Vision Benefit 5
- 401(k) Retirement Plan – Fidelity NetBenefits 6
- Life Insurance 6
- Voluntary Life and AD&D..... 7
- Voluntary Hospital Indemnity Plan 7
- Voluntary Accident Plan 8
- Voluntary Critical Illness Plan 8
- Employee Assistance Program..... 9
- Health Reimbursement Arrangement (HRA) Plan 10
- Flexible Spending Account (FSA)..... 10
- Discount Programs11
- Annual Enrollment Notices and Disclosures 14

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 18 for more details.

Benefits Overview

T.M. Cobb Company is proud to offer a comprehensive benefits package to full-time employees who work 30 hours per week. T.M. Cobb / Haley Bros. currently offers the following benefits to its eligible employees.

Benefit Plans Offered

- Medical
- Dental
- Vision
- 401(k) Retirement
- Health Reimbursement Arrangement (HRA)
- Flexible Spending Account (FSA)
- Basic Life and AD&D
- Voluntary Life and AD&D
- Voluntary Hospital Indemnity
- Voluntary Accident Plan
- Voluntary Critical Illness
- EAP

Eligibility

You and your dependents are eligible for T.M. Cobb Company benefits on the first of the month after 60 days (2 months) of employment.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or T.M. Cobb Company eligible dependents.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

Medical Insurance Waiver

Employees who waive the medical insurance offered by T.M. Cobb and provide a copy of their current medical insurance card will receive a monthly \$50 reimbursement on the first paycheck of every month.

Open Enrollment

Medical, Dental and Vision

Open enrollment for medical, dental and vision is typically in August every year. Benefits for the new benefit plan year will begin September 1st each year.

Flexible Spending Account

Open enrollment for FSA begins on 12/1 and closes on 12/30 for the next calendar year beginning on 1/1.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Medical Benefits

Administered by Aetna

IMPORTANT: If you live out of state, please contact Alexis Cash, Benefits Specialist, for alternative medical benefits.

Aetna AWH HMO vs. Full HMO

The Aetna AWH HMO and Full HMO have the same benefits.

The choice between a narrow network and a full network depends on individual preferences, healthcare needs, and budget. If your health provider is found within the AWH HMO plan network, consider moving to the AWH HMO plan for lower premiums without losing your current provider assignment.

Contact Aetna Member Services to change your Primary Care Physician: **800.445.5299**

Go to [Aetna.com/individuals-families/find-a-doctor.html](https://www.aetna.com/individuals-families/find-a-doctor.html) to find a doctor or hospital now.

The **Aetna AWH Network** features large, well-recognized medical groups close to where you live or work. Here's a sample of the groups included.

- Beaver Medical Group
- Optum Care Network
- Prospect Medical Group
- Riverside Medical Group
- Hill Physicians
- Mercy Medical Group

Plan Name	Full HMO and Aetna AWH HMO IN Only ACO 3000 \$45/45
	In-Network Benefits
PLAN DESIGN	
Calendar Year (CY) Deductible (Individual / Family)	\$3,000 / \$6,000
CY Out-of-Pocket Max (Individual / Family)	\$6,000 / \$12,000
Coinsurance (member pays after deductible)	N/A
Preventive Care	Covered 100%; no deductible
Primary Care Visit	\$45; no deductible
Specialist Visit	\$45; no deductible
Urgent Care	\$45; no deductible
Emergency Room	\$150; no deductible. Waived if admitted.
Inpatient Hospital	40% after deductible
Outpatient Surgery	0% coinsurance
Phys / Occ / Speech Therapy (visit limits may apply)	\$45; no deductible
Diagnostic Test (X-ray, blood work)	Covered 100%; no deductible
PHARMACY	
Retail	
Tier I / Tier II / Tier III	\$10 / \$30 / \$50
Specialty	20% to max \$250

Medical Contributions

Benefit Plan	Full HMO	AWH HMO
Per Paycheck Cost	Low	Lowest
Network	Larger	Narrow
	Wider range of physicians within network	Smaller range of physicians within network

BOTH PLANS OFFER THE SAME LEVEL OF COVERAGE

Employee	\$78.54	\$54.98
Employee + Spouse	\$236.45	\$184.99
Employee + Child(ren)	\$193.46	\$163.01
Family	\$333.19	\$270.70

Dental Benefits

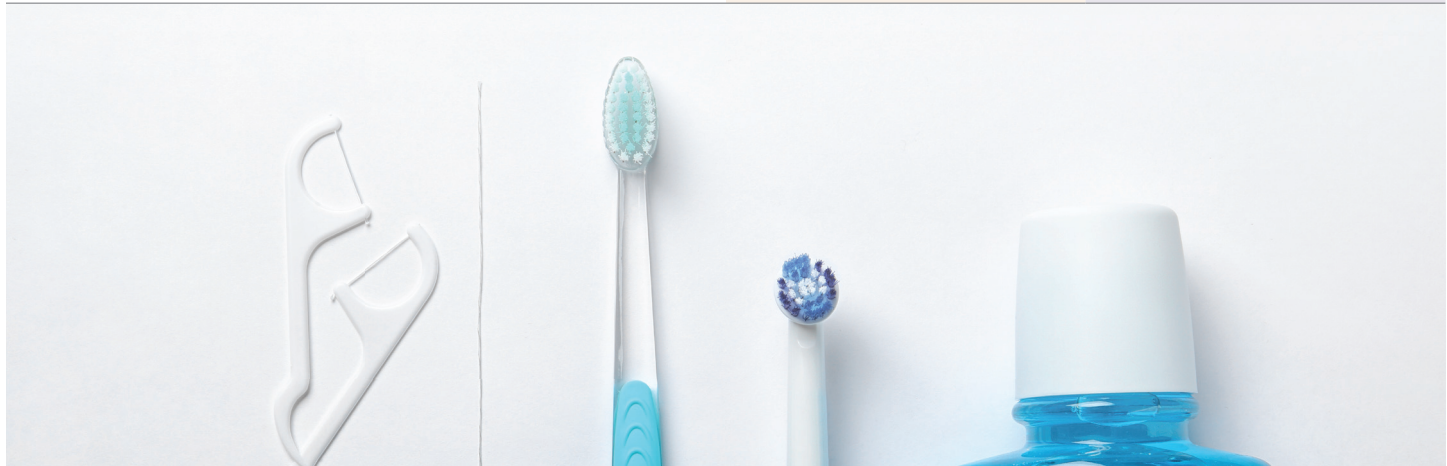
Administered by Aetna

You will now have two dental plan offered through Aetna. The dental HMO is a lower cost option; however, you can only access in network providers. The dental PPO plan, offers both in network and out of network coverage; however, your dollar go further when seeking care through an in network provider. To determine whether your dentist is in or out of your insurance network, visit <http://www.aetna.com> or call 877.238.6200.

Aetna Managed Dental HMO	
In-Network Only	
Annual Deductible	N/A
Annual Maximum	Unlimited
Office Visit	\$0 copay
Preventative Services	Copay Varies
Basic Services	Copay Varies
Major Services	Copay Varies
ORTHODONTIA SERVICES	
Adult	\$2,000
Child up to age 19	\$2,000

Aetna Dental PPO		
	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE		
Individual	\$100	\$100
Family	\$300	\$300
Annual Maximum	\$1,000	\$1,000
Preventative Services	80%	50%
Basic Services	80%	50%
Major Services	50%	50%
Orthodontia Services	Not covered	Not covered

Tier	DHMO Per Paycheck Cost (Bi-Weekly)	DPPO Per Paycheck Cost (Bi-Weekly)
Employee	\$1.72	\$4.27
Employee + 1	\$3.36	\$8.54
Employee + 2	\$5.54	\$12.80



Vision Benefit

Administered by Aetna

Regular eye examinations can not only determine your need for corrective eyewear but may also detect general health problems in their earliest stages. Protecting your eyes should be a major concern for everyone. Please note that there are both in-network and out-of-network providers with Aetna. When seeking vision care, ensure that your provider is in-network with Aetna Vision Preferred to receive deeper discounts. To find a provider, visit eyedoclocator.aetnavision.com.

Choice Network	Bi-Weekly	
Exam	Once every 12 months, based on calendar year	
Lenses	Once every 12 months, based on calendar year	
Frames	Once every 24 months, based on calendar year	
	In-Network	Out-of-Network
Exam	\$10 Copay	Up to \$30
Frame Allowance	\$150 allowance, + 20% off balance	Allowance up to \$75
	Lenses	
Single Vision Lenses	\$25 Copay	Allowance up to \$25
Bifocal Lenses	\$25 Copay	Allowance up to \$40
Trifocal Lenses	\$25 Copay	Allowance up to \$55
	Contact Lenses (in lieu of frames)	
Elective	\$150 allowance + 15% off balance	Allowance up to \$120
Medically Necessary	100% covered after \$10 copay	Allowance up to \$200

Tier	Per Paycheck Cost (Bi-Weekly)
Employee	\$1.00
Employee + 1	\$1.50
Employee + 2	\$2.00



401(k) Retirement Plan – Fidelity NetBenefits

Employees Hired	Meeting Month (Dates to be Determined)	Effective Month
Jan-Mar	March	April 1
April-June	June	July 1
July-September	September	October 1
October-December	December	January 1

During the 401(k) Meetings, employees interested in contributing to their 401(k) Retirement Account will be required to attend and register online through www.401k.com.

Dedicated financial advisors are available with Morgan Stanley, Richard Bratincevic and Gladys Lugo at **626.304.2419** for questions/concerns.

Minimum contribution is 2%. The company matches 25% of the initial 5% contributed by employees. Your account is fully vested after 5 years of service with the company.

401(k) contributions may be adjusted as needed online through www.401k.com.

Life Insurance

100% company paid, available to all Full-Time employees. Confirm Paycom has your Primary and Secondary Beneficiary(ies) listed!

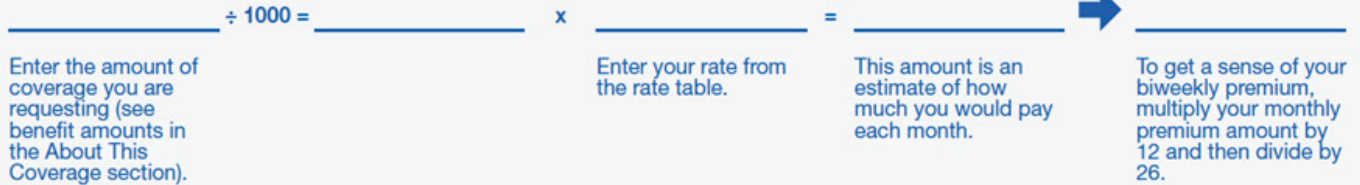
Life Insurance Class	
Class 6	\$4,000
Class 5	\$5,000
Class 4	\$10,000
Class 3	\$20,000
Class 2	\$40,000
Class 1	\$50,000



Voluntary Life and AD&D

If you would like to supplement your employer-paid insurance, additional Life and AD&D coverage is available for yourself and your spouse. Please note that the deduction varies based on age and election amount. For assistance with calculations, contact the Benefits Specialist. Coverage amounts will reduce 65% of original amount at age 70, and reduce 50% of original amount at age 75.

Use this formula to calculate your premium payment:



For Employees: increments of \$10,000 up to 5 times your annual salary, not to exceed \$500,000, whichever is less with a guaranteed issue amount of \$150,000.

For Your Spouse: Increments of \$5,000 up to a maximum of \$250,000, not to exceed 100% of employee elected amount with a guaranteed issue of \$25,000.

For Your Child(ren): Flat \$10,000 from birth to age 26.

Please note: You will need to complete an Evidence of Insurability (EOI) form if you request more than the Guarantee Issue amount or after declining the first time coverage is offered.

Voluntary Hospital Indemnity Plan

Hospital indemnity coverage eases the financial impact of an employee’s hospitalization and can be used to supplement medical insurance to help handle additional out-of-pocket costs by providing a lump sum payment. This can include: Copayments, Coinsurance, Deductibles, and Incidental hospital expenses or other expenses such as transportation and lodging needs.

How does it work?

Hospital Indemnity Insurance provides fixed payments directly to members when they have a covered inpatient hospital stay. You also have the opportunity to purchase coverage for your spouse and dependent children.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like copays and deductibles.
- Guaranteed Issue every year for employees and their families – even if coverage waived in the past
- The cost is conveniently deducted from your paycheck

Plan Features	
Plan Highlights	This benefit also provides: <ul style="list-style-type: none"> • Family coverage • Guarantee issue • No pre-existing condition limitations • Portable • \$50 Wellness Benefit
Initial Hospital Admission	\$1,000
Initial Hospital Admission ICU	\$2,000
Hospital Confinement per Day	\$200 (up to 30 days / plan year)
ICU Hospital Confinement per Day	\$400 (up to 30 days / plan year)
Either Confinement or ICU Confinement Benefit is Payable Once Per Covered Accident / Illness	
Pregnancy	Covered (No waiting period)

Tier	Per Paycheck Cost (Bi-Weekly)
Employee	\$13.68
Employee + Spouse	\$27.35
Employee + Child(ren)	\$24.61
Employee + Family	\$38.29

Voluntary Accident Plan

Accident Insurance provides financial protection for you by paying a benefit if you suffer a covered accident. The amount you receive is based on the amount of coverage in effect on the date of the accident according to the terms and provisions of the policy. You also have the opportunity to purchase coverage for your spouse and dependent child(ren). See full benefit summaries for additional details about this plan.

How does it work?

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like copays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

Benefit Type	Benefit Amount
INJURIES	
Fractures	Up to \$12,000
Dislocations	Up to \$9,000
Cuts / Lacerations	Up to \$600
MEDICAL SERVICES AND TREATMENT	
Ambulance	Ground \$300 / Air \$1,500
Emergency Room Treatment	\$150
Therapy Services	\$50 (Up to 10 visits)
HOSPITAL COVERAGE (ACCIDENT)	
Admission	\$1,000 (non-ICU) / \$2,000 (ICU) per accident
Confinement	\$200 (non-ICU) / \$400 (ICU) per accident
Health Screening Wellness Benefit	\$25 per Insured per calendar year

Tier	Per Paycheck Cost (Bi-Weekly)
Employee	\$5.24
Employee + Spouse	\$10.49
Employee + Child(ren)	\$11.01
Employee + Family	\$16.25

Voluntary Critical Illness Plan

Critical Illness Insurance can help protect your finances from the expense of a serious health problem, such as a stroke or heart attack. Your initial benefit provides a lump-sum payment upon first diagnosis of one of the following covered conditions. You have the option to elect between a \$10,000, \$20,000, or \$30,000 benefit.

You also have the opportunity to enroll in family coverage where your spouse can enroll up to 100% of your election and child(ren) can enroll in up to 50% of your (employee) initial election.

The cost of this coverage varies by your age, election amount, and election tier so be sure to check Paycom and the benefit summary for specifics. Contact Benefits Specialist for assistance with calculating deduction based on age and election amount.

Benefit Type	Benefit Amount
Cancer Invasive	100% of Initial Benefit
Heart Attack	100% of Initial Benefit
Stroke	100% of Initial Benefit
Coronary Artery Bypass Surgery	25% of Initial Benefit
Coma	100% of Initial Benefit
Advanced Alzheimer's Disease	100% of Initial Benefit
Major Organ Failure	100% of Initial Benefit
Many Other Covered Conditions	25% – 100% of Initial Benefit
Health Screening Wellness Benefit	\$25 for Employee and Spouse per calendar year

Employee Assistance Program

A helping hand when you need it.

Rely on the support, guidance and resources of your Employee Assistance Program.





There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program¹, which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential – information will be released only with your permission or as required by law.


Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)² and all household members can contact the program's master's-level counselors 24/7. Reach out through the mobile EAP app or by phone, online, live chat, and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three counseling sessions per issue. Sessions can be done in person, on the phone or through video.

EAP services can help with:

-  **Depression, grief, loss and emotional well-being**
-  **Family, marital and other relationship issues**
-  **Life Improvement and goal-setting**
-  **Addictions such as alcohol and drug abuse**
-  **Stress or anxiety with work or family**
-  **Financial and legal concerns**
-  **Identity theft and fraud resolution**
-  **Online will preparation and other legal documents**



Contact EAP

888.293.6948
(TTY Services: 711)
24 hours a day, seven days a week

Healthadvocate.com/standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

With EAP, personal assistance is immediate, confidential and available when you need it.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs life education, adoption, daily living and care for your pet, child or elderly loved ones.

Online Resources

Visit healthadvocates.com/standard3 to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

¹ The EAP services is provided through an arrangement with Health AdvocatesSM, which is not affiliated with The Standard. Health AdvocateSM is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10-2,499 lives. This service is only available while insured under The Standard's group policy.

² Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

Standard Insurance Company | 1100 SW Six Avenue, Portland, OR 97204 | standard.com

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

Health Reimbursement Arrangement (HRA) Plan

Administered by P&A Group

Employees, and their covered dependents, currently enrolled in a medical plan offered by TM Cobb are eligible for HRA Reimbursements **at no extra cost**. Accounts are **employer funded** and can be used to reimburse covered participants for inpatient and outpatient hospital services throughout the year.

Reimbursable Expenses

Coinsurance and deductible expenses affiliated with hospital services

- Inpatient Hospital Services: Surgery, Illness, Childbirth, Traumatic Injury, etc.
- Outpatient Hospital Procedures: ER Visits, Mole Removal, Hernia Repair, Knee Replacement, Cataract Surgery, etc.

How the HRA works:

Employee Responsibility: \$500 of each eligible hospital admission or outpatient surgery performed on the same date of service

Reimbursement: After the first \$500 is paid, the HRA will reimburse any remaining eligible out of pocket expenses covered under the group health plan up to the HRA Maximums

Annual HRA Maximums

Employee Only: \$5,500 per plan year

Employee + Family: \$11,500 per plan year

NOTE: HRA account balances reset at the start of each plan year. Unused funds **do not** carry over.

Flexible Spending Account (FSA)

Administered by P&A Group

IRS-regulated. There are 2 types of FSA and both are pre-tax.

Healthcare FSA	Dependent Care FSA
Can be used to pay for eligible out-of-pocket costs such as deductibles, copays, over-the-counter medication and coinsurance.	Can be used if you pay for daycare for your children or other dependents so you can work. However, if you are married, your spouse must go to work full time, go to school full time for at least 5 months out of the year, or be disabled and unable to care for dependents.

FSA Debit Cards

- **Where can I use my FSA Debit Card?** Medical, dental and vision providers. Doctors' offices, hospitals, pharmacies, stores that have pharmacies (Target, CVS, Walmart, etc.)
 - www.fsastore.com
 - www.Amazon.com
- **Tip:** Enroll in Direct Deposit through your online P&A account to receive reimbursements quicker!
- **FSA Open Enrollment:** 12/1 – 12/30
- **FSA Plan Year:** 1/1 – 12/31
- **FSA Contribution:** \$200 – \$3,300
- **Dependent Care FSA Max. Contribution:**
 - \$3,750 per spouse, if married and filing separately
 - \$7,500 per year per family if married and filing jointly, and total earnings are less than \$155,000
- You must provide dated, itemized receipts/invoices for qualifying reimbursements.

FSA Reimbursement Claims

- Claims are easy to submit! Login into your online P&A account. Go to Member Tools > Upload Claim / Documentation. Enter your Claim Information, upload your Claim Documentation and Submit.
- A confirmation containing a UPV # will be sent to your e-mail address we have on file. If you do not have an e-mail address in your P&A account, write down your UPV #.
- You can track your Claims through your P&A account by going to Member Tools > Track a Claim and using the UPV # provided.

***Note:** FSA Claims should only be submitted if you did not use your FSA debit card and paid out-of-pocket.

Discount Programs

Access Your Perks Program Today!



working
ADVANTAGE



More perks. More savings. More of what makes you happy.

We're here to support your personal and financial well-being through exclusive deals and limited-time offers on the products, services and experiences you need and love.



START SAVING ON

**Electronics • Appliances • Apparel • Cars • Flowers • Fitness Memberships
Gift Cards • Groceries • Hotels • Movie Tickets • Rental Cars • Special Events
Subscriptions • Flights • Cruises • Theme Parks and More!**

New to Working Advantage? Getting Started is Easy.

Maximize your time away from the workplace and start saving today!

- 1** Visit WorkingAdvantage.com
- 2** Click *Become a Member*
- 3** Enter your company code or work email to create an account

YOUR COMPANY CODE

TMCBBFUN

NEED HELP? EMAIL US: CUSTOMERSERVICE@WORKINGADVANTAGE.COM

TM Cobb



UNLOCK EXCLUSIVE DISCOUNTS
SIGN UP FOR FREE!

VISIT YOUR DISCOUNT ENTERTAINMENT WEBSITE TODAY!

<https://tmchbiperks.funex.com>

STEP 1

Visit **the link above** or scan the QR code.

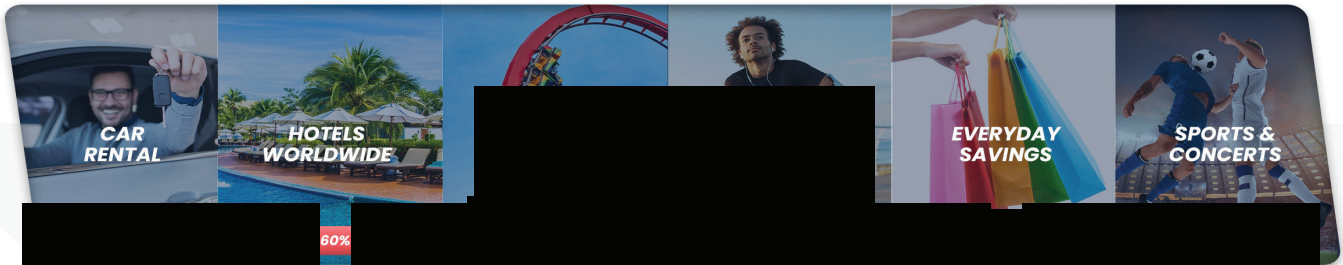
STEP 2

Click on **"Sign Up"** on the top of the page.

STEP 3

Enter full name & email to complete registration.

GET EXCLUSIVE ACCESS TO:



AND MANY MORE



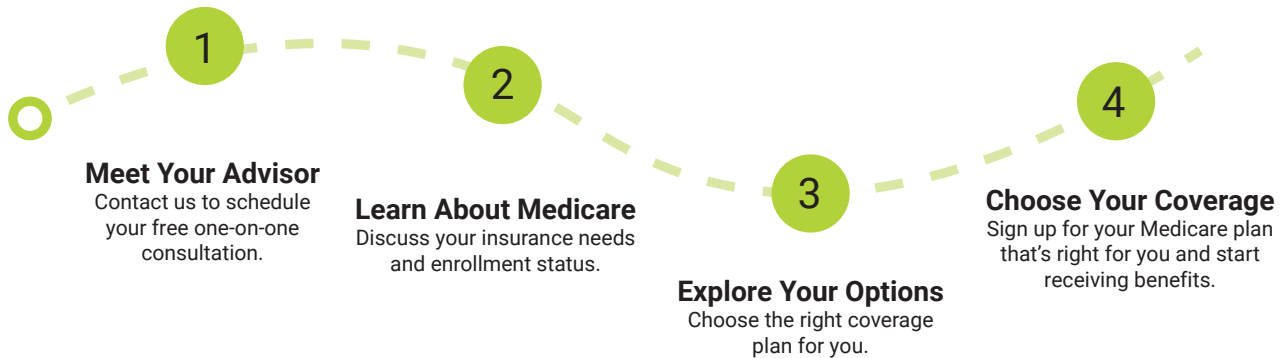
In partnership with Gallagher

We're LIG Solutions, Your New Medicare Advisors!

Offering a no-cost consulting service to Medicare eligible employees and retirees to review coverage options.



Find The Best Plan In 4 Steps



Let's Find The Right Coverage For Your Needs.

Employer-Sponsored Coverage

Health coverage that's offered through you or spouses employer. Usually offered to active staff of the company, Federal laws allow you to extend employer coverage from 18-36 months after employment.

Original Medicare: Parts A & B

The most essential element of Medicare, Part A covers inpatient care and skilled nursing facilities. Part B focuses on outpatient and preventative services.

Medicare Part C

Also known as the Medicare Advantage Plan, Part C combines the coverage of other Parts of Medicare in a comprehensive, privately-offered package.

Medicare Part D

Medicare Part D covers prescription drugs, giving you peace of mind about your medication expenses.

Medicare Supplement

Medicare supplements are insurance plans that fill the gaps in your Medicare coverage – like co-payments, coinsurance, and deductibles.



Plans are Ready for Review!

LIG Solutions' dedicated staff is here to educate and answer all questions around your coverage options.



We do not offer every plan available in your area. Currently we represent 7 organizations which offer over 200 products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options.

Contact LIG Solutions' Medicare Enrollment Team:
Partner.LIGSolutions.com/Medicare
(866) 210-0639

Annual Enrollment Notices and Disclosures

Patient Protections Disclosure

The T.M. Cobb Company Health and Welfare Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources by reaching out to Alexis Cash at **951.248.2407** or at **alexisc@tmcobb.com**.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from T.M. Cobb Company Health and Welfare Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna by visiting **<http://www.aetna.com/>**.

Women's Health & Cancer Rights Act

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

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

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

If you would like more information on WHCRA benefits, please call your Plan Administrator by contacting Human Resources by reaching out to Alexis Cash at **951.248.2407** or at **alexisc@tmcobb.com**.

Newborns' and Mothers' Health Protection 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 **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 **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

<http://myalhipp.com>
855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
<http://myakhipp.com/> | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

<http://myarhipp.com>
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
916.445.8322 | Fax: 916.440.5676 | Email: hipp@dhcs.ca.gov

COLORADO – Medicaid and CHIP

Health First Colorado (Colorado’s Medicaid Program)
<https://www.healthfirstcolorado.com>
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
<https://hcpf.colorado.gov/child-health-plan-plus>
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
<https://www.mycohibi.com/>
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid

www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid

GA HIPP: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
678.564.1162, Press 1
GA CHIPRA: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
678.564.1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
<https://www.in.gov/medicaid/> | 800.457.4584
Family and Social Services Administration
<http://www.in.gov/fssa/dfr/> | 800.403.0864

IOWA – Medicaid and CHIP (Hawki)

Medicaid: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid>
800.338.8366
Hawki: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki>
800.257.8563
HIPP: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp>
888.346.9562

KANSAS – Medicaid

<https://www.kancare.ks.gov/>
800.792.4884 | HIPP Phone: 800.967.4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: <https://kynect.ky.gov/> | 877.524.4718
Medicaid: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

www.medicaid.la.gov or www.ldh.la.gov/lahipp
888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – Medicaid

Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US
800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium:
<https://www.maine.gov/dhhs/ofi/applications-forms>
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

<https://www.mass.gov/masshealth/pa>
800.862.4840 | TTY: 711 | Email: masspreassistance@accenture.com

MINNESOTA – Medicaid

<https://mn.gov/dhs/health-care-coverage/>
800.657.3672

MISSOURI – Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
573.751.2005

MONTANA – Medicaid

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
800.694.3084 | Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

<http://www.ACCESSNebraska.ne.gov>
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

T.M. Cobb Company

NEVADA – Medicaid

<http://dhcftp.nv.gov>
800.992.0900

NEW HAMPSHIRE – Medicaid

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 |
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid>
800.356.1561
CHIP: <http://www.njfamilycare.org/index.html>
800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392

NEW YORK – Medicaid

https://www.health.ny.gov/health_care/medicaid/
800.541.2831

NORTH CAROLINA – Medicaid

<https://dma.ncdhhs.gov>
919.855.4100

NORTH DAKOTA – Medicaid

<https://www.hhs.nd.gov/healthcare>
844.854.4825

OKLAHOMA – Medicaid and CHIP

<http://www.insureoklahoma.org>
888.365.3742

OREGON – Medicaid and CHIP

<http://healthcare.oregon.gov/Pages/index.aspx>
800.699.9075

PENNSYLVANIA – Medicaid and CHIP

<https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
800.692.7462
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

<http://www.eohhs.ri.gov>
855.697.4347 or 401.462.0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

<http://www.scdhhs.gov>
888.549.0820

SOUTH DAKOTA – Medicaid

<http://dss.sd.gov>
888.828.0059

TEXAS – Medicaid

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
800.440.0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
<https://medicaid.utah.gov/upp/> | Email: upp@utah.gov | 888.222.2542
Adult Expansion: <https://medicaid.utah.gov/expansion/>
Utah Medicaid Buyout Program: <https://medicaid.utah.gov/buyout-program/>
CHIP: <https://chip.utah.gov/>

VERMONT – Medicaid

<https://dvha.vermont.gov/members/medicaid/hipp-program>
800.250.8427

VIRGINIA – Medicaid and CHIP

<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 and Chip: 800.432.5924

WASHINGTON – Medicaid

<https://www.hca.wa.gov/>
800.562.3022

WEST VIRGINIA – Medicaid and CHIP

<https://dhr.wv.gov/bms/> or <http://mywvhipp.com/>
Medicaid: 304.558.1700
CHIP Toll-free: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
800.362.3002

WYOMING – Medicaid

<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
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/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

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.

T.M. Cobb Company

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

T.M. Cobb Company is committed to the privacy of your health information. The administrators of the T.M. Cobb Company Health and Welfare Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Alexis Cash, Benefits Specialist at **951.248.2407** or alexisc@tmcobb.com.

HIPAA Special Enrollment Rights

T.M. Cobb Company Health and Welfare Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the T.M. Cobb Company Health and Welfare Plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources by reaching out to Alexis Cash at **951.248.2407** or alexisc@tmcobb.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

T.M. Cobb Company

Notice of Creditable Coverage

Important Notice from T.M. Cobb Company 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 your current prescription drug coverage with T.M. Cobb Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. T.M. Cobb Company has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current T.M. Cobb Company coverage will not be affected.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with T.M. Cobb Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through T.M. Cobb Company 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.

T.M. Cobb Company

For More Information About Medicare Prescription Drug Coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call **800.MEDICARE (800.633.4227)**. TTY users should call **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 **800.772.1213** (TTY **800.325.0778**).

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

Date: September 1, 2025
Name of Entity/Sender: T.M. Cobb Company
Contact: Alexis Cash
Benefits Specialist
Address: 500 Palmyrita Avenue
Riverside, CA 92507-1801
Phone Number: 951.248.2407

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

****Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

T.M. Cobb Company

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources by reaching out to Alexis Cash at 951.248.2407 or alexisc@tmcobb.com.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, **Children's Health Insurance Program (CHIP)**, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

T.M. Cobb Company

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

T.M. Cobb Company
Alexis Cash, Benefits Specialist
500 Palmyrita Ave
Riverside, CA 92507-1801
951.248.2407
alexisc@tmcobb.com

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

Marketplace Notice

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 Employer 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. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%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 9.12% of the employee’s household income.^{1,2}

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.

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.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

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.

T.M. Cobb Company

Marketplace-eligible individuals who live in states served by **HealthCare.gov** and either submit a new application or update an existing application on **HealthCare.gov** between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit **HealthCare.gov** or call the Marketplace Call Center at **800.318.2596**. TTY users can call **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, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. 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 Human Resources by reaching out to Alexis Cash at **951.248.2407** or alexisc@tmcobb.com.

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

T.M. Cobb Company

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 T.M. Cobb Company		4. Employer Identification Number (EIN) 95-1525865	
5. Employer address 500 Palmyrita Ave.		6. Employer phone number 951.248.2407	
7. City Riverside	8. State CA	9. ZIP code 92507-1801	
10. Who can we contact about employee health coverage at this job? Alexis Cash			
11. Phone number (if different from above)		12. Email address alexisc@tmcobb.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:
Working 30 hours or more per week

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

- » Legal Spouse or qualified domestic partner
- » Dependent Children (under the age of 26 for medical, dental, & vision, and under age 25 for voluntary life)
- » Children of your spouse or domestic partner
- » Dependent children of any age who are incapable of self-sustaining employment because of mental or physical handicap, and who receive from you or your spouse all of their support and maintenance, and who were continuously enrolled on the current medical plan before the age of 26.

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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

T.M. Cobb Company

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

T.M. Cobb Company



T.M. COBB
DOORS • WINDOWS • MILLWORK

TO BE COMPLETED AND RETURNED TO ALEXIS CASH, BENEFITS SPECIALIST

DESIGNATION OF LIFE BENEFICIARY FORM

Group Number: 629233

Employee Name: _____

Social Security Number: _____ **Date of Birth:** _____

Address: _____
Street City State Zip Code

Marital Status: Single Married

Beneficiary(ies)

The total of the percentages cannot exceed 100%. When more than one Beneficiary is designated, and no percentage is specified, payment will be made in equal shares to each surviving Beneficiary, or all to the last surviving Beneficiary.

I hereby designate the following person(s) as primary Beneficiary(ies) of my Life Insurance payable in the event of my death. *If you wish to name your estate, write "Estate".*

Full Name	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Secondary Beneficiary(ies)

Benefits are only payable to a Secondary Beneficiary if you are not survived by one or more Primary Beneficiary(ies). The total of the percentages cannot exceed 100%.

Full Name	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

T.M. Cobb Company

Signatures

I understand that if there is no designated Beneficiary upon my death, payment of my Account shall be made to my surviving spouse, or, if none, my estate. I reserve the right to revoke or change any Beneficiary designation. By designating the Beneficiary(ies) above, I hereby revoke all my prior designations (if any).

Employee Signature

Date

Rev 2/2025

ELECTRONIC DISCLOSURE & CONSENT FORM

Subject: Important Benefit Disclosures under ERISA

Dear Participants enrolled in a T.M. Cobb benefit plan:

As a Participant, you are entitled to receive certain information about our benefits as required by the Employee Retirement Income Security Act of 1974 (ERISA). T.M. Cobb Company intends to provide this information to you by electronic delivery. Included are the following:

- Summary Plan Descriptions
- Summaries of Material Modification
- Summaries of Benefits and Coverage
- Summary Annual Reports
- Annual Notices (Included within TM Cobb Benefit Guide)

To access these documents, please login into your Paycom Employee Self-Service account and go to the Benefits tab and select Documents and Links.

If you cannot access these documents via Paycom, please contact Alexis Cash by mail to T.M. Cobb Company, 500 Palmyrita Ave, CA, 92507, by email to alexisc@tmcobb.com, or call at (951) 248-2507.

You have a right to receive a paper version of any electronically transmitted document at no charge. Please contact T.M. Cobb, attention: Alexis Cash, email alexisc@tmcobb.com, or call at (951) 248-2407 to obtain a paper copy.

To receive documents electronically, you must take the following steps:

1. Provide your consent to receive documents electronically by completing the attached Consent form.

NOTE: You may withdraw this consent at any time by notifying Alexis Cash in writing at T.M. Cobb Company, 500 Palmyrita Ave, CA, 92507 or via email at alexisc@tmcobb.com with “Consent Withdrawn for Electronic Disclosure” in the subject matter line. Include your full name, address, and phone number in the body.

NOTE: To update your email address, you must notify Alexis Cash in writing at T.M. Cobb Company, 500 Palmyrita Ave, CA, 92507 or via email at alexisc@tmcobb.com with “Change in Email Address for Electronic Disclosure” in the subject matter line.

CONSENT TO RECEIVE ELECTRONIC DISCLOSURES

I authorize you to send, and I consent to receiving the following documents by electronic means:

- Summary Plan Descriptions
- Summaries of Material Modification
- Summaries of Benefits and Coverage
- Summary Annual Reports
- Annual Notices

I understand that if my mailing address or email address changes, I must notify Alexis Cash in writing at T.M. Cobb Company, 500 Palmyrita Ave, CA, 92507 or via email at alexisc@tmcobb.com.

I affirm that I have the ability to access information in my Paycom Employee Self-Service account. I understand that I will receive the documents listed above only in electronic form unless I request a paper copy of such documents by notifying Alexis Cash in writing at T.M. Cobb Company, 500 Palmyrita Ave, CA, 92507 or via email at alexisc@tmcobb.com with “Request for Paper Copy” in the subject line.

I understand that this consent may be withdrawn at any time by notifying Alexis Cash in writing at T.M. Cobb Company, 500 Palmyrita Ave, CA, 92507 or via email at alexisc@tmcobb.com with “Consent Withdrawn for Electronic Disclosure” in the subject matter line. Include your full name, address, and phone number in the body.

Employee Name (please print): _____

Employee Signature: _____

Date: _____

Notes



This benefits guide prepared by



Gallagher

Insurance | Risk Management | Consulting