Delta Vision Summary 2026

DELTA DENTAL®

DeltaVision®

YOUR VISION BENEFITS

Prepared for the employees of SC Swiderski LLC

The summary below does not cover all plan details. Further information can be found in the vision benefit handbook, which provides a thorough explanation of your vision plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

DeltaVision® Full Plan

Network	Insight
Frame/Contact Allowance	$150/$150
Copay (exams/standard plastic lenses)	$0/$0
Frequency (exams/lenses or contact/frames) Based on calendar year	12 months/12 months/12 months
Dependent Age Limit	To age 26

Benefit Details	Network Benefit	Out-of-Network Reimbursement
Comprehensive Glasses Exam	Member pays $0, plan pays balance	$35
Retinal Imaging	Member pays up to $39	None
Standard Contact Lens* Fit and Follow-Up	Member pays up to $40	None
Premium Contact Lens Fit and Follow-Up**	10% discount off retail	None
Frames *(any available frame at provider location)*	$150 allowance, then 20% off balance	$75
Laser Vision Correction *(Lasik or PRK)*	15% off retail price or 5% off promotional price	None

Includes Diabetic Eye Care Benefits that provide an additional office visit and diagnostic testing for those who have diabetes.

Standard Plastic Lenses		
Single Vision	Member pays $0, plan pays balance	$25
Bifocal	Member pays $0, plan pays balance	$40
Trifocal	Member pays $0, plan pays balance	$55
Standard Progressive	Member pays $65	$40
Premium Progressive	See next page for benefit details	
Lens Options		
UV Coating	Member pays $15	None
Tint *(solid and gradient)*	Member pays $15	None
Standard Scratch Resistance	Member pays $15	None
Standard Polycarbonate	Member pays $40	None
Standard Anti-Reflective Coating	Member pays $45	None
Premium Anti-Reflective Coating	See next page for benefit details	
Other Add-Ons and Services	20% off retail	None

*Lenses that are spherical power only, soft lens materials, including planned replacement and conventional lenses. Lenses are to be used in a daily wear (removed prior to sleep) mode only.

**Includes all lens powers and designs other than spherical powers (i.e. toric, multifocal, etc.), modes of wear that are extended or overnight schedules, and rigid or gas-permeable materials.

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Benefit Details (continued)	Network Benefit	Out-of-Network Reimbursement
Contact Lenses – In lieu of glasses (Contact lens allowance covers materials only)		
Conventional	$150 allowance, then 15% off balance	$120
Disposable	$150 allowance	$120
Medically Necessary***	Paid in full	$200
Premium Progressive Lens		
Tier 1	$85 copay	$60
Tier 2	$95 copay	$60
Tier 3	$110 copay	$60
Tier 4	$65 copay, 80% of charge less $120 allowance	$60
Premium Anti-Reflective Coating		
Tier 1	$57	None
Tier 2	$68	None
Tier 3	80% of charge	None

Additional In-Network Discounts

- 20% discount on items not covered by the plan at network providers. This discount may not be combined with any other discounts or promotional offers. This discount does not apply to an EyeMed® provider's professional services (i.e. exams) or contact lenses. Retail prices may vary by location.
- 40% discount on complete eyeglass purchases after your plan benefits have been fully used (includes prescription sunglasses).
- 15% discount on conventional contact lenses after your plan benefits have been fully used.
- Members can purchase eyeglasses online and apply their in-network eyeglass benefits at www.glasses.com, lenscrafters.com, targetoptical.com, or rayban.com.
- Members can purchase contact lenses online and apply their in-network contact lenses benefits at www.contactsdirect.com.
- Discounts do not apply for benefits provided by other group benefit plans.

How to Maximize Your DeltaVision Plan

- Use providers participating in your vision plan network; your benefit dollars will go farther at participating providers. For an up-to-date listing of EyeMed providers in your area, visit our website at https://www.deltadentalwi.com/vision or call EyeMed's Customer Care Center at 844-848-7090.
- For laser vision correction, LASIK*Plus* is the network provider offering members additional benefits. Additional information can be obtained by calling 1-800-988-4221 or visiting eyemedlasik.com.
- Use your full benefit allowance. Frames and lenses (plastic or contact) each have an annual benefit allowance. **The benefit allowance must be used on a single day purchase; there is no remaining balance if entire allowance is not used after initial purchase.**
- Frequency of benefits: your benefit frequency is based on calendar year. For example, you'll be covered for another pair of glasses as of January 1 of the next calendar year.
- Participating providers may offer promotional pricing on vision materials. You can partake in either the DeltaVision Network Benefit or the promotional price available, but not both. Your provider can help you to determine which is best for you. If you select the promotional pricing you can submit your expenses for Out-of-Network Reimbursement.
- Prescription sunglasses can be purchased with your benefit allowance for frames and plastic lenses.
- A 20% discount may be available on selected brands of non-prescription sunglasses from participating providers — ask your vision provider.
- Premium progressive lenses are more costly than standard progressive lenses. Please discuss your costs for progressive lenses with your vision provider.

***Medically necessary contacts require authorization from a vision doctor when some conditions are present. Please contact the plan for more information.

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Plan Limitations/Exclusions

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan.
- Services provided as a result of any worker's compensation law.
- Plano nonprescription lenses and nonprescription sunglasses (except for 20% discount).
- Aniseikonic lenses.
- Services or materials provided by any other group benefit providing vision care.
- Two pairs of glasses in lieu of bifocals.
- Lost or broken materials are not covered.

DeltaVision is underwritten byWyssta Insurance Company.

DELTAVISION
SUMMARY OF BENEFITS
FOR COVERED EMPLOYEES OF:

S C Swiderski LLC

(See Vision Benefits Handbook for definitions of capitalized terms.)

GROUP NUMBER: 46402

EFFECTIVE DATE OF PROGRAM: January 1, 2024

OPEN ENROLLMENT

Changes in enrollment status will be considered during an Open Enrollment Period 30 days prior to the Contract renewal date, with changes becoming effective on the renewal date.

WAITING PERIOD

Employees and their Dependents who apply for coverage after their initial eligibility period or without a qualifying event (loss of spousal benefits, marriage, divorce, birth or adoption, or the loss of employee coverage through another insurer) will:

Wait until the next Open Enrollment Period.

TERMS OF ELIGIBILITY

Eligibility begins:
For eligible new employees, eligibility begins the first day of the month following the waiting period.
For eligible rehired employees, eligibility begins the date of rehire.

For eligible new employees, the waiting period is 0 days.

For employees enrolling their dependents:
Dependent children are eligible through the end of the month in which they attain age 26, regardless of student status, or if age 26 and beyond, to the date they lose eligibility due to the Dependent's inability to meet all of the requirements in the Handbook.

Part-time employees are not covered; minimum hours worked must average at least 30 per week.

SCHEDULE OF BENEFITS, LIMITATIONS AND COVERAGE PERCENTAGE

This Plan provides the following Benefits subject to the Allowance or Copayment amount listed for each Benefit. The Allowances and Copayments may vary based upon the network membership of the vision provider at the time the services were rendered.

Contracted Provider Network: Insight

To be entitled to benefits, a network provider must be utilized. Please see the vision provider search on either the Delta Dental of Wisconsin or Vision Provider's website.

SPECIAL CONDITIONS

Changes in coverage due to a qualifying event will be effective the date of the event.

Network Benefit = Contracted Vision Provider

Non-Network Reimbursement = Noncontracted Vision Provider

DeltaVision

	Network Benefit	Non-Network Reimbursement
Comprehensive Spectacle Exam	Member pays $0	$35
Retinal Imaging	Member pays $39	None
Contact lens fit and follow-up		
Standard – lenses that are spherical power only, soft lens materials, including planned replacement and conventional lenses. Lenses are to be used in a daily wear (removed prior to sleep) mode only.	Member pays up to $40	$0
Premium – includes all lens powers and designs other than spherical powers (i.e., toric, multifocal, etc.), modes of wear that are extended or overnight schedules and rigid or gas permeable materials.	10% discount off retail	$0
Frames -- *Any available frame at provider location.*	$150 allowance, then 20% off balance	$75
Standard plastic lenses		
Single vision	Member pays $0	$25
Bifocal	Member pays $0	$40
Trifocal	Member pays $0	$55
Lens options		
UV coating	Member pays $15	None
Tint (solid & gradient)	Member pays $15	None
Standard scratch resistance	Member pays $15	None
Standard polycarbonate	Member pays $40	None
Standard progressive	Member pays $65	$40
Premium progressive		
Tier 1	Member pays $85	$60
Tier 2	Member pays $95	$60
Tier 3	Member pays $110	$60
Tier 4	Member pays $65, 80% of charge, less $120 allowance	$60
Standard anti-reflective coating	Member pays $45	None
Premium anti-reflective coating		
Tier 1	Member pays $57	None
Tier 2	Member pays $68	None
Tier 3	80% of charge	None
Other add-ons and services	20% off retail price	None
Contact lenses – In lieu of Spectacles *Contact lens allowance covers materials only*		
Conventional	$150 allowance, then 15% off balance	$120
Disposable	$150 allowance	$120
Medically necessary	Paid in full	$200

Laser vision correction – ***Lasik or PRK***	**15% off retail price or 5% off promotional price**	**None**
Frequency **Exams:** **Lenses or Contact Lenses:** **Frames:**	**Every Calendar year** **Every Calendar year** **Every Calendar year**	

Additional in-network discounts

- 20% discount on items not covered by the Plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to Contracted Provider's professional services, or contact lenses. Retail prices may vary by location.
- Members also receive a 40% discount on complete eyeglass purchases and a 15% discount on conventional contact lenses once the funded benefit has been used.
- Not all network providers offer Laser Vision correction services. Please contact your provider for availability of these services.

DeltaVision – Diabetic Benefits

	Network Benefit	Non-Network Reimbursement
Office service visit (medical follow-up exam)	**Member pays $0**	**$77**
Retinal imaging	**Member pays $0**	**$50**
Extended ophthalmoscopy	**Member pays $0**	**$15**
Gonioscopy	**Member pays $0**	**$15**
Scanning Laser	**Member pays $0**	**$33**
Frequency – Exams / Services	**Up to two services every calendar year**	

Definitions

- **Office Service Visit (Medical Follow-up Exam):** Office visit for the evaluation and management of an established patient. The office visit includes patient history, follow-up examination services as deemed appropriate by the provider, and medical decision making. Members also receive a 40% discount on complete eyeglass purchases and a 15% discount on conventional contact lenses once the funded benefit has been used.
- **Extended Ophthalmoscopy** with retinal drawing and interpretation and report: A serious retinal condition must exist or be suspected (based on results of routine ophthalmoscopy) which requires further detailed study.
- **Gonioscopy:** A procedure to look at the anterior chamber structures of the eye between the cornea and the iris. Gonioscopy can be used in detection or treatment of conditions that can be more prevalent in diabetics such as glaucoma or neovascularization of the angle.
- **Scanning Laser**: Scanning computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report.

Exclusions and Limitations

The Diabetic Benefit covers diabetic eyecare evaluation services only for Type 1 and Type 2 diabetics. The following services and benefits are excluded:

- **Costs associated with securing frames, lenses, or any other materials**
- **Orthoptics or vision training and any associated supplemental testing**
- **Surgical procedures, including laser or any other form of refractive surgery, and any pre- or post-operative services**
- **Pathological treatment of any type for any condition**
- **Any eye examination required by an employer as a condition of employment**
- **Insulin or any medications or supplies of any type**
- **Services and/or materials not included in this Rider**

DeltaVision® Handbook

Delta Dental Of Wisconsin

DeltaVision Contact Information

Benefits & Information

Contact EyeMed's Customer Care Center for questions concerning benefits, claims payments, and ID cards.

Toll-free: 844-848-7090
EyeMed Hours: Monday-Saturday 7 a.m. to 10 p.m. (CT) Sunday 10 a.m. to 7 p.m. (CT)

Provider Locations

For a list of the most convenient EyeMed Vision Care provider locations, members may visit the Delta Dental website, or the EyeMed Vision Care website, or call EyeMed customer service (number and hours listed above).

Delta Dental: www.deltadentalwi.com/provider-search/vision
EyeMed: www.Eyemedvisioncare.com/locator

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Welcome

DeltaVision is offered through Wyssta Insurance Company, Inc., a wholly-owned subsidiary of Delta Dental of Wisconsin, Inc. Claims processing, claims service and network administration for DeltaVision are handled through an agreement with EyeMed Vision Care, LLC.

Wyssta Insurance Company, Inc. has been selected by Your employer to provide Your group vision coverage. We are pleased to bring these important Benefits to You and any Dependents You have enrolled for coverage.

It is important for You to read this Vision Benefit Handbook with the Summary of Benefits page inserted. The Summary of Benefits lists the specific Benefits of Your group vision coverage. Together, the Vision Benefit Handbook and the Summary of Benefits comprise Your Certificate of insurance.

This Certificate is not the insurance policy. It is merely evidence of insurance provided under the Contract between Wyssta and Your employer. All Benefits are paid according to the terms, conditions, and provisions of Your Group's Contract. This Certificate describes the essential features of such insurance. This Certificate replaces and supersedes all Certificates, endorsements, and riders that we may have previously issued to You prior to the effective date of this Certificate.

The Contract issued to Your employer is the complete document of insurance and governs all claims processing. It will serve as Wyssta's primary resources when answering questions regarding Your vision claims. You may examine Your Group's Contract any time by contacting Your employer or Wyssta during normal business hours.

All claims are settled based on a specific methodology. The eligible amount of a claim may be less than the provider's billed charge.

If a clerical error or other administrative mistake occurs, that error will not deprive You of coverage under the policy that You would otherwise have had. A clerical error or other administrative mistake also will not create coverage that does not otherwise exist under the policy.

Definitions

"Allowance" means the amount or percentage shown in the Summary of Benefits for vision Benefits that Wyssta will pay toward the applicable vision service or product provided.

"Benefit" means those vision Benefits that are covered by Wyssta under the terms of Your Group's Contract as specified in the Summary of Benefits.

"Certificate" means the Vision Benefit Handbook and Summary of Benefits issued to a Subscriber insured through the Group. The Certificate outlines the Benefits provided by Your Group's Contract.

"Contracted Vision Provider" means a vision care provider who has entered into an agreement to provide vision Benefits through Wyssta to Subscribers and Covered Dependents.

"Copayment" means the dollar amount or percentage shown in the Summary of Benefits that You are required to pay directly to a Contracted Vision Provider or a Noncontracted Vision Provider for each service or product received that is a Benefit under the Contract, as specified in the Summary of Benefits. The Copayment is applied to the fee for Benefits that Wyssta contracts with the Contracted Vision Provider to pay or to the Allowance for Benefits, whichever is applicable.

"Covered Dependent" means a Dependent who (a) is listed in the documents necessary for coverage under the Contract, (b) has been accepted by Wyssta for coverage, and (c) for whom the appropriate Premium has been paid.

"Dependent" means a person who has satisfied the criteria for eligibility listed in Your Group's Contract.

"Eligible Employee" means an employee or member of the Group who has satisfied the criteria for eligibility listed in Your Group's Contract.

"Grievance" means any dissatisfaction with the administration, claims practices, or provision of services by Wyssta that is expressed in writing by or on behalf of a Subscriber or Covered Dependent.

"Group" means the employer, association, union or other organization contracting with Wyssta to provide Benefits to its Eligible Employees or members and their Dependents, if applicable.

"Master Group Contract" or **"Contract"** means the group vision insurance policy issued by Wyssta to the Group in which Wyssta agrees to provide vision Benefits to Subscribers and Covered Dependents. The Contract includes the group application, the Declarations, the Master Group Contract, and any attached addenda, appendixes, endorsements, schedules or riders.

"Noncontracted Vision Provider" means a vision care provider who has not entered into an agreement to provide vision Benefits through Wyssta to Subscribers and Covered Dependents.

"Open Enrollment Period" means an enrollment period during which time any Eligible Employees and/or Dependents may apply to become a Subscriber and/or Covered Dependent, and existing Subscribers may apply to change to another provider network or coverage option, if available, or elect to terminate coverage.

"Premium" means the total monthly fee due for this Contract. The Premium will be based on the Rate and the number of Subscribers.

"Rate" means the monthly fee required for each Subscriber in accordance with the terms of Your Group's Contract.

"Subscriber" means an Eligible Employee or member of the Group who (a) has completed and signed the documents necessary for coverage under the Contract, (b) has been accepted by Wyssta as a Subscriber, and (c) for whom the appropriate Premium has been paid.

"Summary of Benefits" is a listing of the specific Benefits and Benefit limitations for vision Benefits provided under the terms of Your Group's Contract. The Summary of Benefits is provided as an insert with the Vision Benefit handbook.

"Urgent Care Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by Wyssta that requires immediate attention. Such Grievance must be delivered in writing to Wyssta. See the Grievance Procedures section of this Vision Benefit Handbook.

"Wyssta" means Wyssta Insurance Company, Inc.

"You" and **"Your"** means the Subscriber.

Filing Claims

Using a Contracted Vision Provider

Follow these simple steps to access Your network vision Benefits:

1. Present Your employee identification card to Your provider or provide Your name, address and date of birth
2. Your provider will confirm Your eligibility as a DeltaVision member
3. You will receive services and Your provider will calculate any out-of- pocket expenses after the Benefit has been applied. You are responsible for any out-of- pocket expenses at the time of service
4. Your provider takes care of the rest.

Using a Noncontracted Vision Provider

When You visit a non-network vision provider You may file a claim as follows:

1. Pay in full for services and materials to Your Noncontracted Vision Provider at the time of service
2. Request an itemized receipt from Your provider
3. Contact EyeMed via phone or website to obtain a claim form
4. Submit the total claim on the EyeMed claim form, attaching the itemized receipt
5. You will be reimbursed by EyeMed at non-network DeltaVision plan Benefit levels

Applicability of Allowances

Vision Benefit Allowances are available for a single application toward the cost of vision services and materials covered under this plan. Any Allowance balance remaining may not be applied to any other services.

Covered Vision Procedures

Only vision procedures indicated as Benefits on Your Summary of Benefits insert are covered under Your Group's Contract.

Covered vision Benefits are subject to the limitations described in the Summary of Benefits insert and the exclusions outlined in this Vision Benefit Handbook. Wyssta will pay up to the Allowance shown in the Summary of Benefits for vision Benefits and You will be responsible for any remaining amount.

You will also be responsible for any vision care products and services that are not Benefits under the Contract regardless of whether the vision care services were provided by a Contracted Vision Provider or a Noncontracted Vision Provider.

Exclusions

1. Any vision procedures, supplies, treatment, or any other services, as applicable, provided or commenced prior to the effective date of the Subscriber's or Covered Dependent's coverage under the Contract
2. Any vision procedures, supplies, treatment, or any other services to treat injuries or conditions compensable under worker's compensation or employer's liability laws
3. Charges for completion of forms
4. Charges for consultation
5. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
6. Aniseikonic lenses
7. Medical and/or surgical treatment of the eye, eyes, or supporting structures
8. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under this Contract
9. Plano nonprescription lenses and nonprescription sunglasses
10. Benefits combined with any discount, promotional offering, or other group benefit plans

11. Lost or broken materials

12. Two pairs of glasses in lieu of bifocals (does not apply to Primary-Plus plan members or Preferred-Plus plan members)

13. Any vision procedures, supplies, treatment, or any other services, as applicable, except as provided in the Summary of Benefits

14. Vision procedures not specifically covered under this Contract

Eligibility

Covered Employee

You are eligible for coverage under Your Group's Contract while You are a regular employee of the Group who averages the number of hours as determined by the Group's Contract and who has completed any waiting period indicated on the Summary of Benefits.

You may also be covered by Your Group's Contract if You no longer meet these conditions but have elected to continue coverage as described in the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Covered Dependents

If You are enrolled for family coverage, the following persons may be covered under Your Group's Contract as Your Dependents:

1. Your lawful spouse

2. Your children including step and adopted children and children placed for adoption with You, who are less than 26 years of age

3. Your children's children until Your child reaches age 18

4. Notwithstanding 1, 2 and 3 above, Your adult Dependent children, including step-children and adopted children and children placed for adoption with You may be covered under this policy if the adult child satisfied all of the following:

    a. The child is a full-time student, regardless of age; and

    b. The child was under 26 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full time basis, an institution of higher learning; and

    c. The child re-enrolled as a full-time student within 12 months of returning from active duty.

5. A Dependent child over age 26 who is financially dependent on the Eligible Employee because of physical or mental incapacity that commenced while covered under this policy and prior to the Dependent child reaching age 26, provided a physician's certificate of disability is submitted within six months following

the Dependent child's 26th birthday. Wyssta reserves the right to request proof of continued disability from time to time, but not more than annually after the two-year period immediately following the Dependent child's attainment of the limiting age.

Dependents in military service are not covered by Your Group's Contract.

Dependents no longer meeting the above requirements because of divorce or separation from an Eligible Employee, or the end of a child's dependency status may elect to continue coverage. Please see the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Effective Dates of Coverage

You are covered by Your Group's Contract beginning on the first day the Contract becomes effective or as determined by Your Group's Contract.

Your Eligible Dependents are covered beginning on the first day You become covered under Your Group's Contract If You elect coverage for them. A newborn is covered at birth and coverage continues for 60 days. If an additional Premium is required to cover the newborn, You must make written request to Wyssta and pay the required Premium within 60 days of the birth. You may, however, request coverage for a newborn after the 60-day period but within one year of the birth provided, however, that You pay any required Premium including an interest rate of 5.5%. If You adopt a child, coverage begins on the day the child is adopted, placed for adoption, or on the day of the final order granting adoption, whichever comes first. Changes in enrollment due to birth or adoption must be received by Wyssta within 60 days of the birth or adoption.

An Eligible Employee who waived coverage because he/she was covered under other insurance may elect coverage to be effective on the first day of the month following the loss of such other coverage. The Eligible Employee must apply for such change in coverage within 30 days of the event causing the loss of the other coverage.

Changes in Coverage

You may change Your enrollment in this vision plan if You experience a qualifying event such as a change in marital status, the acquisition of a Dependent, or the loss of coverage through your spouse's plan. The enrollment change will be effective the first of the month following the qualifying event. Notification of this enrollment change must be received by Wyssta within 30 days of the qualifying event.

You may change Your enrollment without a qualifying event if You contribute toward Your Premium and if an Open Enrollment Period is offered by the Group. Elective coverage changes can be considered by Wyssta only at that time.

Notices

Notice to Your employer or Wyssta will be considered sufficient if mailed to each party's regular office address. Notices to You, as a Subscriber, will be considered sufficient if mailed to Your last known address or the last known address of Your Group. It is the responsibility of Your Group to notify You regarding changes or termination of Your coverage.

Termination of Coverage

Your coverage and that of Your Covered Dependents ceases on the day You or Your Covered Dependents are no longer eligible or the day Your Group's Contract is terminated.

If You or Your Dependents lose eligibility under the plan, You or Your Dependents may elect to continue coverage as described in the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Continued Coverage

Under Title X of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), if You are part of an employer group of more than 20 employees, You ("Qualified Beneficiaries") are permitted to elect continuation of vision coverage under this Contract upon the occurrence of any of the following "Qualifying Events":

Subscriber:

1. Termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or
2. Reduction in hours to less than the minimum required to be an Eligible Employee under this Contract.

Covered Dependents

1. If you are the Subscriber's spouse:
    a. Death of Subscriber; or
    b. Termination of Subscriber's employment, except for reasons of gross misconduct; or
    c. Reduction of Subscriber's hours to fewer than the minimum required for eligibility for coverage under this Contract; or
    d. Divorce or legal separation from Subscriber; or
    e. Subscriber's Medicare entitlement.
2. If you are the Subscriber's child:
    a. Child ceases to be a Dependent; or
    b. Death of Subscriber; or
    c. Termination of Subscriber's employment, except for reasons of gross misconduct; or
    d. Reduction in Subscriber's hours to less than the minimum required to be eligible as a Subscriber under this Contract; or
    e. Subscriber becomes entitled to Medicare; or
    f. Parents become divorced or legally separated.

Your Group must provide notice to You of Your right to elect COBRA continuation coverage.

If Your coverage is terminated due to divorce, legal separation or cessation of eligibility for coverage, You must provide Your Group notice of such event within 60 days of its occurrence.

An election of continuation coverage must be made within 60 days beginning on the later of the date of Qualifying Event or the day You receive notice of election rights. The COBRA election by You is deemed an election by all others who would lose coverage as a result of the same Qualifying Event unless otherwise specified in the election or the Covered Beneficiary independently elects COBRA continuation coverage.

If election of COBRA continuation coverage is timely, the coverage begins on the date of the Qualifying Event and ends on the earlier of:

1. 18 months after the Subscriber's employment termination or reduction in hours

2. 29 months after the Qualifying Event for (a) a Qualified Beneficiary who is determined to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage and who notifies the Group of such determination within the first 18 months of COBRA coverage; and for (b) any nondisabled Qualified Beneficiaries with respect to the same Qualifying Event

3. For Qualified Beneficiaries other than the Subscriber, 36 months after the date of the initial Qualifying Event for all other Qualifying Events

4. The date on which the Qualified Beneficiary receiving continuation in coverage fails to make a timely payment of Premium. Wyssta will not reinstate COBRA continuation coverage once terminated for nonpayment of Premium

5. The date on which the Group ceases to offer this Contract to any of its employees or members

6. The date on which coverage begins under another vision plan. However a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.

7. The date the Qualified Beneficiary becomes entitled to Medicare benefits

The first Premium must be paid to the Group within 45 days of the election of COBRA continuation coverage. Future Premium payments must be paid by the first day of each month.

Under ERISA Section 602(3), premium for a Qualified Beneficiary will not exceed 102% of the single, family, or other applicable monthly Rate in effect for the group, except that the premium for a Qualified Beneficiary who becomes disabled during the first 60 days of COBRA coverage will be 150% of the single, family, or other applicable monthly Rate in effect for the group during months 19 through 29 of COBRA coverage.

If You have any questions about continued vision coverage, the human resources department at Your company should be able to assist You.

Wyssta's Liability

In no instance is Wyssta liable for any conduct, including but not limited to tortious conduct, negligence, or wrongful acts or omissions by any service provider or other professional practitioner or their agents or employees in the provision or receipt of health care. In no instance is Wyssta liable for services of facilities that, for any reason, are unavailable to You.

Grievance Procedures

How to Contest a Claim Denial

Urgent Care Situations:

Method of Notification. Notice of an Urgent Care Grievance will be accepted by Wyssta if made by You in writing, in person, or by telephone directed to:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481
888-838-4875

Resolution Process. If the Urgent Care Grievance cannot be resolved through informal discussions, consultations or conferences during the first 48 hours after Wyssta's receipt of the Urgent Care Grievance, You may appear before Wyssta's Grievance committee to present written or oral information with the right to ask questions before the Grievance committee.

Time Limitation for Resolution. An Urgent Care Grievance will be resolved, whether informally or by the Grievance committee, within 72 hours of its receipt by Wyssta.

All Other Grievance Situations Not Including Urgent Care:

Denial of a Claim for Benefits. If a Subscriber or Covered Dependent makes a claim for Benefits under this Contract and the claim is denied in whole or in part, You will receive written notification within 30 days after Wyssta receives the claim, unless special circumstances require an extension of time for processing. The claims decision will be sent on a form entitled "Explanation of Benefits".

If additional time is necessary for processing a claim for Benefits, Wyssta will notify You of the extension and the reason it is necessary within the initial 30-day period. If an extension is needed because either You or Your provider did not submit information necessary to make a Benefits determination, the notice of extension will describe the required information. You or Your provider will have 45 days from receipt of the notice to provide the specified information.

Appealing a Claim Denial. If You have questions about the denial of Your claim for Benefits, You should contact EyeMed Vision Care, LLC at 866-723-0513. Because most questions about Benefits can be answered informally,

Wyssta encourages You to first try to resolve any problem by talking with EyeMed. However, You have the right to file an appeal requesting that Wyssta formally review the Benefits determination.

To file a Grievance or to appeal a Benefits determination, contact Wyssta's Benefit Services Department at 888-838-4875 or mail Your request to:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481

You should provide the reasons why You disagree with Wyssta's Benefits determination and include any documentation you believe supports Your claim. You should include Your name, and the employee's name and employee's member number on all supporting documents.

Resolution Procedure. Wyssta will acknowledge the Grievance or Benefits determination appeal within 5 days of its receipt by Wyssta. Wyssta will attempt to resolve the Grievance or Benefits determination appeal through informal discussions, consultations or conferences. In the event that the Grievance or appeal remains unresolved, You have the right to appear before Wyssta's Grievance committee to present written or oral information and to question the Grievance committee. The committee shall advise You of the time and place of the meeting at least 7 calendar days before the meeting.

If You do not exhaust the appeal procedures described above, and if You file a lawsuit against the Group's vision plan and/or Wyssta seeking payment of Benefits, the court may not permit You to go forward with Your lawsuit because You failed to utilize Wyssta's Grievance/claims appeal procedures. No legal action can be brought against Wyssta more than 3 years after the date of the Grievance committee's final decision on the review of the Benefits determination.

Time Limitations for Resolution. Wyssta will attempt to resolve all Grievances within 30 calendar days after receipt by Wyssta. Wyssta will inform You of its decision in writing. If the Grievance is denied in whole or in part, the notice will include the following information:

1. The specific reasons(s) for the denial of the appeal

2. The reference to the specific Contract provision(s) on which the denial is based

3. A statement that You are entitled to receive, upon request, and free of charge, reasonable access to, and copies of all documents, records, and information relevant to the claimant's claim

4. A statement describing any voluntary appeal procedures offered by Wyssta and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA

5. If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to You upon request

6. If the denial of the appeal was based on necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Contract to Your circumstances, or a statement that such explanation will be provided free of charge upon request

If the Grievance cannot be resolved within 30 days from receipt by Wyssta, Wyssta will notify You in writing that it intends to extend the period of time for resolution an additional 30 days. The notification will state when resolution may be expected and the reasons for the additional time needed.

All Grievances will be resolved within 60 days from the date of receipt by Wyssta.

Wyssta's Grievance committee will consist of four persons: a consultant chosen by Wyssta, a representative of Wyssta management, Wyssta's claim administrator, and a Subscriber in a Wyssta plan who is not a Wyssta employee.

You may resolve any Grievance through Wyssta's Grievance procedure outlined above.

Notice of Legal Action

No legal action can be brought against Wyssta until at least 60 days after proof of loss has been furnished as required by the policy or such proof of loss has been waived, or Wyssta has denied payment, whichever is earlier.

If you have any questions, please contact our office:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481
888-838-4875 or 715-344-6087

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
www.deltadentalwi.com
800-236-3712

DELTA DENTAL®

BR215-1802

Vision Plan Highlights

Your eyes provide doctors with a clear picture of your overall health. A comprehensive eye exam can identify serious medical problems such as high blood pressure, diabetes, heart disease and much more. That's why S.C. Swiderski offers vision care insurance administered by Delta Vision.

Delta Vision	**EyeMed Insight Network Benefit**	**Out of Network Reimbursement**
Frequency		
Vision Exam	Once per 12 months	
Frames	Once per 12 months	
Lenses	Once per 12 months	
Contacts (In Lieu of Glasses)	Once per 12 months	
Annual Vision Exam	Covered in Full	$35
Retinal Imaging	Member pays up to $39	N/A
Contact Lens *(fit and follow-up)*		
Standard	Member pays up to $40	N/A
Premium	10% off retail	
Allowance Summary		
Frames	$150 allowance, then 20% off balance	$75
Lenses		
Single Vision	Covered in Full	$25
Bifocal	Covered in Full	$40
Trifocal	Covered in Full	$55
Standard Progressive	$65 Copay	$40
Contact Lenses (In Lieu of Glasses)		
Conventional	$150 allowance, then 15% off balance	$120
Disposable	$150 allowance	$120
Medically Necessary	Paid in Full	$200
Laser Vision Correction	15% off retail or 5% off promotional	N/A

Additional In-Network Discounts:

- 40% off additional complete pair of prescription eyeglasses after your plan benefits have been fully used
- 20% off non-covered items at network providers
- 15% discount on conventional contact lenses after your plan benefits have been fully used
- Check summary of benefits for allowance/reimbursement on lens options
- See Network Providers for best level of benefits.

Monthly Premiums	**Employee Cost**
Employee	$2.28
Employee + Spouse	$4.55
Employee + Child*(ren)*	$4.65
Family	$6.92

401k Retirement Plans

Invest in your future by taking advantage of SC Swiderski's retirement plan options. Full-time employees, who are at least 21 years of age or older have access to 401(K) with Edward Jones retirement planning via Transamerica.

Employees can enroll in the plans on the 1st of the month following their hire date. New hires will be auto enrolled at 4% and will require the employee to remove this deduction to avoid contributions if desired. Those who wish to enroll in the 401(K) plan should contact Marc Bouwer at 715-693-9522 or marc.bouwer@scswiderski.com or their designated HR Representative.

SC Swiderski will continue to provide an employer match, dollar for dollar, up to 4%. Take advantage of the extra retirement savings by putting aside at least 4% of your earnings. With the employer match, your contribution will be at least 8% towards your retirement!

Contributions To Your Retirement

The maximum amount you can contribute to your retirement in any specific year is governed by the IRS and will be provided to you in writing upon election to the 401(K) plan.

Special catch-up provisions may be available for employees age 50 and older. If you are, or will be, age 50 or older by the respective year-end, you may be eligible to contribute an additional catch-up election into the plan for that year. Some special restrictions may apply.

Enrollments Or Changes

You may change your investment elections, your deferral percentage, obtain balance information and achieve a variety of other transactional activities by going online to Transamerica via Paylocity. You can reach out for individual financial advice questions by calling Thomas Knoedler at Edward Jones at (715) 693-2245 or Thomas.Knoedler@edwardjones.com.

It's a great idea to set up your own account through Transamerica. You will have immediate access and control of your account. Go to transamerica.com/create-account to get started. You can also contact Transamerica by calling 800.755.5801 or by downloading the mobile app: Transamerica Retirement App.

This guide summarizes the key features of the SC Swiderski benefit plans. This guide is not a plan document or summary plan description for any benefit plan, and it does not amend the plan documents or summary plan descriptions in any way. Please refer to the plan documents for exact terms and conditions of coverage. If any information in this guide conflicts with information in the official plan documents, the terms of the plan documents will govern in all cases. SC Swiderski and its affiliated entities reserve the right to change, modify or terminate the benefit plans at any time and for any reason. This guide does not constitute a contract of employment between SC Swiderski and any individual, or an obligation by SC Swiderski to maintain any particular benefit program, practice or policy or make any benefit payment.

REQUIRED FEDERAL NOTICES

1. HIPAA Notice of Special Enrollment Rights (newly eligible / open enrollment)
2. WHCRA Notice (newly covered members / open enrollment)
3. HIPAA Notice of Privacy Practices (newly covered members of the FSA Plan)
4. Medicare Part D Creditable Coverage Notice - all health plans are creditable (newly eligible / prior to October 15th each year / becoming eligible for Medicare)
5. Marketplace Notice (all new hires)
6. CHIP Notice (newly hires / open enrollment)
7. Initial COBRA Notice (newly covered members)

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 towards 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).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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.

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 obtain more information, contact Marc Bouwer, Human Resource Manager, at (715) 693-7831.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) ENROLLMENT NOTICE

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; 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 this plan. Please see your Summary of Benefits and Coverage (SBC) for deductible and coinsurance information.

If you would like more information on WHCRA benefits, call your health insurance company at the number on the back of your ID card.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: January 1, 2026

Who will follow this notice:

This notice describes the health information practices of SC Swiderski, as the plan sponsor of the Flexible Spending Account (FSA) plan (the "Plan") and that of any third party that assists in the administration of Plan claims.

Our pledge to you:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This notice is required by the Standards for Privacy of Individually Identifiable Health Information regulations (the "Rule"). This notice will tell you about the ways in which we may use or disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose medical information, as permitted by law. The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose medical information to carry out treatment, payment and health care operations or other purposes permitted or required by law.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose your medical information to SC Swiderski ("Plan Sponsor") for purposes related to treatment, payment and health care operations. The plan sponsor has amended its plan documents to protect your medical information as required by the Rule.

Treatment means the provision, coordination, or management of health care by one or more health care providers, or a health care provider and a third party.

Payment means activities undertaken by a health plan to determine coverage responsibilities and payment obligations for the provision of health care, or activities undertaken by a health care provider, or a health plan to obtain or provide reimbursement for health care.

For example, the Plan may disclose to your provider that you are eligible for benefits.

Health Care Operations means activities directly related to the provision of health care or the processing of health information. This includes internal quality oversight review, credentialing and health care provider evaluation, underwriting, insurance rating and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits.

For example, the Plan may use medical information about you to project future benefit costs.

The Plan will disclose medical information about you when required by federal, state or local law.

HIPAA NOTICE OF PRIVACY PRACTICES (Continued)

The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

The Plan may disclose medial information if you are a member of the armed forces and this is required by military command authorities.

The Plan may disclose medical information about you for workers' compensation or similar programs.

The Plan may disclose medical information about you for public health activities. These activities may include the following:

- to prevent or control disease, injury or disability;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

The Plan may disclose medical information to a health oversight agency for activities authorized by law.

The Plan may disclose medical information about you if you are involved in a lawsuit or a dispute and we are responding to a court or administrative order. Also, the Plan may disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

The Plan may disclose medical information about you if asked to do so by law enforcement official, such as in response to a court order, subpoena, warrant, summons or similar process;

The Plan may disclose medical information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure to funeral directors, as necessary to carry out their duties, is permitted.

The Plan may not disclose psychotherapy notes (under most circumstances), may not disclose protected health information for marketing purposes, and may not make disclosures that constitute a sale of protected health information unless authorized by the individual. Other disclosures not mentioned in this notice also require authorization from the individual.

The Plan may not disclose protected health information that is genetic information under the Genetic Information Nondiscrimination Act ("GINA") for underwriting purposes.

YOUR RIGHTS

You have the following rights regarding medical information the Plan maintains about you:

You have the right to request an inspection and a copy of your medical information contained in a "designated record set," for as long as the Plan maintains your medical information in the designated record set.

"Designated record set," means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and care or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or for health care operations and not used to make decisions about individuals is not in the designated record set.

The Plan has the right to charge a reasonable, cost-based fee for providing a copy of your medical information or summary or explanation of your medical information.

The Plan has the right to deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

HIPAA NOTICE OF PRIVACY PRACTICES (Continued)

If you feel the medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have a right to request an amendment for as long as the information is kept by the Plan.

To request an amendment, your request must be in writing and should be addressed to the following individual: Human Resources Manager, SC Swiderski, 401 Ranger Street, Mosinee, WI 54455. All requests for amendment of your medical information must include a reason to support the requested amendment.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy.

You have the right to request an "accounting of disclosures," where such disclosure was made for any purpose other than treatment, payment or health care operations. Additionally, no accounting of disclosures will be made for the following reasons:

- if the disclosure was made to the individual about his or her own medical information;
- if the disclosure was made pursuant to an authorization;
- if the disclosure was made to certain person involved in your care or payment for your care;
- if the disclosure was made prior to the compliance date of April 14, 2004.

To request an accounting of disclosures, address your request to the following individual: Human Resources Manager, SC Swiderski, 401 Ranger Street, Mosinee, WI 54455.

If you request more than one accounting in a 12-month period, the Plan can charge a reasonable, cost-based fee for each subsequent accounting, unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or payment for your care, such as friends or family members.

The Plan is not required to agree with your request.

You have the right to restrict certain disclosures of protected health information to a health plan where you pay out of pocket in full for the health care item or service.

To request restrictions, you must make your request in writing to the following individual: Human Resources Manager, SC Swiderski, 401 Ranger Street, Mosinee, WI 54455. The request must include (a) what information you want to limit, (b) whether you want to limit the Plan's use, disclosure or both, and (c) to whom you want the limits to apply.

You have the right to request to receive communications of your medical information from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate all such reasonable requests.

You will be required to request confidential communications of your medical information in writing. The request should be addressed to the following individual: Human Resources Manager, SC Swiderski, 401 Ranger Street, Mosinee, WI 54455.

HIPAA NOTICE OF PRIVACY PRACTICES (Continued)

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

To obtain a paper copy of this notice, contact the following individual: Human Resources Manager, SC Swiderski, 401 Ranger Street, Mosinee, WI 54455.

You have the right to be notified following a breach of unsecured protected health information.

If you believe your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: Human Resources Manager, SC Swiderski, 401 Ranger Street, Mosinee, WI 54455. You may also file a complaint with the Secretary of Health and Human Services.

The Plan will not retaliate against you for filing a complaint. The Plan will only release the minimum amount of PHI necessary to complete the required task or request.

Other uses or disclosures of your medical information not covered by this notice or the laws that apply will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke the authorization at any time, providing the revocation is done in writing. You understand that the Plan is unable to take back any disclosures already made with your permission.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE
Health Plan – All Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SC Swiderski, LLO 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. S.C. Swiderski has determined that the prescription drug coverage offered by the S.C. Swiderski's health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage **and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

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 SC Swiderski coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current SC Swiderski coverage, be aware that you and your dependents will not be able to get this coverage back until open enrollment or a special enrollment event, provided that you are still an active employee. Also please note – all HSA contributions must stop once you are eligible for and enrolled in any type of Medicare, including Medicare Part D.

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 S.C. Swiderski 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 S.C. Swiderski changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC **Updated April 1, 2011**

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 15, 2025
Name of Entity/Sender:	S.C. Swiderski
Contact:	Human Resources Manager
Address:	401 Ranger St, Mosinee, WI 54455
Phone Number:	(715) 693-7831

MARKETPLACE COVERAGE NOTICE

GENERAL INFORMATION

When key parts of the health care law took effect, you were eligible for a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you look at options for you and your family, this notice provides some basic information about the new Marketplace and the employment-based coverage offered to you.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Annual open enrollment for private health insurance coverage through the Marketplace runs during the months of November, December, January and February. The specific timeline will be announced each year.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you are eligible for depends on your household income.

DOES THE HEALTH INSURANCE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered you health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in our health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of self-only coverage under our health plan is more than 9.83% of your household income for the year, or if our health plan does not meet the "minimum value"[1] standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution – as well as your employee contribution – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION ABOUT THE MARKETPLACE?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. You can 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.

1

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

MARKETPLACE COVERAGE NOTICE (continued)

INFORMATION ABOUT THE HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

If you complete an application for coverage through the Marketplace, you will be asked for information about our health plan. The information below will help you complete an application for coverage in the Marketplace.

Employer Name: SC Swiderski
Employer Identification Number (EIN): 39-1938146 (Leasing); 47-2832735 (Construction); 47-2837847 (Management); 47-2832650 (Land Company)
Employer Address: 401 Ranger Street Mosinee, WI 54455
Employer Phone Number: (715) 693-9522
Who can we contact about employee health coverage at this job? Phone Number (if different from above): Marc Bouwer, Human Resource Manager E-mail address: mbouwer@scswiderski.com

- You may also be asked whether or not you are currently eligible for our health plan or whether you will become eligible within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

- If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.

- If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.

- If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

- If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact your Employer at the phone and/or email listed above.

- You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

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, 2023. 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

CHIP (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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	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://kidshealth.ky.gov/Pages/index.aspx 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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

CHIP (continued)

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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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)

CHIP (continued)

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, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

COBRA Notice

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE AND CONVERSION RIGHTS

Federal and Wisconsin law require that some group health plans offer individuals who would otherwise lose their coverage: (1) the opportunity for a temporary extension of health coverage (called **"COBRA Continuation coverage"**) at group rates, and/or (2) the opportunity to convert to individual health insurance coverage (called "**Conversion coverage**").

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. **You, your spouse and any dependents should take the time to read the entire notice carefully.**

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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.

YOU MAY HAVE OTHER OPTIONS AVAILABLE TO YOUR 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.

ELIGIBLE INDIVIDUALS

Employees - If you are an employee of SC Swiderski who is covered by its group health plan (which includes the medical, dental, vision, and prescription drug plans) you have the right to elect COBRA Continuation coverage for yourself (and your spouse and dependents to the extent that they would also lose coverage) if you lose this group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part), subject to the terms and conditions of the insurance contract. You may also have some additional rights if you lose this group health coverage while you are on a leave of absence to serve in the military – but any separate right(s) that you may have to receive COBRA Continuation coverage (e.g., under the Uniformed Services Employment and Reemployment Rights Act) will be run in conjunction with any rights under COBRA.

COBRA Notice (Continued)

Spouse - If you are or were the spouse of an employee and you are covered by the group health plan(s), you have a separate right to elect COBRA Continuation coverage for yourself (and your dependents under age 18 if they would also lose coverage) if you lose group coverage for any of the following reasons:

1) Your spouse's death;
2) Your spouse's termination of employment (for reasons other than gross misconduct) or reduction in hours of employment;
3) divorce, legal separation or annulment from your spouse;
4) Your spouse's entitlement to Medicare benefits (Part A, Part B or Both); or
5) The bankruptcy of your spouse's employer, if your spouse is retired.

Dependents - If you are the dependent child of an employee and you are covered by the group health plan(s), you have a separate right to elect COBRA Continuation coverage for yourself if you lose group health coverage for any of the following reasons (if you are under age 18, your parent may exercise this right for you):

1) Your parent's death;
2) Your parent's termination of employment (for reasons other than gross misconduct) or reduction in hours of employment;
3) Your parents' divorce or legal separation;
4) Your parent's entitlement to Medicare benefits (Part A, Part B or Both);
5) Your ceasing to be a "dependent child" as defined by the group health plan; or
6) The bankruptcy of your parent's employer, if your parent is retired.

A child who is born to or adopted by a former employee, while such employee maintains COBRA Continuation coverage, is also entitled to elect COBRA Continuation coverage. Such coverage will be treated as though it started on the same date as the former employee's continuation coverage for purposes of determining the child's maximum period of coverage. The former employee must comply with the same enrollment rules that apply to active employees in order to obtain coverage for such a child.

Please note, if you lose group health plan coverage "in anticipation" of one of the previously described events, you may have the right to elect COBRA Continuation coverage even if you had lost coverage prior to the event.

REQUIRED NOTICES

When to Notify Us - Under the law, the employee or a family member has the responsibility to inform the health plan administrator of a divorce, legal separation, or a child losing dependent status under the group health plan. This notice must be given to the administrator within 60 days after the later of the event or the date on which coverage is lost under the plan because of such event. You must provide notice to: **SC Swiderski's Human Resource Department.** Failure to notify SC Swiderski of the aforementioned events within 60 days, after the later of the event or the date on which coverage would end under the plan because of such event, will result in your group health plan coverage ending.

Under the law, SC Swiderski will notify the health plan administrator of the employee's death, termination of employment (for reasons other than gross misconduct), reduction in hours of employment, or Medicare entitlement so that the appropriate notices can be sent.

COBRA Notice (Continued)

Your Election Rights - When the health plan administrator is notified that one of the events described in the Eligible Individuals Section of this notice has occurred, it will notify you that you have the right to choose COBRA continuation coverage. Under the law, you have 60 days from the later of the date you would lose coverage (because of one of the previously described events) or the date of this notice to you after the events previously mentioned to inform SC Swiderski that you want COBRA continuation coverage. ***If you do not choose COBRA continuation coverage or you do not respond within this time period, your group health plan coverage will end.***

COBRA CONTINUATION COVERAGE

Coverage Rights - If you choose COBRA continuation coverage, the plan is required to give you coverage which is identical to the coverage provided currently under the plan to similarly situated employees or family members.

Maximum Period of Coverage - The law requires that you be afforded the opportunity to maintain COBRA continuation coverage for up to 36 months unless you lost group health coverage because of a termination of employment (other than for gross misconduct), a reduction in hours or a leave for military service. In such cases, the required COBRA continuation coverage period is 18 months. The 18 month period may, however, be extended by up to 11 additional months (29 months in total) if: (1) an individual (the employee, spouse or dependent) is determined to be disabled (for Social Security disability purposes) at the time of the termination of employment or the reduction in hours or at any time within the first 60 days after such an event; and (2) the plan administrator is notified of the determination of disability by the Social Security Administration within 60 days (but not after the end of the original 18 month period). Under the law, an individual must notify the plan administrator within 30 days of any final determination that the individual is no longer disabled (for Social Security disability purposes). The 18 month (and the 29 month) period may also be further extended to a maximum of 36 months from the date of termination of employment or the reduction in hours if another event (such as a death, divorce, or legal separation) occurs during that 18 month (or 29 month) period and while you maintain COBRA continuation coverage provided you have notified the plan administrator in the 60 day time frame. You must provide notice of this new event to **SC Swiderski's Human Resource Department.** You will be asked to provide a copy of your Social Security award letter.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, COBRA continuation coverage is provided subject to your eligibility for coverage; the health plan administrator reserves the right to terminate your COBRA continuation coverage retroactively if you are subsequently determined to be ineligible.

Expiration of Coverage - Except under limited circumstances involving SC Swiderski bankruptcy, COBRA continuation coverage will never last beyond 36 months from the date of the event that originally made someone eligible to elect coverage. However, the law does provide that your COBRA continuation coverage period may be cut short for any of the following reasons:

1) SC Swiderski no longer provides group health coverage to any of its employees;
2) The premium for your COBRA continuation coverage is not paid on time;
3) You become covered by another group health plan under which the pre-existing condition limitation period does not limit or restrict your plan coverage (after consideration of any Creditable Coverage you may have);
4) You become entitled to Medicare; or
5) You extended your COBRA continuation coverage due to a disability and there has been a final determination that the individual is no longer disabled for purposes of Social Security disability benefits.

In addition, your COBRA continuation coverage under the insurance contract could end at the time you establish residence outside of the coverage area, this is particularly true of HMO Contracts.

Health Insurance Premiums - Under the law, you may have to pay all or part of the premium for your COBRA continuation coverage. You may also be required to pay an additional administrative fee. The administrative fee is generally equal to 2% of the monthly premium and must be paid at the same time as the premium. The administrative fee may, however, increase to 150% of the monthly premium for the 11 month extension on disability described previously, provided the disabled individual remains covered under COBRA continuation coverage, with the higher administrative fee continuing if you experience another event that allows you to extend continuation coverage from 29 months to 36 months. All premiums must be paid on or before the first day of the month to which the premium relates. There is, however, a 30-day grace period for all premiums, except the first premium, which must be paid within 45 days after you elect COBRA continuation coverage (together with all premiums that would ordinarily have been due during that period). ***Your COBRA continuation coverage will be terminated and you will not be permitted to reenroll for coverage if you fail to pay any premium (including the appropriate administrative fee) in a timely manner.*** All COBRA payments should be made to **SC Swiderski** and sent to the Human Resources Department.

CONVERSION COVERAGE (HEALTH INSURANCE ONLY)

At the expiration of your COBRA coverage period or at any time while you maintain COBRA continuation coverage, you may convert to an individual medical insurance policy without having to prove your insurability. Conversion coverage is an individual policy of insurance, which is issued by an insurance company and is separate from the group health plan offered by SC Swiderski. This is an insured policy of health coverage and is subject to the terms and conditions of the insurer offering the coverage. To obtain this coverage, you must file a request with the insurance carrier. The insurance carrier will provide you with an explanation of the type of medical conversion coverage that is available, **if any**, the policy application, the monthly premium cost and the premium payment procedures.

ARE THERE OTHER COVERAGE OPTIONS AVAILBABLE 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, Medicaid, 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.

ADDITIONAL INFORMATION

If you have any questions about this notice or the law, please contact **Marc Bouwer, SC Swiderski, 401 Ranger Street, Mosinee, WI 54455 or (715) 693-7831.** Please also use this address to promptly notify SC Swiderski of your current address or of any event that may entitle you or another individual to elect continuation coverage under federal law.

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