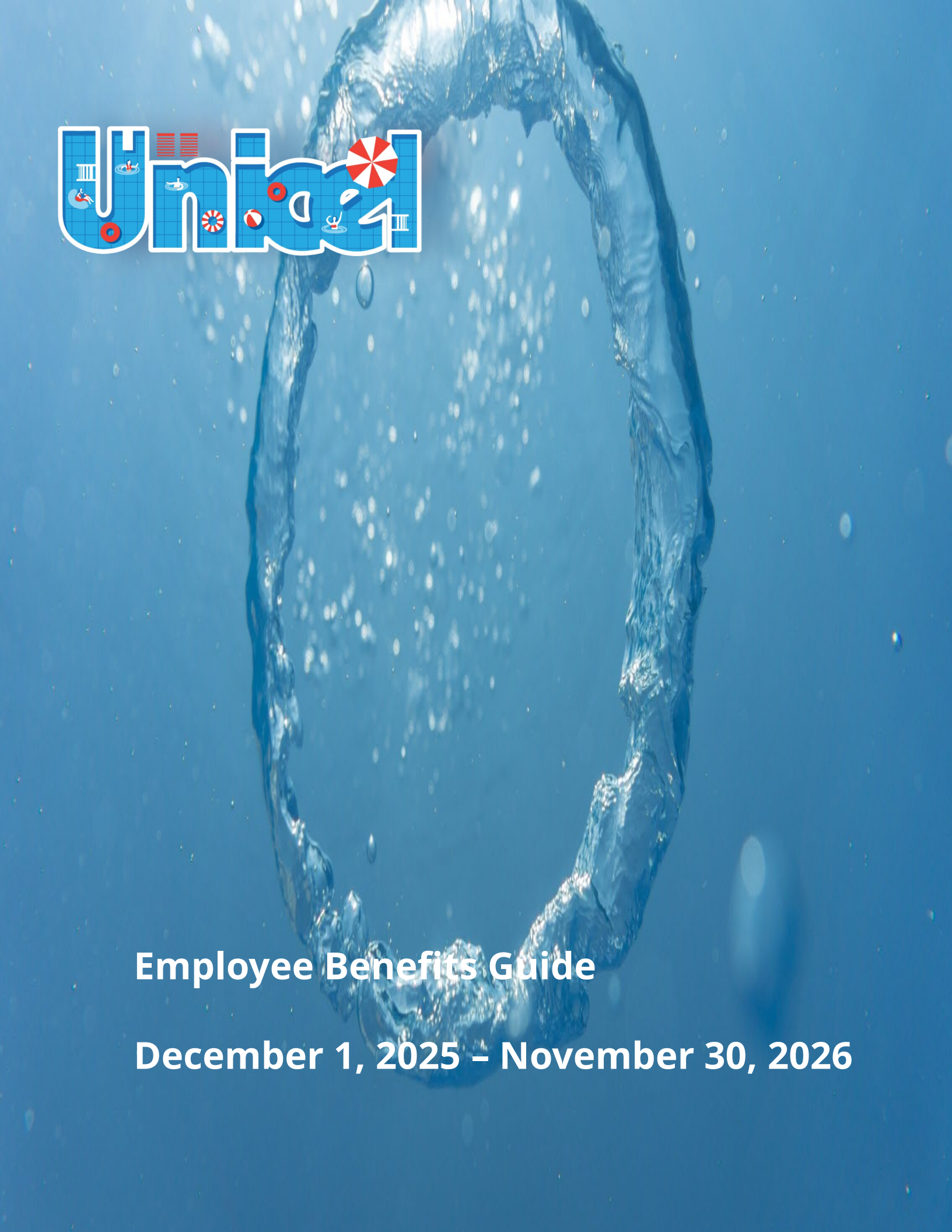


Employee Benefits Guide

December 1, 2025 – November 30, 2026

Table of Contents

Benefit Information

NEW HIRE WAITING PERIOD & ELIGIBLE EMPLOYEES

You are eligible for most benefit plans as a Meissner Mfg. Co., Inc. All full-time associates who regularly work 24+ hours per week are eligible. Your coverage begins on the first of the month following 60 days. You will have the opportunity to re-enroll in the benefits program each year during the Annual Open Enrollment period, unless you have a Qualifying Event. You can change your doctor and other providers year-round.

TERMINATION OF BENEFITS

When your employment with the company is terminated, your benefits will stop: Medical, Dental, and Vision at the end of the month. All other end on the date of termination.

WHO IS ELIGIBLE TO ENROLL

Your coverage begins the first of the month following 60 days of continuous employment. You may also enroll your qualified eligible family member(s), including:

- Spouse or domestic partner
- Your married or unmarried dependent children, regardless of student status:
- Up to the last day of their birthday month at age 26 (includes stepchildren, legally adopted children, children placed with you for adoption, and foster children)
- Or a dependent child, regardless of age, provided he or she is incapable of self support and is fully dependent on you due to a mental or physical disability as indicated on your federal tax return and is approved by your medical plan to continue coverage past age 26

MAKING PLAN CHANGES DURING THE YEAR

If you've had a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc…) during the year, you're able to make coverage changes to your plan even though it's outside of the Open Enrollment window. Please make changes in your benefits platform within 30 days of your Qualifying Event to ensure it will be processed in a timely manner. PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it once it's available.

COBRA

In the event your employment is terminated with the company, you will receive a packet in the mail giving you the opportunity to continue your Medical, Dental and Vision benefits for up to 18 months. This is called COBRA coverage. You will be responsible for 102% of the actual cost of the insurance if you wish to continue with it.

STAY IN NETWORK

To obtain the best benefits, it's important to stay in the insurance carrier's network. Always check online or verify over the phone that a doctor or hospital is contracted in-network *before* your visit. Also, when having a procedure done in a hospital/facility, ask the hospital staff to make sure *every* doctor/nurse/radiologist/anesthesiologist/etc... is in your network.

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

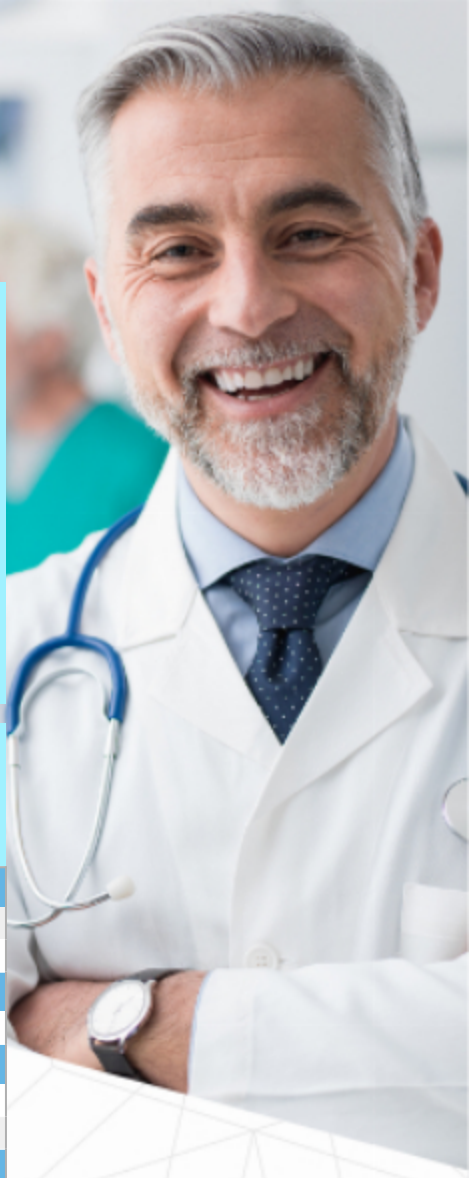
RATES, CONTRIBUTIONS AND BENEFIT SUMMARIES

The guide provides cost details for healthcare, supplemental, and protection benefits—including medical, dental, vision, pet discount plan, and identity theft coverage. Rates for the Aflac and LegalShield can be accessed through your benefits portal. Benefit Summaries are available via clickable links on each page or by visiting your benefits portal, where both pricing and summary information are housed. The cost of benefits is a partnership between the Company and employees. Meissner Mfg. Co., Inc. bears the majority of the cost by paying, on average, the monthly employee premium of the Gold TRIO HMO plan minus $65.00 per month. You pay a portion of the cost through your payroll contributions, co-payments, and co-insurance.

DISCLAIMER

The information included in this guide is intended as an overview only. It is not a complete description, nor is it a substitute for the applicable benefit plan documents, insurance certificates, or Summary Plan Description (SPD). In all cases, the official plan documents govern and are the final authority on the terms of the benefit plans. The company reserves the right to modify, amend or terminate the benefit plans at any time and for any reason. Receiving this document or participating in company benefits is not a guarantee of future or continued employment or benefits.

HMO Medical Plans



Plan Explanation

With the Health Maintenance Organization (HMO) plan, you must choose a Primary Care Physician (PCP) or medical group/Independent Practice Association within the Blue Shield Network. To receive specialty care, you must obtain a referral from your PCP or medical group to a Specialist within the network. And, except in the case of an emergency, you're only covered for care you receive from providers, facilities and pharmacies that are in the Blue Shield Network. Employee contributes $65 for employee-only cost towards the base plan (Gold Trio HMO 1000/35 OffEx) a month & Meissner pays the employee cost balance.

- Platinum HMO 0/30 OffEx: **(full network / narrow network)**
- Platinum 0/30 TRIO HMO **(narrow network)**
- Gold Access+ HMO 500/35 OffEx **(full network)**
- Gold TRIO HMO 1000/35 OffEx - **BASE PLAN** **(narrow network)**

	Blue Shield of California | Platinum Access+ HMO 0/30 OffEx	Blue Shield of California | Gold Access+ HMO 500/35 OffEx	Blue Shield of California | Gold Trio HMO 1000/35 OffEx
DEDUCTIBLE	IN-NETWORK	IN-NETWORK	IN-NETWORK
Single	$0	$500	$1,000
Family	$0	$1,000	$2,000
COINSURANCE			
Member %	0%	20%	20%
OUT OF POCKET MAXIMUM			
Single	$2,700	$7,500	$7,500
Family	$5,400	$15,000	$15,000
COMMONLY USED SERVICES			
Primary Care Physician Office Visit	$30 copay	$35 copay	$35 copay
Specialist Office Visit	$55 copay	$60 copay	$70 copay
Urgent Care	$30 copay	$35 copay	$35 copay
Emergency Room	$250 copay	$300 copay	$300 copay
PREVENTIVE CARE			
Preventive Services	No charge	No charge	No charge
MAJOR MEDICAL EXPENSES			
Outpatient Surgery	Ambulatory : $100 / Hospital : $150	Ambulatory : $150 / Hospital : $300	Ambulatory : $150 / Hospital : $300
Inpatient Hospitalization / Surgery	$500 per day up to 4 days per admission	20% after deductible	20% after deductible
CT scan, PET scan, MRI	Radiology : $100 / Hospital : $250	Radiology: $100 / Hospital: $250	Radiology : $100 / Hospital : $300
Hospital Newborn Delivery	$500 per day up to 4 days per admission	20% after deductible	20% after deductible
PRESCRIPTION DRUG COVERAGE			
Prescription Deductible	None	None	$0
Generic (Tier 1)	$5 copay	$15 copay	level A : $15 / level B : $20
Brand Name (Tier 2)	$25 copay	$50 copay	level A : $40 / level B : $60
Non-Preferred (Tier 3)	$30 copay	$70 copay	level A : $60 / level B : $90
Specialty (Tier 4)	20% up to $250	20% up to $250	20% up to $250
Mail Order - 90 day Supply	$10 / $50 / $60 / 20% up to $500	$30 / $100 / $140 / 20% up to $500	$30 / $80 / $120 / 20% up to $500

PPO Medical Plan

Blue Shield of California | Gold Full PPO 0/35 OffEx

Plan Explanation

The Full PPO Network, Blue Shield's largest in California and offers lower out-of-pocket costs when using in-network providers, allows access to out-of-network care at higher rates, requires no specialist referrals, includes nationwide coverage through the BlueCard® program, and provides flexibility in choosing providers with added savings when staying in-network.

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Single	$0	$1,000
Family	$0	$2,000
Member % after deductible	None	40%
OUT OF POCKET MAXIMUM		
Single	$7,900	$15,800
Family	$15,800	$31,600
COMMONLY USED SERVICES		
Primary Care Physician Office Visit	$35 copay	40% after deductible
Specialist Office Visit	$60 copay	40% after deductible
Urgent Care	$35 copay	40% after deductible
Emergency Room (waived if admitted)	$250/visit plus 30%	$250/visit plus 30%
PREVENTIVE CARE		
Preventive Services	No Charge	Not covered
MAJOR MEDICAL EXPENSES		
Outpatient Surgery	Ambulatory: 30% / Hospital: $150 + 30% after deductible	40% after deductible
Inpatient Hospitalization / Surgery	30% after deductible	40% after deductible
CT scan, PET scan, MRI	Hospital: 30% / Radiology: $100 + 30% after deductible	40% after deductible
Hospital Newborn Delivery	30% after deductible	40% after deductible
Generic (Tier 1)	$25 copay	Not covered
Brand Name (Tier 2)	$50 copay	Not covered
Non-Preferred (Tier 3)	$70 copay	Not covered
Specialty (Tier 4)	30% up to $250	Not covered
Mail Order - 90 day Supply	$50 / $100 / $140 / 30% up to $500	Not covered

blue california

Dental DHMO Plan

Blue Shield | DHMO

Plan Explanation

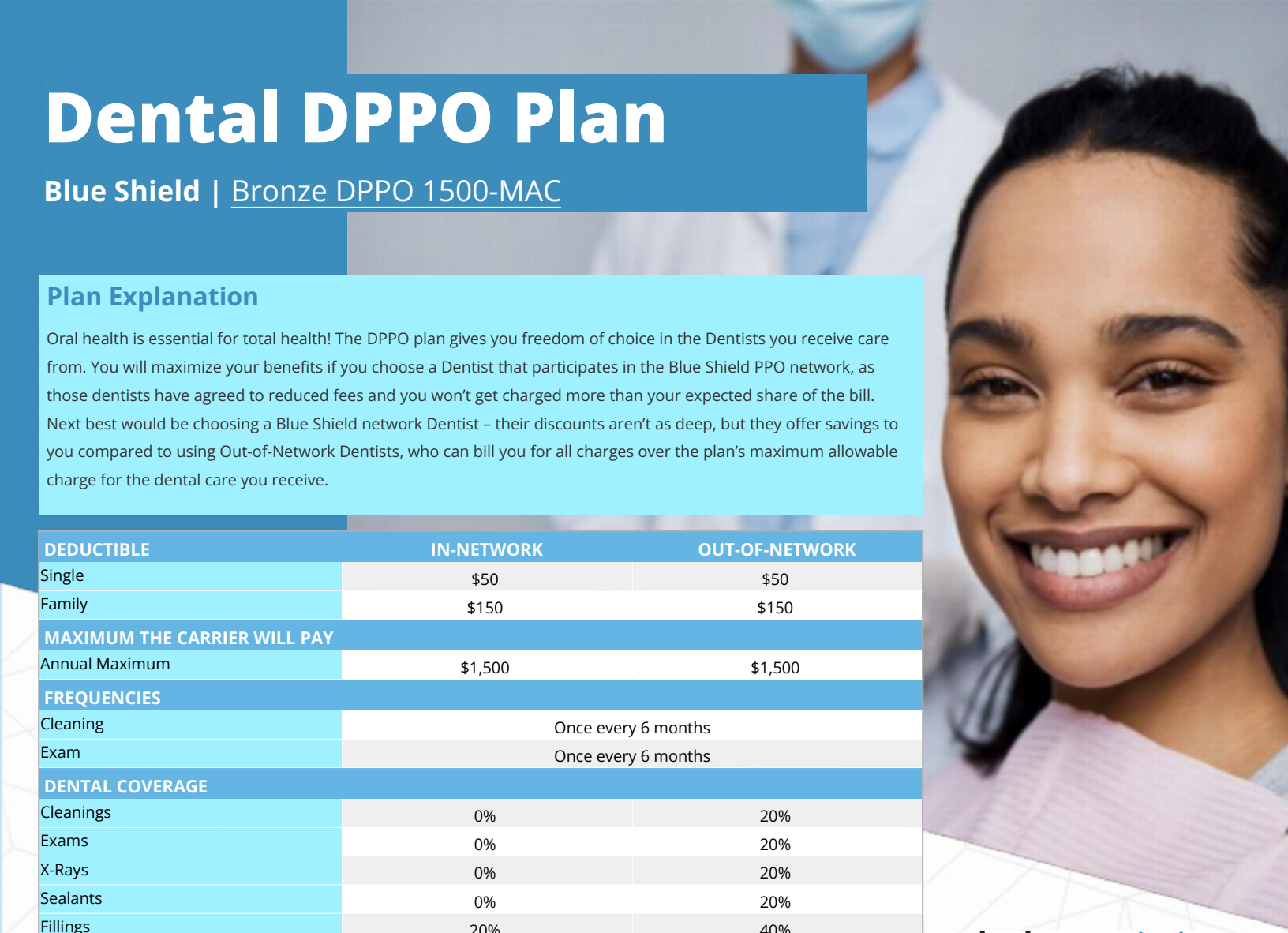
Blue Shield Dental offers a comprehensive DHMO plan with Orthodontia coverage. The DHMO plan has a set copay schedule for every treatment covered by the plan. The patient charge schedule applies to in-network general dentists and specialists when an appropriate authorized referral is made to a Network Specialty dentist such as an Oral Surgeon, Periodontist and Endodontist. Prior authorization for all speciality except Pediatric dentist.Meissner Mfg. Co., Inc. pays 100% of your enrolled premium for DHMO employee-only dental coverage if you elect this coverage.

MAXIMUM THE CARRIER WILL PAY	
Annual Maximum	Unlimited
FREQUENCIES	
Cleaning	Once every 6 months
Exam	Once every 6 months
DENTAL COVERAGE	
Cleanings	0%
Exams	0%
X-Rays	0%
Sealants	0%
Fillings	Copays Vary
Simple Extractions	Copays Vary
Root Canal	Copays Vary
Periodontal Gum Disease	Copays Vary
Oral Surgery	Copays Vary
Crowns	Copays Vary
Orthodontia (adult & children)	$1,500 / $1,200
Orthodontia Maximum Age	Dependents are covered up to age 26

PREMIUM PER PAYCHECK	
Employee Only	$0.00
Employee + Spouse	$10.62
Employee + Child(ren)	$14.12
Family	$21.18

Dental DPPO Plan

Blue Shield | Bronze DPPO 1500-MAC



Plan Explanation

Oral health is essential for total health! The DPPO plan gives you freedom of choice in the Dentists you receive care from. You will maximize your benefits if you choose a Dentist that participates in the Blue Shield PPO network, as those dentists have agreed to reduced fees and you won't get charged more than your expected share of the bill. Next best would be choosing a Blue Shield network Dentist – their discounts aren't as deep, but they offer savings to you compared to using Out-of-Network Dentists, who can bill you for all charges over the plan's maximum allowable charge for the dental care you receive.

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Single	$50	$50
Family	$150	$150
MAXIMUM THE CARRIER WILL PAY		
Annual Maximum	$1,500	$1,500
FREQUENCIES		
Cleaning	Once every 6 months	
Exam	Once every 6 months	
DENTAL COVERAGE		
Cleanings	0%	20%
Exams	0%	20%
X-Rays	0%	20%
Sealants	0%	20%
Fillings	20%	40%
Simple Extractions	20%	40%
Root Canal	20%	40%
Periodontal Gum Disease	20%	40%
Oral Surgery	50%	50%
Crowns	50%	50%
Dentures	50%	50%
Bridges	50%	50%
Implants	50%	50%
Orthodontia	Not Covered	Not Covered
OUT OF NETWORK EXPLANATION		
	Your insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist, which may result in a balance bill.	

PREMIUM PER PAYCHECK	
Employee Only	$6.18
Employee + Spouse	$22.89
Employee + Child(ren)	$31.25
Family	$46.29

Vision Plan

EyeMed | Vision

Plan Explanation

The EyeMed vision plan delivers expert eye care and access to high-quality lenses and frames through a wide network of optical professionals. You'll enjoy enhanced benefits when you choose in-network providers. But your vision coverage goes beyond just copays—it's packed with value. Members save an average of 71% off retail prices, and exclusive special offers stretch your benefits even further.

NEW!! Stay informed with helpful resources and text alerts designed to make using your benefits seamless and straightforward. Plus, you can save even more at select in-network "PLUS" providers that offer added value on top of your standard benefits. These include trusted names like LensCrafters, Pearle Vision, Target Optical, and the Independent Provider Network.

VISION COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	$0 copay PLUS Provider/Non-Plus Provider $10 copay	Up to $49
Single Vision Lens	$10	Up to $35
Lined Bi-Focal Lens	$10	Up to $49
Lined Tri-Focal Lens	$10	Up to $74
Contact Lens Allowance	PLUS Provider$165 / Non-Plus Provider $115 allowance then 15% off balance	Up to $92
Frame Allowance	PLUS Provider $150 / Non-Plus Provider $100 allowance then 20% off balance	Up to $70
FREQUENCIES		
Exam Frequency	Once every 12 months	
Lens Frequency	Once every 12 months	
Frame Frequency	Once every 12 months	
OUT OF NETWORK EXPLANATION		
	While you will receive a reimbursement when you visit an out of network provider, they are not required to file the claim for you.	

PREMIUM PER PAYCHECK	
Employee Only	$5.40
Employee + 1	$10.21
Employee + 2 or more	$14.97

Employer Paid Life and AD&D

Mutual of Omaha | Life and AD&D

Plan Explanation

Meissner Mfg. Co., Inc. automatically provides you with Basic Life and Accidental Death & Dismemberment (AD&D) at no cost to you, even if you elect to waive medical and dental coverage.

LIFE INSURANCE BENEFITS	
Life Insurance Coverage	A benefit in the amount of 1 times your annual salary to a maximum of $200,000 will be provided to your beneficiary in the event of your passing.
Accidental Death & Dismemberment	Accidental Death & Dismemberment (AD&D) is an additional benefit you or your beneficiary will receive in the event that you are dismembered our you pass away due to an accident or dismemberment. This amount equals the amount of life insurance you've elected.
Age Reduction Schedule	Your benefits will reduce after you've reached certain ages. You will have a 35% reduction in benefits at age 65, 50% reduction at age 70 and a 60% reduction at age 75+.
Beneficiary	The Beneficiary is the person (or people) who receive(s) the death benefit from the insurance carrier in the event of your passing. Please make sure this is kept updated at all times with your employer or HR department.

Disability Plans

Plan Explanation

Short-term Disability (STD) income replacement protects you if you are temporarily disabled due to an accident, sickness, or pregnancy. **Your employer pays for this coverage**, offered through Mutual of Omaha. Short-Term Disability works with Social Security and any other group disability coverage to provide you with a combined weekly benefit. Please refer to your Benefit Admin portal for full plan details.

Long-Term Disability (LTD) income replacement protects you if you are disabled for an extended period of time. **Your employer pays for this coverage**, offered through Mutual of Omaha. If you become totally and permanently disabled, benefits begin 180 days after the start of your illness or injury. Long Term Disability works with State Disability, Social Security, and any other group disability coverage to provide you with a combined monthly benefit.

Mutual of Omaha | Short Term Disability

STD INSURANCE BENEFITS	
How does my insurance carrier define Disability?	Mutual of Omaha considers you disabled if you've lost 1 or more material and substantial duties of your own occupation, AND you've lost at least 20% of your pre-disability earnings due to an accident or illness.
Weekly Benefit	If you've lost income as a result of a disability, you will receive 60% of your pre-disability income up to the allowed amount. Maximum weekly amount, $1,386.
When do benefits start? (Elimination period)	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: · On the 60th day of your disabling injury · On the 60th day of your disabling illness
How long do my benefits pay out?	Your benefits will pay you for up to 17 weeks. Please note that benefits will only pay out while you are disabled and have a loss of income.

Mutual of Omaha | Long Tern Disability

LTD INSURANCE BENEFITS	
How does my insurance carrier define Disability?	Mutual of Omaha considers you disabled if you've lost 1 or more material and substantial duties of your own occupation, AND you've lost at least 20% of your pre-disability earnings due to an accident or illness.
Monthly Benefit	If you've lost income as a result of a disability, you will receive 60% of your pre-disability income up to the allowed amount. Maximum Monthly Benefit $6,000.
When do benefits start? (Elimination period)	Your benefits begin on the later of 180 calendar days after the onset of your disabling injury or illness or the date your short-term disability ends.
How long do my benefits pay out?	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.

Value Added Services

Mutual of Omaha | Additional Benefits

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the Resources Advisor, provided by Mutual of Omaha, is all about.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done. **Available to all covered employees. Family members are eligible regardless of location or relationship.**

Online: **www.mutualofomaha.com/eap/** or Toll Free: 800.316.2796.

SERVICES FOR YOU AND YOUR FAMILY

Your Resources Advisor offers these services to help you and to your family deal with the big and little things. Up to **3 face-to-face** counseling sessions per household per issue.

- Self-assessments for identifying issues with stress, depression or substance use
- Health and wellness articles, guides, webinars, podcasts and calculators
- Dependent and Elder care resources
- Tips on parenting and grandparenting
- Online will preparation
- Help with teen and adolescent issues, including eating disorders and relationships
- Legal and financial resources

WORLDWIDE TRAVEL AND ID THEFT

The Worldwide Travel Assistance Program through Mutual of Omaha provides you with security when you are at least 100 miles away from home, whether you are traveling for business or pleasure.

Mutual of Omaha is also available to help you while you are away with locating medical care and prescription suppliers, interpreter services, emergency transportation and repatriation, and emergency passport or ticket replacement.

Contact Worldwide Travel and ID Theft Assistance: Within the US: 800-856-9947, outside of the US call collect 312-935-3658 for more information.

LEARN ABOUT MEDICARE!

Are you thinking of retiring, turning age 65, enrolling in Medicare, or simply want to know what Medicare is? Meissner Mfg. Co., Inc. wants to provide the best assistance possible to walk you through Medicare decisions.

We have partnered with SGIA, and will work with any member to find the best healthcare plan available through Medicare. They will provide enrollment assistance and continued support; this is a free and confidential services. Please contact Lucy Parker for additional information at 888-329-0224 or email **lparker@sgiain.com**.

-

Worksite Benefits

Aflac | Supplemental Benefits

WORKSITE BENEFITS THROUGH AFLAC

Financial protection from the unexpected for you and your family is a key component of Meissner Mfg. Co., Inc. benefits program. AFLAC Worksite Benefit Plans allows you to tailor an insurance portfolio that protects you and your family. Below is a brief listing and description of the offered products for you and your family members.
If you are interested, please contact AFLAC Stephanie Sanders at 661-702-9416 or email stephanie_sanders@us.aflac.com to discuss which plans best suit your needs and budget.

ACCIDENT INSURANCE

Accident Insurance is designed to help offset unexpected medical expenses, such as emergency room fees, deductibles, and copayments that can result from a fracture, dislocation, or other covered accidental injury.

HOSPITAL INDEMNITY INSURANCE

This is an individual hospital confinement indemnity plan that complements your core major medical coverage, offering benefits such as hospital confinement, outpatient surgeries, emergency room visits, and health screenings.

The coverage provides a lump-sum benefit for covered hospital confinement and covered outpatient surgery to help offset the gaps caused by co¬payments and deductibles in most major medical plans.

CRITICAL ILLNESS INSURANCE

Critical Illness insurance helps supplement your major medical coverage by providing a lump-sum benefit that you can use to help pay the direct and indirect costs related to a covered critical illness.

SHORT-TERM DISABILITY

Replaces a portion of your income to help make ends meet if you are totally disabled due to a covered accident or covered sickness. This coverage helps you to maintain your lifestyle.

DENTAL - ESSENTIALS

Aflac will pay benefits when a charge is incurred for covered dental treatment that is received while coverage is in force. Benefits will be paid based on the current ADA coding convention.

AFLAC'S COVERAGES SHARE IMPORTANT FEATURES:

- Coverage is available for your spouse and children with most products
- Benefits are paid directly to you unless you specify otherwise
- With most plans, you can continue coverage when you retire or change jobs, with no increase in premiums
- With most plans, you receive benefits regardless of any other insurance you may have with other insurance companies
- Premiums are payroll-deducted for easy administration

Pet Plans

Pets Best Solutions | Total Pet Discount Plan & Wishbone Insurance

Plan Explanation

Your Pets Are Family - Protect Them Like It

We know your pets are more than just companions - they're cherished members of your household. Their health and happiness matter deeply, which is why we're offering two tailored Pet Plans to help you care for them with confidence and ease.

1. **Total Pet Plan -** *Discount-Only Membership*

Perfect for pet parents who want everyday savings without the commitment of traditional insurance. Single Pet: Premium Per Paycheck $5.42 & Unlimited pets $8.54.

Benefits include: Discounts on routine veterinary visits and wellness exams, reduced pricing on vaccinations, dental cleanings, and spay/neuter services, savings on prescriptions, flea/tick prevention, and pet food, access to a nationwide network of participating vets and pet care providers- no deductibles, no claims- just instant savings.

This plan is ideal for managing regular pet care expenses while keeping your budget under control.

Visit **https://www.petbenefits.com/land/meissnermfg** for more information.

2. **Wishbone Pet Insurance -** *True Insurance Coverage*

This is true insurance for your pet. Looking to maximize your savings with comprehensive accident and illness pet insurance coverage? With 90% reimbursement, a low annual deductible, and optional wellness add-ons, Wishbone Pet Insurance helps you and your pets enjoy a life well-lived.

Benefits include Coverage for accidents, illnesses, surgeries, and emergency care, as well as reimbursement for diagnostics, medications, and specialist visits. Customizable plans to fit your pet's age, breed, and health needs-Flexible reimbursement options and annual deductible choices-Coverage for dogs and cats of all ages.

Wishbone offers peace of mind when life throws you a curveball **,** because your pet's health shouldn't be a financial burden. Wishbone also comes with a durable pet ID tag, lost pet recovery services, and free 24/7 pet telehealth. Use the link below to get a quote and enroll. **Rates are based on breed, age, and zip code. View available pricing at View available pricing at https://www.petbenefits.com/land/meissnermfg**

Whether you're looking for simple savings or full protection, we've got a plan that fits your lifestyle and your pet's needs.

Identity Protection

Allstate | Identity Protection Privacy Armor Plus

Plan Explanation

Protect your identity from data breaches with Allstate Identity Protection's Privacy Armor Plus. This benefit helps you safeguard your finances, reputation and credit against theft and abuse with unique tools and proactive monitoring.

ID THEFT BENEFIT	
Coverage Maximum	$2,000,000 of coverage
Security Consultation	Participants have unlimited access to consultation with a LPI when they have questions about a recent data breach, an identity-related issue or any other concern, such as receiving a suspicious email or phone call, notification of a change on their credit report, or concerns about proactively protecting their personal information. A participant doesn't have to be a victim of identity theft to take advantage of consultation services.
Dark Web Surveillance	Comprehensive Dark Web Monitoring provides extensive monitoring of the participant's personally identifiable information (PII) across the Dark Web, a series of black market websites where criminals purchase personal information.
Credit Monitoring	Your credit is continually monitored with all 3 credit bureaus (Experian, Equifax and Transunion).
Credit Inquiry alerts	Hard credit inquiry alerts continuously monitor a participant's Experian credit report for new hard inquiries and triggers notifications to the participant in real-time, when the inquiry is made by the creditor. The alert is triggered when a participant, or someone using their PII, completes an application that includes a credit check such as when applying for a loan, mortgage, or credit card.
VPN coverage	VPN coverage protects your online privacy and security by masking your IP address.
Social Media Monitoring	Your most popular social media platforms are monitored: Facebook, LinkedIn, Twitter, and Instagram for information that may put the participants' privacy at risk, such as home address, email address, date of birth and Social Security number. Additionally, participants are alerted to reputational risks within their content feeds such as instances of vulgar, harmful, or threatening and/or sexual language, drug and alcohol references and discriminatory language.
Who is eligible?	You, your spouse and children are eligible for this line of coverage.

PREMIUM PER PAYCHECK	
Employee Only	$4.59
Family	$8.28

NEW Legal Benefits

Legal Shield | Legal Benefits

Plan Explanation

The Legal Services Benefit is provided to assist you when unexpected legal questions or situations arise. Whether it's Family matters, Will preparation, 24/7 consults or IRS audit services, the Legal Services Benefit can offer you peace of mind.

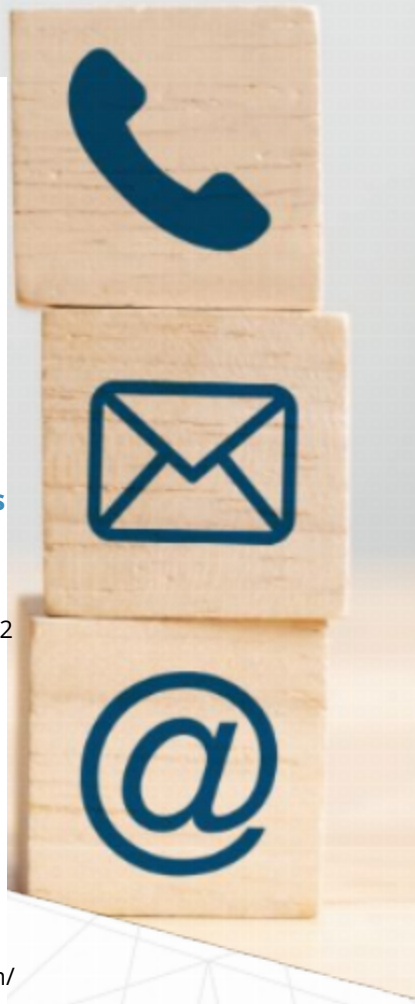
LEGAL SERVICES BENEFIT	
General Advice & Consultation	This service includes Phone Consultations, Legal research, Office visits, and 3rd party demand letters from a legal professional.
Wills & Estate Planning	This service includes assistance with Wills, Living Wills, Trusts, Power of Attorney and Probate.
Identity Theft Assistance	This service covers advice, consultation and review of documents regarding potential creditor actions against the covered persons resulting from identity theft. This includes the provider law firm's legal services as needed to contact creditors, credit bureaus and financial institutions.
Uncontested Name Change	This service covers advice, consultation, preparation of documents and pleadings and representation at court hearings for a legal name change for a covered person.
Uncontested Adoption	This service covers advice, consultation, document review and representation for an adoption of a minor in the United States for the participant or spouse. This service covers advice, document review and representation for a legal determination of paternity in the United States for the participant or spouse.
Uncontested Separation/Divorce	This service covers advice, consultation, preparation, document review and court representation of up to twenty hours, for the participant's contested divorce, separation, or annulment. If the divorce, separation, or annulment is uncontested and all issues are agreed upon in writing by the parties, the attorney's time is paid in full.
Non-Criminal Moving Traffic Violations	This service covers advice, consultation, negotiation, review of documents and representation of the covered person in court for all misdemeanor and non-criminal moving traffic violations.
IRS Audit Services	This service covers advice, consultation and representation of the covered person when notified in writing by any federal, state, or local taxing authority of an audit, investigation, or exam of his or her tax return. These services include a written request to appear at the offices of a federal, state, or local taxing authority about his or her tax return.

PREMIUM PER EMPLOYEE PAYCHECK	
Employee Only	$11.52
Family	$11.52

Medical Rates

Gold 500/35 - Access+ HMO		Platinum 0/30 - Access+ HMO		Gold 1000/35 - Trio HMO		Platinum 0/30 - Trio HMO		Gold 0/35 - Full PPO	
Age	Rates	Age	Rates	Age	Rates	Age	Rates	Age	Rates
0-14	$383.26	0-14	$412.36	0-14	$324.64	0-14	$356.75	0-14	$459.11
15	$417.33	15	$449.02	15	$353.49	15	$388.46	15	$499.92
16	$430.36	16	$463.03	16	$364.53	16	$400.59	16	$515.53
17	$443.38	17	$477.05	17	$375.56	17	$412.71	17	$531.13
18	$457.41	18	$492.14	18	$387.44	18	$425.77	18	$547.94
19	$471.44	19	$507.24	19	$399.33	19	$438.83	19	$564.74
20	$485.97	20	$522.87	20	$411.63	20	$452.35	20	$582.15
21	$501.00	21	$539.04	21	$424.36	21	$466.34	21	$600.15
22	$501.00	22	$539.04	22	$424.36	22	$466.34	22	$600.15
23	$501.00	23	$539.04	23	$424.36	23	$466.34	23	$600.15
24	$501.00	24	$539.04	24	$424.36	24	$466.34	24	$600.15
25	$503.00	25	$541.19	25	$426.06	25	$468.21	25	$602.55
26	$513.02	26	$551.98	26	$434.55	26	$477.53	26	$614.55
27	$525.05	27	$564.91	27	$444.73	27	$488.73	27	$628.96
28	$544.58	28	$585.93	28	$461.28	28	$506.91	28	$652.36
29	$560.62	29	$603.18	29	$474.86	29	$521.84	29	$671.57
30	$568.63	30	$611.81	30	$481.65	30	$529.30	30	$681.17
31	$580.66	31	$624.75	31	$491.84	31	$540.49	31	$695.57
32	$592.68	32	$637.68	32	$502.02	32	$551.68	32	$709.98
33	$600.20	33	$645.77	33	$508.39	33	$558.68	33	$718.98
34	$608.21	34	$654.39	34	$515.18	34	$566.14	34	$728.58
35	$612.22	35	$658.70	35	$518.57	35	$569.87	35	$733.38
36	$616.23	36	$663.02	36	$521.97	36	$573.60	36	$738.18
37	$620.24	37	$667.33	37	$525.36	37	$577.33	37	$742.99
38	$624.24	38	$671.64	38	$528.76	38	$581.06	38	$747.79
39	$632.26	39	$680.27	39	$535.55	39	$588.52	39	$757.39
40	$640.28	40	$688.89	40	$542.34	40	$595.99	40	$766.99
41	$652.30	41	$701.83	41	$552.52	41	$607.18	41	$781.39
42	$663.82	42	$714.23	42	$562.28	42	$617.90	42	$795.20
43	$679.85	43	$731.48	43	$575.86	43	$632.83	43	$814.40
44	$699.89	44	$753.04	44	$592.84	44	$651.48	44	$838.41
45	$723.44	45	$778.37	45	$612.78	45	$673.40	45	$866.62
46	$751.50	46	$808.56	46	$636.55	46	$699.51	46	$900.22
47	$783.06	47	$842.52	47	$663.28	47	$728.89	47	$938.03
48	$819.13	48	$881.33	48	$693.83	48	$762.47	48	$981.24
49	$854.70	49	$919.60	49	$723.96	49	$795.58	49	$1,023.86
50	$894.78	50	$962.72	50	$757.91	50	$832.89	50	$1,071.87
51	$934.36	51	$1,005.31	51	$791.44	51	$869.73	51	$1,119.28
52	$977.95	52	$1,052.20	52	$828.36	52	$910.30	52	$1,171.49
53	$1,022.04	53	$1,099.64	53	$865.70	53	$951.34	53	$1,224.31
54	$1,069.63	54	$1,150.85	54	$906.02	54	$995.64	54	$1,281.32
55	$1,117.23	55	$1,202.06	55	$946.33	55	$1,039.94	55	$1,338.33
56	$1,168.83	56	$1,257.58	56	$990.04	56	$1,087.98	56	$1,400.15
57	$1,220.93	57	$1,313.64	57	$1,034.17	57	$1,136.48	57	$1,462.56
58	$1,276.54	58	$1,373.47	58	$1,081.28	58	$1,188.24	58	$1,529.18
59	$1,304.10	59	$1,403.12	59	$1,104.62	59	$1,213.89	59	$1,562.19
60	$1,359.71	60	$1,462.95	60	$1,151.72	60	$1,265.65	60	$1,628.81
61	$1,407.80	61	$1,514.70	61	$1,192.46	61	$1,310.42	61	$1,686.42
62	$1,439.37	62	$1,548.66	62	$1,219.20	62	$1,339.80	62	$1,724.23
63	$1,478.95	63	$1,591.24	63	$1,252.72	63	$1,376.64	63	$1,771.64
64-99	$1,502.99	64-99	$1,617.11	64-99	$1,273.08	64-99	$1,399.02	64-99	$1,800.45

Employee Contacts



Blue Shield of California Medical & Dental

Plan# W00532151

HMO 888.319.5999 / PPO 888.256.3650 / DPPO 888.702.4171

www.blueshieldca.com/en/home

EyeMed Vision

Plan# 9692773

866.723.0513

www.eyemed.com/en-us

Mutual Of Ohama Life, Disability & EAP

Plan# G00AIU9

800.877.5176 / EAP 800.316.2796

www.mutualofomaha.com / www.mutualofomaha.com/eap/

Aflac Supplemental Benefits

Plan# 282417

661.702-9416 / Claims 800.992.3522

www.aflac.com/

Pet Benefit Solutions

Plan# 4497

888. 913.7387

www.petbenefits.com/land/meissnermfg

Allstate Identity Theft

Plan # 5612

800.789.2720

www.allstateidentityprotection.com/

LegalShield

833. 690.6121

www.legalshield.com/contact

Exclusive Discounts And Savings

https://libertydiscountmarketplace.benefithub.com/app/discounts/home

Insurance Terms and Definitions

PPO (PREFERRED PROVIDER ORGANIZATION)

A PPO is a type of insurance network. In this type of network, you may choose to obtain care in or out of your network. If you choose to visit a Blue Shield's "Preferred" or "In-Network" provider, your out-of-pocket expense will be significantly less than if you visit a provider outside your network. The reason for this is that the In-Network provider agrees to accept set, contracted rates as payment in full for their services in return for being part of the insurance carrier's Preferred Provider network.

HMO (HEALTH MAINTENANCE ORGANIZATION)

A Health Maintenance Organization (HMO) is a network of medical providers who work together to help keep healthcare costs down. Blue Shield's HMO plan offers in-network coverage only, meaning you must use contracted physicians, specialists, and hospitals to receive benefits. These providers have agreed to set rates and will handle and submit your benefit claims for you. As part of the plan, you'll need to choose a Primary Care Physician (PCP) or an IPA/Medical Group, who will coordinate your care and provide referrals when needed.

.

DEDUCTIBLE

The amount you pay before the insurance carrier starts sharing the expense of your medical care. Major medical expenses apply to the deductible like inpatient/outpatient surgeries, MRI's, CT Scans, etc…

PRIMARY CARE PHYSICIAN (PCP)

Your Primary Care Physician (PCP) is the doctor you choose from the provider directory to serve as your main point of contact for all medical needs. Whenever you require care—including in emergencies, if you're able—your PCP should be your first call. They will assess your situation, provide treatment within their office, or refer you to an appropriate specialist. If hospitalization is necessary, your PCP will help coordinate your care throughout your stay.

INDEPENDENT PHYSICIANS' ASSOCIATION (IPA OR MEDICAL GROUP)

An Independent Physicians' Association (IPA), also known as a Medical Group, functions similarly to a Primary Care Physician (PCP). Instead of selecting a single doctor, you gain access to a group of physicians who collectively manage your medical care. The same requirements apply when choosing an IPA as when selecting a PCP. For appointments, referrals, and even emergencies (when possible), you'll contact the medical group's main office to coordinate your care.

DEDUCTIBLE PERIOD

This is the 12 month time period in which all medical expenses that would apply to your deductible accumulate. Your deductible will reset after this period ends. This time period is important to note, because it does not always align with your plan year.

CO-INSURANCE

After you've reached your deductible for the year, the insurance carrier will split the balance of the major medical expense with you. They pay a percentage and you pay a percentage of your medical expense until you've reached your Out of Pocket Maximum

OUT OF POCKET MAXIMUM

This is the maximum amount you will pay for covered medical expenses during your deductible period

CO-PAYS

This is a set Dollar amount you pay when you receive medical care from a PCP, Specialist, Urgent Care, Emergency Room, or Pharmacy. It's called a CO-pay, because you pay the set dollar amount and your insurance carrier pays the rest of the actual charge from the doctor/facility. Co-pays DO NOT apply to the deductible

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

Special Enrollment Notice

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 toward your or your dependents' other coverage). However, you must request enrollment within 30 after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

To request special enrollment or obtain more information, contact Christine M. Schaeffer, President, 818.678.0400 ext. 104, christine@meissnermfg.com.

Patient Protection Model Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

Blue Shield HMO generally REQUIRES the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the group health plan designates one for you For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Christine M. Schaeffer, President, 818.678.0400 ext. 104, christine@meissnermfg.com.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add: For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add: You do not need prior authorization from Blue Shield HMO or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Christine M. Schaeffer, President, 818.678.0400 ext. 104, christine@meissnermfg.com

Newborn's Act Disclosure

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

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. Therefore, the following deductibles and coinsurance apply: Gold Access $500 Individual / $1,000 Family and 20% after deductible Gold Trio $1,000 Individual / $2,000 Family 20% after deductible.

If you would like more information on WHCRA benefits, call your plan administrator 818.678.0400 ext. 104

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 818.678.0400 ext. 104 for more information.

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

RETIREE COVERAGE ONLY:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Meissner Mfg Co dba UNICEL, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Retiree coverage only: Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within after the qualifying event occurs. You must provide this notice to: Meissner Mfg Co dba UNICEL.

How is COBRA continuation coverage provided?

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

continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Christine M. Schaeffer, President, 818.678.0400 ext. 104, christine@meissnermfg.com

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

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

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your employer via the information provided below.

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

---

1. Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2024.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Meissner Mfg Co dba UNICEL		4. Employer identification Number (EIN) 95-2308719
5. Employer Address 21701 Prairie Street		6. Employer Phone Number 818.678.0400 ext. 104
7. City Chatsworth	8. State CA	9. Zip Code 91311
10. Who can we contact about employee health coverage at this job? Christine M. Schaeffer, President, 818.678.0400 ext. 104, christine@meissnermfg.com		
11. Phone number (If different from above) 818.678.0400 ext. 104		12. Email address christine@meissnermfg.com

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

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

☐ All Employees, Eligible employees are:

☑ Some Employees, Eligible employees are:

You are eligible for most benefit plans as a Meissner Mfg. Co., Inc. All full-time associates who regularly work 24+ hours per week are eligible.

• With respect to dependents:

☑ We do offer coverage, Eligible dependents are:

Your legal spouse or domestic partner. Your married or unmarried dependent children, regardless of student status: Up to the last day of their birthday month at age 26 (includes stepchildren, legally adopted children, children placed with you for adoption, and foster children) A dependent child, regardless of age, provided he or she is incapable of self support and is fully dependent on you due to a mental or physical disability as indicated on your federal tax return and is approved by your medical plan to continue coverage past age 26

☐ We do not offer coverage.

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

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

Important Notice from Meissner Mfg Co dba UNICEL About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Meissner Mfg Co dba UNICEL 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. Meissner Mfg Co dba UNICEL has determined that the prescription drug coverage offered by the Blue Shield 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.

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 Meissner Mfg Co dba UNICEL coverage WILL NOT be affected. Meissner Mfg. Co., Inc. has determined that the prescription drug coverage offered by the Blue Shield Plans 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. .
If you do decide to join a Medicare drug plan and drop your current Meissner Mfg Co dba UNICEL coverage, be aware that you and your dependents WILL NOT be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Meissner Mfg Co dba UNICEL 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 Meissner Mfg Co dba UNICEL changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call1-877-486-2048.

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: 12/01/2026

Name of Entity/Sender: Meissner Mfg Co dba UNICEL

Contact: Christine M. Schaeffer, President, 818.678.0400 ext. 104, christine@meissnermfg.com -- Position/Office: President

Phone Number: 818.678.0400 ext. 104

Address: 21701 Prairie Street, Chatsworth, CA, 91311

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NOTES

NOTES

NOTES

Unicel

The information included in this guide is intended as an overview only. It is not a complete description, nor is it a substitute for the applicable plan documents, Summary Plan Descriptions or insurance contracts. In all cases, the official plan documents govern and are the final authority on the terms of the benefit plans. The company reserves the right to modify, amend or terminate the benefit plans at any time and for any reason. Receiving this document or participating in company benefits is not a guarantee of future or continued employment or benefits.

LIBERTY