2026

Corporate Benefits

RSCS
Radiation Safety & Control Services

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RSCS is proud to support our employees' overall wellbeing with a variety of benefit options. This guide offers details on our 2026 offerings for you and your family. Contact the Human Resources department with any questions.

See **page 28** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to RSCS. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

3 Welcome

RSCS appreciates the hard work and dedication you bring to our team every day. To do our part, we are committed to keeping your benefits affordable and beneficial for you and your eligible family members.

RSCS strives to provide benefits that:

- Meet your needs
- Are easy to understand and use
- Provide excellent value for affordable costs

To be your healthiest and help keep costs down, we ask that you take advantage of the provided wellness activities and preventive features.

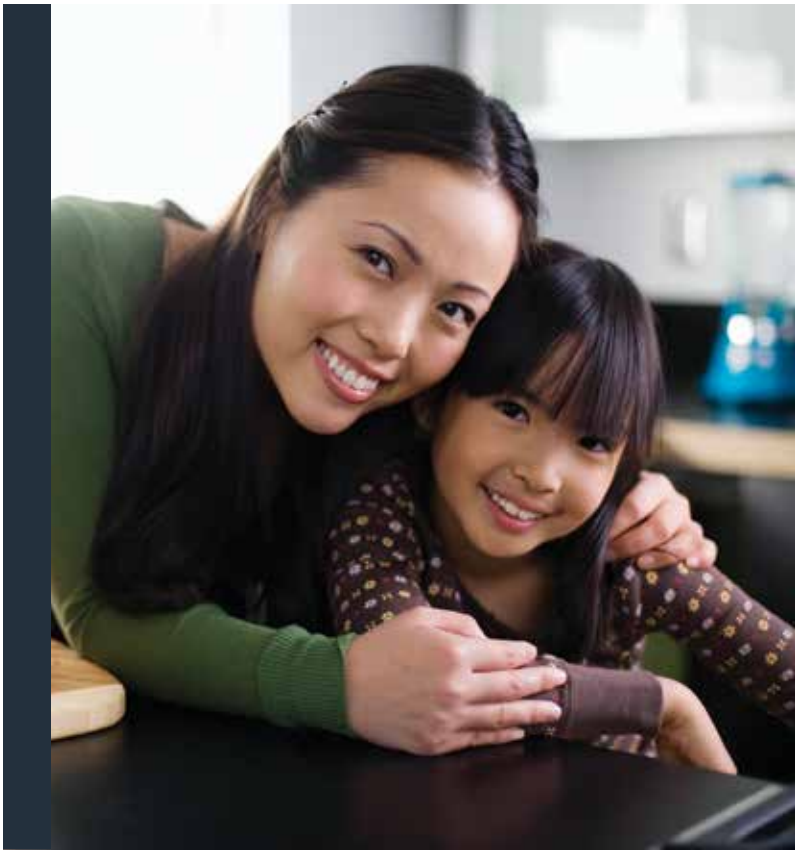
This guide is designed to assist you and your family in making the best choices for your needs in 2026. It contains explanations of each benefit, contact information for benefits vendors, and costs you can expect for each benefit. Please review this guide in its entirety and keep as a resource throughout the year.

Any questions?

We're here to help. Contact Human Resources at 603-474-6702.

Benefit Plans Offered

- Medical
- Dental
- Vision
- Group Term Life/AD&D Insurance
- Voluntary Life/AD&D Insurance
- Short-Term Disability Insurance
- Long-Term Disability Insurance
- Healthcare & Dependent Care FSA
- Employee Assistance Program (EAP)
- Voluntary Benefits
- Retirement Benefits
- Health Savings Account (HSA)
- Health Reimbursement Arrangement (HRA)
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance



4 Eligibility and Enrollment

RSCS' benefits are designed to support your unique needs.

Eligibility

If you are a full-time employee of RSCS who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in medical, dental, vision, life and disability plans, and additional benefits.

Coverage Dates

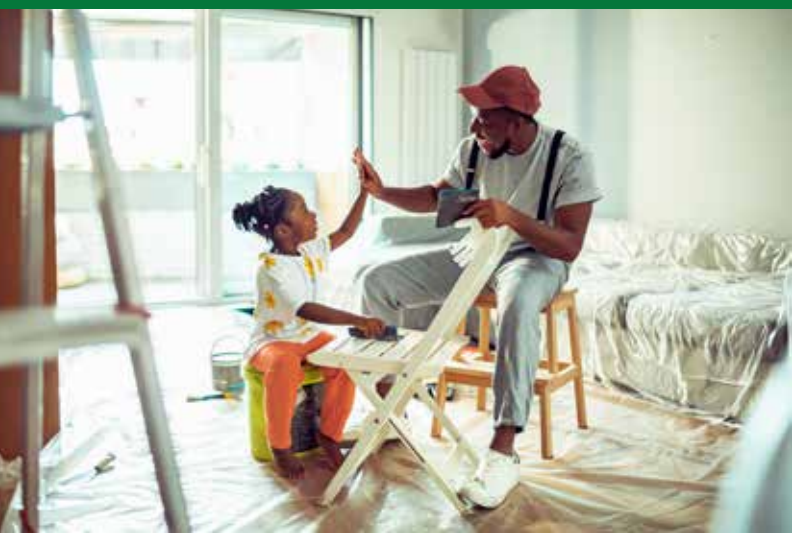
Your elections are effective on your date of hire. Benefits cannot be changed until the next enrollment period unless you experience a Qualifying Life Event.

Dependents

Dependents eligible for coverage include:

- Your legal spouse.
- Children under the age of 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
- Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility may be required upon enrollment.



Passive Enrollment

This year's Open Enrollment will follow a passive enrollment process. If you do not make any changes, your current benefit elections will automatically carry over into the new plan year — with two exceptions:

Flexible Spending Accounts (FSAs) require re-enrollment each year.

Health Savings Account (HSA) contribution elections must also be re-elected annually.

Enrollment elections will be in place until December 31, 2026, unless you experience a Qualifying Life Event.

How to Enroll

Visit the Benefits Homepage by using the QR Code or link provided below:

Scan Me

https://rscs.benefitsinfo.com

Register as a new user to get started.

Schedule your personalized appointment with a Benefits Counselor to learn more about your benefit options.

Now's the Time to Enroll!

What are Qualifying Life Events?

You can update your benefits when you start a new job or during Open Enrollment each year. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Your change in coverage must be consistent with your change in status.

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)
- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Entitlement to Medicare or Medicaid
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Death in the family (leading to change in dependents or loss of coverage)
- Turning 26 and losing coverage through a parent's plan
- Changes in address or location that may affect coverage
- Eligibility for coverage through the Marketplace (Healthcare.gov)
- A change in your legal marital status (marriage, divorce, or legal separation)

Reach out to RSCS' Human Resources with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!

6 Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) helps you and your family manage your total health, including mental, emotional, and physical. And there's no cost to you — whether or not you're enrolled in a company-sponsored medical plan.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone and a designated number of face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with RSCS. For more information about the program, visit GuidanceResources.com, download the GuidanceNow mobile app, or call 888-628-4824.

Login credentials are:
Username: LFGSupport
Password: LFGSupport1

The Program provides referrals to help with:

- Emotional health and wellbeing
- Alcohol or drug dependency
- Marriage or family problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

An important aspect of your overall wellbeing is emotional wellness — the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses.

These five actions have been shown to improve emotional wellness.

The Big Five of Emotional Wellness

Practice mindfulness.
Practice deep breathing, take a walk, enjoy nature, and stay present in each moment.

Strengthen social connections.
Reach out to a friend or family member daily — even if it's just a call or text.

Get quality sleep.
Keep a consistent sleep schedule and limit electronic use before bed.

Improve your outlook.
Treat people with kindness, including yourself.

Deal with your stress in healthy ways.
Think positively, exercise regularly, and set priorities.

Other Mental Health Resources

No matter your problem, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

988 Suicide & Crisis Lifeline

Dial 988 to be connected with 24/7/365 emotional support.

Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line

Text "HOME" to 741741

Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center

Veterans and their families call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.

Note

According to the Centers for Disease Control, nearly 22% of adults received help for mental health in 2021.

8 Medical Benefits

Medical benefits are provided through Anthem. Consider the physician networks, premiums, and out-of-pocket costs for each plan when making a selection. Keep in mind your choice is effective for the entire 2026 plan year unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your plan selection and level of coverage determines your contribution amount.

How to Find a Provider

Visit www.anthem.com or call Customer Care at 833-772-4122 for a list of Anthem network providers.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.anthem.com to learn more.

Sydney

Sydney is Anthem's interactive app. This app will allow you to find care, check costs, see claims, check your benefits, view ID cards, and use the chatbot to have an interactive conversation. Download the app today in the app store.

Live Health Online

Visit www.livehealthonline.com or download the app. 24/7 access to doctors who can assess your condition, provide treatment options and even send a prescription to the pharmacy if needed.

Note

To get the most value out of your medical plan, be sure to visit in-network providers whenever possible.

Medical Plan Summary

This chart summarizes the 2026 medical plan options provided by Anthem. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	BLUE CHOICE OPEN ACCESS POS		BLUE CHOICE OPEN ACCESS HSA	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
INDIVIDUAL	$5,000	$6,000	$5,000	$6,000
FAMILY	$12,000	$12,000	$10,000	$12,000
COINSURANCE (PLAN PAYS)	100%*	80%*	100%*	80%*
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$6,500	$6,500	$6,250	$9,375
FAMILY	$13,000	$13,000	$12,500	$18,750
COPAYS/COINSURANCE				
DEDUCTIBLE REIMBURSEMENT	HRA: Last $3,000 per member	N/A	N/A	N/A
PHYSICIAN VISIT COPAY	$25/$50	20%*	Deductible, then $25/$50	20%*
URGENT CARE CENTER	$50	Covered as in-network	Deductible, then $25	Covered as in-network
EMERGENCY ROOM	$250*	Covered as in-network	Deductible	Covered as in-network
OUTPATIENT SURGERY	$125 Site of Service Provider; All Others: Deductible	20%*	Deductible	20%*
HOSPITALIZATION	Deductible	20%*	Deductible	20%*
PREVENTIVE CARE	Covered in full	20%*	Covered in full	20%*
HIGH TECH IMAGING	$250 Site of Service Provider; All Others: Deductible	20%*	Deductible	20%*

*After deductible

	BLUE CHOICE OPEN ACCESS POS	BLUE CHOICE OPEN ACCESS HSA
	IN-NETWORK	IN-NETWORK
RETAIL RX (30-DAY SUPPLY)		AFTER MEDICAL DEDUCTIBLE
	$5 | $20 | $40 | 30% up to $300 | 40%, up to $600	$5 | $15 | $35 | $50 | 30%, up to $300*
MAIL ORDER RX (90-DAY SUPPLY)		AFTER MEDICAL DEDUCTIBLE
	$10 | $40 | $80 | 30% up to $600 | 40%, up to $600	$10 | $30 | $70 | $150 | 30%, up to $300*

*After medical deductible

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member will contribute more than the individual deductible amount to the "per family" deductible amount. The same applies for the out-of-pocket maximum.

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they are held to the same rigid FDA standards. But generic versions cost 80% to 85% less on average than the brand-name equivalent. To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Lowering Medication Costs

How do prescription discount programs work? These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: If you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription may not count toward your deductible or out-of-pocket maximum under the benefit plan.

GoodRx is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80% on generics. **Optum Perks** also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data. Another discount option is the **Amazon Prime Rx Savings** discount card, which is included with an Amazon Prime membership and is administered by InsideRx. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies. **Cost Plus Drug Company** is a web-based pharmacy that claims to keep costs low by buying directly from the manufacturer. It currently only offers a certain selection of medications and accepts a handful of prescription insurance providers, but it may be worth checking the price difference between Cost Plus and your regular pharmacy.

11 Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

12 Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance. Some common covered services include:

- **Wellness visits, physicals, and standard immunizations**
- **Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes**
- **Pediatric screenings for hearing, vision, obesity, and developmental disorders**
- **Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women**
- **Iron supplements (for infants at risk for anemia)**

It's important to take advantage of these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What vaccines are covered 100% under preventive care?

Many vaccines are covered under preventive care when delivered by a doctor or provider in your plan's network. These include chickenpox, flu, shingles, and tetanus. For a full list, visit www.healthcare.gov/preventive-care-adults/.

13 Health Savings Account

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in a HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

CPI will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in the RSCS Blue Choice Open Access HSA Plan.
- You are not covered by your spouse's or parent's non-HDHP.
- You or your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Arrangement.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Note

Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax-free after retirement.

You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

You must be enrolled in the RSCS Blue Choice Open Access HSA Plan to contribute to an HSA account. Enroll in your HSA through the Employee Navigator benefits portal. Employees will receive a debit card from CPI.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with CPI. The money in your HSA (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.*

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2026, contributions are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,400
FAMILY	$8,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

The RSCS HSA is established with CPI. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.mycpiteam.com.

*State income taxes are also waived on HSA contributions in almost all states.

15 Health Reimbursement Arrangement

RSCS provides you with tax-free reimbursement for certain qualified medical expenses through an HRA – Health Reimbursement Arrangement. CPI reimburses you for eligible expenses upon receipt of required documentation. You must be enrolled in the Blue Choice Open Access POS Medical Plan to be eligible.

Effective Date: January 1, 2026

Basic Facts about your HRA Benefits:	
Who is eligible for reimbursement?	Employees and IRS-defined dependents enrolled in the Anthem Open Access POS.
What types of expenses are reimbursed?	Deductible as defined by the Anthem plan.
What is the coverage period?	The coverage period is a calendar year from January 1 to December 31.
How do I submit a request for reimbursement?	To submit a claim for your HRA, please complete the claim form and send it to CPI. Be sure to include your Anthem Explanation of Benefits (EOB) that shows the deductible amounts.
How can I check the status of a reimbursement request?	Access the Participant Portal from CPI's website at www.mycpiteam.com to view all account transactions.
What happens if my coverage ends mid-year?	If your coverage ends mid-year (due to termination of employment or change in eligibility status), claims incurred during your coverage period will continue to be processed for 90 days after your coverage end date.
May I waive HRA coverage?	Yes, any eligible employee may opt-out of HRA coverage. Please contact your employer.
Who is NOT eligible for HRA Reimbursements?	Company shareholders, domestic partners or participants with secondary medical coverage may be required by the IRS to waive HRA coverage. See your employer for more information.

Here Is How the Plan Shares Expenses With You:

DEDUCTIBLE:	YOU PAY THE FIRST:	HRA PAYS THE LAST:
Single: $5,000	$2,000	$3,000
Two Person: $10,000*	$4,000*	$6,000*
Family: $12,000*	$6,000*	

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

1. The Health Reimbursement Arrangement is administered by CPI.
2. Easy claim filing using the mobile app, the online portal, or completing a manual claim form.
3. You will need to include a copy of your Explanation of Benefits (EOB) from Anthem when submitting your claim.

Questions?

Contact the CPI Team at 866-241-0237 or email cpisupport@mycpiteam.com.

16 Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $3,400 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Who Is Eligible

If you are enrolled in the Blue Choice Open Access POS Plan, you are eligible to participate.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $7,500 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- Care of a preschool child by a licensed nursery or daycare provider
- Before- and after-school care
- Day camp
- In-house dependent daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

The CPI Debit Card will be pre-funded with the value of your annual Medical FSA election amount. Use your card at the time of service and the amount of your eligible expense will be automatically withdrawn from your account.

Submit a claim form along with the required documentation. Contact CPI with reimbursement questions. If you need to submit a receipt, CPI will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2026 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must "use it or lose it" — any unused funds will be forfeited.
- Up to $680 may be rolled over to the next plan year at the end of 2026 for Healthcare FSAs.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $160,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

Note

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

On the Go... 24/7/365

Download the CPI mobile app and manage your account on the go. You can see your available balance as well as file claims and upload receipts for card transactions when required.

18 Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. RSCS offers affordable plan options from Lincoln for routine care and beyond.

Stay In-Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Lincoln Financial Group at www.lfg.com.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your plan selection and your level of coverage will determine your premium amount.

Dental Plan Summary

This chart summarizes the dental coverage provided by Lincoln for In-Network providers.

	LOW OPTION	HIGH OPTION
	IN-NETWORK	IN-NETWORK
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$0	$0
FAMILY	$0	$0
ANNUAL MAXIMUM		
PER PERSON	$1,000	$2,000
COVERED SERVICES		
PREVENTIVE SERVICES Routine Exams & Cleanings, Bitewing X-rays, Full Mouth X-rays, Fluoride, Sealants	Covered at 100%	Covered at 100%
BASIC SERVICES Periodontal maintenance, Fillings, Oral Surgery, Simple Extractions	Covered at 80%	Covered at 80%
MAJOR SERVICES Crowns, Core buildup, Implants, Bridges, Dentures	Not covered	Covered at 50%
ORTHODONTICS	Not covered	Not covered

Note

In addition to keeping your teeth healthy, regular dental checkups can help dentists spot symptoms of other serious conditions such as osteoporosis, cancer, and diabetes.

19 Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through Lincoln Financial Group w/Spectera.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

Vision Plan Summary

This chart summarizes the vision coverage provided by Lincoln/Spectera Vision Care for 2026.

Find a Provider

Visit www.lvc.lfg.com or call 800-440-8453.

	VISION PLAN		
	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
EXAMS			
COPAY	$10	Up to $45	Once every 12 months
LENSES			
SINGLE VISION	$25 copay	Up to $30	Once every 12 months
BIFOCAL	$25 copay	Up to $50	
TRIFOCAL	$25 copay	Up to $65	
LENTICULAR	$25 copay	Up to $100	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION	Up to $60 copay	N/A	Once every 12 months
ELECTIVE	$125 allowance	Up to $105	
MEDICALLY NECESSARY	$25 copay	Up to $210	
FRAMES			
COPAY	$25 copay	N/A	Once every 24 months
ALLOWANCE	$130 allowance	Up to $70	
OTHER SERVICES			
LASER VISION CORRECTION	Preferred pricing	N/A	N/A

20 Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection for your loved ones in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

RSCS provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through Lincoln Financial Group, which guarantees that your spouse or other designated survivor(s) receives a benefit after your death.

Your Basic Life and AD&D insurance benefit is 1x your base annual salary, up to $500,000. If you are a full-time employee, you receive Life and AD&D insurance even if you waive other coverage.

Limitations and exclusions apply. Coverage amount will reduce to 65% at age 65 and to 50% at age 70.

Voluntary Life/AD&D

With Voluntary Life Insurance you pay the full cost for coverage through payroll deductions. You may purchase coverage based on the requirements in the chart below. Spouse coverage may not exceed 100% of the employee's coverage amount. You must elect coverage for yourself to cover any dependents. Dependents may only be added to coverage if they are not a full-time, benefit eligible employee of RSCS.

Benefit amounts over the guaranteed issue amount will require you to provide health information and go through medical underwriting for approval.

Late Entrant - If you did not elect coverage as a new hire when you were originally eligible, all amounts will require medical underwriting approval.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact Human Resources or your own legal counsel with any questions.

IMPUTED INCOME:

When your Life insurance coverage exceeds $50,000, the IRS considers the value of the coverage above this threshold as "imputed income." This means you'll see this amount reflected on your pay stubs and W-2 forms and it will be subject to federal income tax.

Note

Currently enrolled employees may increase their coverage amount by two increments not to exceed the guaranteed issue amount. Currently enrolled Spouse coverage can also be increased by two increments not to exceed the guaranteed issue amount.

	EMPLOYEE	SPOUSE	CHILDREN
Minimum Coverage	$10,000	$5,000	$5,000
Increments	$10,000	$5,000	$5,000
Maximum Coverage	$300,000	$150,000	$10,000
Guaranteed Issue	$200,000	$30,000	$10,000
Age Reductions	Age 65 – to 65% Age 70 – to 50%		

Note: Exclusions and limitations apply
Dependent children under 14 days old receive a $1,000 benefit.

21 Income Protection

You and your loved ones depend on your regular income. That's why RSCS offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

Voluntary Short-Term Disability (STD)

Short-Term Disability (STD) benefits are available for purchase on a voluntary basis. This insurance replaces a portion of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

WEEKLY BENEFIT AMOUNT	60%
WEEKLY MAXIMUM BENEFIT	$1,000
ELIMINATION PERIOD	7 days Accident 14 days Illness
MAXIMUM BENEFIT PERIOD	Up to 13 weeks
PRE-EXISTING CONDITIONS	3 months prior / 6 months insured

Voluntary Long-Term Disability (LTD)

Long-Term Disability (LTD) benefits are available for purchase on a voluntary basis. This insurance replaces a portion of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

MONTHLY BENEFIT AMOUNT	60%
MONTHLY MAXIMUM BENEFIT	$11,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.
PRE-EXISTING CONDITIONS	3 months prior / 6 months insured

Late Entrants

If you were previously eligible for but did not enroll, you are a late entrant. You will be required to provide proof of good health upon enrollment and go through medical underwriting for approval.

22 Supplemental Health Benefits

RSCS offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Full-time employees can purchase Accident Insurance through Lincoln. With this coverage in place, cash payments are paid directly to you for on & off-the-job injuries and are in addition to any health insurance coverage you may also have. In the case of accidental injuries such as burns, fractures, lacerations, emergency room visits, ambulance and more, Accident Insurance has you covered. Benefits may be used in any way you choose and are paid to help cover out-of-pocket expenses. You also have the option to add accident coverage for your family members including spouse and children.

Accident Coverage

You can't always prevent accidents, but you can be prepared for them, including readying for any financial impact. Accident coverage through Lincoln Financial Group provides benefits for you and your covered family member for expenses related to an accidental injury that occurs outside of work. Health insurance expenses such as a mortgage or car payment. Benefits are payable to you to use as you wish, but this coverage is an additional layer of protection that can help pay deductibles, copays, and even typical day-to-day helps with medical expenses.

ACCIDENT COVERAGE

LIFE AND DISMEMBERMENT LOSSES	
ACCIDENTAL DEATH –EMPLOYEE	$50,000
ACCIDENTAL DEATH – SPOUSE	$25,000
ACCIDENTAL DEATH – CHILD	$12,500
COMMON CARRIER DEATH (AD&D)	2x benefit
CATASTROPHIC LOSS	Up to $30,000
DISLOCATIONS	
FOOT (EXCEPT TOES), HIP, KNEE (EXCEPT KNEECAP)	$3,000
ANKLE	$1,000
WRIST	$800
COLLARBONE, HAND (EXCEPT FINGERS), LOWER JAW, SHOULDER	$400
FINGERS, TOES	$100
FRACTURES	
HIP, PELVIS, SKULL	$4,000
ARM, COLLARBONE, LEG	$1,000
ANKLE, ARM (ELBOW TO WRIST), FOOT (EXCEPT TOES), HAND (EXCEPT FINGERS), KNEECAP, WRIST	$800
SHOULDER BLADE	$725
FACE BONES, JAW, NOSE, VERTEBRAL PRCESS	$600
ELBOW	$250
COCCYX, RIB	$200
FINGERS, STERNUM, TOES	$100

EMERGENCY CARE	
AMBULANCE	$200
AIR AMBULANCE	$800
EMERGENCY CARE / TREATMENT	$200
INITIAL CARE VISIT	$125
MAJOR DIAGNOSTIC EXAM (CT, CAT, EEG, MRI, PET)	$275
HOSPITAL SERVICES	
HOSPITAL ADMISSION	$1,000
INTENSIVE CARE ADMISSION	$2,000
HOSPITAL DAILY CONFINEMENT	$250
INTENSIVE CARE DAILY CONFINEMENT	$500
OCCUPATIONAL, PHYSICAL, AND CHIROPRACTIC THERAPY (UP TO 10)	$65
SPECIFIC INJURIES	
CONCUSSION	$150
2ND DEGREE BURNS	$100-$1,450
3RD DEGREE BURNS	$1,300-$15,000
LACERATION	$75-$1,500
TRAUMATIC BRAIN INJURY	$7,500
SURGICAL BENEFITS	$400-$1,125

Policy limitations & exclusions apply.
This is not a complete list; only a highlight summary.
Additional benefits may be found in the policy.

MONTHLY CONTRIBUTIONS

EMPLOYEE ONLY	$10.74
EMPLOYEE + SPOUSE	$17.43
EMPLOYEE + CHILD(REN)	$18.77
EMPLOYEE + FAMILY	$25.39

Critical Illness Coverage

Critical Illness coverage through Lincoln Financial Group pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. Examples include helping pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs, or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
  - Employee: $5,000, $10,000, or $20,000
  - Spouse: $5,000, $10,000, or $20,000 (up to 100% of employee's amount)
  - Child(ren): $5,000, $7,500, or $10,000 (up to 100% of employee's amount)

CRITICAL ILLNESS COVERAGE

COVERED CONDITIONS	
HEART ATTACK	100%
STROKE	100%
INVASIVE CANCER	100%
END STAGE RENAL (KIDNEY) FAILURE	100%
MAJOR ORGAN FAILURE	100%
NONINVASIVE CANCER (IN SITU)	25%
SUPPLEMENTAL CONDITIONS	
ADVANCED ALZHEIMER'S	100%
AIDS	100%
BENIGN BRAIN TUMOR	100%
ADDITIONAL CHILDHOOD CONDITIONS	
CEREBRAL PALSY	100%
CLEFT LIP, CLEFT PALATE	100%
CYSTIC FIBROSIS	100%
DOWN SYNDROME	100%
MUSCULAR DYSTROPHY	100%
SPINA BIFIDA	100%
TYPE 1 DIABETES	100%
WELLNESS BENEFIT	
EXAM, SCREENING OR IMMUNIZATION	$50

MONTHLY CONTRIBUTIONS

SPOUSE RATE BASED ON EMPLOYEE AGE

(AS OF 1/1/2026)	$5,000	$10,000	$20,000
< 24	$0.795	$1.590	$3.180
25-29	$1.310	$2.620	$5.240
30-34	$1.930	$3.860	$7.720
35-39	$2.910	$5.820	$11.640
40-44	$4.390	$8.780	$17.560
45-49	$6.365	$12.730	$25.460
50-54	$9.170	$18.340	$36.680
55-59	$12.340	$24.680	$49.360
60-64	$17.680	$35.360	$70.720
65-69	$25.045	$50.090	$100.180
70+	$41.745	$83.490	$166.980
CHILD COVERAGE	$1.615	$2.423	$3.230

Limitations and exclusions may apply.

Hospital Indemnity Coverage

Hospital Indemnity coverage through Lincoln Financial Group pays you cash benefits directly if you are admitted to the Hospital or an Intensive Care Unit (ICU) for a covered stay. You can use the benefits to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

Plan Highlights

FIRST DAY BENEFITS – PAYABLE PER BENEFIT YEAR	
HOSPITAL ADMISSION (FOR ONE DAY PER CALENDAR YEAR)	$1,000
INTENSIVE CARE ADMISSION (FOR ONE DAY PER CALENDAR YEAR)	$2,000
INTENSIVE CARE ADMISSION (FOR ONE DAY PER CALENDAR YEAR)	
HOSPITAL CONFINEMENT – THIS BENEFIT PAYS FOR EACH DAY OF CONFINEMENT IN A HOSPITAL AS A RESULT OF A SICKNESS/AN INJURY STARTING ON 2ND DAY OF CONFINEMENT.	$100 per day Up to 30 days per calendar year
INTENSIVE CARE UNIT (ICU) CONFINEMENT – THIS BENEFIT PAYS FOR EACH FULL OR PARTIAL DAY OF CONFINEMENT IN AN ICU AS A RESULT OF A SICKNESS/ AN INJURY STARTING ON 2ND DAY OF CONFINEMENT.	$200 per day Up to 30 days per calendar year
COMPLICATIONS OF PREGNANCY	Included
NEWBORN CARE	$100 per day Up to 2 days per calendar year
WELLNESS SCREENING BENEFIT	
HEALTH ASSESSMENT BENEFIT – RECEIVE A CASH BENEFIT EVERY YEAR YOU AND ANY OF YOUR COVERED FAMILY MEMBERS, COMPLETE A SINGLE COVERED EXAM, SCREENING OR IMMUNIZATION	$50

MONTHLY CONTRIBUTIONS	
EMPLOYEE ONLY	$20.61
EMPLOYEE + SPOUSE	$44.02
EMPLOYEE + CHILD(REN)	$31.83
EMPLOYEE + FAMILY	$57.63

Admissions

- Admission or admitted means accepted for inpatient services in a hospital or intensive care unit for a period of more than 20 hours.
- If admitted to a hospital or ICU within 90 days after being discharged from a preceding stay for the same or related cause, the subsequent admission will be considered part of the first admission.
- If both hospital and ICU admission or hospital and ICU confinement become payable for the same day, only the hospital ICU admission benefit will be paid.

25 Retirement Planning

RSCS 401(k) Plan

As an employee of Radiation Safety & Control Services, Inc., you may be entitled to participate in the RSCS 401(k) Plan provided you satisfy the conditions for participation as described below:

Eligible Employee

To participate under the Plan, you must be an Eligible Employee.

The following categories of employees are not eligible to participate in the Plan:

- Employees covered under a collective bargaining agreement (i.e., union employees)
- Non-resident aliens who do not receive any compensation from U.S. sources
- Leased employees

Minimum Age Requirement

You must be at least 18 to make Salary Deferrals under the Plan.

Special Minimum Service Requirement

There is no special minimum service requirement to make Salary Deferrals under the Plan.

You will be eligible to participate in the Plan as of the first Entry Date based on when you satisfy the minimum age and service requirements.

Salary Deferrals

To make Salary Deferrals under the Plan, you must be an Eligible Employee, and you must satisfy the following minimum age and service requirements listed under Matching Contributions.

Matching Contributions

In order to receive Matching Contributions under the Plan, you must be an Eligible Employee and you must satisfy the following minimum age and service requirements.

- Minimum age requirement. To receive Matching Contributions under the Plan, you must be at least age 18.
- Special minimum service requirement. To receive Matching Contributions under the Plan, you must satisfy the following requirements: You must complete 1 year of service and 1,000 hours of service.

26 Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- **Limited Use FSA –** Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Reimbursement Arrangement (HRA) – A personal healthcare account funded by your employer that you can use to pay for qualified medical expenses.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Minimum Essential Coverage plan – Covers 100% of the cost of certain preventive services, when delivered by a network provider. Helps cover the costs of certain medical expenses incurred due to an accident or sickness at a specified benefit amount for a limited number of days per year.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered. These medications are usually required to be filled at a specific pharmacy.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to guide employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice From RSCS About Your Prescription Drug Coverage and Medicare Under the Blue Choice Open Access POS & HSA Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with RSCS 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. RSCS has determined that the prescription drug coverage offered by the Blue Choice Open Access POS & HSA plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. 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 RSCS coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may 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 RSCS 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 at the end of these notices 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 RSCS 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 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 Medicare Part D 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:	January 1, 2026
Name of Entity/Sender:	RSCS
Contact—Position/Office:	Human Resources
Address:	93 Ledge Road Seabrook, NH 03874
Phone Number:	603-474-6702

Women's Health and Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- 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. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 603-474-6702.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 603-474-6702.

HIPAA 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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 603-474-6702.

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, 2025. 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

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

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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)

34 Important Contacts

Medical
Anthem
833-772-4122
www.anthem.com
Policy #: L07133

Dental
Lincoln Financial Group
800-423-2765
www.lfg.com
Policy #: 1230916

Vision
Lincoln Financial Group
800-423-2765
www.lvg.lfg.com
Policy #: 1230916

Health Savings Account
CPI
866-241-0237
www.mycpiteam.com
Email: cpisupport@mycpiteam.com

Health Reimbursement Arrangement
CPI
866-241-0237
www.mycpiteam.com
Email: cpisupport@mycpiteam.com

Flexible Spending Accounts
CPI
866-241-0237
www.mycpiteam.com
Email: cpisupport@mycpiteam.com

Accident
Lincoln Financial Group
800-423-2765
www.lfg.com
Policy #: 1230916

Critical Illness
Lincoln Financial Group
800-423-2765
www.lfg.com
Policy #: 1230916

Hospital Indemnity
Lincoln Financial Group
800-423-2765
www.lfg.com
Policy #: 1230916

Life and AD&D
Lincoln Financial Group
800-423-2765
www.lfg.com
Policy #: 1230916

Disability
Lincoln Financial Group
800-423-2765
www.lfg.com
Policy #: 1230916

401(k)
Transamerica
800-755-5801
www.transamerica.com/portal
Plan #: 512946-00000

Employee Assistance Program
EmployeeConnect
888-628-4824
GuidanceResources.com

RSCS
93 Ledge Road
Seabrook NH, 03874
603-474-6702
hr@radsafety.com

RSCS

Radiation Safety & Control Services