



**PACIFIC RIM
MECHANICAL**

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Benefits Guide 2026

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Welcome to Pacific Rim Mechanical!

Hello there! You're now part of our team, and we're very excited to have you onboard.

Pacific Rim Mechanical is pleased to offer you this opportunity to learn about all of the benefits available to you and your dependents. Each year we work with our benefit consultants to carefully review benefits and search for ways to maintain the quality of our benefit plans. It is very important to us to be able to provide a comprehensive benefit package to our employees and their families and minimize any disruption to your existing plan and services. This benefits guide has been designed to provide you with information about the benefit choices you have and how to effectively use all of the benefit programs throughout the year. Please review this information carefully along with your other enrollment materials. In addition, we encourage you to discuss the benefit options with your eligible family members.

This guide provides an overview of benefit plans offered by Pacific Rim Mechanical. Not all of the plan provisions, limitations and exclusions are described. You must consult each plan's legal documents, insurance contracts or Evidence of Coverage booklets for a complete description of the benefits, limitations and exclusions. In the event of any difference between this benefits guide and the official plan documents, the provisions of the official plan documents will govern.

Best regards,

John Heusner
President



Mission Statement

Our mission is to provide a safe work environment where our employees are treated with honesty, integrity, and respect.

To convey these values to our clients through partnership in construction projects and facility services that are highest quality, greatest value, and transcend into long term working relationships.

We utilize these concepts to be the preferred employer and contractor in Southern California.

We believe we must create a great place to work where individual opportunity is provided to all equally, openly and fairly.

Using the merit shop concept, individuals are recognized and rewarded based on their achievements.

Under these principles, the company's revenue and reputation have evolved into a firm recognized for performing high quality work in San Diego, Orange County, Riverside, San Bernardino, and Los Angeles counties.



Types of Employees Eligible for Insurance

01

Full-Time

Eligible for all available insurance

02

ABC Apprentices

Eligible for all available insurance, except basic medical and basic dental

03

Interns

Eligible for medical, dental and EAP

Waiting Periods for Insurance

If you are classified as a regular, full-time employee working at least 130 hours per month, you are eligible to enroll in the benefits program, unless you are otherwise excluded. If you are a new or rehired employee, the following waiting periods will apply:

01

Newly-hired Employees

First day of the month following 30 days of employment

02

ABC Graduates

First day of the month after termination of insurance from ABC Program

03

Employees Rehired within a Year

First day of the month following date of rehire

04

Employees Rehired over a Year

First day of the month following 30 days of employment



Dependent Eligibility

Coverage is available for you and your family. You may cover:

- Your legal spouse or registered domestic partner (RDP)
- Your child(ren) or step-child(ren) up to age 26
- Your dependent children of any age who are not able to support themselves due to a physical or mental disability



Dependent Verification

All dependents enrolled on Pacific Rim Mechanical's Benefits Plan (including Wellness) will need to be verified via dependent verification documents as outlined on the next page. Documents may include birth certificates, marriage certificates, court orders and proof of residency. If you do not have these documents on hand, begin obtaining them now, as you will have about 30 days from enrollment to verify your dependent(s). Unverified dependents will be removed from Pacific Rim Mechanical's insurance.



Dependent Verification Requirements

You will have 30 days from the date a dependent is added to your insurance to provide the following documents.

Please submit them to the Pacific Rim Mechanical Benefits Team through the [Pacific Rim Mechanical Employee Portal](#).

Dependent Type	Eligibility Criteria	Documents Required For Verification
Spouse	The person is currently your legal spouse (excluding Common Law)	Copy of your marriage certificate AND One form of dated (within 6 months) documentation establishing current marital status such as: a joint household bill, joint bank/credit account, joint mortgage or lease, or front page of last year's jointly filed federal tax return (with blacked out financial information) or front page of most recently filed federal tax return. If you do not have any joint bills or accounts, you may also submit 2 separate bills, one in each of your names, provided that they are addressed to the same common residence and dated within the past six months.
Domestic Partner	The person is currently your California Registered Domestic Partner AND Resides with you on a full time basis	Copy of California Certified Declaration of Domestic Partnership AND One forms of dated (within 6 months) documentation establishing current partnership status such as: a joint household bill, joint bank/credit account, joint mortgage or lease, or front page of last year's jointly filed federal tax return (with blacked out financial information) or front page of most recently filed federal tax return. If you do not have any joint bills or accounts, you may also submit 2 separate bills, one in each of your names, provided that they are addressed to the same common residence and dated within the past six months.
Natural Born Child	Your natural born child AND Under age 26	A copy of a state/county issued birth certificate naming you as the child's parent (if your name is not on the birth certificate, verification of Spouse/Registered Domestic Partner is required, along with a copy of a state/county-issued birth certificate naming your spouse as child's parent.)
Stepchild	Your Stepchild AND Under age 26	Verification of Spouse (See Spouse) AND A copy of a state/county issued birth certificate naming your spouse as the child's parent
Legally Adopted Child or Child Placed for Adoption or Legal Guardianship	Your Legally Adopted Child or Child Placed for Adoption or Child in Legal Guardianship AND Under age 26	A copy of adoption decree naming you as the child's adoptive parent or Legal documentation showing that you have full permanent custody of the child AND A copy of a legal document showing child's age or Amended birth certificate
Overage Disabled Child who is at least 26 and Disabled	Your Natural born child, Stepchild, or Legally Adopted child or Child Placed for Adoption or Legal Guardianship AND At least 26 years old AND Physically or mentally incapable of self-support AND The incapacity occurred before age 26 as an eligible covered dependent	A copy of a state/county issued birth certificate naming you as the child's parent OR a copy of a state/county issued birth certificate naming your spouse as the child's parent OR a copy of adoption decree naming you as the child's adoptive parent along with a legal document showing the child's age AND Physicians' statement showing the date of disability
Child Covered by a QMCSO	Your child covered under a National Medical Support Order or a Qualified Medical Child Support Order	A copy of the NMSN or QMCSO



Qualifying Status Changes and Life Events



Open Enrollment is once a year. If you miss the enrollment deadline, you may not enroll in a benefit plan, unless you have a Qualified Life Event (QLE) per IRS regulations, during the plan year. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the QLE.

You cannot drop most benefits without a Qualifying Life Event.

To report any Qualifying Status Changes, please submit a ticket to the [Pacific Rim Mechanical Employee Portal](#) within **30 days** of the Qualifying Life Event.

Required documentation (proof of Qualified Life Event, Dependent Verification documents, etc.) will be requested (outside of child turning 26) to make changes to your benefits outside Open Enrollment.

A qualifying change includes:

- Marriage, registered domestic partnership, or divorce
- Birth, adoption, placement, guardianship or court-ordered coverage of dependent child
- Covered employee's spouse obtains employment and coverage
- Covered employee's child turning 26
- Death of employee or dependent
- Employee and/or dependent(s) lose coverage under their spouse's plan due to termination of spouse's employment or loss of coverage due to change from full-time to part-time status
- Covered employee and/or dependent(s) obtain coverage outside of Pacific Rim Mechanical



Leave of Absences



To request a Leave of Absence (LOA), please submit a ticket through the [Pacific Rim Mechanical Employee Portal](#) as soon as you are aware you will need it.

To be eligible for a leave under the Family Medical Leave Act (FMLA) and the California Family Rights Act (CFRA), employee must (1) have worked for the company at least 12 months and have worked at least 1,250 hours in the 12-month period prior to the leave. Eligible employees are entitled up to 12 weeks of unpaid leave. Eligible employees can apply for certain leave paid benefits through edd.ca.gov.

During the leave period the company shall maintain an employee's health insurance coverage, if any, at the same level of coverage prior to the commencement of the leave, so long as they do not exceed 12 weeks on leave. After 12 weeks of leave, eligible employees are eligible to apply for COBRA for certain coverages.

If the Leave of Absence reaches six (6) months, employment will be terminated.



Enrolling in Benefits Online via Employee Navigator

employeenavigator.com

employeenavigator.com/benefits/account/login



Employee Navigator is our online benefit enrollment tool. The site is accessible via online at employeenavigator.com. The following tips will help you prepare for and complete the online enrollment process. Instructions are on the next page.

This year, Pacific Rim Mechanical is requiring all full-time employees to complete their enrollment, even if you are choosing to waive or keep your insurance the same.

For Open Enrollment 2026: Not all benefits from 2025 are guaranteed to roll over to 2026, along with benefits for your dependents. It is important to go through the entire enrollment process on Employee Navigator and **Sign and Agree** to confirm benefit choices for you and your dependents.

For eligible full-time new hires and rehires during 2026:

You will receive an email from Employee Navigator about 1-2 weeks after your orientation with registration instructions.

If you do not enroll, you will automatically be enrolled in the:

- Cigna Medical LocalPlus Plan – Employee-only coverage*
- Principal Dental EPO Plan – Employee-only coverage*
- Principal Life Group Life Insurance**
- Principal Life Long-Term Disability insurance**
- Cigna Employee Assistance Program
- Pac Rim Wellness**

* Excludes ABC Apprentices

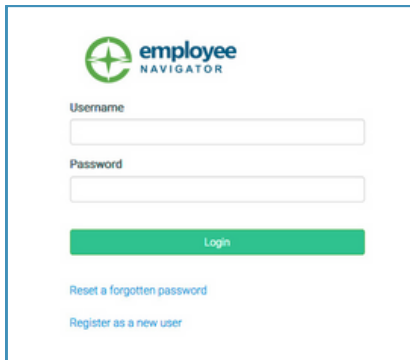
** Excludes Interns



Step 1: Log In

Go to employeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click “*Reset a forgotten password*”.
- **First time users:** Click on your Registration Link in the email sent to you by your admin or Register as a new user. Create an account, and create your own username and password.



The login form features the Employee Navigator logo at the top. Below it are two input fields labeled 'Username' and 'Password'. A green 'Login' button is positioned below the password field. At the bottom, there are two links: 'Reset a forgotten password' and 'Register as a new user'.

Step 2: Start Enrollments

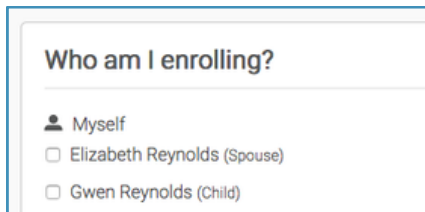
You will be asked to complete some personal and dependent information before moving on to elect your benefits.

TIPS:

- Have dependent details handy. To enroll a dependent in coverage, you will need their date of birth and Social Security Number. You will also be asked for dependent verification documents from the Benefits Department.
- Have Life Insurance Beneficiary information handy as well. You will be asked names, phone numbers, email addresses, as well as benefit allocation amounts.

Step 3: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**

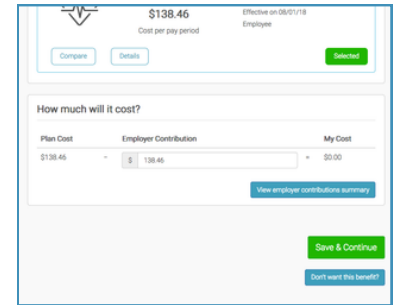


The form titled 'Who am I enrolling?' shows a selection interface. It includes a radio button for 'Myself' and two checkboxes for dependents: 'Elizabeth Reynolds (Spouse)' and 'Gwen Reynolds (Child)'.

Below “**Who am I**

enrolling?”, you can view available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

Click **Save & Continue** at the bottom of each screen to save your elections.



This screen displays plan costs. At the top, it shows '\$138.46 Cost per pay period' and 'Effective on 08/01/18 Employee'. Below are 'Compare' and 'Details' buttons, and a green 'Selected' button. A section titled 'How much will it cost?' contains a table with columns 'Plan Cost', 'Employer Contribution', and 'My Cost'. The values are '\$138.46', '\$ 138.46', and '\$0.00' respectively. A blue button 'View employer contributions summary' is below the table. At the bottom right are green 'Save & Continue' and blue 'Don't want this benefit?' buttons.

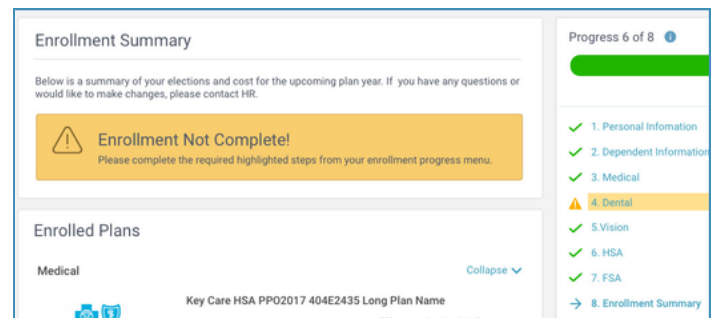
If you do not want a benefit, click Don't want this benefit? at the bottom of the screen and select a reason from the drop-down menu.

For Group Life and Voluntary Life insurance, you will be asked for Beneficiary information.

Step 6: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



The Enrollment Summary page shows a progress bar at the top right indicating 'Progress 6 of 8'. A yellow warning box states 'Enrollment Not Complete! Please complete the required highlighted steps from your enrollment progress menu.' Below this, 'Enrolled Plans' lists 'Medical' and 'Key Care HSA PPO2017 404E2435 Long Plan Name'. On the right, a checklist shows steps 1 through 7 as complete (green checkmarks), while step 4 'Dental' is highlighted in yellow with a warning icon. Step 8 'Enrollment Summary' is the current step, indicated by a blue arrow.

Step 7: HR Tasks

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

If you elected into Voluntary Life benefits, you may be asked to complete an online Evidence of Insurability form in order to be eligible for the requested benefit. Instructions will be emailed to you at a later date.



Cigna Medical

mycigna.com / (800) 244-6224



Pacific Rim Mechanical offers two medical plans via Cigna: **LocalPlus-IN** (new for 2026) and **Open Access Plan with In-Network Only Benefits (OAP-IN)**

Both plans offer access to a broad provider network and allow participants to make their own health care choices. For example: You can see any participating physician within the network you choose throughout the plan year. You have the freedom to visit any in-network specialist without a referral. During an emergency or urgent care situation, you may visit any urgent care or emergency room, even outside of California or out of the country.

The main difference between the plans is that the OAP-IN network offers more providers. If you have existing preferred providers, verify **with Cigna** which network your provider takes.

Cigna One Guide® Support

Cigna One Guide® is Cigna's highest level of customer service and there to help you find providers based on your needs, help you resolve billing issues, and more.

Cigna One Guide® service is available to guide you through the complexities of the health care system and help you avoid costly missteps. The goal is a simpler health care journey for you and your family. Cigna One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find hospitals and health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

How to Use the Plan

How to Find an In-Network Provider

1. Go to Cigna.com.
2. Click on "Find a Doctor."
3. If asked "How are you Covered?" click on "Employer or School."
4. Enter your location in the search box.
5. Then select the type of search you'd like to perform and follow the prompts to search for a provider.
6. Confirm your location under "I Live in" and click "Continue."
7. Choose one of the below medical plans to see providers in either of the two networks offered:
 - **LocalPlus-IN**
 - **OAP-IN**

NOTE: Providers are subjected to change on a daily basis. Always contact Cigna directly at (800) 244-6224 to verify the health provider is covered in your plan when scheduling your appointment and on the day of your actual appointment.

TIP: If trying to choose between plans, and you have preferred providers, use the instructions above to see if all your providers are covered under LocalPlus. If not, check if covered with OAP-IN, as that network has all the LocalPlus providers, and more.

For more personalized directories and estimated costs, go to mycigna.com or the myCigna app.



Preventative Care

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

Which Preventative Care Services are Covered?

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

- Routine physical exam
- Well baby and child care
- Well women visits
- Immunizations
- Routine bone density test
- Routine breast exam, mammogram, pap smear, gynecological exam
- Screening for Gestational diabetes
- Obesity screening and counseling
- Routine digital rectal exam
- Routine colonoscopy/colorectal cancer screening
- Routine prostate test
- Routine lab procedures
- Smoking cessation
- Health education/counseling services
- Health counseling/testing for HPV, STDs and HIV
- Screening and counseling for domestic violence

Routine Exam

For items like physical exams, mild fever and pains, chronic pain, headaches, colds and flu, contact your personal physician's office during office hours, and they will provide you with medical advice and/or schedule an office visit for you. As long as your physician is in the enrolled network, the majority of your services will be covered. For specialty care (such as orthopedic or heart disease), make an appointment with a covered specialist for an initial assessment, and, if needed, they will provide medical advice and treatment.

Again, as long as the specialist is within the selected Cigna network, the majority of your services will be covered.

Urgent and Emergency Care

For urgent medical care (for fever, sprains or strains, eye or ear infections, or severe sore throat), call your personal physician. They will assess your situation, and, if necessary, give you advice on where to seek immediate care. During an urgent care situation, you can also go to an Urgent Care center that is out-of-network. For emergency care (such as poisoning, chest pains, broken bones, uncontrolled bleeding, loss of consciousness or sudden paralysis) you can also go to an emergency room that is out-of-network, outside of California or even out of the country. Go to the nearest emergency facility or call 911. Call Cigna Member Services (number above) as soon as reasonably possible and your personal physician will coordinate all follow-up care.

Lab Work

Your doctor may order tests to help find out more about your health (i.e. to see if you have diabetes, or to find out if your thyroid medicine is working). Save money by telling your doctor you want to have those lab tests done at a Cigna network lab. If you use a lab that is not in the Cigna network, you could be responsible for the bill without any insurance discounts. You may even have to pay the full cost of the service with no discount at all. Get bigger savings by going to a national lab such as Quest Diagnostics or Laboratory Corporation of America (LabCorp) – you can save up to 75% when you choose a national lab. Contact Cigna for more details and in-network labs.

MRI

Helping you get the right care at the right time in the right setting is important. If your doctor is in-network, they are required to get precertification when requesting non-emergency MRI. Cigna reviews the precertification for medical necessity based on the information provided. Cigna will either approve or deny the request. Only make your appointment after you receive the approval from Cigna.



myCigna.com — Personalized For Your Health

Let [myCigna.com](https://mycigna.com) connect you to better health:

- Personalized health improvement plans: Cigna will review your health risks and specific preferences to create a plan that meets your needs
- Health advocates: Personalized help in the areas you're concerned about: Weight loss, fitness, smoking cessation, emotional support, chronic conditions and more
- Tools & resources: Website features so you can better understand your health, coverage and spending. With [myCigna.com](https://mycigna.com) you can find quality, affordable care. Plus, you'll learn new ways to take better care of yourself and your family

myCigna Mobile App — Medical Information From Your Smart Phone

Do you use your mobile phone to look up information? Cigna has created an app. It's an easy way to access provider directories, ID cards, claims, drug search, etc. There are many instances when having the myCigna mobile app right on your phone can help you improve your health and save money:

- Quickly view/print ID cards (front and back) for the entire family
- Instantly see the information specific to your plan (your coverage, your network of doctors and hospitals) just like when you log on to myCigna.com through your computer
- Find an in-network provider – and use the GPS services to help you get there
- Find out which pharmacy near you has the lowest cost for your prescription drug – or a less expensive generic version – from the doctor's office
- Look up a condition if someone gets hurt while you're away from your computer

Download the myCigna mobile app from the Apple App Store or Google Play.

Cigna Telehealth Connection/MDLIVE

Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office.

Use Cigna Telehealth Connection to connect with a doctor about:

- Sore throats
- Headaches
- Stomach aches
- Fevers
- Colds and flu
- Allergies
- Rashes
- Acne
- UTIs and more

Cigna Telehealth Connection is available 24/7/365 through MDLIVE! It is even available if you are out of the country via phone, myCigna app or on [myCigna.com](https://mycigna.com). However, each member (employee and dependents) must register for their own [myCigna.com](https://mycigna.com) account in order to utilize these services.

Cigna Virtual Behavioral Health Providers (for Cigna Medical Plan Enrollees)

Talkspace

- Available nationwide
- Connect with a licensed therapist or psychiatrist online, by video or text using Talkspace, available for Cigna Behavioral customers, ages 13 and up
- To schedule an assessment, go to talkspace.com/Cigna

Meru Health

- Only available to customers in CA, CO and AZ
- This 12-week virtual counseling program offers support for people suffering from depression, anxiety or burnout
- The program includes live virtual counseling and private texting with licensed therapists, as well as an online peer support community and other educational resources for ages 18 and above
- To schedule your free screening session, go to meruhealth.com/cigna

NOCD

- Only available to customers in CA, MI and NC
- Get personalized treatment for obsessive compulsive disorder (OCD) through virtual live therapy and app-based digital tools, including texting with a therapist
- Available to Cigna Behavioral customers ages 6 and up
- For a free assessment, go to TreatMyOCD.com



Cigna Healthy Pregnancies, Healthy Babies (800) 615-2906

Cigna offers this program for covered participants. Live support 24 hours a day with nurses. You can even get rewards between \$75–\$150 depending on when the pregnancy was reported.

This program also offers to covered participants a free breast pump.

Cigna Vision (877) 478-7557

The Cigna Medical plan also provides vision benefits. With Cigna Vision, you have access to quality vision care for you and your family's eye care needs. Your plan covers vision and eye health exams including dilation, refraction and prescriptions for glasses. Contact the number above (or refer to your plan materials) for details, along with a list of covered providers

However, if you and/or any potentially eligible dependents utilize or need eye hardware (i.e. glasses, contacts, etc.), consider the Principal Vision plan on [page 21](#). Cigna Vision can provide some discounts on hardware, but the discount is more with Principal Vision.

Description	Cigna Vision
Vision Exam	In-Network: \$30 copay Out-of-Network: up to \$45 allowance
Retinal Exam	In-Network: up to \$39 allowance Out-of-Network: N/A
Vision Hardware	In-Network: up to 30% Out-of-Network: N/A

Omada — Diabetes and Heart Disease Prevention omadahealth.com/prmech

Omada has partnered with Cigna to provide employees/spouses/registered domestic partners on our Cigna Medical plan a free coaching service to those who are at risk for diabetes or heart disease. Let a professional Omada health coach help you build healthy habits through a weekly interactive program.

- Eat healthier and increase activity
- Overcome challenges and strengthen habits – stay healthy for life
- Qualified participants will receive a free digital scale



1095 Tax Form for Health Insurance

The Affordable Care Act, or Obamacare, includes both the individual mandate and the employer mandate. The individual mandate requires that most Americans have qualifying health care coverage or potentially face a fine. The employer mandate requires employers with 50 or more full-time equivalent employees to offer health care coverage to their full-time employees or potentially face a fine. Much like the Form W-2 is used to determine whether or not you owe taxes, the IRS will use the information from your Form 1095-C to determine whether you (or your employer) may have to pay a fine for failing to comply with the Affordable Care Act.

The Form 1095-C contains important information about the health care coverage offered or provided to you by your employer. Information from the form may be referenced when filing your tax return and/or to help determine your eligibility for a premium tax credit. Think of the form as your “proof of insurance” for the IRS.



Description	Benefit	Notes			
Deductible	None	No deductible applies			
Calendar Year Out-of-Pocket Maximum					
Individual	\$2,000	The max you will have to pay as an individual/family for the year. Once met, remaining benefits are covered in full for the rest of the calendar year.			
Family	\$6,000				
Lifetime Maximum	None				
Coinsurance/Copays					
Inpatient Hospital	\$500 copay	Includes all services provided while inpatient. Physician/surgeon fees are included in the per day fee.			
Outpatient Surgery	\$250 copay	Surgery that does not require overnight hospitalization. Physician/surgeon fees are included in the Facility Fee.			
Emergency Room	\$250 copay	Covered out of network for a true emergency. When possible use Urgent Care benefit for a lower cost and generally quicker service.			
Urgent Care	\$40 copay	Covered when temporarily out of the area for same copay. For services that are not life or limb threatening.			
Lab and X-ray	\$0 copay	\$0 copay for labs and most x-rays			
MRI/CT Scan	\$150 copay	Must receive prior approval for these services			
Preventive Care	\$0 copay	Includes annual exams and well visits. Covered at \$0.			
Office Visit (PCP or Specialist)	\$40 copay	Most services provided are covered under this copayment.			
Office Visit (Mental Health)	\$20 copay	Try utilizing the six (6) free therapy sessions offered via the Employee Assistance Program first if possible for cost savings			
MDLIVE Virtual Care	LocalPlus-IN:\$40 copay OAP-IN: \$20 copay	Virtual doctor appointments are convenient and you may receive a diagnosis or further guidance.			
Ambulance	\$0 copay	If receive a separate bill for ambulatory services, reach out to Cigna.			
Self-Referred Chiropractic	\$10 copay (up to 30 days)	30 days maximum per calendar year IMPORTANT: confirm chosen chiropractor is covered with your plan			
Acupuncture	\$40 copay	12 days maximum per calendar year IMPORTANT: confirm chosen chiropractor is covered with your plan			
Pharmacy					
Retail Prescriptions (up to 30 day supply)					
Generic (Tier 1)	\$15 copay	Preferred Brand (Tier 2)	\$30 copay	Non-Preferred Brand (Tier 3)	\$50 copay
Up to a 30 day supply retail. Copays are for Generic/Brand/Non preferred brand.					
Retail/Mail Order Prescriptions (up to 90 day supply)					
Generic (Tier 1)	\$30 copay	Preferred Brand (Tier 2)	\$60 copay	Non-Preferred Brand (Tier 3)	\$100 copay
Up to a 90 day supply retail or mail order. Copays are for Generic/Brand/Non preferred brand.					



Know Where to Go



Get the right care, at the right time, in the right place.

Whether you have Pacific Rim Mechanical's Cigna Medical plan or a different medical plan, the below chart provided by Cigna provides some cost-saving and time tips when looking for medical care. Copay's listed below pertain to Pacific Rim Mechanical's Cigna Medical plan only.

Not sure which option is best for you? The Cigna Healthcare no-cost Health Information Line puts you in touch with a personal health advocate. These trained nurses are here to answer your health questions and help you make the best choice for your needs. Log in to the myCigna App or [myCigna.com](https://mycigna.com) to chat with a health advocate today.

Lower Cost and Time Greater				
	Virtual urgent care (\$20 copay)	Local provider (\$40 copay)	Urgent care center (\$40 copay)	Emergency room (\$200 copay)
Description	Available on-demand 24/7, via E-Treatment, or schedule a time that works for you to receive care for minor medical illnesses and injuries. Cigna participants can access virtual care on the myCigna® App or myCigna.com ® or call MDLIVE at (888) 726-3171.	Schedule an in person appointment with a local health care provider to treat common ailments and manage care for all health conditions. Find an in-network provider on the myCigna App or myCigna.com .	For medical conditions that aren't life threatening. Find an in-network urgent care center on the myCigna App or myCigna.com .	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life threatening, call 911 or go to the nearest ER.
Ages	All ages. Parent/guardian must accompany minors.	All ages. May vary by provider/service.	All ages. May vary by location. Confirm restrictions for infants as many have age limits.	All ages.
Conditions treated	- Colds and flu - Rashes - Sore throats - Pink eye - Ear pain - Fever - Allergies - Acne - Urinary tract infections (UTIs) - and more	- General health issues - Preventive care - Routine checkup - Vaccines and screenings - Acute sickness - Questions regarding health	- Fever and flu symptoms - Joint pain, sprains and cuts - Minor respiratory symptoms - Stomach pains - STDs - UTIs	- Sudden numbness, weakness - Uncontrolled bleeding - Seizure or loss of consciousness - Shortness of breath - Chest pain - Head injury/major trauma - Blurry or loss of vision - Severe cuts or burns - Overdose
Cost and Time	- More affordable than in-person and urgent care or ER visit - Connect with a doctor in minutes - No need to leave work or home with visits available by phone, video or through E-Treatment	- May charge copay/coinsurance and/or deductible - Usually need appointment - Short wait times	- Lower cost than emergency room (ER) - No appointment needed - Waiting times vary - Available most days of the week - Often have extended hours - In-person treatment	- Most expensive - Available 24/7/365 - No appointment needed - Waiting times vary - In-person treatment



Cigna Employee Assistance Program (EAP)

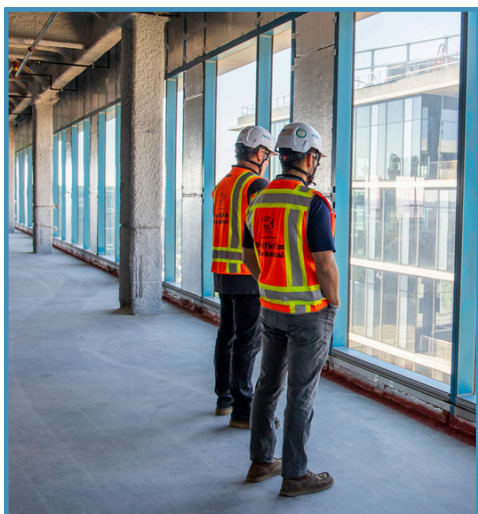
mycigna.com / (800) 244-6224



Pacific Rim Mechanical's Employee Assistance Program (EAP) offers confidential assessments and provides screening and referrals to local providers at no cost to you and your household members.

The mental health of our employees and their families is important to Pacific Rim Mechanical. Available to all Pacific Rim Mechanical full-time employees, even those not on Pacific Rim Mechanical's medical plans.

The Employee Assistance Program (EAP) offers confidential assessments and provides screening and referrals to local providers. You and your dependents can access the work-life balance EAP 24 hours a day, with telephone and online access 7 days a week. The EAP offers you access to licensed counselors to help you resolve personal concerns affecting you at work or at home.



Services Offered

- **Counseling:** Six (6) face-to-face counseling sessions with a counselor in your area.
- **Legal assistance:** 30-minute consultation with an attorney face-to-face or by phone.*
- **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.
- **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.
- **Identity theft:** 60-minute consultation with a fraud resolution specialist.

How to Use the Plan

- Support is available 24/7, and available for all full-time employees and their household members, even those who are not on Pacific Rim Mechanical's medical plan.
- Phone support: (877) 622-4327
- Online support: go to mycigna.com
 - For the initial registration, you will need your EAP Employer ID: pacrim
 - Under the Review My Coverage tab, select EAP

Other Resources

- EAP National Wellness Seminars: Cigna.com/EAPWebCasts
- Behavioral Awareness Series: Cigna.com/knowledgecenter/#mentalandemotionalhealth
- Suicide Awareness and Prevention: Cigna.com/SuicidePrevention
- National Suicide Prevention Lifeline
- Call 988 or visit 988california.org



Principal Dental

principal.com / (800) 247-4695

Pacific Rim Mechanical offers two dental plans via Principal: **Principal Dental EPO** and **Principal Dental POS**

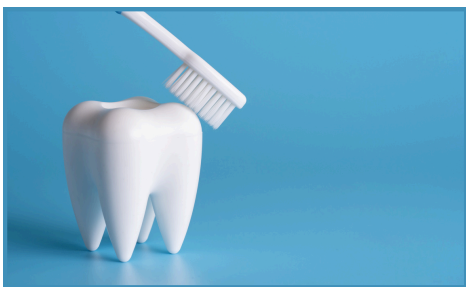
Both of our dental plans offer the same Annual Maximum Benefit of \$2,000. The main difference of the plans are that the POS plan offers more providers to choose from, plus it offers Out-of-Network coverage. Dentists that are in the EPO network, even if you choose the POS plan, are required to adhere to the contractual pricing set by Principal Dental.

How to Use the Plan

How to Find A Dental Provider

1. Go to: principal.com or call (800) 247-4695
2. Click **Find a Dentist** on right hand side under **For Customers**. Then click **Search for dentist**.
 - NOTE: For the Principal EPO Plan, coverage can only be used within covered providers in California or Mexico
3. Choose your correct network: **First Dental Health EPO** (for EPO) or **Principal Point of Service** (POS)
4. Enter all other applicable information

Providers are subjected to change on a daily basis. Always contact Principal directly at (800) 247-4695 to verify the dental provider is covered in your plan when you schedule your appointment and on the day of your appointment.



What To Do Before Treatment Begins

Predetermination of Benefits from your dental providers are usually mandated for treatments outside of preventive services such as crowns, bridges and dentures, scaling and root planing, surgical extractions, etc. This lets you and your dental provider know if the proposed services will be covered and what the anticipated benefit payment will be before treatment begins.

Which Dental Services Are Covered

Principal Financial employs licensed practicing dentists to review covered services for dental necessity. Based on the review of a claim and supporting documentation (e.g., X-rays), a dental service may be allowed, an alternate benefit may be allowed or the claim may be disallowed.

When Benefits Are Payable

It is important to note that benefit decisions are made based on the terms of the policy from Principal Financial.

They are not a decision about whether you or a family member should receive a specific treatment. That is a decision between you and your dental provider. Just because your dental provider recommends certain treatments, does not necessarily mean that it will be covered by insurance.



Principal Provider
Directory



Principal.com



	Principal Dental EPO	Principal Dental Point of Service (POS)		Notes
	In-Network Only	In-Network	Out-of-Network	
Annual Maximum Benefit				
Per Individual	\$2,000	\$2,000		Each covered member has this benefit amount available per year
Calendar Year Deductible				
Individual	\$25 \$0 for preventative	\$25 \$0 for preventative	\$35	Applies to Basic/Major Services per Calendar Year
Family	\$75 \$0 for preventative	\$75 \$0 for preventative	\$105	
Coinsurance for Covered Services				
Preventative	No charge	No charge	20%*	Includes Exam, Cleanings, X-rays
Basic	10%	10%	20%*	Examples: Fillings, Oral Surgery, Periodontoal, Endodontic, Emergency Services
Major	50%	50%	50%*	Examples: Inlays and Onlays, Crowns, Bridges, Dentures
Orthodontia (Children Only)				
Orthodontia	50%	50%	50%*	Only available for dependent children
Orthodontia Deductible	None	None	\$50	
Orthodontia Lifetime Maximum	\$1,000	\$1,000		Once this amount is exhausted per individual, it is not refreshed again

* of the Reasonable and Customary Fee

Important Tips:

- Request a Predetermination of Benefits PRIOR to starting recommended extensive dental services. Otherwise you risk insurance not covering the procedure.
- Certain services have limitations, see plan EOC for more information.



Principal Vision

principal.com / (800) 247-4695



Principal Provider
Directory



Principal.com

Pacific Rim Mechanical offers an optional vision plan through Principal, which utilizes the Vision Service Plan (VSP) Network

Pacific Rim Mechanical offers a vision plan that provides discounts for items like glasses or contacts.

IMPORTANT: If you are not planning on getting glasses or contacts this coming year, you can get a vision exam through your medical provider, and may not need this plan.



How to Use the Plan

How to Find A Vision Provider

Principal Vision is provided through VSP Choice and when searching for a provider in-network you will be rerouted to the VSP website.

1. Go to: principal.com or call (800) 247-4695
2. Select Vision Plan and click Find an Eye Doctor
3. You will be re-routed to the VSP website

Providers are subjected to change on a daily basis. Always contact Principal directly at (800) 247-4695 to verify the vision provider is covered in your plan when you schedule your appointment and on the day of your appointment.

Description	In-Network (Choice Network)	Out-of-Network
Exam	\$10 copay	\$45 allowance
Frames	\$130 allowance	\$70 allowance
Lenses		
Single	\$25 copay	\$30 allowance
Bifocal	\$25 copay	\$50 allowance
Trifocal	\$25 copay	\$65 allowance
Lenticular lenses	\$25 copay	\$100 allowance
Contact fitting and evaluation	\$60 copay	N/A
Contacts (elective) (in lieu of glasses)	\$130 allowance	\$105 allowance
Contacts (medically necessary)	Covered in full after \$25 copay	\$210 allowance
Frequency		
Exams	Every 12 months	
Lenses	Every 12 months	
Frames	Every 12 months	



Principal Life

Pacific Rim Mechanical offers Basic Life Insurance for eligible employees, and Voluntary Life Insurance for eligible employees and their eligible dependents

Your life and accident insurance benefits are some of the most valuable benefits available to you. They are often referred to as “survivor” benefits because they provide financial security to your loved ones if you die or are severely injured in an accident.

Basic Life and AD&D

Pacific Rim Mechanical provides basic life and AD&D coverage through Principal Life for all full-time eligible employees. The full benefit is equal to 1x your base annual earnings to a maximum of \$100,000. The benefit will be rounded to the next highest \$1,000 and paid to your beneficiary in the event of your death.

If your death or injury is accidental, you or your beneficiaries may be entitled to AD&D benefits equal to up to 1x to your base annual earnings. If an accident causes you to lose a limb or partial sight or hearing, a portion of the benefit amount will be paid. The maximum benefit amount from the AD&D is \$100,000.

Refer to the Principal Life Insurance materials that can be found on employeenavigator.com.



Description	Details
Basic Life Benefit	Full Benefit: 1x annual salary up to \$100,000
Basic AD&D Benefit	Full Benefit: 1x annual salary up to \$100,000 for loss of life; other losses may be covered as well.
Reduction in Basic Life and AD&D Benefit	Age 65: Benefit reduces to 65% of original amount Age 70: Additional 15% reduction

Designating Life Insurance Beneficiaries for both Group Life and Voluntary Life Plans

A beneficiary is the person or entity you designate to receive the death benefits of your life insurance policy. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, identify the share for each.

It is important to review and update your beneficiaries annually. California does have specific rules about beneficiaries. Refer to your legal counsel for guidance. Update your Life Insurance Beneficiaries on employeenavigator.com.

Some states dictate if the insured is married, the spouse is the primary beneficiary. If a married individual designates a non-spouse as the primary beneficiary, the requirements of the state will be reviewed prior to claim payment.



Update Life Insurance
Beneficiaries



Voluntary Life and AD&D

In addition, you can purchase added protection in the form of voluntary life insurance for yourself and eligible dependents. Eligibility and premiums are dependent on various factors (i.e. age, smoking status). Premiums will display during enrollment on employee.navigator.com. Some requested benefit amounts require an Evidence of Insurability (see below).

If you are a newly benefits-eligible employee, you may enroll for up to the Guaranteed Issue (GI) amounts without submitting Evidence of Insurability (EOI) to Principal Life. During Open Enrollment, you may be able to enroll for or increase your benefit and your dependents benefit two increments per year during your open enrollment period without providing health information. Each increment is \$10,000.

If you wish to become insured for an amount greater than the GI (for newly benefits-eligible) or two increments (for current employees), an EOI will be required. If you are a late enrollee, you will be required to submit an EOI to Principal Life for amounts above two increments.

Evidence of Insurability (EOI)

This is proof that you are insurable. Such evidence is generally obtained through statements on your application regarding your health, avocations, employment and financial condition. In most cases, medical records are required, and sometimes a medical examination is needed.

Required Evidence of Insurability (EOI) forms must be filled out online **within 60 days of enrollment**, which will be sent separately to you to the email we have on file, from principalcustomerservice@ibuinc.com. If you do not see it in your inbox, please check your spam/junk email folders. If you run into issues, contact the Principal IBU team at (888) 390-5155.

If the application is not completed within 60 days of enrollment, the requested amount above the Guaranteed Issue will be declined. Selecting an amount on Employee Navigator does not guarantee the benefit and does not take place of the EOI application.

Voluntary Life Benefit Description	Details	Guarantee Issue Amount
Employee Coverage Options	Up to 7x earnings in increments of \$10,000 up to \$500,000	\$200,000 during your initial eligibility period
Spouse Coverage Options	Up to 50% of employee's amount in increments of \$5,000 up to \$100,000	\$30,000 during your initial eligibility period
Child Coverage Options	An amount elected in units of \$10,000; Maximum Benefit: \$10,000; The Maximum Benefit for a Dependent Child who is less than 6 months old is \$250.	\$10,000 \$250 for Dependent Child less than 6 months old
Reduction in Benefit	Age 65: Benefit reduces to 65% of original amount Age 70: Additional 15% reduction	N/A



Principal Long-Term Disability (LTD)

Pacific Rim Mechanical's Long-Term Disability (LTD) insurance can keep you financially stable should you experience a qualifying disability and become unable to work

It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience. All this is at no cost to our employees.

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

This is considered a Long Term benefit, as it kicks in after 365 days of disability. In California, we pay into and have State Disability which is a Short Term benefit, that starts on the 8th day of disability. Claims for Short Term Disability through the state of California may be applied for on the edd.ca.gov website.

If you are on a Leave of Absence (LOA) due to a disability, please file for Long-Term Disability Insurance within six months of your LOA to qualify for benefits, even if you don't expect to be on leave longer than that. Applications submitted after the six-month period may not be accepted. Further instructions will be provided if filing for LOA.

Description	Details
Coverage	60% of your pre-disability earnings up to a maximum benefit of \$5,000 per month until you recover or reach your Social Security Normal Retirement Age, (SSNRA) whichever is sooner.
When Benefits Begin	Benefit begins after 365 days of disability.
Election Required	Yes



IGOE Flexible Spending Accounts

goigoe.com/spending-accounts / (800) 633-8818

Pacific Rim Mechanical Flexible Spending Accounts (FSA's) offer employees a significant tax savings opportunity

Flexible Spending Accounts (FSA's) offer employees a significant tax savings opportunity, by allowing employees to pay for eligible health care and dependent care expenses using tax-free dollars — money taken out of your paycheck before Income or Social Security taxes have been calculated.

Health Care Flexible Spending Account

This plan allows you to set aside pretax dollars to help pay for certain out-of-pocket health care expenses. Examples are medical/dental/vision copays, prescriptions, certain over-the-counter medications, blood pressure machines, even bandages. You can contribute up to the IRS Maximum. For 2026, it is \$3,400.

Pacific Rim Mechanical offers a 2.5 month grace period for active employees for the Health Care FSA Plan.

Dependent Care Flexible Spending Account

This plan allows you to set aside pretax dollars to help pay for day care services for your eligible dependents.

The maximum amount you can contribute is \$7,500 per year, \$3,750 if married and filing separate tax returns, for 2026.

How to Use the Plan

Eligible Expenses

For a list of eligible expenses, go to:

- Healthcare FSA: fsastore.com/fsa-eligibility-list
- Dependent Care FSA: goigoe.com/resources (go to **Dependent Care Eligibility List**)

Estimating Amount of Benefit

Please estimate your expenses **conservatively** as the law requires that you use your expenses during the plan year (the “use it or lose it” rule).

A helpful FSA calculator: fsastore.com/fsa-calculator

Calculators only provide an estimate. It is best to advise with a financial advisor if unsure how much to elect.

Expenses can only be incurred while employed at Pacific Rim Mechanical, and during the plan year. Only the Health Care Flexible Spending Account allows for an additional grace period of 2.5 months after the plan year for active employees. Expenses after termination of employment are not eligible.

Carefully note deadline dates of reimbursement and substantiation submission.



Register for the Portal

Registering for an account provided access to real-time balances and activity of your IGOE powered benefits. Follow the steps below for a smooth and secure registration process.

Step 1: Begin Registration

Go to goigoe.com, select Login, select "Spending Account Participants". Select "Register to start the account setup process".

Step 2: Select Verification Method

Select a method to receive your registration verification code. Options include email or text message.

Step 3: Create your login

Setup your login credentials by creating a unique username and a secure password. Follow the password guidelines for added security.

Step 4: Set up Security Questions

Select security questions and provide answers that only you would know. This adds an extra layer of security to your account.

Step 5: Finalize Registration

Verify all your details and finalize your registration to activate your account.

Smart Savings with Flexible Spending Accounts- a Sample Scenario

Julie has an annual gross income of \$55,000 a year, and pays an estimated tax rate of 25%. After estimated her expected out-of-pocket healthcare costs, she plans to enroll in the Health Care FSA for \$2,000. With this election, she is expected to save \$500 in taxes, based on her tax situation.*

**The standard deduction and federal income tax are based on an individual claiming a deduction as head of household + one dependent under age 65. Savings are different for each person.*

Benefit Card FAQ's

Where can I use my Benefits Card?

The Benefits card functions differently than a standard credit or debit card, as it's use and rules are determined by the IRS.

Transactions are allowed only up to the balance available in your account.

Always be prepared with alternate form of payment in case your card is declined. If this happens, you can request reimbursement for expense.

Retain detailed report for all transactions to show what was purchased, where, when and the dollar amount. This may be required by IGOE to validate expense eligibility or in case of a personal IRS audit.

When are funds loaded to the Benefits Card?

Funds are loaded to the Benefits Card after your company processes your deduction amount from your paycheck.

How to request a new Benefits Card?

Employees can report their card lost or stolen online, via the 24/7 IGOE Interactive Voice Response (IVR) or IGOE customer service line at (800) 633-8818.

If an employee needs to access funds and their card is not available to them, they can pay out of pocket and ask for a reimbursement via the online IGOE Participant Portal.

What happens if my Benefits Card declines?

Call the IGOE customer service team at (800) 633-8818 and they can help you understand why this occurred.



Empower 401(k) Retirement

participant.empower-retirement.com / (800) 338-4015



Empower



Update 401(k)
Beneficiaries

Pacific Rim Mechanical's 401(k) plans provide a reliable way to build financial security for retirement. Pacific Rim Mechanical provides a discretionary match of 50% of your contributions, capped at 2% of total earnings.

Traditional 401(k)

Deferral contributions to the Traditional 401(k) plan are pre-tax and reduce your taxable income.

As an example, contributing \$50 per paycheck, may cost you \$37.50 in actual take home pay, because the money is deducted directly from your paycheck before you pay any taxes.

Roth 401(k)

Deferral contributions to the ROTH 401(k) plan are post-tax, meaning you won't be taxed on qualified withdrawals during retirement.

This plan combines the best of both worlds- the convenience of payroll deductions with the tax-free growth potential of a Roth account.

IRS Annual Maximum

You may contribute up to the IRS annual maximum (**\$24,500 for 2026**). Contributions can be made to either plan, but your combined contributions can't exceed the deferral limit.

"Catch-Up" Contributions

For those age 50 or older in 2026, you may make additional "catch-up" contributions up to **\$8,000** for the 2026. You must elect this option- it's not automatic.

The IRS released guidance regarding SECURE 2.0 which might impact you in the following ways.

- If your 2025 year-to-date pay (as shown on your final paycheck) is \$145,000 or more, any catch-up contributions must be made to a Roth 401(k) rather than a traditional 401(k).
- If you'll be between ages 60–63 in 2026, you're also eligible for an additional \$3,250 catch-up contribution, allowing a potential total of \$35,750 or more, depending on the final IRS limits for 2026.

Vesting Schedule

You are always 100% vested in your own contributions and earnings. For any contributions made by Pacific Rim Mechanical on your behalf, contributions and earnings will be vested according to the following schedule:

Years	Hours of Service	Vested Interest
0 to 1	1,000	25%
2	1,000	50%
3	1,000	75%
4	1,000	100%

Designating 401(k) Beneficiaries

A beneficiary is the person or entity you designate to receive the death proceeds of your 401(k) benefits. You can name more than one beneficiary and you can change beneficiaries at any time. Note that there are special legal requirements for 401(k) beneficiaries that spouses are entitled to. California does have specific rules about 401(k) beneficiaries. Refer to your legal counsel for guidance. It is important to review your designated beneficiaries annually. You cannot add/update 401(k) beneficiaries plan on Employee Navigator. Instead, upload the Empower 401k Beneficiary Form found on the [Pacific Rim Mechanical Employee Portal](#), complete and submit it via the **Request Assistance** link on the [Pacific Rim Mechanical Employee Portal](#).



Legal by LegalEASE

legaleaseplan.com/prmech / (800)248-9000

A legal insurance plan can ease the biggest stresses – finding and paying for legal expertise when you need it most.

Life events can lead to unexpected legal concerns that are difficult to handle alone. Enrolling in a legal insurance plan reduces the stress of finding and paying for an attorney when it matters most.

LegalEASE offers a legal insurance plan that provides support and protection for unexpected personal legal issues.

What you get with LegalEASE

- An attorney with expertise specific to your personal legal matter
- Access to a national network of attorneys with exceptional experience that are matched to meet your needs
- In and out-of-network coverage
- Concierge help navigating common individual or family legal issues

To learn more about the LegalEASE insurance plan, visit legaleaseplan.com/prmech or call (800) 248-9000.



The Value of a LegalEASE

As a member, you have access to a national network of over 20,300 attorneys who are matched to your specific legal needs. Being a LegalEASE insurance member also saves you time and costly legal fees. But most importantly, it gives you confidence and provides coverage for:

- Home and consumer
- Financial
- Auto and traffic
- Family
- Estate planning and wills

Plans and Pricing

Coverage	Pricing
Employee & Family	\$13.90 per month



Allstate Identity Protection

myaip.com / (800) 789-2720

Pacific Rim Mechanical's Identity Protection program can help protect your identity and finances from a growing range of threats.

Since so much of daily life is now spent online, it's more important than ever to stay connected. But more sharing online means more of your personal data may be at risk. In fact, 1 in 6 Americans were impacted by an identity crime in 2020.

Identity theft can happen to anyone. That's why your company is offering you Allstate Identity Protection as a benefit.

Prepare for what's next with:

- Financial account and credit monitoring
- 24/7 alerts and fraud recovery
- Up to \$2 million identity theft expense coverage

Plans and Pricing

Coverage	Pricing
Employee Only	\$7.95 per month
Family Coverage	\$13.95 per month



What is included with Allstate Identity Protection Pro+

- See and control your personal data with privacy insights and privacy management in our unique tool, Allstate Digital Footprint
- Learn more about your risk potential by checking your Identity Health Status
- Receive personalized threat insights to help you protect yourself against the latest trends in scams and fraud
- Protect yourself and your loved ones with a family plan that includes senior family coverage for parents, in-laws, and grandparents over the age of 65 (everyone "under your roof and wallet")
- Get reimbursed for many of your out-of-pocket costs, with additional coverage for:
 - Home title fraud expense reimbursement up to \$1 million¹
 - Professional fraud expense reimbursement up to \$2 million¹
 - Stolen wallet emergency cash up to \$500¹
- Monitor social media accounts for questionable content and signs of account takeover
- View and manage alerts in real time
- Catch fraud early with tri-bureau monitoring and an annual tri-bureau credit report and score
- Lock your TransUnion credit report in a click and get credit freeze assistance
- See if your IP addresses have been compromised
- Receive alerts for cash withdrawals, balance transfers, and large purchases
- Get reimbursed for fraud-related losses, like stolen 401(k) & HSA funds, with our identity theft expense coverage¹



Pacific Rim Mechanical Wellness Program

MyPacRimWellness.com / (888) 671-9395

Pacific Rim Mechanical offers a free program to help you build and maintain a healthy lifestyle, all while earning points and the medical premium discount

Pacific Rim Mechanical has partnered with Personify Health, a leading national provider of comprehensive health management solutions, to provide a free, voluntary, robust, healthy, and fun wellness program for you and your Spouse/Registered Domestic Partner (RDP).

Rewards

Save on your Pac Rim medical premiums along with earning up to 500 points each for Employees and eligible, verified Spouses/Registered Domestic Partners (RDP), which can be redeemed for digital gift cards. Each point earned on Pac Rim Wellness equals \$1 on Pac Rim Rewards.

Please review the Pacific Rim Mechanical Wellness flyer that is distributed each wellness year or during your onboarding period.

How to Use the Plan

Eligibility

Offered to all full-time employees, including ABC apprentices. Verified spouses and registered domestic partners.

Part-time and interns are not eligible.

Requirements

The Wellness Program requires participants to meet specific requirements each year to earn annual incentives. Refer to the wellness flyer to view the requirements.

Your Protected Health Information

Your privacy is important to us. All programs through Personify Wellness are confidential and in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Any information shared with the Personify Wellness staff will not be disclosed except in accordance with HIPAA laws. Your Protected Health Information (PHI) will not be shared with Pacific Rim Mechanical.



Pacific Rim Mechanical Rewards Program

MyPacRimRewards.com

Points earned from various activities at Pacific Rim Mechanical via our Wellness program, Bonuses, etc. can be cashed out for digital gift cards.

Redeem points earned from Pac Rim Wellness, bonuses, etc. at MyPacRimRewards.com for digital gift cards. Points available on the Reward website roll over year after year.

Every point earned is equivalent to \$1 of digital gift cards.

It is important that you safeguard your gift cards as you would cash. Pacific Rim Mechanical is not responsible for replacing lost or stolen gift cards once they have been issued.

You have until the last day of the following month upon termination to utilize your points.

How to Use the Plan

Eligibility

All employees are eligible to register for the Rewards program.

However points that spouses and registered domestic partners earn on the Wellness program will be deposited onto the Employee's Rewards account.

Registration

- Go to prmech.mypointrewards.com/register
- Your initial/defaulted username for the Rewards program will be your employee number + the last 4 digits of your social security number, which can be found on your paystubs.



Cost of Coverages

Refer to the chart below to guide your selection of medical, dental, and/or vision benefits for yourself and your eligible dependents.

The chart below includes medical, dental, vision, Legal, and ID Theft.

Costs on Voluntary Life Insurance is dependent on a couple factors (i.e. age, tobacco status, etc.) and available on Employee Navigator.

The amounts shown below represent the **monthly** cost for each plan.



	Cigna Medical- LocalPlus-IN		Cigna Medical- OAP-IN				
	With Wellness Requirements Met	With Wellness Requirements NOT Met	With Wellness Requirements Met	With Wellness Requirements NOT Met	Principal Dental - EPO	Principal Dental - POS	Principal Vision
Employee Only	\$0.00	\$80.00	\$40.00	\$120.00	\$0.00	\$24.00	\$7.91
Employee + Spouse/Registered Domestic Partner	\$376.00	\$456.00	\$416.00	\$496.00	\$16.00	\$68.00	\$6.78
Employee + Child(ren)	\$264.00	\$344.00	\$304.00	\$384.00	\$20.00	\$76.00	\$13.84
Employee + Family	\$624.00	\$704.00	\$664.00	\$744.00	\$32.00	\$120.00	\$22.31
	Legal Ease				Allstate ID Protection		
Employee Only	\$13.90				\$7.95		
Employee + Spouse/Registered Domestic Partner	\$13.90				\$13.95		
Employee + Child(ren)	\$13.90				\$13.95		
Employee + Family	\$13.90				\$13.95		



Payroll

Employees are responsible for reporting any changes to their demographic information (e.g., phone number, email address, mailing address, name, etc.).

Maintaining accurate records is essential, as important correspondence—including physical mail and emails—will be sent to the contact information on file.

Updating Contact Information

Report any name, email, address, and phone number changes immediately by opening a ticket on the [Pacific Rim Mechanical Employee Portal](#)

Updating your W4

Complete the most current W-4 available on the [Pacific Rim Mechanical Employee Portal](#) and submit for processing by opening a ticket on the [Pacific Rim Mechanical Employee Portal](#).



	This Pay
Gross Pay	388.27
Pension	0.00
AVC's	0.00
Taxable Pay	388.27
Tax	0.00
NI	0.00
Sp	0.00
	0.00
	0.00

Accessing Your Paystubs

- Go to employee.prmech.com
- Username: email on file with HR
- For first-time users, register by clicking "Forgot Password"
- From there, enter the email address provided to HR as your username and create your own password.

Copies of your paystubs will be loaded onto Pacific Rim Mechanical's paystub portal. You can view, print and email your paystubs as you like. You will have access to your historical pay information, along with Year-to-Date (YTD) totals and Paid Time Off (PTO) balances.

Since your username is tied with your email on file, report any email changes immediately through the Pacific Rim Mechanical Employee Portal.

Accrued PTO & Submitting PTO Requests

Pacific Rim Mechanical's Paid Time Off (PTO), sick time, vacation, etc., are combined and under one bucket labeled PTO.

Visit [Pacific Rim Mechanical Employee Portal](#) to view PTO balance or submit a PTO request.

Your available PTO hours are listed, along with existing requests.



Glossary of Terms



Plan Types*

- EPO/PPO - A network of doctors, hospitals and other health care providers
- HMO - A network that requires you to select a Primary Care Physician (PCP) who coordinates your health care.
- POS - Combines aspects of a PPO and HMO
- HDHP - A plan that has higher annual deductibles in exchange for lower premiums

* *not all offered by Pacific Rim Mechanical*

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

In-network: A designated list of health care providers (doctors, dentists, etc.) with whom our insurance carriers have negotiated special rates. Using in-network providers lowers the cost of services for you and Pacific Rim Mechanical.

Out-of-network: Health care providers that are not in our insurance carriers' network and who have not negotiated discounted rates. If out-of-network coverage is offered in your chosen plan, the cost of services provided by out-of-network providers is much higher for you and Pacific Rim Mechanical. Additional deductibles and higher coinsurance will apply. If out-of-network coverage is not offered in your chosen plan, you will be responsible for the entire cost of services.

Reasonable & Customary Charges (R&C): Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates apply to out-of-network charges.

Deductible: Amount of money you must pay before the Company shares in the expense of services provided.

Copay: These expenses are your share of cost paid for covered health care services. The amount you pay each time health care services are received. Copays are a fixed dollar amount, and are usually due at the time you receive care.

Coinsurance: These expenses are your share of cost paid for covered health care services. The share of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met and you will be responsible for the remaining 20% of the cost.

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

**Except for Grandfathered medical plans*

Pretax: The contributions you make for medical, dental, vision, FSA health care spending and FSA dependent care spending are not subject to Social Security tax, federal income tax or, in most cases, state and local income taxes.



Frequently Asked Questions (FAQ's)



I'm not making changes to my benefits. Do I still need to enroll on Employee Navigator during Open Enrollment? Yes. Not all benefits roll over onto the next benefit plan year (i.e. Flexible Spending). You also should review your life insurance beneficiaries and make changes if necessary.

Are all my premiums for insurance pre-taxed? No. For most employees, medical, dental, vision, flexible spending, and 401k premiums are pre-taxed. And for certain shareholders, all premiums are post-taxed. The domestic partner portion of a premium is not pre-taxed.

Can I enroll my girlfriend/boyfriend/mother/father onto my insurance? Only those who are your legal dependents (spouse, registered domestic partner, your legal children/step-children under the age of 26, your legal children/step-children who is disabled and over the age of 26) can be enrolled as dependents onto Pacific Rim Mechanical's insurance. Dependent Verification documents must be provided to enroll the dependent(s) onto the insurance.

I thought the medical insurance was free? If you complete the Wellness Requirements each wellness year, the employee-only portion of the medical premiums will be reduced from \$80/month to \$0/month for the Cigna Medical LocalPlus-IN plan; and reduced from \$120/month to \$40/month for the Cigna Medical OAP-IN plan.

I already completed the Wellness Requirements last year. Do I need to complete them again the next wellness year? Yes. Wellness Requirements must be completed in order to continue with the wellness discount on medical premiums and to continue earning points each wellness year.

Where can I update my address, phone number, or email address? Report any name, email, address, and phone number changes immediately to the [Pacific Rim Mechanical Employee Portal](#).

Where are my insurance cards? Cigna no longer mails out physical cards automatically. It is preferred to use the digital card via the myCigna app. Call Cigna if you need a physical card. If you don't receive your Principal Dental or Principal Vision cards, contact Principal.

Where are my paystubs? Paystubs are stored electronically on our pVault portal. See [page 32](#) for instructions. If you haven't set up your account, please submit a ticket on the [Pacific Rim Mechanical Employee Portal](#).



Get In Touch

For a faster, more streamlined response, please email questions regarding Benefits, Wellness, Rewards, Dependent Verification, and HRIS through the [Pacific Rim Mechanical Employee Portal](#)



Ways to Access the Portal - (Phone or Personal Computer)

1. The portal can be accessed via this link: pacrim1.sharepoint.com
2. Click on **Human Resources**
3. Select **Request Assistance**
4. Fill out the **Request Form** and click **Submit**

Pacific Rim Mechanical HR/Benefits/Payroll Department

Emee Atienza <i>Benefits/ Dependent Verification</i>	Cynthia Lopez <i>Benefits/Wellness/Rewards/ LOA/Dependent Verification</i>	Jennifer Mouritzen <i>HR/Benefits/Payroll</i>	Sonia Ortiz <i>HRIS/Onboarding</i>
Carol Misner <i>Payroll/401(k)</i>	Sarah Luong <i>Payroll/PTO/Paperless Deposits</i>	Jacqueline Stellmacher <i>Payroll/PTO</i>	

Cavignac Benefit Team

Our team at Cavignac can also be contacted for any questions related to benefits. Your private health information is protected when speaking to the team at Cavignac.

Ariana Vigil (619) 744-0588 avigil@cavignac.com	Annelise Jarrett (619) 744-0561 ajarrett@cavignac.com	Employee Benefits Advocate (800) 895-7988 EBAdvocate@cavignac.com
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Carrier Contact Information

Benefit	Carrier/Network/Policy/Notes	Website (QR Codes found on corresponding benefit page)	Mobile App	Phone
Benefits Portal	<i>Employee Navigator</i>	employeenavigator.com/benefits/ account/login		
Wellness	<i>Personify Wellness/Pac Rim Wellness</i>	MyPacRimWellness.com Username: email address Enrollment Paraphrase: wealthy-grasshopper-91	Personify	(888) 671-9395
Paperless Paystubs	<i>pVault</i>	employee.prmech.com Username: email address on file with Payroll		Contact Payroll with email changes



Benefit	Carrier/Network/Policy/Notes	Website (QR Codes found on corresponding benefit page)	Mobile App	Phone
Rewards	My Point Rewards/Pac Rim Rewards	MyPacRimRewards.com Initial Username: Employee Number + last four of SSN		
Medical- Cigna	Cigna Medical/Telehealth/MDLive Network: LocalPlus or OAPIN Additional Tier: Cigna One Guide Policy: 3335362 Pharmacy Network: LocalPlus or OAPIN Additional Tier: Cigna One Guide Policy: 3335362 / RxBIN: 017010 RxPCN: 0215COMM Cigna Vision Network: Cigna Vision Policy: 3335362	cigna.com mycigna.com	myCigna	(800) CIGNA24 or (800) 244-6224 (800) 285-4812 (Home Delivery Rx) (888) 726-3171 (Telehealth/MDLive) (877) 478-7557 (Cigna Vision)
Employee Assistance Program (EAP)	Cigna Behavioral	cigna.com mycigna.com Employer ID: pacrim	myCigna	(877) 622-4327
Dental	Principal Networks: * First Dental Health (EPO) * Principal Point of Service (POS) Policy: 1139938	principal.com	Principal Mobile	(800) 247-4695
Vision	Principal Network: VSP Vision Policy: 1196127	principal.com	Principal Mobile	(800) 877-7195
Legal	LegaleASE	legaleaseplan.com/prmech		(800)248-9000
Identity Theft	Allstate	myaip.com	Allstate Identity Protection	(800) 789-2720
Basic/ Voluntary Life & LTD	Principal Life	principal.com		(800) 245-1522 Principal IBU: (888) 390-5155
401(k)	Empower Retirement	participant.empower-retirement.com	Empower Retirement	(800) 338-4015
Flexible Spending	IGOE	goigoe.com/spending-accounts	Igoe Mobile	(800) 633-8818 (Option #1)
COBRA	IGOE	cobralogin.wexhealth.com		(800) 633-8818 (Option #2)

Company Name (the “Company”)

Pacific Rim Mechanical

Effective Date

1/1/2026

Creditable Plan Name(s)Pacific Rim Mechanical Comprehensive
Health and Welfare Benefit Plan**Plan Administrator**Pacific Rim Mechanical
Human Resources
9125 Rehco Road
San Diego, CA 92121
(858) 974-6500**HIPAA Privacy Official**Jennifer Mouritzen
Director of Human Resources
(858) 974-6500**HIPAA Special Enrollment Deadline**

31 days

**Members of Organized Health Care
Arrangement**Allstate
Cavignac Insurance Brokers
Cigna
Employee Navigator
Evernorth Behavioral
IGOE
Kaiser Permanente
LegalEase
Pacific Rim Mechanical
Personify Wellness
Principal

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Women’s Health and Cancer Rights 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:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including Lymphedemas (swelling associated with the removal of lymph nodes).

These benefits may be subject to annual deductibles and coinsurance provisions that are appropriate and consistent with other benefits under your plan or coverage. If you would like more information on WHCRA benefits, contact your chosen health insurance plan or the Pacific Rim Mechanical Benefit Department via the Employee Portal.

Notice of HIPAA Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage 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 days 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 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your chosen health insurance plan or the Pacific Rim Mechanical Benefit Department via the Employee Portal.



Patient Protections Notice

If a qualifying benefit option under a group health plan maintained by the employer generally requires or allows the designation of a primary care provider, the covered individual has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the covered individual. Until the covered individual makes this designation, the Plan may designate a primary care provider for him or her. For children, the covered employee or spouse may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your chosen health insurance plan or the Pacific Rim Mechanical Benefit Department via the Employee Portal.

For any qualifying benefit option, covered individuals do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's 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 your chosen health insurance plan or the Pacific Rim Mechanical Benefit Department via the Employee Portal.

Important Notice from the Company About Your Prescription Drug Coverage and Medicare under the Creditable Plan(s)

All medical plans offered through Pacific Rim Mechanical are Creditable coverage.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. You can find a copy on our Benefit Portal (Employee Navigator), or reach out to the Pacific Rim Mechanical Benefit Department via the Employee Portal.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede 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. The Company has determined that the prescription drug coverage offered by the Creditable 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 15 to December 7.

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

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

If you decide to join a Medicare drug plan, your current Pacific Rim Mechanical coverage will not be affected. Because you have coverage that is, on average, at least as good as standard Medicare prescription drug coverage, your coverage is considered creditable.

This means that if you decide to join a Medicare drug plan, your current company coverage will not be affected. You can keep your current coverage and also join a Medicare drug plan later if you decide to do so.

The Prescription Benefits under Pacific Rim Mechanical's medical plans cover Generic Drugs (Tier 1) \$15 Copay, Preferred Brand Drugs (Tier 2) \$30 Copay and Non-Preferred Brand Drugs (Tier 3) \$50 Copay. Please refer to the Summary Plan Description (SPD Wrap Document) for additional plan information.

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 the Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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



For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the Pacific Rim Mechanical Benefit Department via the Employee Portal 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 the Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://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 [socialsecurity.gov](https://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).

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

Wellness Program and Reasonable Alternative Standard

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all full-time, eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact: the wellness vendor. They will work with you to find a wellness program with the same reward that is right for you in light of your health status.

Rights for Employees Under the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) is a federal law that helps employees balance work and family responsibilities. It allows eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for certain family and medical reasons.

Health insurance coverage continues while you are on FMLA leave, just as if you were still working.

Who is Eligible?

You may be eligible for FMLA leave if:

- You work for a covered employer.
- You have worked for your employer for at least 12 months (these months do not have to be consecutive).
- You have worked at least 1,250 hours during the 12 months before your leave starts.
- You work at a location where your employer has at least 50 employees within 75 miles.

What Employers are Covered?

FMLA applies to:

- All public agencies (local, state, and federal).
- Public and private elementary and secondary schools.
- Private companies with 50 or more employees in 20 or more workweeks during the current or last calendar year.

Reasons You Can Take FMLA Leave

You may take FMLA leave for:

- The birth of a child and care for the newborn.
- Placement of a child with you for adoption or foster care.
- Caring for your spouse, child, or parent with a serious health condition.
- Your own serious health condition makes you unable to perform your job.
- Certain qualifying reasons related to a family member's military service.

If you are the spouse, child, parent, or next of kin of a covered servicemember with a serious injury or illness, you may take up to 26 weeks of FMLA leave in a single 12-month period to care for them.

Your Rights When You Return

When your FMLA leave ends, you have the right to return to your job or an equivalent position with the same pay, benefits, and working conditions.

Other rights include:

- Continued group health insurance coverage during leave.
- Protection from interference or denial of your FMLA rights by your employer.
- Protection from retaliation for using FMLA leave.

Your Responsibilities

- Give your employer 30 days advance notice before taking FMLA leave, when possible. If that's not practical, inform them as soon as you can.
- Follow your employer's usual procedures for requesting leave.
- Provide enough information so your employer can determine if your leave qualifies for FMLA protection. You may have to provide certification from a healthcare provider.

Employer Responsibilities

Your employer must:

- Post this General Notice so all employees and job applicants can see it; if there are employees who do not read English, the notice must be provided in their language.
- Notify you about your eligibility, rights, and responsibilities under FMLA.
- Not interfere with, restrain, or deny your FMLA rights.
- Not retaliate against you for using or requesting FMLA leave.



Health Insurance During Leave

Your group health coverage will continue under the same terms as if you were working. If you usually pay part of your premiums, you must continue to pay your share while on FMLA leave.

Enforcement and Complaints

The Department of Labor's Wage and Hour Division (WHD) enforces FMLA. To file a complaint or get more information:

- Visit the DOL website: dol.gov
- Call 1-866-4US-WAGE (1-866-487-9243)
- Contact your local Wage and Hour Division office

This notice summarizes your rights and responsibilities under the Family and Medical Leave Act. For full details, refer to the law and regulations or contact the U.S. Department of Labor.

For more information: Contact the Pacific Rim Mechanical Benefit Team via the Pacific Rim Mechanical Employee Portal or visit dol.gov/whd/fmla.

Health Insurance Marketplace Coverage Options and Your Health Coverage

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 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 9.96% 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 9.96% 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://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 the Pacific Rim Mechanical Benefit Team via the Pacific Rim Mechanical Employee Portal.

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.

Newborns' and Mothers' Health Protection Act (NMDHPA)

Your health plan follows the Newborns' and Mothers' Health Protection Act of 1996, which ensures that mothers and newborns receive adequate hospital care after childbirth.

Vaginal delivery: minimum 48-hour hospital stay
Cesarean section: minimum 96-hour hospital stay

The attending provider may allow an earlier discharge if medically appropriate. Your plan cannot require prior authorization for a stay consistent with this law. For questions about your maternity coverage, contact your medical insurance provider or the Pacific Rim Mechanical Benefits team via the Pacific Rim Mechanical Employee Portal.

Michelle's Law Enrollment Notice

Under Michelle's Law, if a student covered under your health plan takes a medically necessary leave of absence from school due to a serious illness or injury, your health coverage may continue for up to 12 months during the leave.

Key Points:

- Applies to students who would otherwise lose coverage while on a medically necessary leave.
- Coverage continuation applies to both the student and any dependents covered under the plan.

To request coverage under Michelle's Law, you may need to provide documentation from the attending healthcare provider and the school. For questions about your rights under Michelle's Law or your plan's coverage options, contact the Pacific Rim Mechanical Benefits team via the Pacific Rim Mechanical Employee Portal.

Notice Regarding Designation of a Primary Care Provider

Your health plan may require you to choose a primary care provider (PCP) who will coordinate your medical care. You have the right to select any PCP who participates in the plan's network and who is available to accept you or your family members as patients. If your plan designates a PCP automatically, you may change your PCP at any time by contacting the plan directly. For children, you may choose a pediatrician as the child's PCP. For women, you may obtain care from an OB/GYN or women's health care professional without a referral from your PCP. For information on selecting or changing your PCP, or to obtain a list of participating providers, contact your Medical Insurance .

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 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 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 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.flmedicaidprecovery.com/flmedicaidprecovery.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: KIHIPPPROGRAM@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/la hipp 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: HSHIPPProgram@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)	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
dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Continuation Coverage Rights Under COBRA

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."
- 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."

When is the COBRA Continuation Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Pacific Rim Mechanical Benefit Team via the Pacific Rim Mechanical Employee Portal within 60 days after the qualifying event occurs.

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 Pacific Rim Mechanical Benefit Team via the Pacific Rim Mechanical Employee Portal or the COBRA vendor 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.



To process this extension, documentation from the Social Security Administration (SSA) required and require you provide the following within 60 days of the later of the Social Security Administration determination date or the date your COBRA coverage began:

- A copy of your official Social Security Administration Disability Determination Letter (“Notice of Award”) confirming your disability. This documentation is required to verify your eligibility for the extended COBRA coverage.

Once we receive the Social Security Administration notice, your COBRA coverage will be updated to reflect the disability extension and confirmation will be sent. If you have any questions or need assistance obtaining your Social Security Administration documentation, please contact the COBRA Third-party Administrator (TPA) IGOE at: COBRA@goigoe.com, or 1-800-633-8818, Option 2.

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.

To process this extension, we require documentation of the qualifying event within 60 days. If you have any questions or need assistance, please contact the COBRA Third-party Administrator (TPA) IGOE at: COBRA@goigoe.com, or 1-800-633-8818, Option 2.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children’s Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at 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 period² 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://medicare.gov/medicare-and-you>.

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.

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 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 HealthCare.gov.

COBRA Plan Contact Information

- Active Employees: contact Pacific Rim Mechanical Benefit Team via the Pacific Rim Mechanical Employee Portal
- Non-Active Employees on COBRA: contact our COBRA administrator IGOE (details on page 37)

Your Rights & Protection Against Surprise Billing Under California Law and Federal Law

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “Balance Billing” (Sometimes Called “Surprise Billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.



“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are Protected from Balance Billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

If you believe you’ve been incorrectly balance billed, contact your health plan or the California Department of Managed Health Care for assistance. These protections apply to enrollees in health plans regulated by the California Department of Managed Health Care (<https://dmhc.ca.gov/FileaComplaint.aspx>).

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

If you believe you’ve been incorrectly balance billed, contact your health plan or the California Department of Managed Health Care for assistance. These protections apply to enrollees in health plans regulated by the California Department of Managed Health Care (<https://dmhc.ca.gov/FileaComplaint.aspx>).

When Balance Billing Isn’t Allowed, You Also Have the Following Protections:

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

If you believe you’ve been wrongly billed, the California Department of Managed Health Care. <https://dmhc.ca.gov/FileaComplaint.aspx> and/or the No Surprises Act dispute resolution mechanisms through the Centers for Medicare & Medicaid Services CMS website <https://cms.gov/nosurprises>

Visit Centers for Medicare & Medicaid Services CMS website <https://cms.gov/nosurprises> for more information about our rights under federal law.

If unresolved, you may submit a complaint to:

California Department of Managed Health Care (for health plans regulated by DMHC) <https://dmhc.ca.gov/FileaComplaint.aspx>

California Department of Insurance (for insurance products regulated by CDI) <https://insurance.ca.gov/>

Or, in the federal context, the No Surprises Act dispute resolution mechanisms (or contact the federal No Surprises Help Desk) <https://cms.gov/nosurprises>

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The time required to complete this information collection is estimated to average 3.5 hours per response, 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: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210

Endnotes

1. Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.
2. <https://medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>





YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at <https://www.dol.gov/agencies/vets/>. An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra>
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <https://www.dol.gov/agencies/vets/programs/userra/poster> Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



U.S. Department of Labor
1-866-487-2365



U.S. Department of Justice



Office of Special Counsel



1-800-336-4590
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