EMPLOYEE BENEFITS GUIDE

May 2022

cambridge management inc

VAUGHN BAY CONSTRUCTION

WHAT'S INSIDE

WELCOME TO YOUR BENEFITS!

Cambridge Management, Inc. and Vaughn Bay Construction are proud to offer a robust benefits package to our employees and their families! Our benefits package is designed around choice, flexibility, and value.

To learn about the available plans and choose which ones are right for your lifestyle and budget, take a look at this Benefits Guide. Highlights of all the plans and some additional decision-making tools are available online too. If you have general questions on your benefits or how to enroll, reach out to Human Resources.

In addition, a Summary of Benefits and Coverage (SBC) is available on your Employee Self-Service portal to help you make your healthcare coverage choices. The SBC summarizes information about your medical plan options and is in a standard format required by the Affordable Care Act. A paper copy is also available, free of charge. Please contact Human Resources to request a copy.

BENEFITS PHILOSOPHY

Cambridge Management, Inc. and Vaughn Bay Construction's benefits philosophy is to provide you and your family competitive benefits that are consistent within our local market and industry, while also managing costs for our employees and the company. Healthcare costs continue to rise and as a result, some of these costs need to be shared between employer and employee. Cambridge Management, Inc. and Vaughn Bay Construction's distribution of costs between employer and employee are competitive with both local and national markets.

Descriptions of each of the benefits offered can be found via Employee Self-Service.

ELIGIBILITY

All regular full-time employees scheduled to work **30 or more hours each week** are eligible for benefits. Coverage will begin on the first of the month following 60 days of employment. Benefit selections made during the annual Open Enrollment period will be effective on May 1st. You may enroll your eligible dependents for medical, dental, and vision, voluntary life, and voluntary UNUM products. They are also eligible to receive Employee Assistance Program (EAP) services. Your eligible dependents include:

- Your legal spouse or domestic partner
- Your children up to age 26
- Any overage dependent child who is incapable of self-support because of a physical or mental disability and meets carrier requirements for coverage

MAKING CHANGES TO YOUR BENEFITS

You may make changes to your benefits once a year during Open Enrollment. All benefits you select will be effective for a full plan year, unless you have a "qualified change in status" or are no longer eligible under the plan (e.g. leave employment). Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

QUALIFIED CHANGE IN STATUS EXAMPLES

- Birth or adoption of a child
- Loss of your or a dependent's coverage under another plan
- Change in marital status

If you have a qualified change in status, you can make changes to your benefits by contacting Human Resources within 60 days of the change. The change to your benefits must be consistent with the qualified change in status. For example, if you have a new baby, you can enroll the child as a dependent under your current health plan, but you may not remove another dependent who is already covered. To determine if your situation allows you to make changes to your benefits, please contact Human Resources or a Gallagher Benefit Advocate.

IMPORTANT:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 25 for more details.

NEW HIRE ENROLLMENT OVERVIEW

***For newly eligible employees*. Please follow the steps below to choose your benefits and enroll.**

BENEFIT PLANS

- Medical insurance covering a broad network of doctors and prescriptions
- Dental insurance
- Vision insurance
- Life and accidental death & dismemberment insurance
- Long term disability insurance
- Voluntary short term disability (excludes WA and CA), life and accidental death & dismemberment insurance
- Voluntary accident, hospital indemnity and critical illness
- Employee Assistance Program (EAP)

QUESTIONS

Do you have questions about understanding what benefits are offered or how to enroll?

Contact Human Resources:
253.534.7200
Cambridge Management: hr@cmiweb.net
Vaughn Bay Construction:
hr@vaughnbay.net

Or

Contact a Benefit Advocate
(a service provided by Gallagher).
You can reach a Benefit Advocate at:
bac.cambridgeproperty@ajg.com
or by phone: 833.330.9503,
8:00 a.m. - 6:00 p.m. PT
Monday - Friday

PREPARE EVERYTHING YOU WILL NEED

- Social Security numbers for you and any family members whom you want to cover
- Dates of birth for your family members
- ID cards for any other medical plans under which you or your family members are covered

CHOOSE YOUR BENEFITS

Take the time to review the benefit outlines in this Guide and the Summary of Benefits and Coverage from the insurance company. This will help you understand the plans and how they will fit your lifestyle and budget. To make sure your family doctor and dentist are covered by the plans you have chosen, check the Provider Directory online or call customer service (see “Your Benefits Contacts” toward the back of this Guide).

COMPLETE YOUR ENROLLMENT

- Cambridge Management, Inc. employees will be required to complete their enrollment online via Employee Self-Service. For changes due to a qualifying event, a paper enrollment form is required.

- Vaughn Bay Construction employees will be required to complete their enrollment via paper enrollment forms.

Please contact Human Resources if you have any question regarding Employee Self-Service or if you need enrollment forms.

IMPORTANT

Enrollment timeline may vary in certain situations. See “Special Enrollment Rights” on page 22.

YOU ARE DONE!

OPEN ENROLLMENT OVERVIEW

For employees already enrolled.

Open Enrollment is your only opportunity to make changes to your benefits for the year unless you have specific life events, such as:

- Birth or adoption of a child
- You, your spouse or a dependent loses coverage under another group plan
- Change in marital status

IMPORTANT

Enrollment timeline may vary in certain situations. See "Special Enrollment Rights" on page 22.

COMPLETE YOUR ENROLLMENT

You may make changes to your benefits once a year during Open Enrollment. All benefits you select will be effective for a full plan year, unless you have a "qualified change in status" or are no longer eligible under the plan (e.g. leave employment). Many of your benefits are available on a pre-tax basis, therefore, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

If you have a qualified change in status, you can make changes to your benefits by contacting Human Resources within 60 days of the change. The change to your benefits must be consistent with the qualified change in status. For example, if you have a new baby, you can enroll the child as a dependent under your current health plan, but you may not remove another dependent who is already covered. To determine if your situation allows you to make changes to your benefits, please contact Human Resources or a Gallagher Benefit Advocate.

To make changes outside of Open Enrollment, you will be required to complete an enrollment form which can be obtained from Human Resources.

HOW DO I WAIVE COVERAGE

Cambridge Management, Inc. Employees: If you wish to waive any of the Medical/Rx, Dental, and/or Vision benefits, you must waive benefits via Employee Self-Service.

Vaughn Bay Construction Employees: If you wish to waive any of the Medical/Rx, Dental, and/or Vision benefits, you must complete the paper enrollment/change forms.

BENEFIT COSTS

Cambridge Management, Inc. and Vaughn Bay Construction cover the greater portion of you and your dependent's medical, dental, and vision premiums. Your basic life insurance coverage, long-term disability benefits and Employee Assistance Plan (EAP) are 100% paid for by the company. This table shows how much of the premiums are paid by the company and what part is your responsibility.

	Monthly Cost	Medical Base PPO Plan	Medical Buy-Up PPO Plan	Medical HDHP HSA Plan	Medical HNO Florida Only Plan	Dental	Vision
Employee only	Total Monthly Cost	$666.05	$806.06	$599.44	$581.80	$33.19	$4.83
	Employer Pays	$606.05	$633.06	$599.44	$581.80	$23.19	$2.83
	Your Monthly Cost	**$60.00**	**$173.00**	**$0.00**	**$0.00**	**$10.00**	**$2.00**
Employee plus Spouse	Total Monthly Cost	$1,647.89	$1,994.48	$1,483.11	$1,439.58	$67.47	$7.73
	Employer Pays	$1,145.44	$1,212.30	$1,113.66	$1,105.26	$23.19	$2.83
	Your Monthly Cost	**$502.45**	**$782.18**	**$369.45**	**$334.32**	**$44.28**	**$4.90**
Employee plus Child(ren)	Total Monthly Cost	$1,327.14	$1,606.25	$1,194.43	$1,159.37	$73.53	$7.88
	Employer Pays	$1,083.57	$1,137.41	$1,057.97	$1,051.21	$23.19	$2.83
	Your Monthly Cost	**$243.57**	**$468.84**	**$136.46**	**$108.16**	**$50.34**	**$5.05**
Employee plus Family	Total Monthly Cost	$2,302.31	$2,786.39	$2,072.08	$2,011.78	$123.20	$12.72
	Employer Pays	$1,271.68	$1,365.06	$1,227.27	$1,215.64	$23.19	$2.83
	Your Monthly Cost	**$1,030.63**	**$1,421.33**	**$844.81**	**$796.14**	**$100.01**	**$9.89**

Costs for coverage of domestic partners and their children might not be deducted on a pre-tax basis. If your domestic partner is not an eligible tax dependent as defined in Section 152 of the Internal Revenue Code, then a portion of your contribution will be deducted after-tax and the company's contribution for domestic partner coverage will be taxable income to you and reported as imputed income on your paycheck. For more information, please contact Human Resources.

Cambridge Management, Inc. and Vaughn Bay Construction offers you four medical plans through Aetna. The plans provides excellent coverage of preventive services, such as routine physical exams and immunizations that are very important to you and your family's health. Prescription drug benefits are also included with the medical plan.

MEDICAL BENEFITS – PLAN HIGHLIGHTS

Cambridge Management, Inc. and Vaughn Bay Construction are pleased to provide you a medical and prescription drug plan administered by Aetna. The chart below provides a brief overview of the benefits available to you. Please refer to the plan summaries for more detail. Visit **www.aetna.com** to search for a provider.

Base and Buy-Up Plan: Select Aetna Standard Plans then select Open Choice PPO.

PCY = Per Calendar Year (January 1-December 31)	Base PPO Plan		Buy-Up PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$5,000/ $10,000	$10,000/ $20,000	$2,000/ $4,000	$4,000/ $8,000
What You Pay	30%	50%	20%	50%
Annual Out-of-Pocket Maximum (Individual/Family)*	$7,900/ $15,800	$20,000/ $40,000	$6,350/ $12,700	$20,000/ $40,000
Preventive Care	No charge	50% after deductible	No charge	50% after deductible
Office Visit	$35 per visit	50% after deductible	$20 per visit	50% after deductible
Specialist Visit	$35 per visit	50% after deductible	$20 per visit	50% after deductible
Telemedicine	$35 per visit		$20 per visit	
Mental Health	$35 per visit	50% after deductible	$20 per visit	50% after deductible
Basic Lab & Imaging	30%	50% after deductible	20%	50% after deductible
Complex Lab & Imaging	30% after deductible	50% after deductible	20%	50% after deductible
Surgery	30% after deductible	50% after deductible	20% after deductible	50% after deductible
Rehabilitation	$35 per visit	50% after deductible 45 visits combined PCY	$20 per visit	50% after deductible 45 visits combined PCY
Chiropractic Care	$35 per visit	50% after deductible 12 visits combined PCY	$20 per visit	50% after deductible 12 visits combined PCY
Acupuncture	$35 per visit	50% after deductible 12 visits combined PCY	$20 per visit	50% after deductible 12 visits combined PCY
Urgent Care	$35 per visit	50% after deductible	$20 per visit	50% after deductible
Emergency Room (copay waived if admitted)	$200 copay + 30%		$200 copay + 20%	
Inpatient Hospitalization	30% after deductible	50% after deductible	20% after deductible	50% after deductible

*Until the family out-of-pocket maximum is reached, each person enrolled in the plan to meet their own individual maximum

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

Note: Covered expenses accumulate separately towards in-network/out-of-network deductibles and out-of-pocket maximums.

MEDICAL BENEFITS – PLAN HIGHLIGHTS

Cambridge Management, Inc. and Vaughn Bay Construction are pleased to provide you a medical and prescription drug plan administered by Aetna. The chart below provides a brief overview of the benefits available to you. Please refer to the plan summaries for more detail. To search for a provider go to Aetna.com.

HNO Plan: select Aetna Open Access Plans, then select Aetna Health Network Only (Open Access).

HSA Plan: select Aetna Standard Plans then select Open Choice PPO.

PCY = Per Calendar Year (January 1-December 31)	Florida HNO Plan	HSA Plan	
	In-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$5,000/ $10,000	$5,000/ $10,000	$10,000/ $20,000
What You Pay	30%	20%	50%
Annual Out-of-Pocket Maximum (Individual/Family)*	$7,900/ $15,800	$7,000/ $14,000	$20,000/ $40,000
Preventive Care	No charge	No charge	Not covered
Office Visit	$35 per visit	20% after deductible	50% after deductible
Specialist Visit	$35 per visit	20% after deductible	50% after deductible
Telemedicine	$35 per visit	20% after deductible	50% after deductible
Mental Health	$35 per visit	20% after deductible	50% after deductible
Basic Lab & Imaging	30%	20% after deductible	50% after deductible
Complex Lab & Imaging	30% after deductible	20% after deductible	50% after deductible
Surgery	30% after deductible	20% after deductible	50% after deductible
Rehabilitation	$35 per visit 60 visits combined PCY	20% after deductible 45 visits combined PCY	50% after deductible
Chiropractic Care	$35 per visit 20 visits combined PCY	20% after deductible 12 visits combined PCY	50% after deductible
Acupuncture	$20 per visit 12 visits combined PCY	20% after deductible 12 visits combined PCY	50% after deductible
Urgent Care	$35 per visit + 30%	20% after deductible	50% after deductible
Emergency Room (copay waived if admitted)	$200 copay + 30%	20% after deductible	
Inpatient Hospitalization	30% after deductible	20% after deductible	50% after deductible

*Until the family out-of-pocket maximum is reached, each person enrolled in the plan has to meet their own individual maximum

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

Note: Covered expenses accumulate separately towards in-network/out-of-network deductibles and out-of-pocket maximums.

MEDICAL BENEFITS – RESOURCES

AETNA HEALTH APP AND AETNA WEBSITE

- View your health plans summary and get detailed information about what's covered
- View claims
- Search for providers
- Get cost estimates
- Access your ID card

NURSE LINE - GET ANSWERS TO YOUR QUESTIONS - 24/7

Call Aetna's Informed Healthline at 800.556.1555 anytime to get help for you and others on your Aetna plan. You can talk to a nurse about a variety of topics. You can also ask about ways to manage a current health problem.

AETNA WELLNESS INFORMATION

Your Aetna plan gives you access to many perks to help you achieve your health and wellness goals. To get started, log into your account on the member website at Aetna.com.

On the site you will find:

- Ways to improve your overall health
- Answers to your health care questions
- Discounts on products and services
- Take the online health assessment to understand your health needs
- Set health goals based on your results
- Choose an online health coaching journey that targets your goals, like eating healthier and sleeping better

DISCOUNTS PROGRAMS:

- At-home products
- Fitness and weight management services
- Hearing and vision care
- Dental health care
- Natural products and services (acupuncture, chiropractic, massage and nutrition).

Log in to your member website at Aetna.com.

AETNA VIRTUAL HEALTH - TELADOC®

We all have times when we need to see a provider, but it's inconvenient. You and your eligible dependents can use Teladoc to get treated by doctors by phone or online video, so you have immediate and convenient access to care whenever and wherever you need it.

Common conditions a Teladoc physician can help you handle include sinus problems, allergies, cold and flu symptoms and many other non-emergency illnesses. Your health plan deductible and office visit copays and coinsurance apply, same as seeing your regular doctor.

Visit the Teladoc website at: https://member.teladoc.com/aetna. Click "Set Up Account", and provide the required information in the "My Medical History" tab. You can also call Teladoc at 855.835.2362. After you set up your account, a Teladoc doctor is just a call or click away anytime you need medical care.

On the go? Download the Teladoc mobile app to request a visit anytime.

PRESCRIPTION DRUG BENEFITS

Your medical insurance includes comprehensive prescription drug coverage. The level of coverage depends on whether the drug is preferred generic, preferred brand-name, non-preferred, and whether it is on the Aetna Formulary. Your out-of-pocket cost is the lowest when you buy generic drugs, and highest when you buy non-preferred drugs that are not on the formulary. To find out if your medication is on the formulary, please check the online list at **Aetna.com** and search under **Advanced Control Plan.**

	Base Plan	Buy-Up Plan
Retail Pharmacy - up to 30-day supply	At Participating Pharmacies Only (deductible waived)	At Participating Pharmacies Only (deductible waived for generics, otherwise deductible is $100 Individual / $200 Family)
Preferred Generic	$15	$15
Preferred Brand	$30	$35
Non-Preferred Generic and Brand	30%	$60
Preferred Specialty	$50	Covered at applicable generic/brand copay
Non-Preferred Specialty	30%	Covered at applicable generic/brand copay
Mail Order - up to 90-day supply	2.5 x retail copay (Specialty not included)	2 x retail copay (Specialty not included)

	HSA Plan	Florida HNO Plan
Retail Pharmacy - up to 30-day supply	At Participating Pharmacies Only (Medical deductible applies)	At Participating Pharmacies Only (deductible waived)
Preferred Generic	$15	$15
Preferred Brand	$30	$30
Non-Preferred Generic and Brand	30%	30%
Preferred Specialty	$50	$50
Non-Preferred Specialty	30%	30%
Mail Order - up to 90-day supply	2 x retail copay (Specialty not included)	2.5 x retail copay (Specialty not included)

IMPORTANT

If you are prescribed a brand name drug when a generic equivalent is available, you will be charged the brand name copay, plus the difference in cost between the brand name and generic drug.

Specialty drugs are only available through a specialty pharmacy. You will be notified of the refill procedure if you are taking one of these drugs.

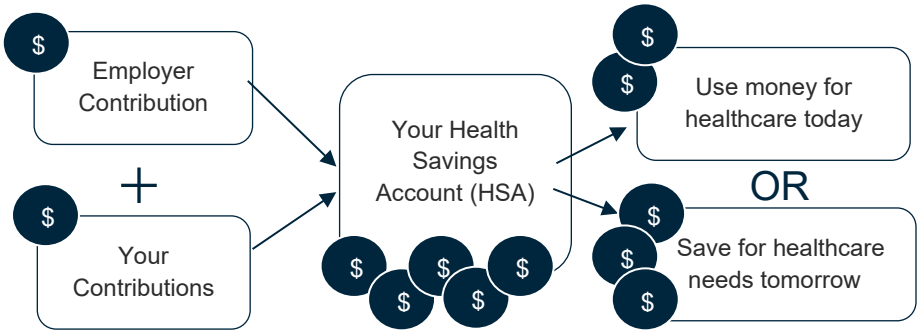
HEALTH SAVINGS ACCOUNT (HSA)

PAYFLEX®

WHAT IS AN HSA?

If you enroll in Cambridge Management, Inc. and Vaughn Bay Construction's High Deductible Health Plan (HDHP), then you may be eligible to open an HSA. An HSA is a bank account where you can set aside money to pay for expenses that your health plan does not cover. The money in your HSA is not considered income, so it is not subject to taxes.

HOW DOES AN HSA WORK?



You can use the money in your HSA at any time to pay for eligible medical expenses. When you visit a provider, no copay is required at the time of service. The provider will submit a claim to your health plan for the services you received. Your health plan will then send you an Explanation of Benefits (EOB) outlining the negotiated/allowed charges. The provider will then send you an invoice reflecting the allowed charges. Make sure the amount matches the EOB sent to you by your health plan. You can then pay the invoice with money from your HSA (either your HSA debit card or as a reimbursement to you). Remember to keep your receipts, in case the IRS requests them.

CONTRIBUTIONS

Cambridge Management, Inc. and Vaughn Bay Construction contribute $50 per pay period to a maximum of $600 per year into your HSA. You can also add your own tax-free contributions.

Together, your contributions and your employer contributions cannot exceed $3,650 (individual) or $7,300 (family) in 2022.

For individuals age 55 or older, an additional $1,000 in "catch-up" contributions are allowed for 2022.

Your money rolls over every year. There is no "use it or lose it" rule.

WHO CAN OPEN AN HSA?

You are eligible to open and contribute to an HSA if you meet the following requirements:

- You must be covered by a qualified high-deductible health plan.
- You must **not** be enrolled in or covered by Medicare or Tricare.
- You must **not** be covered by your own or a spouse's general Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or any other non HSA-qualified health plan.
- You must **not** be claimed as a tax dependent on another person's taxes.
- You have **not** received any Veteran's Administration health benefits for a non-service connected disability in the last three months.
- You have **not** used Indian Health Services coverage in the last three months.

HSAs AND DOMESTIC PARTNERS

Domestic partners are eligible to be enrolled in an HDHP plan, however distributions from the HSA are only allowed if your domestic partner is an IRS qualified tax dependent. Consult your tax advisor for details.

RESOURCES

Download Payflex Mobile Application, visit Payflex.com, or call 844.729.3539

- View account balance, account alerts, claims and transaction history
- Submit a new claim
- Upload claim documentation

The intent of this information is to provide general information about HSA regulations. It is not intended to address specific situations or provide tax advice. Questions regarding specific issues should be discussed with a tax advisor.

DENTAL BENEFITS

Cambridge Management, Inc. and Vaughn Bay Construction are pleased to provide you a dental plan administered by Aetna. The chart below provides a brief overview of the benefits available to you. Please refer to the plan summaries for more detail.

When searching for an in-network dentist search for Dental PPO/PDN with PPOII network. Please see the information in "Your Benefits Contacts" toward the back of this guide.

USUAL, CUSTOMARY & REASONABLE

Benefits are paid at the negotiated fee level for in-network providers. Benefits for services from out-of-network providers will be paid at the 90th percentile of the amount charged by the majority of dentists in the area.

	In-Network	Out-of-Network
Annual Deductible (waived for Preventive & Diagnostic)	$50 per person $150 per family	
Annual Benefit Maximum	$2,000 per person	
Waiting Period	None	
Services		
Preventive & Diagnostic	No charge	No charge
Basic	20% after deductible	20% after deductible
Major	50% after deductible	50% after deductible
Periodontics	Covered under basic	
Endodontics	Covered under basic	
Implants	Covered under major	
Orthodontia (Children only – placed before age 20)		
Services	20%	20%
Lifetime Benefit Maximum	$2,000 per person	

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms, and conditions of the contract.

VISION BENEFITS

Cambridge Management, Inc. and Vaughn Bay Construction are pleased to provide you a vision plan through EyeMed that offers coverage for routine eye exams and prescription glasses or contacts. You can visit any licensed provider. Visit **www.eyemed.com** to find a provider near you, and for more details on your coverage and exclusive savings and promotions for EyeMed members.

	Insight Network	Out-of-Network Reimbursed
Routine Exam	$10 per visit	Up to $40
Lenses		
Single Vision	$25	Up to $30
Lined Bifocals	$25	Up to $50
Lined Trifocals	$25	Up to $70
Frames	$150 allowance then 20% discount	Up to $105
Contact Lenses (in lieu of eyeglasses)		
Fitting and Evaluation	Standard*: up to $40 copay Premium*: 10% discount	Not covered
Elective Contacts – Conventional	$0 copay; $150 allowance, then 15% discount over $150 allowance	
Elective Contacts - Disposable	$0 copay; $150 allowance (no discount over allowance)	
Frequency (Exam/Lenses/Frames/Contacts)	12/12/24/12 months	

*Standard Contact Lens Fit: Routine applications of soft, spherical (astigmatism less than .75D), daily wear contact lenses for single vision prescriptions. Does not include extended/overnight wear.

*Premium Contact Lens Fit: More complex applications, including, but not limited to toric (astigmatism .75D or higher), bifocal/multifocal, cosmetic color, post-surgical and gas permeable. Does include extended/overnight wear for any prescription.

If you purchase oversize lenses or have anything “special” done to your lenses (i.e., tinting, scratch guard, etc.), you will be responsible for this cost.

Note: Frequency begins with first date of service.

LIFE & DISABILITY BENEFITS

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

To help employees protect their family's standard of living in the event of a death, the company provides employer paid life and accident insurance coverage.

	Life/AD&D
Benefit Amount	
On-Site Employees	$25,000
Corporate Employees	1x annual salary up to $150,000
Benefits Reduce To:	65% at age 70; 50% at age 75

WHEN YOU FIRST ENROLL

When you first enroll in life insurance benefits, you will need to designate a beneficiary who would receive the benefits in the event of your death. You may change or update your beneficiary at any time.

TAXES

Employers who pay for employees' group life insurance must tax them on the cost of insurance for amounts exceeding $50,000.

LONG-TERM DISABILITY (LTD) COVERAGE

Cambridge Management, Inc. and Vaughn Bay Construction provide employer paid long-term disability coverage to protect an employee's income in the event of a disability.

	Long-Term Disability
Monthly Benefit Amount	60% of base monthly earnings
Maximum Monthly Benefit	$7,500
Elimination Period	90 days
Benefit Duration	Social Security Normal Retirement Age (SSNRA)
Definition of Disability	Employee is limited from performing the material and substantial duties of their regular occupation due to sickness or injury and they have a 20% or more loss in monthly earnings due to the same sickness or injury

VOLUNTARY LIFE/AD&D BENEFITS

You have the option to purchase life insurance coverage through UNUM. Because these policies are paid by you through payroll deductions, you have the option to keep your policy regardless of job changes by continuing to pay the premiums. If interested in any of these products, please contact Human Resources for additional information.

Voluntary Life – Benefit Outline	
Benefit Options	
Employee	$10,000 Increments
Spouse	$5,000 Increments
Children	
Live Birth to 6 Months	$1,000
6 Months to Age 19, or Age 26 if a Full Time Student	$2,000 Increments
Benefit Maximums	
Employee	Lesser of 5x annual salary or $500,000
Spouse	Up to full employee amount
Children	
Live Birth to 6 Months	$1,000
6 Months to Age 19, or Age 26 if a Full Time Student	$10,000
Guarantee Issue	
Employee	$150,000
Spouse	$25,000
Children	$10,000
Benefits Reduce To:	65% at age 70; 50% at age 75
Waiver of Premium	Included
Portability	Included

Voluntary Life – Monthly Cost Outline		
Age	**Employee Rates** (Per $10,000)	**Spouse Rates** (Per $5,000)
< 25	$0.400	$0.300
25-29	$0.440	$0.325
30-34	$0.590	$0.435
35-39	$0.880	$0.625
40-44	$1.330	$0.945
45-49	$2.080	$1.470
50-54	$3.060	$2.185
55-59	$4.380	$3.225
60-64	$5.630	$4.470
65-69	$8.010	$6.365
70-74	$15.160	$12.040
75 +	$46.840	$37.225
Child(ren) Rate (Per $2,000)	$0.790	

Voluntary AD&D – Monthly Cost Outline	
Employee Per $10,000	$0.352
Spouse Per $5,000	$0.185
Child(ren) Per $2,000	$0.074

VOLUNTARY SHORT-TERM DISABILITY BENEFITS

You have the option to purchase disability insurance coverage through UNUM. Although this is a voluntary benefit, coverage under this plan will end on the last day of active employment, unless the absence is due to a covered layoff or leave of absence. If interested in this product, please contact Human Resources for additional information.

***Please note that Short Term Disability does not apply to Washington and California employees**

Voluntary Short Term Disability (excludes WA and CA) – Benefit Outline	
Description	This disability plan provides financial protection for employees by paying a portion of your income while disabled.
Weekly Benefit Percentage of Weekly Earnings	60%
Maximum Weekly Benefit	$1,500
Minimum Weekly Benefit	$25
Elimination Period	14 Days - Injury 14 Days - Sickness
Pre-Existing Condition Limitation	3/12
Duration of Benefits	11 Weeks

Voluntary Short Term Disability – Monthly Cost Outline	
Age	**Rate Per $10 of Volume**
< 25	$0.259
25-29	$0.545
30-34	$0.769
35-39	$0.525
40-44	$0.346
45-49	$0.337
50-54	$0.417
55-59	$0.545
60-64	$0.705
65 +	$0.854

Calculate your cost			
1. Calculate your weekly disability benefit			
$	/52 = $	X 60%	= $
Your annual earnings	*Your weekly earnings*	*Max % of income covered*	*Max weekly benefit available (if this amount excess the plan max of $1,500, enter $1,500).*
2. Calculate your cost per month			
$	/10 = $	X	= $
Your weekly benefit amount		*Your rate*	*Your monthly cost*

VOLUNTARY BENEFITS

The Voluntary critical illness, accident, and hospital plans provide financial assistance to enhance your current coverage. While major medical insurance covers a lot, these voluntary plans can be used towards your medical out of pocket expenses or everyday bills like rent or mortgage, utilities, and groceries—to help you stay-up-to-speed while recovering. These plans may be able to help you avoid dipping into savings or having to borrow to pay for those out-of-pocket-expenses. These options are all offered alcarte as voluntary, employee paid options.

VOLUNTARY LUMP SUM CRITICAL ILLNESS

Critical Illness provides an affordable option for easing the financial burden that can come with a serious illness. While there are no pre-existing conditions limitations to enroll in this plan, there are limitations on benefits payable. Benefits are only payable when diagnosis occurs after the effective/enrollment date.

Critical Illness – Benefits Outline	
Employee Benefit	You can choose $10,000, $15,000 or $20,000 benefit options
Spouse/Domestic Partner Benefits	50% of employee coverage amount
Re-Occurrence Benefit	100% after 180 days of re-occurrence
Portability	Included
Benefit For Covered Conditions	**Initial Benefit**
Coronary Artery Disease (Major/Minor)	50% / 10%
Kidney Failure	100%
Heart Attack	100%
Major Organ Transplant	100%
Stroke	100%
Dementia (including Alzheimer's Disease)	100%
Invasive Cancer	100%
Non-Invasive Cancer	25%
Skin Cancer	$500

Age Band	Employee or Spouse/DP *† Monthly Rates per $1,000
<25	$0.12
25 – 29	$0.18
30 – 34	$0.26
35 – 39	$0.37
40 – 44	$0.54
45 – 49	$0.77
50 – 54	$1.10
55 – 59	$1.55
60 – 64	$2.25
65 – 69	$3.30
70 – 74	$4.98
75 – 79	$6.95
80 – 84	$9.21
85+	$13.55

*Employee and spouse/domestic partner premiums are calculated with the individual enrolling of employee or individual enrolling age as of spouse as the effective date of the plan. Rates are adjusted once each year on the plan anniversary date that coincides with or follows the day an employee or spouse reaches the starting age of the next age band.

†Child insurance is automatic when employee enrolls. A separate premium is not required. Your eligible Dependent child(ren) is covered for 50% of the employee CI coverage amount Sum.

Calculate your cost								
Calculate your Critical Illness Premiums – Age 40 Example								
$ 10,000	/	1,000	=	10	X	$ 0.54	=	$ 5.40
Your benefit amount	*/*	*Rates per $1,000*	=	*Number of units*		*Your Rate*		*Your monthly cost*

VOLUNTARY BENEFITS

VOLUNTARY ACCIDENT COVERAGE

Accidents can occur in an instant, affecting you and your loved ones and when they do, UNUM Accident insurance pays you directly.

Voluntary Accident – Benefits Highlight	
Accidental Death	**Principal Sum**
Employee	$75,000
Spouse/Domestic Partner	$37,500
Child	$18,750
Initial Care & Emergency	**Amounts**
Emergency Room	$150
Urgent Care Center	$100
Initial Physician Office Visit	$100
Ambulance	Up to $1,200
Specified Injuries	**Amounts**
Fractures	Up to $5,500
Dislocations	Up to $4,125
Lacerations	Up to $800
Burns (2nd/3rd Degree)	Up to $15,000
Emergency Dental Repair	Up to $450
Hospital	**Amounts**
Admission	$1,000
ICU Admission (in addition to above)	$1,000
Daily Confinement (Up to 365 days)	$350 per day
ICU Confinement (Up to 15 days, in addition to above)	$350 per day
Rehabilitation	$150

Coverage Tier	Monthly Premium Amount
Employee	$14.35
Employee + Spouse/Domestic Partner	$25.19
Employee + Child(ren)	$32.38
Employee + Family	$43.22

BE WELL SCREENING BENEFITS

The voluntary accident and hospital plans include a benefit where covered members can **receive a $50 benefit** once per year (per plan) for included screenings.

Be Well Screenings include, but are not limited to:

- Cholesterol and Diabetes screenings
- Cancer screenings
- Cardiovascular Function screenings
- Imaging Studies
- Annual Examinations by a Physician
- Immunizations

To receive the benefit, file your claim online with a one-time registration on unum.com, or over the phone. Call 1-800-635-5597 to learn more.

VOLUNTARY HOSPITAL CONFINEMENT INDEMNITY

The Voluntary Hospital Confinement Indemnity plan can help enhance your medical coverage when an admission to the hospital occurs.

Voluntary Hospital Confinement Indemnity - Benefit Outline
• Hospital Admission Benefit: $1,000 • ICU Admission (in addition to above): $1,000 • Daily Stay (up to 365 days): $150 • ICU Daily Stay (in addition to above): $150 • Pre-Ex Limit: No coverage for first 12 months if loss occurs due to pre-existing condition.

Coverage Tier	Monthly Premium Amount
Employee	$17.98
Employee + Spouse/Domestic Partner	$34.85
Employee + Child(ren)	$25.76
Employee + Family	$42.63

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms, and conditions of the contract.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Cambridge Management, Inc. and Vaughn Bay Construction provide an Employee Assistance Program (EAP) through Aetna. The EAP offers free and confidential counseling and assistance support situations that may impact your personal or professional life. All Cambridge Management, Inc. and Vaughn Bay Construction employees are automatically covered by the EAP.

AETNA EMPLOYEE ASSISTANCE PROGRAM

The Aetna Resources for Living provides free short-term counseling and referrals to help you deal with a variety of issues that can affect you at work or at home, such as:

- Managing stress and anxiety
- Depression
- Parenting
- Alcohol or drug problems
- Coping with grief and loss
- Legal assistance
- Debt management and budgeting
- Elder care options

IF YOU VISIT A COUNSELOR

Up to 3 sessions per situation are provided at no charge to you. If more sessions are needed, the EAP professionals can work with your health plan to determine further coverage.

EAP counselors are available to assist you 24 hours a day, seven days a week by calling 888.238.6232. All calls are confidential. When you or a family member contacts the EAP, your call will be answered by a trained professional who will discuss your personal concerns with you and make sure you have access to appropriate resources.

You can go online at:
Resourcesforliving.com
Username: CMI
Password: EAP

UNUM EMPLOYEE ASSITANCE PROGRAM

Cambridge Management, Inc. and Vaughn Bay Construction provides an EAP through UNUM with Lifebalance to assist employees and their families with work or personal life concerns. The EAP provides consultation, referrals and educational material and is a confidential service.

To talk with an EAP consultant or schedule an appointment, call 800.854.1446

You can also go online at: www.unum.com/lifebalance

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFITS

NON-NETWORK COSTS

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

Certain services require authorization like inpatient hospitalization and hospice. There is a penalty of $500 for failure to obtain pre-authorization for out-of-network care.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

- All stages of 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 treatment of physical complications of all stages of mastectomy, including lymphedema.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or copays and co-insurance amounts.

OUT-OF-AREA BENEFITS (PPO PLANS)

Aetna covers the cost of services based on whether doctors are "in-network" or "out-of-network"; and wants to help you understand how much Aetna pays for your out-of-network care and share how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna will limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance, and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how Aetna pays out-of-network benefits visit the Aetna website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor". If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), Aetna will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFITS (CONTINUED)

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.

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 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

ORGAN TRANSPLANT

Organ and bone marrow transplants require pre-authorization with Aetna.

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

HIPAA requires Cambridge Management, Inc. and Vaughn Bay Construction to notify its employees that a privacy notice is available from the Human Resources Department. To request a copy of Cambridge Management, Inc. and Vaughn Bay Construction's Privacy Notice or for additional information, please contact Human Resources at 253.534.7200.

HEALTHCARE REFORM & YOUR BENEFITS

Cambridge Management, Inc. and Vaughn Bay Construction offers a medical plan option that provides valuable comprehensive coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. Also note, it's unlikely that you are eligible for financial help from the government to help you pay for insurance purchased through a Marketplace because you have access to an employer plan that complies with the affordability standard.

PATIENT PROTECTION DISCLOSURE NOTICE

Aetna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna listed under "Your Benefits Contacts" in the back of this Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the Aetna listed under "Your Benefits Contacts" in the back of this Guide.

PREVENTIVE CARE

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed under "Your Benefits Contacts" in the back of this guide.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1.855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1.866.251.4861
Email: CustomerService@MyAKHIPP.com Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1.855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid
Website:Health Insurance Premium Payment (HIPP) Program
https://www.dhcs.ca.gov/hipp
Phone: 916.445.8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1.800.221.3943/ State Relay 711
CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1.800.359.1991/ State Relay 711
Health Insurance Buy-up Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1.855.692.6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1.877.357.3268

GEORGIA – Medicaid
A 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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740. TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

CHIP (CONTINUED)

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html CHIP
Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
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)

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
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
Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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 January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

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

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

IMPORTANT NOTICE FROM CAMBRIDGE MANAGEMENT, INC. AND VAUGHN BAY CONSTRUCTION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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).

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cambridge Management, Inc. and Vaughn Bay Construction and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your company has determined that the prescription drug coverage offered by the Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current company coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company benefit plan.

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.

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE *(CONTINUED)*

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. **Note:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through 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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Date: May 1, 2022

Name of Entity/Sender: Cambridge Management, Inc. and Vaughn Bay Construction

Contact--Position/Office: Tracy Jones, Director of Human Resources

Address: 1916 64th Ave West, Tacoma, WA 98466

Phone Number: 253.534.7200

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the documents governing the plan, including the insurance contract and a copy of the latest annual report (Form 5500 Series) if any filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

You have a right to continue healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the claims procedures available to you under the Plan (see your plan document or summary plan description for more detail), you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement, or your rights under ERISA, or if you need assistance or information regarding your rights under HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR BENEFITS CONTACTS

GALLAGHER BENEFIT ADVOCATES

Benefit Advocates (a service provided by Gallagher), are available to provide confidential, free help with your insurance needs.

- Help with understanding what is or what isn't covered
- Guidance on claims issues
- Assistance resolving billing errors

You can reach a Benefit Advocate by:
Email: at bac.cambridgeproperty@ajg.com
Phone: 833.330.9503, 8:00 a.m. - 6:00 p.m. PT Monday - Friday

CAMBRIDGE MANAGEMENT, INC. AND VAUGHN BAY CONSTRUCTION HUMAN RESOURCES:

Cambridge Management, Inc.: hr@cmiweb.net
Vaughn Bay Construction: hr@vaughnbay.net
Phone: 253.534.7200

Benefit	Administrator	Group Number	Contact Information		Website
Medical/RX	Aetna	0169731	Customer Service Nurseline Prescription Customer Service/Mail Order Pharmacy	877.869.4077 800.556.1555 888.792.3862	www.Aetna.com
Dental	Aetna	0169731	Customer Service	877.204.9186	www.Aetna.com
Vision	EyeMed	1016954	Customer Service	866.723.0513	www.Eyemed.com
Life/AD&D, Voluntary Life/AD&D	UNUM	836446/ 910248	Customer Service Portability/Conversion	800.445.0402 800.434.5406	www.UNUM.com
Long Term Disability	UNUM	836446	Disability Claims (LTD and STD)	877.851.7637	www.UNUM.com
Voluntary STD	UNUM	837168	Customer Services	866.679.3054	
Employee Assistance Program	Aetna	0169731	24/7 Support	888.238.6232	Resourceforliving.com Username: CMI Password: EAP
Employee Assistance Program	UNUM		24/7 Support	800.854.1446	www.unum.com/lifebalance
Accident/Hospital/ Critical Illness	UNUM		Claim Support	800.635.5597	www.UNUM.com

KEY TERMS

BRAND NAME PRESCRIPTION DRUG

A prescription drug that is sold under a trademarked name. An equivalent generic drug may or may not be available at lower cost, depending on whether the patent on the brand name drug has expired.

COPAY

A flat dollar amount you pay for a medical service.

COINSURANCE

The percentage of the charges you are responsible for paying. For example, the plan pays 80% and you pay 20%.

DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses not subject to a copay.

EXPLANATION OF BENEFITS

The statement you receive from your insurance company detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

GENERIC PRESCRIPTION DRUG

A prescription drug made and distributed after the brand name drug patent has expired, and available at a lower cost than brand name prescriptions.

OUT-OF-POCKET (OOP) MAXIMUM

The most you pay in a calendar year for covered medical services. Once the OOP maximum is met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for covered services.

IN-NETWORK

Services from a provider or facility that is contracted with the insurance company. In-network providers agree to accept set fees for covered medical services and not bill you for any amounts over those fees. In-network providers also agree to bill the insurance company directly, so you will not have to pay up front and submit your own claims to the insurance company.

OUT-OF-NETWORK

Services from a provider or facility that is not contracted with the insurance company. If you receive services out-of-network, then you will typically have a higher coinsurance and you will be responsible for the difference between the provider's billed charge and the allowable charge.

PREVENTIVE CARE

Measures taken to prevent diseases. This includes routine cancer screenings, exams and certain drugs and immunizations. Most preventive care is covered-in-full by the plan, with no cost to you.

NOTES

This benefit summary prepared by:

Please note:

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.