BENEFITS GUIDE 2026

HEALTHY TOGETHER

kinexion

A family of services. A lifetime of care.

IGHL
Independent Group Home Living Program, Inc.

EAST END DISABILITY ASSOCIATES, INC.
EEDA
Creating Opportunities for Happy Lives

Maryhaven
Enriching the Lives of People with Special Needs

NIS
A Learning Center for Children & Families

the Center
CREATING & DEVELOPING DREAMS

Angela's HOUSE

Head Injury Association
A BRIDGE TO HOPE AND HEALING

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BULLDOGS

Your Kinexion Benefits

Healthy Together: Your 2026 Benefits Guide

At Kinexion, we believe that staying Healthy Together — physically, emotionally, and financially — is essential to the important work you do every day. That's why we're committed to providing you and your agency with the resources and support you need, including a flexible, comprehensive benefits package designed to help you live your best life.

This guide offers a summary of your 2026 benefits. Please review it carefully to choose the coverage that's right for you and your family. It's a key step in our shared journey toward Healthy Together.

Summary of Material Modifications (SMM)

This Benefit Guide contains important updates about a new medical plan offering under the Kinexion Pre-tax Health Plan that takes effect on January 1, 2026, and therefore also serves as a Summary of Material Modifications (SMM) for that plan. See pages 7 and 8 of this guide for details.

Benefits Basics

Who can enroll

In general, you and your eligible dependents can enroll for medical benefits if you are an employee regularly working at least 30 hours a week. Your eligible dependents include your legal spouse or domestic partner, and your dependent child(ren) (up to age 26). Contact your agency if you have questions about your eligibility for benefits through Kinexion.

When you can enroll

Open enrollment is your once-a-year opportunity to choose your benefits to be effective January 1. As a new hire, the elections you make will go into effect the first of the month following 60 days from your date of hire. They will remain in effect through December 31 unless you have a qualifying life event (including marriage, divorce, birth, adoption, etc.). If you have a life event, you have up to 30 days from that event to make a change to your benefits.

How to enroll

Employees will have the ability to use UKG (Kronos) Employee Self-Serve (ESS) to make their benefit elections.

Log in at kronos.ighl.org. Navigate to Main Menu > My Benefits > Enrollment, then select the appropriate enrollment type (Open Enrollment, New Employee Enrollment or Life Change Event Enrollment).

Enrolling in your benefits

Create an account or log in with your existing account at kronos.ighl.org.

Begin the benefits enrollment process

Elect the benefits you want

Save or submit your elections

Print a copy of your elections for your records

Benefit Basics

Your benefits are a partnership between you and your Agency. The table below outlines how you and your Agency share costs for benefits. The tax treatment shows whether your contribution is taken from your paycheck before or after taxes.

Benefit	Tax Treatment	Who Pays
Medical and Pharmacy	Pretax	Agency & You
Dental	Pretax	Agency & You
Vision	N/A	Agency
Flexible Spending Accounts	Pretax	You
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance*	N/A	Agency
Voluntary Life and AD&D Insurance	After-tax	You
Basic Short-Term Disability	N/A	Agency & You
Voluntary Short-Term Disability	After-tax	You
Long-Term Disability	Pre or After Tax	Agency
Accident, Critical Illness, Hospital Indemnity	After-tax	You
Legal	After-tax	You
Pet Insurance	After-tax**	You
ID Protection	After-tax	You
Retirement Plans	Pre-tax	Agency & You

*Life insurance in excess of $50,000 is deemed to be income and is "imputed" to the employee via the annual W-2 and subsequently taxed by the IRS.
**Paid via direct bill, not through payroll deduction.

The Mobile Wallet Card keeps all of your benefit contacts in one place. For easy access to your benefit carriers' group numbers, phone numbers and websites from your smartphone, tablet or computer, bookmark https://mymobilewalletcard.com/kinexion/

SCAN ME

Eligibility

Who's eligible?

Employees

Generally, employees who work at least 30 hours per week are eligible for the benefits described in this guide. Your Employee Assistance Program (EAP) benefits are effective immediately.

All other benefits are effective the first of the month following 60 days from your date of hire. Eligible employees should enroll via UKG (Kronos) Employee Self Serve.

Eligible Dependents

- Your legal spouse
- Your domestic partner
- Your children up to age 26

Making changes to your benefits

Generally, you may only make or change your benefit elections as a new hire or during the annual Open Enrollment period. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss or gain of other coverage by you or your dependent
- Eligibility for Medicare or Medicaid

You have 30 days from the qualified life event to make changes to your coverage

- Depending on the type of event, you may need to provide proof of the event, such as a marriage license.
- If you do not make the changes within 30 days of the qualified event, you will have to wait until the next Open Enrollment period to make changes (unless you experience another qualified life event).
- To make a change and/or elect benefits due to a qualifying life event, log into UKG and navigate to Main Menu > My Benefits > Enrollment > Select Life Change Event Enrollment.

Please review plan documents for full plan details.

Enrolling dependents? Items to have ready

When you add dependents to your coverage, you must provide the following information:

- Legal name
- Date of birth
- Social Security number
- Supporting documentation, such as marriage certificate, birth certificate, adoption papers, and tax documents.

Submit documentation within five days of enrollment to prevent any delays in processing or coverage.

Upload documents via UKG (Kronos)/HR Action. Log in to UKG and navigate to Main Menu > my HR Actions > HR Actions > Select Start for the Benefit Documentation HR Action.

If you do not provide the required information, your dependents may be dropped from coverage.

Medical and Pharmacy Plan Overview

Below is an overview of your medical plans, insured by Cigna, the cost of coverage (including payroll deductions) and how the plan covers services throughout the year.

Understanding how your plan works

1. Plan deductibles

- You may pay out-of-pocket for medical expenses until you reach the deductible. Copay or coinsurance will apply once the deductible has been met.

2. Your coverage

- The plan shares the cost of covered medical and pharmacy expenses. The plan will pay a portion of each eligible expense, and you will pay the rest through copays or coinsurance.

3. Your out-of-pocket maximum

- When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year.

Making the most of your plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.

Understanding your pharmacy coverage

- **Preventive drugs:** Many preventive drugs and those used to treat chronic conditions like diabetes, high blood pressure, high cholesterol and asthma are on the Preventive Condition Drug List. These prescriptions are covered at 100% (no cost to you) when you use an in-network pharmacy.
- **Mail order pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the Mail Order Pharmacy to save on a 90-day supply.
- **Prescription categories:** Medications are categorized by cost, safety and effectiveness. These tiers also affect your coverage.
  - **Generic** – A drug that's equivalent to brand-name drugs in use, dose, strength, quality and performance, but is not trademarked.
  - **Brand preferred** – A drug with a patent and trademark name that is considered "preferred" because it's safe and effective and usually less expensive than other brand-name options.
  - **Brand non-preferred** – A drug with a patent and trademark name that is "not preferred" because it's usually more expensive than other generic and brand preferred options.
  - **Specialty** – A drug that requires special handling, administration or monitoring. Most can only be filled by Cigna's Pathwell Specialty Network and have additional required approvals. Designed to help you find affordable care, Cigna Pathwell Specialty provides personalized support and guidance to those taking specialty medications. Visit Cigna.com/pathwellspecialty for more information.

Medical and Pharmacy Coverage

Medical Plan Provisions	Signature Plan		Core Plan		Value Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual / Family)	$1,000 / $2,000	$5,000 / $10,000	$2,000 / $4,000	$6,000 / $12,000	$6,000 / $12,000	$7,500 / $18,000
Out-of-Pocket Maximum (Includes Deductible)	$5,000 / $10,000	$15,000 / $30,000	$7,000 / $14,000	$21,000 / $42,000	$9,200 / $18,400	$30,000 / $60,000
Preventive Care	No Charge	70% after deductible	No Charge	60% after deductible	No Charge	50% after deductible
Plan Coinsurance	90%	70%	80%	60%	70%	50%
Primary Care Provider Office Visit	$20	70% after deductible	$30	60% after deductible	70% coinsurance	50% after deductible
Specialist Office Visit	$35	70% after deductible	$60	60% after deductible	70% coinsurance	50% after deductible
X-Ray and Lab	90% after deductible	70% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Inpatient Hospital Services	90% after deductible	70% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Outpatient Hospital Services	90% after deductible	70% after deductible	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Urgent Care	$20	70% after deductible	$40	60% after deductible	70% after deductible	50% after deductible
Emergency Room	$500 (Waived if admitted)		$750 (Waived if admitted)		70% after deductible	
Prescription Drug Deductible	None		None		None	
Retail Pharmacy						
Tier 1 (Generic)	$10	70% coinsurance	$15	60% coinsurance	$25	50% coinsurance
Tier 2 (Brand preferred)	$30	70% coinsurance	$45	60% coinsurance	$50	50% coinsurance
Tier 3 (Brand non-preferred)	$50	70% coinsurance	$60	60% coinsurance	$75	50% coinsurance
Mail Order						
Tier 1 (Generic)	$20	-	$30	-	$50	-
Tier 2 (Brand preferred)	$60	-	$90	-	$100	-
Tier 3 (Brand non-preferred)	$100	-	$120	-	$150	-

Flexible Spending Accounts

Your Flexible Spending Account (FSA) helps you pay for health care or dependent care costs using tax-free dollars. Your contribution is deducted from your paycheck on a pretax basis and put into the FSA. When you incur expenses, you can access the funds in your account to pay for eligible expenses.

This chart shows the eligible expenses for each FSA and how much you can contribute each year. Each of these options reduces your taxable income.

Account type	Eligible expenses	Annual contribution limits
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan, such as copays, coinsurance, deductibles, eyeglasses, orthodontia and prescriptions.	Maximum contribution is $3,400 per year*. Minimum contribution is $10 per paycheck. Funds are deducted throughout the year, but all funds are available on January 1.
Dependent Care FSA	Dependent care expenses including day care, after school programs for children under age 13 or elder care programs so you can work or attend school full-time.	Maximum contribution is $7,500 per year*. ($3,750 if married and filing separate tax returns). Minimum contribution is $10 per paycheck.

Important information about FSAs

- FSA elections do not automatically continue from year to year; you must actively enroll each year.
- Your FSA elections are effective from January 1 through December 31.
- Claims for reimbursement must be submitted by March 31 of the following year.
- Up to $680* of your unused Health Care FSA funds can “roll over” to the following year. The roll over provision does not apply to the FSA for Head Injury Association (HIA) employees.
- Please plan your contributions carefully. Any unused money remaining in your account(s) above the FSA rollover amount will be forfeited. This is known as the “use it or lose it” rule and it is governed by Internal Revenue Service regulations.
- You can only change your FSA contribution amount if you experience a qualified status change.
- The FSA plans are not interchangeable. You must enroll in each separately and funds are non-transferrable.

*2026 limit

Dental Plan

Dental plan options are offered through the Kinexion Network and Cigna. It's important to have regular dental exams and cleanings so problems are detected before they become painful – and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health.

Plan Provisions	Dental-Low Plan		Dental-High Plan		DHMO*
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible (Single / Family)	$75 / $225		$50 / $150		None
Annual Maximum	$1,500		$2,500		None
Deductible / Annual Maximum Accumulation Period	Calendar Year		Calendar Year		N/A
Type A - Preventive	100% no deductible	100% of R&C, no deductible	100% no deductible	100% of R&C, no deductible	Schedule of patient
Type B - Basic Restorative (Fillings, Extractions, etc.)	80%	80% of R&C	80%	80% of R&C	Schedule of patient charges
Type C - Major Restorative (Inlays/Onlays, Crowns, Bridges, Dentures, Implants, etc.)	50%	50% of R&C	60%	60% of R&C	Schedule of patient charges
Type D - Orthodontia	Not covered		60%	50% of R&C	Member fees: Child - $1,608 Adult - $2,592
Lifetime Orthodontia Maximum	Not covered		$3,000 Employees and Dependents		No dollar maximum
Out-of-Network Reimbursement Percentile	N/A	80th	N/A	80th	N/A

*Enrollment in DHMO requires selection of a Primary Care Dentist

Note: Benefits are based on the Reasonable & Customary (R&C) charges for the treatment provided. R&C refers to the average fee charged for similar services in a specific geographic area.

Get the most from your dental plan

- Stay in-network – You have the option of choosing any provider, however you will save money when you use in-network dentists. Out-of-network providers have not agreed to charge you a negotiated rate.
- Free annual check-up every six months – Use free preventive care to keep your mouth and gums healthy all year long.
- Use your FSA funds – Help pay for eligible out-of-pocket dental expenses.

Vision Plan

The vision plan is insured by EyeMed and provided through the Kinexion Network. EyeMed provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. Visit PLUS providers and receive a $0 exam and an additional $50 towards frames. Look for a PLUS provider at eyemed.com.

	Vision	
Frequency		
Exams	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Benefit	**In-Network**	**Out-of-Network**
Exams	$5 copay (no copay at PLUS providers!)	Up to $40
Lenses	$10 copay	Varies by lens type
Single	$10 copay	Up to $30
Bifocal	$10 copay	Up to $50
Trifocal	$10 copay	Up to $70
Lenticular	$10 copay	Up to $70
Frames	$150 allowance ($200 allowance at PLUS providers!)	Up to $105
OR		
Contact Lenses	Elective: $135 allowance Non-Elective: No copay	Elective: Up to $95 Non-Elective: Up to $300

Pay for vision expenses tax-free

Use your FSA to pay for your exam copay and eyeglasses or contacts.

Life, Accidental Death & Dismemberment (AD&D) and Disability Insurance

Life and AD&D insurance

Through the Kinexion Network, your Agency provides basic life and AD&D insurance for employees and offers voluntary insurance options for employees and your dependents through Prudential.

Basic life and AD&D insurance

- Life insurance is an important part of your financial wellbeing, especially if others depend on you for support.
- Your Agency provides basic life and AD&D insurance through Prudential to all eligible employees at no cost equal to 1x for non-exempt employees or 2x for exempt employees times your base annual earnings, up to a maximum of $600,000.
- Coverage is automatic; you do not need to enroll.

Voluntary life and AD&D insurance

- You may choose to purchase additional life and AD&D coverage through Prudential for you and your dependents at affordable group rates.
- Rates are based on age and the coverage level chosen.
- Guaranteed issue amounts only apply when you enroll in this coverage as a new hire. If you add this coverage for the first time during Open Enrollment, you will be subject to Evidence of Insurability. Completion of a Statement of Health (SOH) will be received via email from Prudential directly. Failure to complete the SOH will result in a decrease of coverage amount or declination of coverage, determined by Prudential underwriting.

Voluntary life and AD&D insurance for you	Voluntary life and AD&D insurance for your dependents	
Employee	Spouse	Child(ren)
▪ Increments of up to 6 times your base annual salary ▪ Up to a $700,000 maximum ▪ Guaranteed issue up to $300,000	▪ Increments up to $100,000 not to exceed 50% of your voluntary life and AD&D coverage) ▪ Guaranteed issue up to $20,000 ▪ Enrollment in Employee Life is required	▪ Child 15 days to 6 months old & more than 6 months old, but less than 1 year old: $2,000 ▪ Child more than 1 year old to a maximum of age 26: $2,000 increments to a maximum of $10,000 ▪ Enrollment in Employee Life is required

Protect your loved ones

- Affordable supplemental coverage – Take advantage of the group rates offered to get the best deal on your coverage. Investing in insurance gives you peace of mind and the financial protection for you and your loved ones.
- Be sure to designate your beneficiary – You must choose a beneficiary for life and AD&D insurance. Keep your beneficiaries up to date.

Disability insurance

Disability insurance through Prudential provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. Your Agency provides eligible associates with basic disability coverage at no cost as shown below. Coverage is automatic; you need only to enroll in a buy-up option. Voluntary STD is available as a buy-up option with two benefit levels to choose from, see below for additional information. Note: If you enroll for Voluntary STD for the first time during Open Enrollment, you will need to provide Evidence of Insurability.

Short-Term Disability	Long-Term Disability
▪ Your Agency pays for 60% of your weekly salary, to a maximum of $170 per week for the first 26 weeks of a disability after the one-week waiting period. ▪ Voluntary STD: You can elect to buy up to an additional $500 or $2,000 per week.	▪ 60% of your base salary, to a maximum of $10,000 per month if you are disabled and are unable to work for more than 180 days. ▪ Benefits are offset with other sources of income, such as Social Security and Workers' Compensation.

Additional Benefits

Employee Assistance Program (EAP)

The EAP provides 24/7 confidential support, resources and information. You and your family have access to three (3) free consultations with a licensed clinician per incident, per individual, per calendar year. Services include:

- Mental health & emotional wellbeing support
- Legal services
- Financial services
- Childcare and eldercare assistance
- Identity theft recovery services

Confidential assistance is available any time by calling 800-523-5668 or logging on to magellanhealth.com.

Health Advocate

Health Advocate is an independent, third-party service designed to help you navigate the health care industry at no cost! You are automatically enrolled in Health Advocate if you are enrolled in the medical insurance. Some reasons to call Health Advocate are:

- For help with insurance claims and billing issues
- To find doctors and make appointments
- For help to understand an illness
- For help with medical issues and healthcare needs that your parents or parents in-law might have (they are also eligible for the service)
- Assistance with understanding any issues with your prescription drugs
- Call 866-695-8622 to speak with an advocate!

Voluntary Benefits Enrollment Information

For 2026, you can enroll in the voluntary benefits through the UKG ESS enrollment portal.

Voluntary Benefits

Accident – Covers you 24 hours a day, on and off the job, in the event of an accident. The benefit amount is determined by the treatment you receive in the event of an accident.

Critical Illness – Pays you a lump sum benefit upon diagnosis of a critical illness such as a Heart Attack, Stroke, Major Organ Transplant, Cancer, etc.

Hospital Indemnity – Provides supplemental payments directly to you to help cover expenses that your medical plan doesn't cover for hospital stays, deductibles, surgery, ambulance services, etc.

Call 866-455-1002 or visit Prudential.com/mybenefits.

MetLife Pet – Get protection for every stage of your pet's life. Visit www.metlife.com/getpetquote or call 1 (800) GET-MET8 for a quote. Rates are based on type and age of pet.

Legal Assistance through LegalEASE

Assistance with affordable legal protection, including Estate Planning, Living Wills, Guardianship, Powers of Attorney, etc.

Allstate Identity Theft Protection

Affordable identity theft protection. Call 800-789-2720 or visit www.myaip.com.

Helpful Benefit Terms

- **Brand Preferred Drugs** – A drug with a patent and trademark name that is considered "preferred" because it's safe and effective and usually less expensive than other brand-name options.
- **Brand Non-Preferred Drugs** – A drug with a patent and trademark name that is "not preferred" because it's usually more expensive than other generic and brand preferred options.
- **Calendar Year Maximum** – The maximum benefit amount paid each year for each family member enrolled in the dental plan.
- **Coinsurance** – The sharing 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. You will be responsible for the remaining 20% of the cost.
- **Copay** – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service.
- **Deductible** – The amount you have to pay for covered services each year before your health plan begins to pay.
- **Elimination Period** – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.
- **Flexible Spending Accounts (FSA)** – FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.
- **Generic Drugs** – A drug that is equivalent to brand-name drugs in use, dose, strength, quality and performance, but is not trademarked.
- **Health Savings Account (HSA)** – An HSA is a personal savings account for those enrolled in a High Deductible Health Plan (HDHP). You may use your HSA to pay for qualified medical expenses such as doctor's office visits, hospital care, prescription drugs, dental care and vision care. You can use the money in your HSA to pay for qualified medical expenses now, or in the future, for your expenses and those of your dependents, even if they are not covered by the HDHP.
- **Health Reimbursement Arrangement (HRA)** – A fund you can use to help pay for eligible medical costs not covered by your medical plan. Funds are contributed to the HRA by the company.
- **High Deductible Health Plan (HDHP)** – A qualified High Deductible Health Plan (HDHP) is defined by the Internal Revenue Service (IRS) as a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually and are subject to change.
- **In-Network** – A designated list of health care providers (doctors, dentists, etc.) with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.
- **Inpatient** – Services provided to an individual during an overnight hospital stay.
- **Mail Order Pharmacy** – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.
- **Out-of-Network** – Providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Higher deductibles and coinsurance will apply.
- **Out-of-Pocket Maximum** – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.
- **Outpatient** – Services provided to an individual at a hospital facility without an overnight hospital stay.
- **Primary Care Provider (PCP)** – A doctor (generally a family or internal medicine practitioner or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.
- **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 may apply to out-of-network charges.
- **Specialist** – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).
- **Specialty Drugs** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Benefit Acronyms

ACA – Affordable Care Act
AD&D – Accidental Death & Dismemberment
FSA – Flexible Spending Account
HDHP – High Deductible Health Plan
HMO – Health Maintenance Organization
HSA – Health Savings Account
LPFSA – Limited Purpose Flexible Spending Account
LTD – Long-Term Disability
PPO – Preferred Provider Organization
STD – Short-Term Disability

Contact Information

The Mobile Wallet Card keeps all of your benefit contacts in one place. For easy access to your benefit carriers' group numbers, phone numbers and websites from your smartphone, tablet or computer, bookmark https://mymobilewalletcard.com/kinexion/.

Coverage	Carrier	Phone	Website
Medical and Prescription	Cigna Group 3346436	888-806-5042 (pre-enrollment) 1-800-244-6224 (if already enrolled)	https://www.cigna.com/
Wellness	Health is Wealth™	631-878-8868	join.personifyhealth.com/ighl
Dental	Cigna Group 3346436	888-806-5042 (pre-enrollment) 1-800-244-6224 (if already enrolled)	https://www.cigna.com/
Vision	EyeMed	866-939-3633	www.EyeMed.com
Flexible Spending Accounts	Health Equity Ameriflex (HIA only)	877-924-3967 888-868-3539	www.wageworks.com/employees myameriflex.com
Basic Life and AD&D Insurance	Prudential Group 72901	800-524-0542	http://www.prudential.com/mybenefits
Voluntary Short-term Disability (STD) and Long-term Disability (LTD)	Prudential Group 72901	800-842-1718	http://www.prudential.com/mybenefits
Voluntary Critical Illness, Accident, and Hospital Indemnity	Prudential Group 72901	844-455-1002	http://www.prudential.com/mybenefits
Pet Insurance	MetLife Group 245923	800-GET-MET8	MyBenefits.MetLife.com
ID Theft	AllState Group 9280	800-789-2720	www.myaip.com
Legal	LegalEASE Group 2001433	800-248-9000	https://www.legaleaseplan.com/lphd
Health Advocate	Health Advocate Group Your Affiliate Name	866-695-8622	www.healthadvocate.com
Employee Assistance Program (EAP)	Magellan Healthcare	800-523-5668	member.magellanhealthcare.com

Important Notices

The following notices are required by the Federal Government. Please carefully review these notices as they contain important information for both you and your family.

Women's Health and Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply. See page 8 for details.

If you would like more information on WHCRA benefits, call your plan administrator Cigna at 888-806-5042 (pre-enrollment) or 1-800-244-6224 (if already enrolled).

Patient Protection

Cigna generally allows the designation of a primary care provider (and pediatrician as the primary care provider for your children). 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.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Cigna at 888-806-5042 (pre-enrollment) or 1-800-244-6224 (if already enrolled).

You do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Cigna at 888-806-5042 (pre-enrollment) or 1-800-244-6224 (if already enrolled).

HIPAA Special Enrollment

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as 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.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30 day period applies to most special enrollments.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage may eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you may not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraphs above, however, regarding enrollment in the event of marriage, birth, adoption, placement for adoption, loss of eligibility for Medicaid or a state CHIP, and gaining eligibility for a state premium assistance subsidy through Medicaid or a state CHIP.) To request special enrollment or obtain more information, contact Human Resources, Benefits Dept. at: 631-878-8868 or 60 Montauk Highway, East Moriches, NY 11940

Availability of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

Kinexion's Pretax Health Plan (the "Plan") provides health benefits to eligible employees of Kinexion and its affiliated agencies (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact Director of Human Resources, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach this contact person at: 631-878-8868 or 60 Montauk Highway, East Moriches, NY 11940

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Kinexion and its affiliated agencies may use aggregate information it collects to design a program based on identified health risks in the workplace, Health is Wealth™ will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach, registered nurse, or fitness instructor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Christina Frey at 631-878-8868 ext. 213 or CFrey@ighl.org.

Reasonable Alternative Standards for a Wellness Program

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all 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 us at 631-878-8868 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

FLORIDA – Medicaid	NEW YORK – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	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)

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

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

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

Paperwork Reduction Act Statement

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

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

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

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] 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 9.12% of the employee's household income.[1] [2]

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.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)	
5. Employer address	6. Employer phone number	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:

    Full time employees working 30 or more hours per week.

  - ☐ Some employees. Eligible employees are:

    [ ]

- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:

    [ ]

  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☒ **Yes** (Continue)

13. a If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? Completion or 90 days employment. _____ **(mm/dd/yyyy) (Continue)**

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Policy on the Rights of Employees to Express Breast Milk in the Workplace

Introduction and purpose

New York State Labor Law Section 206-c gives all employees in New York the right to express breast milk in the workplace. This law applies to all public and private employers in New York State, regardless of size or the nature of their business.

The New York State Department of Labor has developed the official policy on breast milk expression in the workplace as required by the law, ensuring that all employees know their rights and all employers understand their responsibilities. This policy is the minimum required standard, but employers are encouraged to include additional accommodations tailored to their workplace.

With the information provided below, employees will learn how much time they are allowed for breast milk expression, the kind of space employers are required to provide for breast milk expression, how to notify employers about the need to express breast milk in the workplace, and how to notify the Department of Labor if these rights are not honored.

Employers are required to provide this policy in writing to all employees when they are hired and again every year after. Employers are also required to provide the policy to employees as soon as they return to work following the birth of a child.

Using break time for breast milk expression

Employers must provide thirty (30) minutes of paid break time for their employees to express breast milk when the employee has a reasonable need to express breast milk. Employees must be permitted to use existing paid break or meal time if they need additional time for breast milk expression beyond the paid 30 minutes. This time must be provided for up to three years following childbirth. Employers must provide paid break time as often as an employee reasonably needs to express breast milk. The number of paid breaks an employee will need to express breast milk is unique to each employee and employers must provide reasonable break times based on the individual. Employers are prohibited from discriminating in any way against an employee who chooses to express breast milk in the workplace.

An employer is prohibited from requiring an employee to work before or after their normal shift to make up for any time used as paid break time to express breast milk.

All employers must continue to follow existing federal and state laws, regulations, and guidance regarding mealtimes and paid break time regardless of whether the employee uses such time to express breast milk. For additional information regarding what constitutes a meal period or a break period under state and federal law, please see the following resources:

- NY Department of Labor Website on Day of Rest, Break Time, and Meal Periods: dol.ny.gov/day-rest-and-meal-periods
- NY Department of Labor FAQs on Meal and Rest Periods: dol.ny.gov/system/files/documents/2021/03/meal-and-rest-periods-frequently-asked-questions.pdf
- U.S. Department of Labor FLSA FAQ on Meal and Rest Periods: dol.gov/agencies/whd/fact-sheets/22-flsa-hours-worked
- U.S. Department of Labor FLSA Fact Sheet on Compensation for Break Time to Pump Breast Milk: dol.gov/agencies/whd/fact-sheets/73-flsa-break-time-nursing-mothers

While an employer cannot require that an employee works while expressing breast milk, Labor Law 206-c does not otherwise prevent an employee from voluntarily choosing to do so if they want to.

Paid breaks provided for the expression of breast milk must be 30 minutes. An employee must be allowed to use regular break or meal time to take a longer paid break if needed. Employees may also opt to take shorter paid breaks.

Employees who work remotely have the same rights to paid time off for the purpose of expressing breast milk, as all other employees who perform their work in-person.

Making a request to express breast milk at work

If an employee wants to express breast milk at work, they must give the employer reasonable advance notice, generally before returning to the workplace if the employee is on leave. This advance notice is to allow the employer time to find an appropriate location and adjust schedules if needed.

Employees wishing to request a room or other location to express breast milk in the workplace should do so by submitting a written request to their direct supervisor or individual designated by their employer for processing requests. Employers must respond to this request for a room or other location to express breast milk in writing within five days.

Employers must notify all employees in writing through email or printed memo when a room or other location has been designated for breast milk expression.

Lactation room requirements

In addition to providing the necessary time during the workday, employers must provide a private room or alternative location for the purpose of breast milk expression. **The space provided for breast milk expression cannot be a restroom or toilet stall.**

The room or other location must:

- Be close to an employee's work area
- Provide good natural or artificial light
- Be private – both shielded from view and free from intrusion
- Have accessible, clean running water nearby
- Have an electrical outlet (if the workplace is supplied with electricity)
- Include a chair
- Provide a desk, small table, desk, counter or other flat surface

There does not need to be a separate space for every nursing employee. An employer may dedicate a single room or other location for breast milk expression. Should there be more than one employee at a time needing access to a lactation room, an employer may dedicate a centralized location to be used by all employees.

Any space provided for breast milk expression must be close to the work area of the employee(s) using the space. The space must be in walking distance, and the distance to the location should not significantly extend an employee's needed break time.

Employers located in shared work areas, such as office buildings, malls and similar spaces may work together to establish and maintain a dedicated lactation room, as long as such space(s) are a reasonable distance from the employees using the room. Each employer utilizing this common space is individually responsible for making sure the room meets the needs of their employees.

If there is not a separate room or space available for lactation, an employer may use a vacant office or other available room on a temporary basis. This room must not be accessible to the public or other employees while an employee is using it for breast milk expression.

As a last resort, an available cubicle may be used for breast milk expression. A cubicle can only be used if it is fully enclosed with a partition and is not otherwise accessible to the public or other employees while being used for breast milk expression. The cubicle walls must be at least seven feet tall to insure the employee's privacy.

To ensure privacy, if the lactation room has a window, it must be covered with a curtain, blind or other covering.

In addition, the lactation space should have a door equipped with a functional lock. If this is not possible (such as in the case of a fully enclosed cubicle), as a last resort, an employer must utilize a sign advising the space is in use and not accessible to other employees or the public.

If the workplace has a refrigerator, employers must allow employees to use it to store breast milk. However, employers are not responsible for ensuring the safekeeping of expressed milk stored in any refrigerator in the workplace.

Employees are required to store all expressed milk in closed containers and bring milk home each evening.

The space designated for expressing breast milk must be maintained and clean at all times.

If an employer can demonstrate undue hardship in providing a space with the above requirements, the employer must still provide a room or other location - other than a restroom or toilet stall - that is in close proximity to the work area where an employee can express breast milk in privacy, that meets as many of the requirements as possible.

Undue hardship is defined in the statute as "causing significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business." **However, an employer may not deny an employee the right to express breast milk in the workplace due to difficulty in finding a location.**

New York state department of labor resources

If an employee believes that they are experiencing retaliation for expressing breast milk in the workplace, or that their employer is in violation of this policy, they should contact the New York State Department of Labor's Division of Labor Standards. Call us at **1-888-52-LABOR**, email us at LSAsk@labor.ny.gov, or visit our website at dol.ny.gov/breast-milk-expression-workplace **to file a complaint.**

A list of our offices is available at dol.ny.gov/location/contact-division-labor-standards.

Complaints are confidential.

Federal resources

The federal PUMP Act went into effect in 2023, expanding protections for almost all employees expressing breast milk at work. Under the PUMP Act, any covered workers not provided with breaks and adequate space for up to a year after the birth of a child are able to file a complaint with the U.S. Department of Labor or file a lawsuit against their employers. For more information, please visit dol.gov/agencies/whd/pump-at-work.

Notice of Extended Coverage to Participants Covered Under a Group Health Plan

Federal legislation known as “Michelle's Law” generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

Kinexion’s Pre-tax Health Plan (the “Plan”) currently permits an employee to continue a child’s coverage past the child’s 26th birthday if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution’s registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.

Medically necessary leave of absence means a leave of absence or any other change in enrollment:

- of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
- which is medically necessary; and
- which causes the dependent child to lose student status under the terms of the Plan.

For the Michelle’s Law extension of eligibility to apply, a dependent child’s treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence; or
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle’s Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

Notes

kinexion

A family of services. A lifetime of care.

About this Guide

This benefit summary provides selected highlights of the Kinexion benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Kinexion reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.