

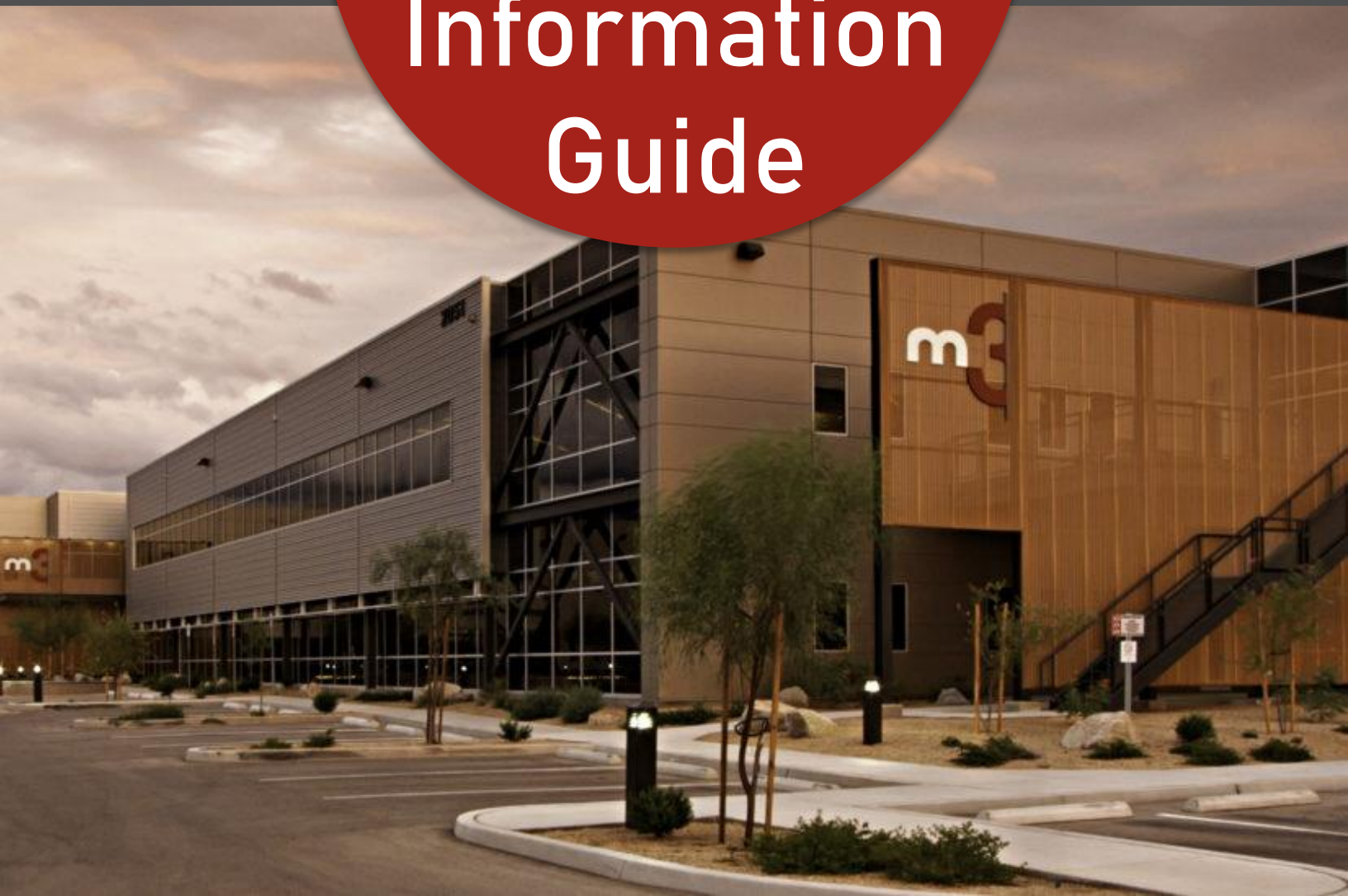


ARCHITECTURE

ENGINEERING

CONSTRUCTION MANAGEMENT

2026 Benefits Information Guide



This guide outlines benefits designed to enhance your life beyond work and helps you choose and use them effectively throughout the plan year.

For detailed coverage, refer to the Evidence of Coverage (EOC) or Summary Plan Description (SPD), which serve as the binding agreements for your plan. Any discrepancies should be resolved using these documents, and they also provide information necessary for claim review or dispute.

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How do I sign up?

To sign up, go to the [Benefits Enrollment Link](#). For assistance, contact Human Resources.

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. Refer to the Annual Notices booklet for more details.



Eligibility & Enrollment



Who can sign up?

Employees working at least 30 hours per week can enroll in our benefit programs, covering spouses and eligible children.

When does my coverage start?

You can sign up as soon as the date you're hired and your coverage starts on the 1st of the month after your date of hire.

Once you enroll in benefits, your decisions will remain in effect until the end of the plan year, which is from January 1st, 2026 – December 31st, 2026. If you miss the deadline to sign up, you will not be able to enroll until the next open enrollment period or unless you experience a Qualifying Life Event (QLE).

Can I make changes after I sign up?

Outside of your Initial Enrollment period or Open Enrollment, changes can be made if you experience a QLE, such as marriage or childbirth, within 30 days. If you lose eligibility or enroll in Medicaid, you have 60 days to submit your request.

Do I have to sign up?

You can waive coverage if you have another plan, but you cannot re-enroll until next year unless you experience a QLE.

If you don't enroll in any health insurance, you may face a penalty. While the federal penalty is currently \$0, some states have their own mandates. To avoid penalties, you can enroll in our benefits program or purchase coverage through a State or Federal Health Insurance Exchange.

For more information on Healthcare Reform and the Individual Mandate, contact Human Resources or visit www.healthcare.gov. You can also check www.coveredca.com for details on the Covered California State Health Insurance Exchange.

How do I sign up?



UKG

Available as an app for iOS and Android



- Log into your UKG account at [Benefits Enrollment Link](#)



Medical Plans



You and your eligible dependents will have the opportunity to enroll in a medical plan through Blue Cross Blue Shield of Arizona. You can select from an PPO or an HDHP medical plan. We encourage you to review the coverage details and select the option that best suits your needs. For more information on the medical benefits, go to UKG.

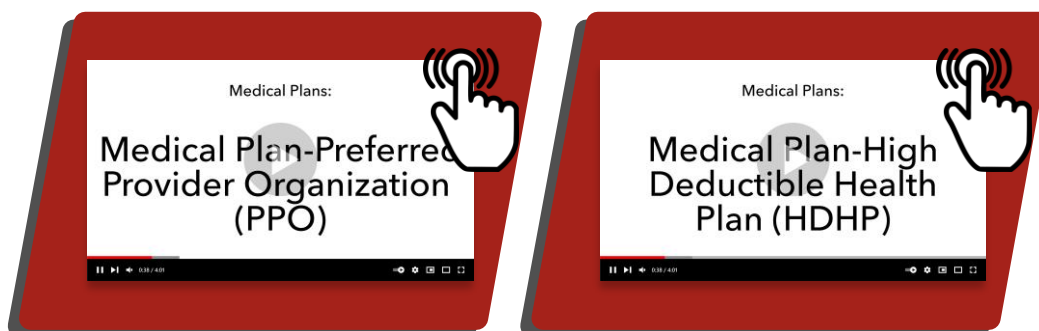
Plan Highlights ⁽¹⁾	BCBSAZ PPO Plan		BCBSAZ HDHP/HSA Plan	
	In-network (Statewide)	Out-of-Network	In-network (Statewide)	Out-of-Network
Annual Calendar Year Deductible				
Individual	\$0	\$500	\$1,700	\$1,700
Family	\$0	\$1,000	\$3,400	\$3,400
Maximum Calendar Year Out-of-pocket ⁽²⁾				
Individual	\$3,000	\$4,500	\$3,300	\$6,600
Family	\$6,000	\$9,000	\$6,600	\$13,200
Professional Services				
Primary Care Physician (PCP)	\$15 copay	40% after deductible	0% after deductible	50% after deductible
Specialist	\$30 copay	40% after deductible	0% after deductible	50% after deductible
Preventive Care Exam	No Charge	40% after deductible	No Charge	50% after deductible
Hospital Services				
Inpatient	\$100 copay	40% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	\$100 copay	40% after deductible	0% after deductible	50% after deductible
Urgent Care	\$50 copay	40% after deductible	0% after deductible	50% after deductible
Emergency Room	\$100 copay		0% after deductible	
Retail Prescription Drugs (30-day supply)				
Tier 1	\$10 copay	\$10 copay	\$10 after deductible	\$10 after deductible
Tier 2	\$30 copay	\$30 copay	\$30 after deductible	\$30 after deductible
Tier 3	\$45 copay	\$45 copay	\$45 after deductible	\$45 after deductible
Tier 4	\$60 copay	Not Covered	0% after deductible	Not covered

1. Table shows in-network benefits information only. Please see benefits summaries for Out-of-Network information.

2. Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Click on the image below to view a video on the medical plans offered:





Important Medical Tips

- Preventive Care is covered at 100% if you stay in-network. Preventive care includes well-exams for adults and children as well as immunizations.
- Consider an urgent care center for non-emergencies. Urgent care centers do not require an appointment, and the copay is more cost-effective than an emergency room visit.
- Save money by switching to a generic medication. Talk to your doctor to see if a generic medication will work for your condition. You can save money on a prescription by enrolling in mail-order services for maintenance medications.
- When choosing a doctor, make sure they are in your medical plan's network to receive the best discount. Call the doctor's office before your appointment or find a provider using the instructions below.

Telehealth Services

You can easily connect with a doctor for a video or voice consultation using your smartphone or desktop computer! These virtual visits save you time and effort.

If your provider recommends a prescription medication during your virtual visit, BlueCare Anywhere will send it to a local pharmacy. You can also get your medication through the mail.

Through BlueCare Anywhere, telehealth services will cost \$0 per e-Visit on the PPO plan and 0% after deductible on the HDHP plan and is based on billed charges. The dependents on your health plan can use it, too. Video visits for all! Start your telehealth visit by calling 844.606.1612 or visit www.bluecareanywhereaz.com.

To find a provider in your plan's network: **BlueCross BlueShield of Arizona Statewide**

- Go to www.azblue.com and select "Find Care" then "Find a Doctor, Provider or Facility"
- Select "Employer Provided" for the "Type of Coverage"
- Select "Statewide / National PPO" for the "Network"
- Enter your location and search by name, specialty, or advanced search
- Available providers' profiles and locations will appear





Saving money on your medications



Tier 1 – Generic formulary:

These medications have the same active ingredients as brand-name medications, but they cost less.



Tier 2 – Brand name:

These medications are only made by one manufacturer. They're proven to be the most effective medications in their class.



Tier 3 – Non-formulary:

Medications not on your health plan's formulary typically occur when a safer, more affordable alternative—often a generic—is available. If your doctor prescribes a non-formulary medication, consider discussing generic options with them or your pharmacist.



Tier 4 – Specialty:

These medications treat chronic or complex conditions. They often require step therapy and/or prior authorization to be approved to fill.

Why pay more for your medications?



Use the mail

You can save time and money by getting your medications shipped directly to you through a mail-order service. You can have a larger quantity, usually a 90-day supply, regularly shipped to your door. Go to www.azblue.com to sign-up for delivery service.



Shop around

Some pharmacies offer less expensive medications. Try calling pharmacies inside warehouse clubs or discount stores to see if they offer a lower price. Shopping around could pay off.



Try over-the-counter

For colds, headaches, and other common conditions, over-the-counter medications can sometimes work just as well as prescription ones—and cost a lot less, too.



Supplemental Health Plans



Critical Illness Insurance

If you choose to sign up for this coverage, Symetra will pay you a lump sum of money if you're diagnosed with a specific critical illness. Some of the covered medical conditions include cancer, heart attack, stroke, kidney failure, and organ transplant. This coverage pays you directly in cash, so you can use the funds however you want.

Click on the image below to view a video on the critical illness plans offered:



Hospital Insurance

Hospital stays are difficult, especially if your health plan doesn't cover costs. To help ensure you can afford a hospital stay, you can sign up for hospital insurance through Symetra. This benefit will pay cash to you or your family to offset medical and non-medical bills that you get after staying in the hospital.

Click on the image below to view a video on the Hospital plans offered:



This type of coverage pays you directly in cash, so you can use the funds however you want. Here are a few examples of what these funds can cover:

- Copayments
- Deductibles
- Lodging expenses for a companion
- Child care
- Transportation expenses
- Lost income

Accident Insurance

We all know they happen, but not everyone is prepared. Accident insurance through Symetra is optional coverage that helps you pay for expenses if something unexpected occurs. The benefits are paid directly to you to help cover specific treatments, and the amount depends on the type of injury you have and what care you need.

Click on the image below to view a video on the accident insurance plans offered:



This type of coverage pays you directly in cash, so you can use the funds however you want. You could use the funds to pay for:

- Emergency room visits
- Hospital admission
- Outpatient therapy
- Ambulance transportation
- Surgery
- Diagnostic imaging
- Doctor visits
- Medical equipment



Wellness Programs & Employee Assistance Program



What is wellness and why is it important?

Choosing your benefits is becoming clearer, but remember, it's about the journey, not just the destination. Bring the right tools and a supportive network! Healthy lifestyles can reduce the risk of chronic diseases and lower healthcare costs. Your wellness benefits promote total well-being for your mind and body—and they're free!

Monthly challenges and prizes

Our benefits broker, Marsh McLennan Agency, provides the Altitude Newsletters and Total Health Monthly Challenges to help you stay engaged with your well-being and win cool stuff.

When you choose to participate in our Monthly Challenges, you throw your hat in the ring to win prizes worth over \$1,000 per month.

Employee Assistance Program

Your Employee Assistance Program (EAP) is a set of services that can support you through personal and professional challenges with resources, information, and counseling. Everything is confidential—what you talk about won't be shared with your employer—and free.

Program Component and Coverage Details

Number of Sessions

- 6 face-to-face sessions per year per member per incident

How to Access

- Phone or face-to-face sessions.
- Call 888.52.5400 or visit www.jorgensenbrooks.com with Website code: m3eng

Topics may include

Mental Health Support:

- Marital, relationship or family problems
- Bereavement or grief counseling
- Substance use disorder and recovery

Community Support:

- Child and eldercare
- Legal services and identity theft
- Financial support

Who can utilize

- You, your dependents, and even other members of your household



Dental Plans



Dental Plan(s)

You and your eligible dependents have the opportunity to enroll in a Dental Health Maintenance Organization (HMO) plan through Delta Dental of Arizona or a Dental Preferred Provider Organization (PPO) plan offered by MetLife. We encourage you to review the coverage details and select the option that best suits your needs.

To find out if your dentist is in your provider network, you can search on www.deltadental.com or www.metlife.com/dental.

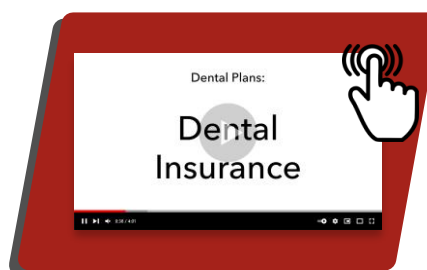
Plan Highlights	Delta Dental DHMO Plan
	In-network Only (DeltaCare USA)
Calendar Year Deductible (Individual / Family)	None
Calendar Year Annual Maximum (per person)	None
Preventive Services (Exams / X-rays / Cleanings)	See Schedule D70
Basic Services (Fillings / Extractions / Root Canal)	See Schedule D70
Major Services (Bridges / Dentures / Crowns / Implants)	See Schedule D70
Orthodontia Services	See Schedule D70
Adults / Children	See Schedule D70

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights	MetLife DPPO Plan	
	In-network Only (PDP)	Out-of-Network
Calendar Year Deductible (Individual / Family)	\$25 / \$75	\$50 / \$150
Calendar Year Annual Maximum (per person)	\$5,000	\$5,000
Preventive Services (Exams / X-rays / Cleanings)	Covered at 100%	Covered at 100%
Basic Services (Fillings / Extractions / Root Canal)	Covered at 80% after deductible	Covered at 80% after deductible
Major Services (Bridges / Dentures / Crowns / Implants)	Covered at 50% after deductible	Covered at 50% after deductible
Orthodontia Services		
Adults / Children to age 26	50% up to a \$2,500 Lifetime Maximum	50% up to a \$2,500 Lifetime Maximum

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Click on the image below to view a video on the dental plans offered:





Vision Plan

You and your eligible dependents will have the opportunity to enroll in vision coverage with Superior Vision. With the vision plan, you can pick where to receive services. Just keep in mind that your vision plan has settled on lower rates with in-network providers.

To find out if a vision provider is in your network, you can search on www.superiorvision.com/locator.

Plan Highlights	Plan Name	
	In-network (Superior National)	Out-of-Network
Exam – Every 12 months	\$10 copay	Up to \$34 reimbursement
Lenses – Every 12 months		
Single	\$10 copay	Up to \$29 reimbursement
Bifocal	\$10 copay	Up to \$43 reimbursement
Trifocal	\$10 copay	Up to \$53 reimbursement
Frames – Every 12 months		
Frames Allowance	\$150 Allowance plus 20% off amount over allowance	Up to \$47 reimbursement
Contacts – Every 12 months	In lieu of lenses & frames	
Medically Necessary	Covered in full	Up to \$210 reimbursement
Elective	\$100 Allowance plus 20% off amount over allowance	Up to \$100 reimbursement
Contact Lens Fitting	\$30 copay	Not covered
LASIK	Multiple discounts on laser vision correction procedures may be available to you. To learn more, visit www.superiorvision.com	

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Click on the image below to view a video on the vision plans offered:



Spending Accounts



Health Savings Account (HSA)

Administered by Health Equity, a Health Savings Account (HSA) allows you to save money for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses. The HSA we offer works in conjunction with the BCBSAZ \$1,700 High Deductible Health Plan (HDHP). The money you put in your HSA is not federally taxed.

Plan Highlights	M3 Contribution	Employee Maximum Contribution	2026 IRS Contribution Limit
Employee Only	\$1,700	\$2,700	\$4,400
Employee + Dependents	\$3,400	\$5,350	\$8,750
Additional "catch-up" if 55 or older	N/A	\$1,000	\$1,000 in addition to the above maximums

The maximum contribution is reduced pro-rata for partial year enrollment. Contact Human Resources to learn more about the HSA, including advantages, if you qualify, how to activate your account, and how to use your funds.

Click on the image below to view a video on the health savings account offered:





Life Insurance and AD&D

In the event of your passing, life insurance will provide your family members or other beneficiaries with financial protection and security. You are automatically enrolled for this benefit and your family will be paid a lump sum of money upon your passing. If your passing was caused by an accident, your chosen beneficiaries may receive an additional pay out.

M3 Engineering & Technology pays for 100% of this benefit through Symetra. It includes the following:

- You will see your Basic Life and AD&D Insurance amount in UKG.
- Your benefits will reduce when you turn 70

Quick note on IRS Regulations: You can receive employer-paid life insurance coverage up to \$50,000 on a tax-free basis and do not have to report the payment as income. However, coverage of more than \$50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

Voluntary Life and AD&D

You can choose to add more life insurance and AD&D coverage for you and/or your dependents. The cost of these benefits would be taken out of your regular paycheck by Symetra. Here are details on the

For employees: Increments of \$1,000 up to 5x your salary or \$500,000 with a guaranteed issue benefit of \$150,000 if you enroll in the plan within 30 days of your initial eligibility.

For your spouse: Increments of \$5,000 up to a \$130,000 maximum with a guaranteed issue benefit of \$30,000 if you enroll in the plan within 30 days of your initial eligibility.

For your child(ren): Live birth up to age 26, increments of \$1,000 up to a \$10,000 maximum

Optional AD&D: Coverage is available for purchase in the same amounts as optional life insurance amounts above

If you choose to get additional coverage during your enrollment period, the insurance company may want to make sure you're in good health. The insurance amounts here are subject to review and won't be effective until the insurance company approves. There's more info in the Summary Plan Description.

Please note: Benefits coverage may reduce when you turn 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Take a look at your Summary Plan Description for exclusions and further detail.

Don't forget to update your beneficiaries!

The people or entities who you want to receive benefits from your policy are called beneficiaries. It's very important that they are up to date.

- You may change your beneficiaries at any time
- To select or change your beneficiary, contact Human Resources





Disability Insurance

When you're too sick or injured to work, you need time to focus on healing—not worrying about your income. Enrolling in disability insurance offers you and your family peace of mind by helping to replace some of your income if you have a non-work related illness or injury. Your eligibility may be based on disability for your occupation or any occupation.

Employer-Paid Short Term Disability (STD)

Administered by Symetra, STD coverage provides a benefit equal to 70% of your earnings, up to \$2,328 per week for a period of up to 26 weeks. The plan begins paying these benefits immediately after an injury or after you have been absent from work for 7 consecutive days due to illness.

Employer-Paid Long Term Disability (LTD)

If your disability extends beyond 180 days, the LTD coverage through Symetra can replace 60% of your earnings, up to maximum of \$8,750 per month. Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.

Note: Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.





Pet Insurance

Optional pet insurance from MetLife can cover your dogs, cats, birds, and some exotic animals. You can view your options at www.metlifepetinsurance.com. If you're having trouble deciding, contact them at 800.438.6388. They'd love to help you choose the best plan for your best friend.

Why is pet insurance important?

- A small monthly payment can help you prepare for unexpected vet expenses down the road
- More than 6 in 10 pet owners said their pet has had an emergency medical expense
- 24% of pet parents have credit card or personal loan debt to cover pet health and vet costs
- Average annual cost for a routine vet visit is \$212 for a dog and \$160 for a cat; and average annual cost for a surgical vet visit is \$426 for a dog and \$214 for a cat
- Pet insurance does not cover pre-existing conditions – so don't wait

What does it cover?

- Accidents
- Illnesses
- Exam fees
- Surgeries
- Medications
- Ultrasounds
- Hospital stays
- X-rays
- Diagnostic tests

Coverage also includes:

- Hip dysplasia
- Hereditary conditions
- Congenital conditions
- Holistic care
- Chronic conditions
- Alternative therapies
- And much more!



Costs Breakdown

Let's sum it all up!

The rates below are effective January 1st, 2026 – December 31st, 2026

Coverage Level	Payroll Deduction
	Employee Biweekly
BCBSAZ PPO Medical Plan	
Employee Only	\$0
Employee and Spouse	\$0
Employee and Child(ren)	\$0
Employee and Family	\$0
BCBSAZ HDHP/HSA Medical Plan	
Employee Only	\$0
Employee and Spouse	\$0
Employee and Child(ren)	\$0
Employee and Family	\$0
Delta Dental DHMO Plan	
Employee Only	\$7.48
Employee and Spouse	\$14.51
Employee and Child(ren)	\$14.81
Employee and Family	\$22.14
MetLife DPPO Plan	
Employee Only	\$21.32
Employee and Spouse	\$44.07
Employee and Child(ren)	\$53.41
Employee and Family	\$84.11
Superior Vision PPO Plan	
Employee Only	\$0
Employee and Spouse	\$0
Employee and Child(ren)	\$0
Employee and Family	\$0

Directory & Resources



Below, please find important contact information and resources for m3 Engineering & Technology.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources:			
Trish Mallon		520.293.1488 ext 7483	Trish.Mallon@m3eng.com
Kathy Chavez		520.293.1488 ext 7527	Kathy.Chavez@m3eng.com
Online Enrollment Vendor:			
UKG			Benefits Enrollment Link
M3 Benefits Website			www.mym3benefits.com
Medical Coverage			
BlueCross BlueShield of Arizona			
PPO	30946	602.864.4400	www.azblue.com
HDHP/HSA			
BlueCare Anywhere – Telemedicine	30946	844.606.1612	www.bluecareanywhereaz.com
Dental Coverage			
Delta Dental – DeltaCare	70334	800.422.4234	www.deltadentalins.com
DHMO			
MetLife	2997835	800.772.9772	www.metlife.com/dental
DPPO			
Vision Coverage			
Superior Vision			
PPO	035142-G	800.507.3800	www.superiorvision.com
Life, AD&D and Disability			
Symetra			
STD			
LTD			
Basic Life and AD&D	12760000	877.3776773	www.Symetra.com
Voluntary Life AD&D			
Worksite			
Health Savings Account			
HealthEquity		866.346.5800	www.healthequity.com
Employee Assistance Plan			
Jorgensen Brooks Group	m3eng	888.520.5400	www.jorgensenbrooks.com
Benefits Broker			
Marsh & McLennan Insurance Agency LLC		800.321.4696	www.MarshMMA.com
4703 E Camp Lowell Suite 101			
Tucson, AZ 85712			
CA Insurance License# 0H18131			
Courtney Jackson	Client Executive	520.722.3000	Courtney.Jackson@MarshMMA.com
Erin Figueroa (Freker)	Sr. Client Manager	520.722.7135	Erin.Freker@MarshMMA.com
Shan O'Connor	Claims Advocate	602.385.7069	Shan.O'Connor@MarshMMA.com





Prepared by: **Marsh & McLennan Insurance Agency LLC**

www.MarshMMA.com | CA Insurance Lic: 0H18131

M3 Engineering & Technology' Health and Welfare Benefits Annual Notice Packet

For the January 1st, 2026 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact Human Resources.

Medicare Part D Creditable Coverage Notice

Important Notice from M3 Engineering & Technology Corporation About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with M3 Engineering & Technology Corporation 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. M3 Engineering & Technology Corporation has determined that the prescription drug coverage offered by BCBSAZ is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in M3 Engineering & Technology Corporation coverage as an active employee, please note that your M3 Engineering & Technology Corporation coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in M3 Engineering & Technology Corporation coverage as a former employee.

You may also choose to drop your M3 Engineering & Technology Corporation coverage. If you do decide to join a Medicare drug plan and drop your current M3 Engineering & Technology Corporation coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with M3 Engineering & Technology Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through M3 Engineering & Technology Corporation changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2026

Name of Entity/Sender: M3 Engineering & Technology Corporation

Contact-Position/Office: Human Resources

Address: 2051 W Sunset Rd, Ste 101, Tucson, AZ 85704-1722

Phone Number: 520.293.1488 x 7483

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in M3 Engineering & Technology Corporation group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Human Resources at 520.293.1488 x7483.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

M3 Engineering & Technology Corporation (“M3 Engineering & Technology”) sponsors certain group health plan(s) (collectively, the “Plan” or “We”) to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the “Notice”) describes the legal obligations of M3 Engineering & Technology, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- (1) your past, present or future physical or mental health or condition;
- (2) the provision of health care to you; or
- (3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by M3 Engineering & Technology, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the M3 Engineering & Technology HIPAA Privacy Officer:

M3 Engineering & Technology
Attention: HIPAA Privacy Officer
2051 W Sunset Rd, Ste 101
Tucson, AZ 85704-1722
520.293.1488 x7483

Effective Date

This Notice as revised is effective January 1, 2026.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and

- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- (2) treating such person as your personal representative could endanger you; or
- (3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your

protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see [Your Rights Under HIPAA](#).

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html>.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	INDIANA – Medicaid Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	LOUISIANA – Medicaid Website: www.medicicaid.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.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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 Email: HSHIPPPProgram@mt.gov	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Women’s Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women’s Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 520.293.1488 x7483.

Newborns’ and Mothers’ Health Protection Act (NMHPA) Notice

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

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA ****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the

second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

If you have questions

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

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>. These rules are different for people with End Stage Renal Disease (ESRD).

Keep your Plan informed of address changes

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

Plan contact information

M3 Engineering & Technology Corporation
Human Resources
2051 W Sunset Rd Ste 101
Tucson, AZ 85704-1722
520.293.1488 x7483

APPENDIX

These are additional notices that may be appropriate based upon an employer's circumstances. We included the Surprise Billing Notice to assist with an employer's obligation to post the notice on its website (in those rare circumstances where it may be necessary).

- ☐ Fixed Indemnity Policy Notice
- ☐ HIPAA Privacy Notice of Availability
- ☐ Surprise Billing Notice – “Your Rights and Protections Against Surprise Medical Bills”

Fixed Indemnity Policy Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit [HealthCare.gov](https://www.healthcare.gov)** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

HIPAA Notice of Availability of Notice of Privacy Practices

The M3 Engineering & Technology Corporation Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources at 520.293.1488 x7483.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

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

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

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

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

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

When balance billing isn't allowed, you also have the following protections:

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

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to [learn more about protections from surprise medical bills](#) and for [contact information for the state department of insurance or other similar agency/resource in your state](#) to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.