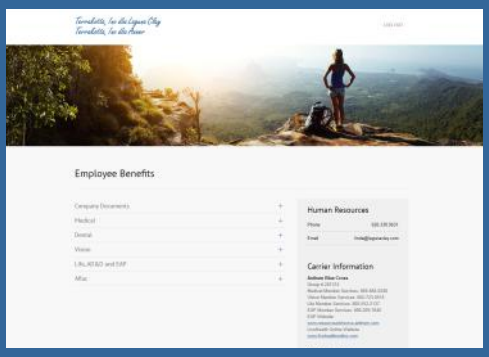
Terrakotta, Inc. dba Kemper Tools

EMPLOYEE BENEFITS GUIDE

June 1, 2026 through May 31, 2027



Your Benefits Website

For in-depth information about your benefits, log on to the benefits website, your hub for all of our employee benefits and wellness information. You will also find a wealth of resources from our carrier partners and vendors. Log on today and check it out!

www.lagunaclay.benefitsmap.com

username: laguna
password: benefits

Terrakotta, Inc. dba Kemper Tools is pleased to provide you with our Employee Benefits Guide.

Each year you have the opportunity to review the benefits offered and to decide which programs will best fit your needs over the coming year.

This brochure briefly highlights the benefits offered to all eligible employees and dependents. The content in this brochure provides you with an overview of our benefit plans, please refer to your **Summary of Benefit and Coverage documents (SBCs**) and/or carrier booklets and certificates for more detailed benefit information.

When Can You Enroll or Make a Change?

Annual Open Enrollment — Offers you the opportunity to make changes to your current elections or to participate in a benefit plan for which you have not previously enrolled.

New Employee — You have 30 days from the day you become eligible to elect or waive coverage.

Eligibility

To be eligible to enroll in our company's benefit plans, you must be a **regular employee, have satisfied the waiting period, and work the minimum hour requirements.**

You may also enroll your eligible dependents in the benefit plans including:

- Your legal spouse (same sex or opposite sex)
- Your qualified domestic partner (same sex or opposite sex)
- Your children up to **age 26** can be covered regardless of student and marital status

Declining Coverage & Family Status Change

It is important to note that if you waive any coverage, you will not be able to enroll in the health benefit plans unless you have a designated family status change event. You will need to wait until the next open enrollment period.

Federal regulations define a change in family status as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- A child becoming ineligible for dependent coverage
- Death of a spouse or child
- A change from full time to part time (or the opposite)
- An unpaid leave of absence
- A change in your spouse's employment
- A move out of the service area
- A Qualified Medical Child Support Order
- A substantial change in your or your spouse's benefits coverage

Note: Please contact Human Resources immediately to complete the appropriate forms if you have a qualified family status change. If you do not update your coverage within 30 days from the date of the qualified family status change, you must wait until the next Annual Open Enrollment period.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. See page 7 for details.

This brochure provides you with an overview of our benefit plans, but in all cases, the plans will be administered in accordance with the governing plan documents. Refer to the plan Certificate Booklet, Evidence of Coverage, and/or Summary of Benefits and Coverage (SBC) for more detailed information.

New! Aetna Medical

We offer you two medical HMO plan options with **Aetna**. Please refer to the carrier **Summary of Benefits and Coverage document (SBC**) and/or benefit summaries for more detailed benefit information. A **Health Maintenance Organization (HMO)** plan requires you to select a Primary Care Physician (PCP) who will coordinate your care through a specific network of doctors, medical groups and hospitals. If you need specialized services you will be referred by your PCP to a specialist in your medical group.

FEATURES	Aetna AWH Southern CA HMO CA25 $30/$60 AWH (Smallest Network)	Aetna AVN HMO CA25 $30/$60
Network	**AWH Southern CA HMO**	**Aetna Value Network HMO**
Calendar Year Deductible	None	None
Office Visit	PCP: $30 copay Specialist: $60 copay	PCP: $30 copay Specialist: $60 copay
Preventive Care	No charge	No charge
Hospitalization	30%	30%
Urgent Care	$50 copay	$50 copay
Outpatient Surgery	30%	30%
Emergency Room	$150 copay	$150 copay
Diagnostic Lab and X-Ray	$40 copay	$40 copay
Complex Imaging (CT/PET scans, MRIs)	30%	30%
Chiropractic	$15 copay (20 visits/year)	$15 copay (20 visits/year)
Acupuncture	$30 copay (20 visits/year)	$30 copay (20 visits/year)
Prescription Drugs Calendar Year Deductible Preferred Generic Generic Preferred Brand-Name Non-Preferred	 None $10 co-pay $30 co-pay $50 co-pay 30% up to $250	 None $10 co-pay $30 co-pay $50 co-pay 30% up to $250
Calendar Year **Out of Pocket Maximum**	$4,500 per person / $9,000 per family	$4,500 per person / $9,000 per family
Cost Per Weekly Paycheck Employee only Employee + 1 Dependent Employee + 2 or more	 $25.61 $173.84 $295.13	 $30.03 $203.89 $346.14

New! Aflac Dental

We are pleased to offer you a choice of 2 dental plans: Dental PPO Low plan and Dental PPO High plan with Aflac.

The dental PPO plans cover a wide range of dental services. These plans are designed to give you the freedom to receive dental care from any dentist of your choice. However, you can maximize your benefits by seeing a dentist in the PPO network. If you visit an out-of-network provider, you may be responsible for any amount owed after insurance has paid. Please see the Aflac benefit summary and/or Certificate of Insurance for important benefit details.

TIPS:

Be sure to ask your dental office to submit a pre-estimate plan to your insurance carrier prior to receiving major dental work. Your insurance carrier will provide an Explanation of Benefits illustrating services the insurance will cover or not cover and how much will be your responsibility.

Aflac	DPPO Low Plan		DPPO High Plan	
	In-Network	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Calendar Year Deductible	$75; Max 3 per family	$75; Max 3 per family	$50; Max 3 per family	$50; Max 3 per family
Deductible Waived for Preventive	Yes	Yes	Yes	Yes
Calendar Year Benefit Maximum	$1,000 per person	$1,000 per person	$1,500 per person	$1,500 per person
Preventive Services	100%	80%	100%	100%
Basic Services	80%	60%	80%	80%
Major Services	50%	40%	50%	50%
Claims Payment Basis	Fee Schedule	MAC	Fee Schedule	UCR 95th
Cost Per Weekly Paycheck Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	 $3.46 $6.83 $8.91 $12.74		 $10.13 $20.27 $22.55 $34.33	

1. You are responsible for any amounts over Aflac's allowed amounts for care and services.

New! Aflac Vision

Whether your vision is 20/20 or less than perfect, everyone needs to receive regular vision care. The **Aflac Vision Plan** provides professional vision care and high quality lenses and frames through a broad network of optical specialists. Similar to a PPO plan, you may take advantage of the highest level of benefit by receiving services from in-network vision providers.

FEATURES	Aflac—Davis Network	
Exam / Frames / Lenses (Eyeglasses or Contacts)	Every 12 Months / Every 24 Months / Every 12 Months	
Copays	Exam: $10 / Materials: $25	
	In-Network	**Out of Network Reimbursement**
Exam	Covered in full after copay	Up to $40
Frames	$130 allowance or $180 allowance at Visionworks, then 30% off balance	Up to $50
Eyeglass Lenses	Select lenses covered in full after copay	Up to $80
Contact Lenses Elective Medically Necessary	 $130 allowance + 15% off balance No charge	 Up to $105 Up to $225
Cost Per Weekly Paycheck Employee only Employee + 1 Dependent Employee + 2 or more	 $1.51 $2.98 $4.41	

Flexible Spending Accounts (FSA)

OPEN ENROLLMENT IN DECEMBER FOR 2027 CALENDAR YEAR

Keep more of the money you earn. **HealthEquity | WageWorks** administers the Flexible Spending Account. The FSA allows you to put aside pre-tax dollars for health care and dependent care expenses. Using a spending account is like getting a discount on certain expenses—not because the expenses are less, but because you are paying for them with the money that has not been taxed. You can use a spending account to get reimbursed for eligible health care expenses.

A dependent care FSA is a great way to pay dependent care expenses and lower your taxable income. Here is how it works:

- You direct part of your before-tax pay into a special account to help pay work-related dependent care costs
- You can use your account throughout the year to help pay for eligible expenses
- Your expense must be for the purpose of allowing you and, if married, your spouse to be employed

Qualifying dependents include

- A tax dependent of yours who is under age 13, or
- Any other tax dependent of yours, such as an elderly parent, who is physically or mentally incapable of self-care and have the same principal residence as you
- A spouse who is physically or mentally incapable of self-care and has the same principal residence as you

	With FSA	Without FSA	FSA Savings
Annual Income	$40,000	$40,000	
Estimated Care Pretax Contributions	$5,000	$0	
Taxable Income	$35,000	$40,000	
Estimated Federal Withholding	$4,713	$5,463	
Estimated Social Security Tax	$2,678	$3,060	
Dependent Care Expenses	$0	$5,000	
Tax Credit for Dependent Care	$0	$660	
After-Tax Income	$27,609	$27,137	**$472**

Gateway Travel Insurance

Traveling away from home? Gateway Travel Medical Insurance will protect you in the event of an injury or illness. It will pay for your medical bills abroad and even pay for you to be evacuated back to the U.S. if necessary. The cost of an international travel insurance policy is quite low compared to the protection it provides. For more information, please call **877.808.7434** or visit the website at **www.gatewayplans.com/individuals/leisure-travel/gateway-international**. Travel insurance is NOT sponsored by your employer. In order to access this coverage, you must purchase it online.

Employer Paid Life/AD&D Insurance

FREE TO YOU! We provide eligible employees with $25,000 of Group Term Life and Accidental Death & Dismemberment (AD&D) insurance through **United Healthcare.** Benefits are reduced to $16,250 at age 65 and to $12,500 at age 70.

You may continue your life insurance after you leave our company or are no longer eligible for this coverage due to other reasons. However, you must request continued coverage within 31 days of your loss of this insurance. Please visit our Benefits Website and your insurance Certificate Booklet for more information.

United Healthcare Voluntary Life/ AD&D

If you need additional financial protection for your family, you also have the opportunity to purchase additional Term Life and AD&D insurance. A voluntary AD&D benefit is included when you purchase voluntary life insurance. The amount for the Life and AD&D is equal. This premium is paid with after-tax dollars through payroll deductions.

Benefits are available to employees and dependents up to a maximum. Employees must enroll in order to purchase additional life insurance for dependents.

Please remember that if you choose to enroll in Voluntary Life and AD&D insurance after your initial eligibility date, Evidence Of Insurability (EOI) will be required.

If you would like additional information please refer to United Healthcare's documents.

Aflac Voluntary Worksite Benefits

Even the best benefit plans do not cover all out-of-pocket expenses, and that is where Aflac fits your additional needs. Aflac pays cash to help protect your assets and income when you are hurt or sick. You can choose from one or more of the following plans:

FEATURES	
Accident Advantage	For covered accidents, you receive cash benefits for use as you see fit. This plan helps provide a financial cushion if an accident occurs. Coverage is 24/7.
Cancer Protection	Pays prevention, diagnosis, treatment and recovery
Critical Care	Helps provide financial peace of mind if you experience a serious health event, such as a heart attack or stroke. You will receive a lump sum benefit upon diagnosis of a covered event.
Disability	In the case of illness or injury off the job, disability coverage helps you maintain your standard of living and helps you pay your bills.
Hospital Confinement	Helps with non-covered expenses of a hospital stay. Also includes physician visits. This umbrella policy covers any illness and any injury.

Notice to Medicare Eligible Employees

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

If you have Medicare and other health insurance (like from a group health plan, retiree coverage, or Medicaid), each type of coverage is called a "payer." When there's more than one payer, "coordination of benefits" rules decide who pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" (supplemental payer) to pay. If you have questions about who pays first, or if your coverage changes, call the Benefits Coordination & Recovery Center at 1-855-798 -2627 (TTY: 1-855-797-2627).

If you would like to learn more about Medicare and the various plan options, reach out to Martin & Associates Insurance Services for a no-cost phone consultation to discuss your situation: www.MartinMedicare.com.

Find a Provider

Medical

- Go to www.aetna.com
- Click "Find a doctor" on the home page
- On the next page, select "Plan through employer"
- Under "Continue as guest" enter your location and location parameters. Select "Search"
- Select a plan/network
  - For the Aetna AWH HMO plan, select "AWH Southern CA HMO" located under the Aetna Whole Health Plans
  - For the Aetna AVN HMO plan, select "Aetna Value Network HMO" located under the State Based Plans
- On the next page you can search by provider name or category
- You will be provided with list of in-network providers. You can click on the doctor's name for more information

Dental

- Go to www.aflac.com/DentalNetwork and click “Provider Search” or call Aflac directly at 1 (877) 864-0625

Vision

- Go to www.aflac.com/VisionNetwork and click “Provider Search” or call Davis Vision directly at 1 (800) 999-5431

Contact Information

Aetna

www.aetna.com

Medical HMO: (800) 445-5299
Pharmacy: (888) 792-3862
Teladoc :(855) 835-2362
24/7 Nurseline: (800) 556-1555
Behavioral Health HMO: (800) 866-1578

To Find Acupuncture or Chiropractic Care:

(No HMO referral needed for Acupuncture/Chiropractic services)

- For type of service, select “Alternative Medicine” which lists Chiropractors and Acupuncturists

Visit MyAetnaWebsite.com to register for your member website. Get the Aetna Health℠ app by texting “AETNA” to 90156 to receive a download link or scan the QR code to download the Aetna Health app

Aflac

www.aflac.com

Dental PPO: (855) 819-1873
Vision: (800) 999-5431
Voluntary Worksite Benefits: Group #CB567
Daniel Tyler Adamson
(714) 915-0722
Daniel_adamson@us.aflac.com
Lisa Coots
(909) 519-5681
Lisa_Coots@us.aflac.com
One-Day Pay: Aflac.com/smartclaim

United Healthcare

www.myuhc.com

Life: (888) 299-2070

HealthEquity | WageWorks (FSA)

www.wageworks.com

Group L00735
Member Services: (855) 774-7441

Empower Retirement (401k)

www.empower-retirement.com

Group 935596-01
Member Services: (877) 694-4015

Kemper Tools Human Resources

Linda Nguyen
(626) 330-0631 x210
linda@lagunaclay.com

Medicare

Martin & Associates Insurance Services
Elliott Martin
Email : Elliott@WeRetireSmart.com

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: 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

ALASKA – Medicaid

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

CALIFORNIA – Medicaid

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-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-reauthorizationact-2009-chipra
Phone: 678-564-1162, Press 2

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

KENTUCKY – Medicaid

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

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

MINNESOTA – Medicaid

Website:https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

LOUISIANA – Medicaid

Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid Email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
https://www.ldh.la.gov/lahipp
LaHIPP Phone: 1-877-697-6703
LaHIPP Email: La.HIPP@la.gov
LaHIPP Fax: 1-888-716-9787
LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MISSOURI – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW JERSEY – Medicaid and CHIP

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)

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-programhipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

VERMONT– Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

NEW HAMPSHIRE – Medicaid

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 YORK – Medicaid

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

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH DAKOTA - Medicaid

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

UTAH – Medicaid and CHIP

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/

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select
https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ & http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

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

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programsandeligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, 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

Medicare Notice of Creditable Coverage

Important Notice from Terrakotta, Inc. dba Kemper Tools 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 Terrakotta, Inc. dba Kemper Tools 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. Terrakotta, Inc. dba Kemper Tools has determined that the prescription drug coverage offered by the Aetna Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current Terrakotta, Inc. dba Kemper Tools coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Terrakotta, Inc. dba Kemper Tools 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 Terrakotta, Inc. dba Kemper Tools 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 Terrakotta, Inc. dba Kemper Tools 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).

Human Resources
Phone: 626.330.0631
Email: linda@lagunaclay.com
Address: 14400 Lomitas Ave., City of Industry, CA 91746

Other Important Notices and Disclosures

The Women's Health and Cancer Rights Act of 1998—Important Notice

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

Reconstruction of the breast on which the mastectomy has been performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

HIPAA Privacy Notice—Important Notice about Your Health Information

The HIPAA Notice of Privacy Practices applies to Protected Health Information associated with the Group Health plan provided to our employees, employee's dependents and, as applicable, retired employees. The Notice describes that Terrakotta, Inc. dba Kemper Tools may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of the Notice so long as it remains in effect. We reserve the right to change the terms of the Notice as necessary and to make the new Notice effective for all Protected health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health plan. Copies of our current Notice may be obtained by contacting:

Human Resources
Phone: 626.330.0631
Email: linda@lagunaclay.com
Address: 14400 Lomitas Ave., City of Industry, CA 91746

Newborns' and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Patient Protection Disclosure

The Aetna HMO health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna HMO at (800) 445-5299.

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

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a 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 Aetna HMO at (800) 445-5299.

HIPAA Special Enrollment Rights

If you are declining for yourself or your dependent (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependent's other coverage). However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing towards the other coverage). Note: if the change is due to Medicaid/CHIP eligibility, there is a **60 day** window for Medicaid/CHIP eligibility changes only.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't 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" means 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're 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 balanced 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 types of 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 these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible 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:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

DISCLAIMER:

This summary provides an overview of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment; neither is it a legal plan document. If there is a disagreement between this summary and the plan documents, the plan documents will govern. In addition, the plans described in this summary are subject to change without notice. Continuation of any benefit plan or coverage is at the company's discretion and in accordance with federal and state laws. If you need additional information or have any questions please contact Human Resources.