2025-2026

Employee Benefits Overview

john crane
a smiths company

What's Inside

Getting Started

Benefit Details

Enrollment Details

Additional Information

Welcome to Your 2025-2026 Benefits

John Crane offers a comprehensive benefits program, thoughtfully designed with you and your family in mind.

We are enhancing our benefits package by improving your coverage and continuing to contain healthcare costs.

Please contact the Benefit*first* Customer Care Center at **888-322-9374** and use Company ID **1197** if you have any questions regarding your benefits plan.

Who is Eligible?

You are eligible for the John Crane Benefits if you are a full-time employee or an employee approved and scheduled to work at least 20 hours per week.

Eligible dependents include:

- Your legal spouse or domestic partner.
- Children under age 26 (eligibility ends the day they turn 26, may be eligible for COBRA).
- Dependent children of any age (including those of a domestic partner) who have an eligible disability and are dependent on you for support.

Section 125 Plan Premium Conversion

Section 125 Premium Conversion Plan lets you exclude your Medical, Dental and Vision premiums from your taxable income, meaning your premiums will come out of your income pre-tax. This lowers your taxable income. By default, your premiums will be deducted pre-tax, increasing your take-home pay anywhere from a couple hundred dollars to a thousand or more annually.

Summary of Material Modifications

This document is to serve as a Summary of Material Modifications to the Summary Plan Description (SPD) for the John Crane Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

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. Please see Annual Notices section for more details.

Open Enrollment - What You Need To Do

1. **Review your options.** Review the online enrollment platform, Benefit*first*, and this guide to understand your options.
2. **Log in between July 9 - 18, 2025 to:**
   - ☐ Review and make changes to your benefits.
   - ☐ Re-elect a Flexible Spending Account (FSA) or Health Savings Account (HSA).
     - If you have a Health Care, Limited Purpose, or Dependent Care FSA, you will default to no contributions unless you make an election. Changes may only be made during Open Enrollment or within 30 days of a Qualified Life Event.
     - If you have an HSA, you will default to no contributions unless you make an election. Contribution elections do not roll over. You may stop, start, or change your HSA elections at any time by contacting the Benefit*first* Customer Care Center.
   - ☐ Complete your Tobacco Use Certification or pay a surcharge. If you don't take action, you and your covered spouse/domestic partner will be defaulted to tobacco users and pay an annual surcharge of $600 each.
   - ☐ Complete the Spousal Surcharge Certification. If you don't take action, your current certification will roll over. If your spouse/domestic partner has access to other coverage and you choose to enroll them in John Crane medical coverage, you will pay a $300 monthly spousal/domestic partner contribution.

How to Enroll

Benefit*first*™ The leader in benefits management.

With **Benefit*first***, you may enroll from home or work -- with 24-hour access. You may enroll online at **www.Benefitfirst.com** or by downloading the Benefit*first*™ app from the Apple App Store or Google Play.

1. Go to **www.Benefitfirst.com** and click on "Log In" > "Create User ID".
2. Enter Company ID **1197** and your personal information. Then, create a User ID and Password to log in.
3. On the John Crane homepage, choose **ENROLL NOW!**
4. If you are a new hire, choose **ENROLL IN OR DECLINE BENEFITS AS A NEWLY ELIGIBLE EMPLOYEE**.
5. If you are an existing employee going through open enrollment or wanting to make a family status change, choose the appropriate transaction and click **CONTINUE**.
6. Check your personal information for accuracy and click **NEXT**.
7. Add any eligible dependents to the dependent screen and click **NEXT**.
8. Starting with the medical screen, complete your selections. Choose the level of coverage, the plan desired, and the dependents to be added.
9. At the final enrollment screen, you will be required to review your elections and certify them by re-entering your password.
10. The final step is to click the **SUBMIT** button. That's it...the entire process can take as little as 4 minutes to complete.

Login Information

Company ID: 1197

User ID/Password: You Create

Scan the QR code to get started on the Benefit*first* website!

If you have technical questions or would like to enroll by phone, please call the Benefit*first* Customer Care Center at **888-322-9374** and use Company ID **1197** to speak with an Enrollment Specialist. The Benefit*first* Customer Care Center is available Monday through Friday, 8:30 a.m. – 5:00 p.m. EST.

Medical Options

We are proud to offer two comprehensive medical plan options through **BlueCross BlueShield of IL (BCBSIL)**. Consider if the PPO Plan or the High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) is a better fit for you and your family.

Plan	John Crane HSA Contribution	Deductible (In-Network)	Payroll Contributions	Out-of-Pocket Expenses (In-Network)
HDHP (HSA-Eligible)	$1,000 family $500 single	$3,500 family $1,750 single	Lower than the PPO Plan	Lower than the PPO Plan
PPO	N/A	$2,000 family $1,000 single	Higher than the HDHP	Higher than the HDHP

Both plans use the same network of healthcare providers, labs, hospitals, etc. and have the same in-network contracted rates for services. Both plans also cover preventive care, which can help you detect many different types of health problems early, at 100% in-network, regardless of the deductible. After the deductible is met for the HDHP, you typically pay less for services because the plan reimburses at a higher percentage for coinsurance. The HDHP contributions are lower than the PPO each pay period and John Crane contributes money to all who are eligible to help meet your deductible.

Your maximum annual cost for in-network prescription drugs and healthcare services is the out-of-pocket maximum plus payroll contributions.

What's New:

- **In-Network Primary Care Visits – PPO Plan**

  Members enrolled in the PPO Plan will now have a reduced copay of $30 per in-network primary care visit with unlimited visits this plan year! If you're not feeling well or something is not quite right, DO NOT defer care — see your primary care doctor.

- **TextCare**

  Members enrolled in a John Crane medical plan and their dependents will now have access to TextCare, which offers 24/7 medical care via text message from board-certified providers.

Terms to Know

Coinsurance - The percentage you pay when you receive care once you have met the annual deductible, if one applies.

Deductible - The amount you pay first each year before the plan begins paying expenses for covered services. The deductible does not include copays.

In-Network - Doctors, hospitals, or other healthcare facilities that are contracted with the plan.

Out-of-Network - Doctors, hospitals, or other healthcare facilities that are not contracted with a plan.

HSA - A Health Savings Account (HSA) allows you and John Crane to contribute money on a before-tax basis to pay for eligible healthcare expenses. It's similar to a 401(k), but used to pay eligible healthcare expenses.

Out-of-Pocket Maximum - The maximum amount you pay each year for covered services, not including contributions.

Preventive Care - 100% covered in-network; includes annual physicals, routine vaccinations, cancer screenings, and more.

Employee Scenario

Alicia

Age 54, insures a family

Alicia and her family occasionally need treatment for acute illnesses and kids' sports injuries, but they are generally healthy. The whole family plans to take advantage of preventive care. Alicia purchases MetLife pet insurance to help cover the costs of her cat's vet visits.

Please Note: This example reflects coverage for in-network services.

HDHP (HSA-Eligible)

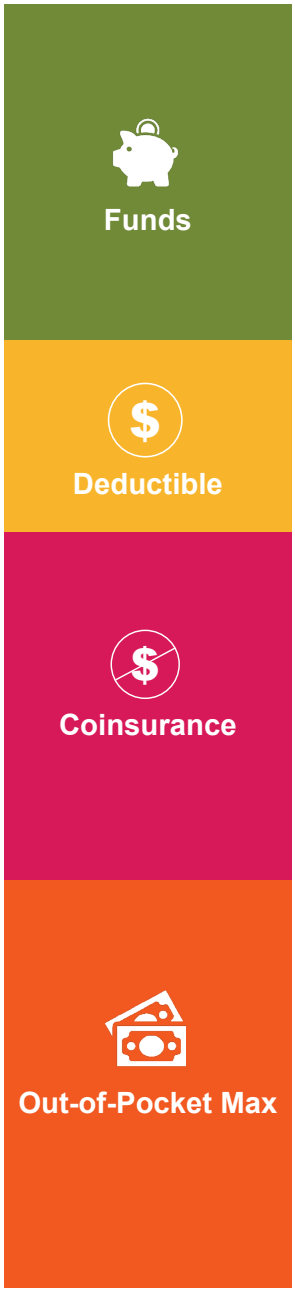
John Crane contributes $1,000 to Alicia's HSA. **Alicia contributes** to her HSA.

Alicia pays up to $3,500 (for two or more enrolled).

Alicia pays 20% of approved charges after deductible.

Plan pays 80% of approved charges.

Plan pays 100% of approved charges AFTER Alicia pays $10,000.



PPO

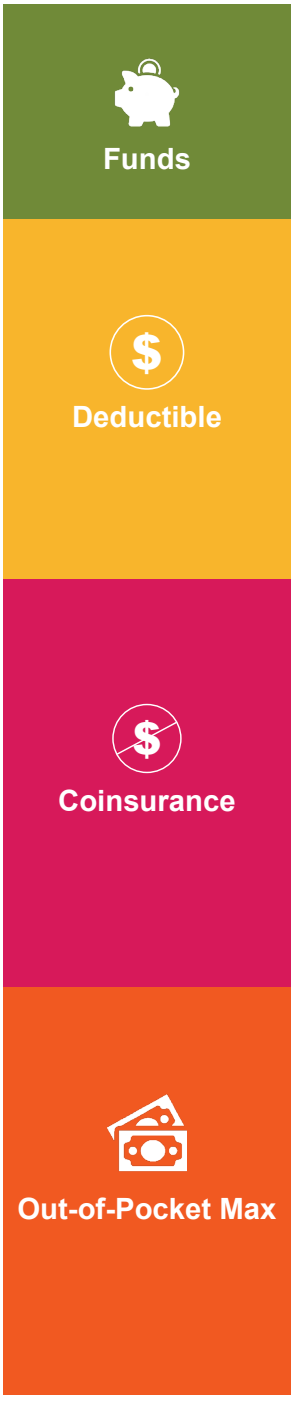
Alicia contributes to an FSA to help cover eligible healthcare expenses before tax.

Alicia pays up to $2,000 (for two or more enrolled).

Alicia pays 25% of approved charges after deductible (except for prescriptions and initial PCP visits).

Plan pays 75% of approved charges.

Plan pays 100% of approved charges AFTER Alicia pays $11,000.



Health Savings Account

BenefitsAssist, inc.

Qualifying for a Health Savings Account (HSA)

To qualify for an HSA, you must:

- Be covered under the High Deductible Health Plan (HDHP).
- Have no other health coverage (except as permitted by law).
- Not be enrolled in Medicare (Parts A or B).
- Not be claimed as a dependent on someone else's tax return.

It is your responsibility to attest to being eligible when you open an account during enrollment. If eligible to receive or make contributions, you must first open your account via the online enrollment website.

Contributions to Your HSA

You will receive a debit card to pay for eligible medical, dental, vision, and prescription drug expenses with the money that you contribute to your HSA. As a plus, **John Crane will deposit money to your HSA annually - $500 for employee only coverage and $1,000 for family coverage - once you open the account.**

If you contribute to an HSA and don't end up needing services, your HSA continues to increase in value. The money in your account is yours to keep and use for eligible healthcare expenses year after year, even if you leave John Crane.

HSA Contributions	Annual Maximum	Company Contributions*	Your Contributions
2025			
Employee:	$4,300	**$500**	**$3,800**
Family:	$8,550	**$1,000**	**$7,550**
2026			
Employee:	$4,400	**$500**	**$3,900**
Family:	$8,750	**$1,000**	**$7,750**
Additional Contributions for those 55+: $1,000			

**To receive this contribution, you must first open your account via the online enrollment website.*

You are responsible for ensuring your contributions plus the contributions from John Crane do not exceed these amounts. For more information on HSAs, please go to **www.irs.gov** and search "Publication 969."

If you are age 65 or over and enrolled in Medicare Parts A or B, your HSA may remain open, but no additional contributions can be made.

New Hires: To be eligible for the company contribution to your account during the plan year, you must open an account by June 30 (30 days prior to the end of the plan year).

You will confirm your HSA eligibility and contributions through Benefit*first*.

You will then be able to access your account, review your HSA transactions, and check balances online at benefitsassist.wealthcareportal.com or via the BenefitsAssist Mobile App.

Flexible Spending Accounts

BenefitsAssist, inc.

John Crane offers three types of Flexible Spending Accounts (FSAs) through **BenefitsAssist** that let you use pre-tax dollars to pay for certain healthcare and dependent care expenses. The Limited Purpose FSA option is new this year, which helps you pay for eligible dental or vision related expenses. While those on the HDHP cannot enroll in the Health Care FSA, they do have the option to enroll in the Limited Purpose FSA in addition to their HSA.

How They Work

- Determine your annual contribution and then contribute money from each paycheck on a before-tax basis.
- Incur eligible healthcare and/or dependent care expenses and pay for them either using your FSA debit card (Health Care FSA only) or out-of-pocket. Be sure to keep your receipts!
- If you pay out-of-pocket, submit claims for reimbursement to BenefitsAssist. **Note:** You may only access dependent care for funds up to the amount available in your account.
- For information on eligible expenses, please go to **www.irs.gov/publications/p502** (Health Care or Limited Purpose FSA), **www.irs.gov/publications/p503** (Dependent Care Account) or consult with a tax advisor.
- If you have any questions about your FSA debit card, log on to the BenefitsAssist WealthCare Portal at **benefitsassist.wealthcareportal.com**, or call **1-865-769-2800**.

Your FSA contributions will not renew automatically. **You must re-enroll in your FSA(s) and elect contributions within 30 days of hire or during Open Enrollment each year.**

FSA Type	2025 Maximum Annual Contribution*	Annual Carry-Over Amount*
Health Care FSA • Savings & spending account for eligible medical, dental, or vision related expenses. • You cannot enroll in the Health Care FSA if you are actively contributing to an HSA.	$3,300	$660
NEW! Limited Purpose FSA • Savings & spending account for eligible dental or vision related expenses only. • Anyone is eligible. You can elect to have both an HSA and a Limited Purpose FSA.	$3,300	$660
Dependent Care Account (DCA) • For eligible dependent care expenses: day care, after-school programs, adult day care & summer camp • Anyone is eligible. You can elect to have a Health Care FSA/Dependent Care FSA OR HSA/Limited Purpose FSA/Dependent Care FSA.	$5,000/household	N/A

*Please refer to www.irs.gov for any updated contribution limits and carry-over amounts.

Important Note - Run-Out Period: If you have money leftover in your FSA from the 2024-2025 plan year, you must submit for reimbursement through BenefitsAssist.

HSA vs. FSA

HSAs and FSAs are two of the most common tax-free benefit plans. You can save money with either, but they have many differences. Here is a brief outline:

	HSA	FSA
Owner	Employee-owned	Employer-owned
Eligibility	Must be enrolled in High Deductible Health Plan (HDHP)	Anyone is eligible, although you can't be enrolled in an HSA and a Health Care FSA
Carryover	All funds you can carry over from year to year	Unused funds do not carry over from year to year
Portability	The HSA is portable, so the funds in the account stay with you wherever you go	FSAs are employer-owned accounts, so the funds are forfeited if you change jobs
Investment Options	You can invest in HSA funds	You can't invest FSA funds
Substantiation	It's not required, but you'll want to keep all documentation in case you're ever the subject of an IRS audit	The IRS requires substantiation for some FSA expenses to show the eligibility of the expense
Availability of Funds	Only the funds that have been contributed are available	All funds are available on the first day
Types of Eligible Expenses	Medical, dental, and vision expenses	Health Care FSA - Medical, dental, and vision expenses
		Limited Purpose FSA - Dental and vision expenses
		Dependent Care FSA - Dependent care expenses

Medical Resources

Through John Crane and BCBSIL, you have access to a variety of resources to help you make informed decisions about your benefits and programs to help you stay well.

Benefits Value Advisors (BVAs)

BVAs are an exclusive perk of John Crane's BCBSIL medical plans. They make it easier to use your health plan, while helping you save time and money. They are available 24 hours a day, seven days a week to explain your benefits and provide guidance on how to use them. BVAs will also help you:

- Find a doctor or facility
- Get cost estimates for procedures and services
- Schedule appointments
- Set up prior authorizations (if needed)

Call **877-485-3037** and ask for a BVA. You can also connect with a BVA via live chat at **www.bcbsil.com** or in the BCBSIL App.

In addition, you can access Provider Finder® to search for in-network doctors, hospitals and more. Visit **www.bcbsil.com**, register or log in to Blue Access for Members and select "Find Care."

Blue Access for Members (BAM)

Get the most from your healthcare benefits with BAM. When you enroll in a BCBSIL medical plan through John Crane, you and all covered dependents age 18 and up can create a BAM account.

With BAM, you can:

- Find care - search for in-network doctors, hospitals, pharmacies, and other health care providers
- Estimate the out-of-pocket costs for medical procedures, treatments, and tests
- Get your digital member ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Sign up for text or email alerts

Use your member ID card to create a BAM account at **www.bcbsil.com** or **text BCBSILAPP to 33633** to download the mobile app.

Wellbeing Management

BCBSIL provides behavioral, mental, and physical health programs to help you work toward better health how, when, and where you want.

- **Cancer Services and Support:** Certified Oncology Clinicians from BCBCIL, along with medical experts via a vendor partner, help members with a cancer diagnosis achieve optimal health outcomes, quality of life and cost-effective care.
- **Women's and Family Health:** Comprehensive support for fertility, pregnancy, parenting, and menopause.
- **Digital Health Programs:** Complementary digital coaching delivered by premier, preferred vendors helps reduce risks involved with costly chronic disease categories.
- **Well onTarget Member Wellness Portal:** Personalized action plans, along with fitness and nutrition device integration, to help jump start your journey toward overall wellbeing. This includes a six-week-long digital self-management program for tobacco cessation.
- **One-on-One Coaching:** Professionally certified coaches offer counseling on health and lifestyle issues through phone contact or secure messaging via the interactive Well onTarget portal.
- **Fitness Program:** You can choose a fitness program plan option that best fits your family's budget and preferences.
- **24/7 Nurseline:** Nurses can guide you to the appropriate level of care for your health issue, answer general health questions, and direct you to an audio library of 1,000+ health topics or to other programs that may be helpful.

Consider Voluntary Benefits Coverage

If you enroll in coverage, you may receive a fixed lump-sum payment from Aflac to cover part or all of your medical costs, depending on your specific situation. See pages 19-20 for more details.

Medical Plan Details

Choosing your plan is an important decision and using it wisely throughout the year is equally essential.

To find a provider in your network, visit **www.bcbsil.com** and select "Participating Provider Organization [PPO]" when using the "Find Care" search function.

Employee Amounts	HDHP (HSA-Eligible)[1] In-Network*	PPO In-Network*
Deductible (Individual / Family)	$1,750 / $3,500 *Shared*[2]	$1,000 / $2,000 *Embedded*[3]
Your deductible runs August 1, 2025 - July 31, 2026		
Out-of-Pocket Maximum (Individual / Family)	$5,000 / $10,000	$5,500 / $11,000
Preventive Care		
Preventive Care Visits	Covered at 100%*	
Office Visits		
Primary Care Provider	Deductible then 20%	$30 copay
Specialist	Deductible then 20%	Deductible then 25%
Imaging Services		
Diagnostic Test (X-ray, Blood Work)	Deductible then 20%	Deductible then 25%
Imaging (MRI, CAT, PET)	Deductible then 20%	Deductible then 25%
Outpatient Surgery		
Facility Fee (i.e. Ambulatory Surgery Center)	Deductible then 20%	Deductible then 25%
Physician/Surgeon Fees	Deductible then 20%	Deductible then 25%
Mental Health, Behavioral Health, or Substance Abuse Services		
Outpatient Office Visit	Deductible then 20%	$30 copay
Other Outpatient Services	Deductible then 20%	Deductible then 25%
Inpatient Services	Deductible then 20%	Deductible then 25%
Urgent & Emergency Care		
Urgent Care	Deductible then 20%	Deductible then 25%
Emergency Room Care *Facility Charges* *ER Physician Charges*	 Deductible then 20% Deductible then 20%	 Deductible then 25% Deductible then 25%
Emergency Medical Transportation	Deductible then 20%	Deductible then 25%
Other Services		
Home Health Care, Durable Medical Equipment, Prosthesis, and Most Other Covered Services	Deductible then 20%	Deductible then 25%

*Review plan documents for out-of-network benefits, prior authorization requirements, limits on the number of visits per year and service restrictions.

[1] John Crane will provide their employees with a $500 individual and $1,000 family HSA contribution.

[2] If you also cover dependents (other family members) under this plan, only the "Family" amounts apply. The "Family" deductible amounts can be satisfied by a family member or a combination of family members. Once the "Family" deductible is met, it is considered met for all family members and coinsurance begins.

[3] If you have other family members on this plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

Note: Family coverage can be employee + 1 or employee + 2 or more.

Prescription Drug Coverage

Prime Therapeutics works with BCBSIL to manage your prescription drug benefits. Your drug list is **Performance Select BioSimilar** and your pharmacy network is the **Traditional Select Network**.

Getting Started with Digital Tools

Before August 1, 2025, you can check coverage of your drugs, get prescription drug cost estimates, and search for network pharmacies near you on **www.MyPrime.com**. Click "explore MyPrime" and follow the prompts in the drop-down menu. Be sure to answer "No" for Medicare Part D when selecting your plan.

After August 1, 2025, you can view your specific prescription drug plan benefit information by registering or logging in to your BAM account from **www.bcbsil.com**. Once in BAM, you can click on "Pharmacy" or link to your own account on **www.MyPrime.com**. You can also download the BCBSIL mobile app to help manage your prescription drug benefits.

Filling Your Prescriptions

When you show your ID card at the pharmacy, your medicine may be eligible for the MedsYourWay® drug discount card program. This program works with your benefit to automatically find available lower costs on your prescriptions. You'll pay the lower available price between drug discount card pricing or your plan cost share amount. Also, what you pay will count toward your plan deductible or out-of-pocket maximum. Not all network pharmacies may participate with MedsYourWay.

You have two options for filling your covered long-term medicines. Your medicine may not be covered if you do not use one of these options:

- You can get up to a 90-day supply at any extended supply retail network pharmacy. To find a location near you, visit **www.MyPrime.com**.
- You also have the option of using **Express Scripts Pharmacy** to have your prescriptions mailed directly to your home. To start using the pharmacy service, create an account at **www.express-scripts.com/rx** or call **1-833-715-0942**. Your doctor can send new prescriptions electronically to EXPRESS SCRIPTS HOME DELIVERY.

Fast Facts

Did you know you can ask your healthcare provider to prescribe a generic instead of a Brand drug? If available, it costs you less, and helps manage claims costs for you and the plan.

Generic – The therapeutic equivalent to its brand-name counterpart because it contains identical active ingredients at the same doses.

- If you are prescribed a brand-name drug, you pay the cost difference between the brand-name and generic drug.
- If you receive a prescription for a brand-name drug where there is no generic available, you will continue to pay the applicable brand copay/deductible.

Preferred Brand – A prescription drug that has been recommended and is continually reviewed by Prime Therapeutics for both quality and cost-effective performance. By selecting a brand preferred drug, you and your physician maximize your health benefits while minimizing overall prescription drug costs to you and John Crane. See which drugs are brand preferred at **www.MyPrime.com**.

Non-Preferred Brand – When your doctor prescribes a brand-name drug that is not on the preferred drug list, you will pay the highest coinsurance.

Coverage Limits – Medical and prescription drugs have certain coverage limits. For example, a medication might be limited to a certain amount (such as the number of pills or total dosage).

Specialty Medications - Accredo

Prescriptions that are approved for self-administration (like oral capsules or injections you can give yourself) must be filled through **Accredo** or another in-network specialty pharmacy to avoid paying higher out-of-pocket costs. To start using Accredo, visit **www.accredo.com** or call **1-833-721-1619**.

Prescription Drug Plan Details

Employee Amounts	HDHP (HSA-Eligible)[1] [2]		PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Rx Network	Traditional Select			
Drug List	Performance Select BioSimilar			
Prescription Drugs	*After satisfaction of network deductible, member pays:*		*Not subject to the deductible, member pays:*	
Retail (30-day supply)				
Generic (Mandatory)	20% coinsurance ($10 min/$20 max)	No coverage	20% coinsurance ($10 min/$20 max)	No coverage
Preferred Brand	30% coinsurance ($20 min/$100 max)	No coverage	30% coinsurance ($20 min/$100 max)	No coverage
Non-Preferred Brand	50% coinsurance ($45 min/$150 max)	No coverage	50% coinsurance ($45 min/$150 max)	No coverage
Specialty	50% coinsurance (limited to 30-day supply)	No coverage	50% coinsurance (limited to 30-day supply)	No coverage
Maintenance/Mail Order (90-day supply)				
Generic (Mandatory)	20% coinsurance ($20 min/$40 max)	No coverage	20% coinsurance ($20 min/$40 max)	No coverage
Preferred Brand	30% coinsurance ($40 min/$200 max)	No coverage	30% coinsurance ($40 min/$200 max)	No coverage
Non-Preferred Brand	50% coinsurance ($90 min/$300 max)	No coverage	50% coinsurance ($90 min/$300 max)	No coverage

[1] John Crane will provide their employees with a $500 individual and $1,000 family HSA contribution.
[2] Family must spend family deductible amount before coinsurance begins.
Note: Family coverage can be employee + 1 or employee + 2 or more.

TextCare

If you need access to medical care, **TextCare** provides board-certified providers via text message - 24/7. When you enroll in your benefits, remember to update your cell phone number in Benefit*first* so that TextCare can contact you.

Services include:

- Direct access to on-demand, high-quality care
- Discuss primary and urgent care needs, chronic condition management and routine medication needs
- Get support finding and scheduling a specialist visit
- Appointments are not required, simply text for care
- Accessible via text message and video chat - there's no app to download and no fees or copays to use the service!
- **Available to those enrolled in a John Crane medical plan and their dependents**

Scan the QR code to save the TextCare contact directly to your phone!

Frequently Asked Questions

Q: How do I contact TextCare?

A: Send a text message to **224-464-4020**. Your care team will respond within 5 minutes. Appointments are not required, and there is no app to download.

Q: What can I use TextCare for?

A: Your care team can help with any health or medical question and should be your first point of contact for any issue. Even if your issue cannot be resolved virtually, the care team provides expert care navigation and will refer you to specialty providers.

Q: Will my TextCare team be able to understand my question or issue via text?

A: Yes! You can chat, upload pictures, or one-click into a video visit with your provider.

Q: What if I need additional care outside of TextCare?

A: Your TextCare provider may refer you to other high-quality, low-cost providers and specialists.

Q: What if I need medication to treat my diagnosis?

A: Your TextCare provider can prescribe medication, and the prescription will be sent to a local pharmacy.

Q: What if my initial visit requires a follow-up?

A: Your care team will reach out via text message to schedule a follow-up appointment.

Q: Should I go to an Urgent Care or the ER?

A: Many urgent care and emergency room visits end up being unnecessary. TextCare is available to you 24/7 and can help triage the situation to avoid a lengthy trip to the ER. However, we encourage you to call 911 or go to the ER if you are experiencing a medical emergency.

Q: Who is eligible for this service? Can my family use TextCare?

A: TextCare is available to those enrolled in a John Crane medical plan and their dependents.

Q: Will my employer have access to my health information?

A: No! All patient information is strictly confidential. TextCare is managed by One to One Health, a workplace healthcare provider headquartered in Chattanooga, Tennessee. One to One Health complies with all HIPAA and healthcare regulations to maintain your privacy, ensuring your health information is kept confidential.

Vision Benefits

You have a choice of two vision plans, administered by **EyeMed Vision Care**. Many of your vision needs — from eye exams to glasses and contacts — are covered through the vision plans.

Core Plan – Provides one exam every other plan year. You may choose to receive either contacts and frames, or frames and lens services once every other plan year.

Enhanced Plan – Provides these benefits once every plan year, plus higher frames and contact allowances.

After your initial enrollment, you will receive an EyeMed Vision Care ID card in the mail. To find a provider in your area online, go to **www.eyemedvisioncare.com**. Visit the EyeMed network provider of your choice and present your vision ID card. Your vision benefit will automatically be calculated.

However, if you go to an out-of-network provider, you will be responsible for paying the provider in full at the time of service and then filing a reimbursement claim. Claim forms are available at **www.eyemedvisioncare.com**.

Type of Service	Core Plan		Enhanced Plan	
	In-Network Cost	Out-of-Network Reimbursement	In-Network Cost	Out-of-Network Reimbursement
Vision Exam				
Eyeglasses	$10 Copay	Up to $40	$0 Copay	Up to $40
Standard Contact Lens Fit & Follow-Up	Up to $40	Not covered	Up to $40	Not covered
Premium Contact Lens Fit & Follow-Up	10% off retail price	Not covered	10% off retail price	Not covered
Standard Plastic Eyeglass Lenses				
Single Vision	$10 Copay	Up to $30	$0 Copay	Up to $30
Bifocal	$10 Copay	Up to $50	$0 Copay	Up to $50
Trifocal	$10 Copay	Up to $70	$0 Copay	Up to $70
Standard Progressive	$75 Copay	Up to $50	$65 Copay	Up to $50
Lens Options (add to lens price above)				
Standard Anti-Reflective Coating	$45	Not covered	$45	Not covered
Standard Polycarbonate	$40		$40	
Other Add-ons and Service	20% off retail price		20% off retail price	
Frames	$0 Copay, plus 20% off balance over $105 allowance	Up to $53	$0 Copay, plus 20% off balance over $160 allowance	Up to $80
Contact Lenses (instead of eyeglass lenses)				
Conventional	$0 Copay, plus 15% off balance over $105 allowance	Up to $60	$0 Copay, plus 15% off balance over $160 allowance	Up to $80
Disposable	$0 Copay, plus balance over $105 allowance	Up to $60	$0 Copay, plus balance over $160 allowance	Up to $80
Medically Necessary	$0 Copay, paid in full	Up to $300	$0 Copay, paid in full	Up to $300
Frequency	Once every two plan years		Once every plan year	

Dental Benefits

You have a choice of two dental plans, administered by **Delta Dental of Illinois**. Good news — you will see no changes to your dental contributions.

Basic Plan – Covers basic dental services for you and your family, such as preventive care, fillings and oral surgery.

Enhanced Plan – Covers a wide range of dental services for you and your family, such as preventive care, fillings, dentures and oral surgery. In addition, this plan covers crowns, bridges, implants and orthodontia, and provides a higher annual maximum than the Basic Plan.

If your dentist participates in the plan, you will automatically receive services at discounted fees. Confirm your dentist participates or search for a new dentist by logging on to **www.deltadentalil.com** or calling **1-800-323-1743**.

You'll typically save the most when you choose a PPO dentist. They have agreed to reduced fees that are usually lower than Premier dentist fees. Plus, you have a higher annual maximum when using PPO dentists.

Covered Dental Service	Basic Plan		Enhanced Plan	
	Delta Dental PPO	Delta Dental Premier® or Non-Network Provider	Delta Dental PPO	Delta Dental Premier® or Non-Network Provider
Annual Deductible (Individual / Family)	$50 / $100		$50 / $100	
Annual Maximum	$1,200 per person	$1,000 per person	$1,700 per person	$1,500 per person
Preventive & Diagnostic Care *Exams & Cleanings (two per benefit year), X-rays, Fluoride Treatments (to age 19), Sealants (to age 16)*	Covered at 100% (deductible does not apply)		Covered at 100% (deductible does not apply)	
Basic Services *Endodontics, Fillings, Extractions, Oral Surgery, Periodontics, Injectable Antibiotics, Repair & Recementation for Bridges, Crowns, Inlays, Onlays & Dentures*	20% after deductible		20% after deductible	
Major Restorative Services *Crowns, Inlays, Onlays, Dentures, Bridges, Implants*	50% after deductible	20% after deductible	50% after deductible	
Orthodontia (up to age 19)	Not included		50% after deductible	
Orthodontia Lifetime Maximum	Not included		$1,000 per person	

Life and AD&D Insurance

Prudential

Our life insurance program offers protection for your family in the event of your death or serious injury. **John Crane provides basic life coverage for all eligible employees equal to 1x eligible wages.**

Basic Life/AD&D	
Coverage Amount	1x annual base pay, not to exceed $600,000
Age Reduction	None

**Benefit will terminate upon retirement.*

Accidental Death and Dismemberment (AD&D) insurance benefits are paid to you or your beneficiary, in addition to your life insurance benefits. If your death is due to an accident, or you have a covered loss, you may be eligible to receive AD&D insurance benefits. Evidence of Insurability (EOI) may be required.

In addition, you may purchase Voluntary Life Insurance for yourself, your spouse/domestic partner, and/or your child(ren). You may also purchase Voluntary AD&D Insurance for yourself or your spouse/domestic partner. The following levels of life insurance are available:

Voluntary Life/AD&D			
	Employee	**Spouse**	**Child(ren)**
Coverage Amount	Up to 5x annual wages, not to exceed $1.5 million	$10,000, $25,000, or $50,000	$3,000, $5,000, or $10,000*
Guarantee Issue Amount	Lesser of 3x salary or $1.5 million	$50,000	$10,000

**These amounts are only for life insurance. There is no AD&D insurance for children.*

- **New hires** — You may elect up to the Guarantee Issue amount for employee or spouse coverage without EOI. Any amounts over the Guarantee Issue require EOI satisfactory to Prudential.
- **Current employees** — This year, any increase in coverage or late entrants will require EOI.

You may provide benefits for your dependent children under age 26 or dependent children up to any age who have an eligible disability and are dependent on you for support. If your spouse/domestic partner is a John Crane employee, you cannot elect the spouse/domestic partner life option.

What Is Evidence of Insurability?

Evidence of Insurability (EOI) is documentation that you provide to **Prudential** — our life insurance carrier — showing that you are in good health at the time you purchase certain amounts of optional life insurance.

If you make an election that requires EOI, you will be prompted to complete your EOI form electronically at https://gi.prudential.com/POGH/Controller/standalone?VR=S2wrSjBTMi9uUkw3dnIxdlIHdGVYQT09&name=JohnCraneInc. If EOI is required, your insurance is not in force until EOI is approved by Prudential in writing.

Have You Elected Your Beneficiary(ies)?

Your beneficiary is the person who receives your benefit in the event of your death. If you are electing coverage for the first time or wish to update your beneficiary(ies), visit **www.Benefitfirst.com** or contact the Benefit*first* Customer Care Center. You are automatically the beneficiary for your spouse and/or child coverage.

Imputed Income

Imputed income is the value of some life insurance benefits that are taxable. The IRS allows companies to provide only $50,000 of life insurance to their employees tax-free. John Crane provides basic life coverage for all eligible employees equal to 1x eligible wages. If 1x your eligible wages exceed $50,000, the IRS considers the cost of providing this additional amount of insurance as taxable wages and calls it “imputed income.”

Short-Term Disability

Prudential

Short-Term Disability (STD) Insurance can help support you and your family should you become temporarily disabled. This coverage is provided by **Prudential** for employees working at least 30 hours per week. The entire cost of your coverage is paid by John Crane.

Short-Term Disability	
Income Replacement	Weeks 1-13: 100% of weekly earnings Weeks 14-16: 50% of weekly earnings*
Accident Elimination Period	0 days, begins on the 1st day
Illness Elimination Period	0 days, begins on the 1st day
Benefit Duration	Up to 16 weeks total during the plan year

**During this three week period of time, you can elect to supplement your weekly benefit up to 100% of weekly earnings with employer paid time off, sick leave, or vacation.*

Voluntary Long-Term Disability

Prudential

When an accident or illness keeps you from working for an extended period of time, it is important to have a continuing source of income. John Crane offers you long-term disability coverage, insured by **Prudential** and designed to replace a portion of your income if you cannot work. You pay the premiums, but the benefits are not taxable.

- The plan begins paying benefits after you are disabled[1] beyond the four month elimination period (pre-existing condition limitation applies).
- Option 1 - Elect to receive a monthly benefit equal to 50% (up to a maximum of $15,000 per month).
- Option 2 - Elect to receive a monthly benefit equal to 60% (up to a maximum of $18,500 per month) of your base pay.
- May require Evidence of Insurability (EOI) if elected or increased more than 30 days after your hire date.
- Certain disability benefits you receive, such as Social Security and Workers' Compensation, will offset your monthly benefit.

Voluntary Long-Term Disability	Option 1	Option 2
Income Replacement	50% of monthly earnings	60% of monthly earnings
Maximum Benefit	$15,000/month	$18,500/month
Accident Elimination Period	Four months	Four months
Illness Elimination Period		
Pre-Existing Condition Limitation (New Hires)	If you are treated for a pre-existing condition within the three months prior to your effective date, then that same disability isn't covered until 12 months after your effective date	If you are treated for a pre-existing condition within the three months prior to your effective date, then that same disability isn't covered until 12 months after your effective date
Benefit Duration	Social Security Normal Retirement Age	Social Security Normal Retirement Age

[1] *As defined in the Summary Plan Description (SPD), which can be accessed at www.Benefitfirst.com.*

Employee Assistance Program

Bree Health's employee assistance program offers a comprehensive range of services designed to support your mental health and well-being. Get seamless access to professional coaching, expert guidance, and essential life services whenever you need them. All contact is completely confidential.

- **Coaching and Counseling Services** - Certified support for personal and professional growth
- **Legal and Financial Resources** - Free consultations and expert advice
- **Health Advocacy** - One-on-one guidance to navigate healthcare, find providers, and manage insurance
- **Individualized Wellness Resources** - Step-by-step guidance tailored to your well-being needs
- **Virtual Concierge** - Assistance with travel, dining, childcare, and more
- **Bree Video Library** - Relaxation videos, meditations, and educational tools
- **Exclusive Discounts** - Special savings on entertainment, shopping, and travel
- **Support for Caregivers and Families** - Work/life services for assistance with child care and elder care
- **24/7 Access** - Access to toll-free phone number **1-800-327-2255** and web support 24/7

Get 8 free virtual/face-to-face counseling sessions per issue annually + unlimited help online at:

https://login.breehealth.com or Download the App

Your Bree Health Company ID will be uploaded to Benefit*first* once available!

Download the Bree Health app!

Voluntary Benefits

Aflac MetLife

Group Hospital Indemnity Insurance

IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage

This Policy	Insurance on HealthCare.gov
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorder	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

Looking for comprehensive health insurance?

- **Visit 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) under "Insurance Departments."

Voluntary Benefits

John Crane offers a number of voluntary plans for an added layer of financial protection and peace of mind. You can choose to elect supplemental medical, pet insurance, or legal insurance coverage.

Group Hospital Indemnity Insurance*

Hospital Indemnity Insurance through **Aflac** helps with the out-of-pocket costs (deductible, coinsurance, etc.) associated with a covered hospital stay, as a result of a covered accident or covered sickness. Includes benefits for hospital admission, confinement, and intensive care.

Group Critical Illness Insurance*

Critical Illness Insurance through **Aflac** provides a lump-sum cash benefit (unless otherwise assigned) in the event of a specific illness like cancer, or a specific event - like a heart attack or stroke. This coverage can help pay for care, allowing you to focus on your health and recovery. Benefits include guaranteed issue coverage, meaning you may qualify for coverage without having to answer health questions.

Group Accident Insurance*

Accident Insurance **through Aflac** provides a cash payout in the event of an injury that requires medical services (like physical therapy, X-rays, CT scans and more). Coverage helps you manage out-of-pocket costs that might arise after a covered accident.

To learn more about supplemental medical coverage, call Aflac at **1-800-433-3036** or log into **https://aflacenrollment.com/JohnCrane/558413452343**. Our group number is AGC0004451408.

Pet Insurance

Our pets are an important part of our family. Pet Insurance helps cover the costs of veterinary care for your dogs and cats, including routine visits, illnesses, medication, and more. Coverage can be elected and paid for directly with **MetLife**.

To learn more about Pet Insurance, call MetLife at **1-800-GET-MET8** or visit **www.metlife.com/getpetquote**.

Legal Insurance

Get support with personal legal issues including home and real estate, civil lawsuits, estate planning, and family matters, through a large network of experienced attorneys. Coverage can be elected during Open Enrollment and paid for via payroll deductions.

Once enrolled, create an account at **members.legalplans.com** to see your coverages and select an attorney for your legal matter. Or, call **MetLife** at **1-800-821-6400** for assistance.

**This is a brief product overview only. The plans have limitations and exclusions that affect benefits payable. Refer to the plans for complete details. Critical Illness, Accident and Hospital Indemnity insurance is underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers. CAIC is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licesnsed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.*

Enrolling or Changing Your Benefit Elections During The Year

New Hires have 30 days to make elections either online or by contacting the Benefit*first* Customer Care Center at **1-888-322-9374**.

After the initial 30-day new hire event, employees may only change their benefit elections during each year's Open Enrollment period, or within 30 days of a qualified life event. A qualified life event — like marriage, legal separation, divorce or the birth or the adoption of a child — allows employees to make certain benefit changes (that are consistent with their life event) before the next Open Enrollment period. To report a life event, please contact the Benefit*first* Customer Care Center within 30 days after the life event.

Benefit Contacts

Contact	Phone	Website	Group/Plan #
Benefit*first* (Enrollment & Customer Care Center)	1-888-322-9374	www.Benefitfirst.com	1197
Aflac Voluntary Benefits	1-800-433-3036	https://aflacenrollment.com/JohnCrane/558413452343	AGC0004451408
BCBS of IL (Medical)	1-800-892-2803	www.bcbsil.com	HDHP: PN2784 PPO: 429174
BCBS of IL - Well onTarget (Tobacco Cessation)	1-877-806-9380	www.wellontarget.com	N/A
BenefitsAssist (HSA/FSA)	1-865-769-2800	www.benefitsassist.net	N/A
Bree Health (Employee Assistance Program)	1-800-327-2255	login.breehealth.com	TBD
Delta Dental of IL	1-800-323-1743	www.deltadentalil.com	20550
EyeMed (Vision)	1-866-723-0514	www.eyemedvisioncare.com	9681719
Fidelity Retirement - 401(k)	1-800-835-5095	www.401k.com	35637
MetLife (Pet Insurance)	1-800-GET-MET8	www.metlife.com/getpetquote	268923
MetLife (Legal Insurance)	1-800-GET-MET8	www.legalplans.com	268923
Prime Therapeutics - Mail Order Rx (Express Scripts)	1-833-715-0942	www.myprime.com	HDHP: PN2784 PPO: 429174
Prime Therapeutics - Specialty Rx (Accredo)	1-833-721-1619	www.myprime.com	HDHP: PN2784 PPO: 429174
Prudential (Disability)	1-800-842-1718	www.prudential.com	72632
Prudential (Life Insurance)	1-800-842-1718	www.prudential.com	72632
SGP Service Center (Pension)	1-844-674-8339	eepoint.wtwco.us/ess/smiths	N/A
TextCare	224-464-4020	N/A	N/A

Smiths Group 401(k)

John Crane offers the Smiths Group Incentive Savings Plan (the "Plan" or "401(k) Plan") through our record-keeper, **Fidelity**, as a convenient, tax-deferred way to save for retirement.

When Can I Enroll in the Plan?

There is no waiting period. Log on to **www.401k.com** or call **1-800-835-5095** to enroll at any time.

How Much Can I Contribute?

Through automatic payroll deduction, you may contribute between 1% and 40% of your eligible pay on a pre-tax basis, up to the annual IRS dollar limits. You may also contribute between 1% and 10% of your after-tax pay.

Combined, your total contribution cannot exceed 50% of your eligible pay. You may request to change your contribution amount at any time by logging on to Fidelity NetBenefits® at **www.401k.com** or by calling the Fidelity Retirement Benefits Line at **1-800-835-5095**.

What Are the Tax Advantages?

Your pre-tax contributions are deducted from your pay before income taxes are taken out. This means that you can actually lower the amount of income taxes you pay each pay period. You pay no taxes on any earnings until you withdraw them from your account.

What Is the Vesting Schedule?

Vesting is a term used to describe the portion of your account balance that you are entitled to under the Plan's rules. You are always 100% vested in your contributions to the Plan as well as any earnings from your contributions.

- The Company matching contributions and associated earnings for employees actively employed by John Crane on or after February 15, 2022 are 50% vested after one year of service and 100% vested after two years of service.
- If you have less than one year of service, all Company contributions and associated earnings will be forfeited at termination; if you have more than one, but less than two years of service, 50% of Company contributions and associated earnings will be forfeited at termination.

When Is My Enrollment Effective?

Your enrollment becomes effective once you elect a deferral percentage. Deductions generally begin with your next pay period or as soon as administratively possible.

Is There a Company Match?

Unless part of a legacy agreement, the Company will match 50% on the first 6% of your basic pre-tax and Roth contributions. You receive the Company match each pay period on pre-tax basic contributions (1%-6%) only. You do NOT receive a Company match on pre-tax supplemental contributions.

May I Make a Catch-Up Contribution to the Smiths Group Plan?

If you are 50 or older, you may make an additional "catch-up" contribution each pay period. Please note that you must make a separate election to take advantage of the catch-up contribution by logging on to **www.401k.com** or calling **1-800-835-5095**. You may elect a contribution percentage from 1% to 35%; it will begin within one to two pay periods of your election. The payroll system will automatically stop your catch-up contributions if you reach the maximum.

What Are My Investment Options?

You have the flexibility to select from more than two dozen investment options that range from more conservative to more aggressive.

If you do not make an investment election for contributions, your account will be invested in the Target Date Fund that has a target retirement date closest to the year you might retire, based on your current age and assuming a normal retirement age of 65.

For more information on your options and the Target Date Funds, log on to **www.401k.com**, or call Fidelity at **1-800-835-5095**.

Smiths Group 401(k)

May I Name a Beneficiary?

A beneficiary can be a person, a trust, an estate or an organization that you assign to be eligible to receive your benefits upon your death. For example, if you assign your spouse as the Primary Beneficiary to your retirement plan, the person will be entitled to receive money or other benefits from that plan — even after your death. Naming and assigning beneficiaries is simple to do and important to ensure that your benefits get to your chosen recipients in a timely manner in the event of your death. If you want to name a beneficiary other than your spouse, your spouse must sign a Spousal Consent Form. Call Fidelity at **1-800-835-5095** for a copy of this form.

May I Roll Over Money From Another Retirement Plan into the Smiths Group Plan?

You are permitted to roll over eligible pre-tax contributions from another qualified 401(a) (e.g., 401(k)), 403(b), governmental 457(b) retirement plan or eligible pre-tax contributions from a rollover individual retirement account (IRA). You may also roll over after-tax contributions (not ROTH) from another qualified 401(a) (e.g., 401(k)) plan. Call **1-800-835-5095** for details.

Thank you for reviewing our US Benefits Guide. Our benefits team works hard to introduce new offerings, protect our current rates, and provide inclusive medical, dental, and vision plans along with voluntary benefits for our employees.

We wish you and yours a safe and healthy year.

- US Benefits Team

Annual Notices

SUMMARY OF BENEFIT COVERAGE The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is provided by your Medical carrier. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual open enrollment period, upon plan renewal and upon request at no charge to you.

CONSENT TO RECEIVE ELECTRONIC NOTICES

By participating in Open Enrollment, and providing an email address, I understand and consent that:

1. The following documents and/or notices may be provided to me electronically: **Summary Plan Descriptions; Summaries of Material Modifications; Summary Annual Reports; COBRA Notices; Summary of Benefits and Coverage; Notice of Health Insurance Marketplace Coverage Options; and Other ERISA required or Model Benefit Notices.**
2. I may provide notice of a revised e-mail address or revoke my consent at any time without charge by sending an e-mail or calling the Human Resources/Finance Department.
3. I am entitled to request and obtain a paper copy of any electronically furnished document free of charge by contacting the Human Resources/Finance Department contact.
4. In order to access information provided electronically, I must have a computer with Internet access; an e-mail account that allows me to send and receive e-mails; and Microsoft Word or Adobe Acrobat Reader.

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).

To see if any other states have added a premium assistance program since **March 17, 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

Alabama	855-692-5447
Alaska	866-251-4861
Arkansas	855-692-7447
California	916-445-8322
Colorado	800-221-3943
Florida	877-357-3268
Georgia	678-564-1162
Indiana	800-403-0864
Iowa	888-346-9562
Kansas	800-792-4884
Kentucky	855-459-6328
Louisiana	855-618-5488
Maine	800-442-6003
Massachusetts	800-862-4840
Minnesota	800-657-3672
Missouri	573-751-2005
Montana	800-694-3084
Nebraska	855-632-7633
Nevada	800-992-0900
New Hampshire	603-271-5218
New Jersey	800-356-1561
New York	800-541-2831
North Carolina	919-855-4100
North Dakota	844-854-4825
Oklahoma	888-365-3742
Oregon	800-699-9075
Pennsylvania	800-692-7462
Rhode Island	855-697-4347
South Carolina	888-549-0820
South Dakota	888-828-0059
Texas	800-440-0493
Utah	888-222-2542
Vermont	800-250-8427
Virginia	800-432-5924
Washington	800-562-3022
West Virginia	855-699-8447
Wisconsin	800-362-3002
Wyoming	800-251-1269

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.

For a listing of State websites, visit: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

For states not listed:
877-543-7669
www.insurekidsnow.gov

OMB Control Number 1210-0137
Expires 1/31/2026

NOTICE OF PATIENT PROTECTIONS

Your medical plan may require the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. Until you make this designation, the medical plan may designate one for you. For information on how to select a PCP, and for a list of the participating providers, contact your carrier.

If you must select a PCP for your child(ren), you may designate a pediatrician as such.

You do not need prior authorization from your carrier or from any other person (including a PCP) 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 your carrier.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Introduction. The Consolidated Appropriations Act of 2021 was enacted on December 27, 2020, and contains many provisions to help protect consumers from surprise bills, including the No Surprises Act under title I and Transparency under title II.

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.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

You are protected from balance billing for:

Emergency service. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be 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 may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).

Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

HIPAA– PRIVACY ACT LEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to

other medical or surgical benefits your group contract providers.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

SECTION 111 OF JANUARY 1, 2009 Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including Social Security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine if the Employer plan or Medicare/Medicaid/SCHIP is primary for those employees covered under a government plan and an employer sponsored plan.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 The Newborns' and Mothers' Health Protection Act of 1996 provides that 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 a 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). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

MICHELLE'S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC), this law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38. The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the USERRA. See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides employees with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans' Preference.

HIPAA SPECIAL ENROLLMENT

SPECIAL ENROLLMENT NOTICE This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage If you are declining 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).

Marriage, Birth, or Adoption If you have a new dependent as a result of a 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, or placement for adoption.

Medicaid or CHIP If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

John Crane HR Department

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Morton Grove, IL 60053-2725

1-888-322-9374

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the "Health Information Technology for Economic and Clinical Health (HITECH) Act." The HITECH Act supports the concept of meaningful use (MU) of electronic health records (EHR), an effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

RESCISSIONS The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to non quantitative treatment limitations (such as medical management standards).

PREVENTIVE CARE Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

HIPAA NOTICE OF PRIVACY PRACTICES

John Crane HR Department

6400 Oakton St
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1-888-322-9374

www.johncrane.com/en

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research & comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting plan administrator.
- You can file a complaint with the U.S. Dept. of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation or include it within a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: understanding your rights.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: understanding this notice.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request or in our office.

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to our company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; 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 the appropriate party.

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) - https://www.healthcare.gov/are-my-children-eligible-for-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 period 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 or https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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/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.

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

John Crane HR Department

6400 Oakton St
Morton Grove, IL 60053-2725

1-888-322-9374

Produced and Printed by The Baldwin Group, 06/2025
www.baldwin.com

Important Notice from Our Company 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 Our Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. 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. Our Company has determined that the prescription drug coverage offered by the medical plans are, 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 employee coverage will not be affected. You can keep this coverage if you elect part D and the Medical Carrier plan will coordinate with Part D coverage.

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every

month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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	07/09/2025
Name of Entity	Smiths Group Service Corp referred to as John Crane Inc
Contact	John Crane HR Department
Address	6400 Oakton St Morton Grove, IL 60053-2725
Phone	1-888-322-9374