HOH TRIBE

THE MAHONEY GROUP®

2026

EMPLOYEE BENEFITS GUIDE

Hoh Indian Tribe

TABLE OF CONTENTS

HOH INDIAN TRIBE BENEFITS

At **Hoh Indian Tribe**, we know our dedicated employees—YOU—are key to our overall success as an organization. We recognize that offering a quality, comprehensive benefit program is an important way to show you how valuable you are to the organization. We understand that navigating the world of employee benefits is challenging and no two employees are alike, which is why we offer this benefits guide to explain the multiple benefit options to improve your physical, financial and mental well-being.

This booklet provides a summary of plan highlights. Please consult the carrier contract for complete information on covered changes, limitations, and exclusions. This is not a binding contract. In the event of any discrepancy, the carrier's contract will prevail. If you have further questions, please contact the insurance carrier or Human Resources.

ELIGIBILITY

If you are a full-time employee (working 30+ hours a week), you are eligible to enroll in our medical, dental and vision benefits and you will be automatically enrolled in our Life and Accidental Death and Dismemberment (AD&D) plan. As a new hire, benefits are effective on the first of the month following the 60 days waiting period. You must enroll by the date before your benefits effective date. If you do not meet this deadline, you will need to wait until the next open enrollment period to enroll.

COVERING YOUR FAMILY MEMBERS

Many of the plans offer coverage for your eligible family members, including:

- Your legal spouse or legally registered domestic partner
- Your dependent children, including your stepchildren, legally adopted children, children placed with you for adoption or for court ordered legal guardianship
- Dependent children are eligible for medical, dental, and vision up to the end of the month in which they turn age 26 (regardless of student or marital status)
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

CHANGING YOUR BENEFITS DURING THE YEAR

Most benefit deductions are withheld from your paycheck on a pre-tax basis (i.e. medical, dental, vision) and therefore your ability to make changes to these benefits is restricted by the IRS. Once enrolled, most pre-tax benefit elections cannot be changed until the next annual Open Enrollment period, unless you have a qualifying life status change (sometimes called a "Qualifying Event" or "Life Event").

The most common qualifying life events are:

- Marriage, legal separation or divorce
- Birth, adoption or change in legal custody of eligible child(ren)
- Change in you or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's open enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order

To make benefit changes as a result of a Qualifying Event as allowed under Section 125 of the IRS Code, you must:

- Notify Human Resources within **30 days** of the date of the qualifying event
- Provide proof of your life status event

COVERAGE STARTS

- As a new hire, coverage is effective **first of the month following the 60 days waiting period.**

QUALIFYING EVENT EFFECTIVE DATES

- Coverage changes from a qualifying event will be effective **first of the month following the event date** unless in the case of a new child, your change in coverage will be effective on the **date of birth or adoption.**

COVERAGE ENDS

- If your employment with **Hoh Indian Tribe** terminates (voluntarily or otherwise), **your benefits will end at the end of the month** (aside from life insurance benefits, which end on the date of your termination).

BENEFITS ENROLLMENT

Open enrollment is the only time during the year that you can change your benefits without experiencing a qualifying life event. During the open enrollment period, you have the opportunity to newly enroll in coverage and/or make changes to your current coverage, including adding or removing dependents. Any changes you make for open enrollment become effective first of the month following 60 days of continuous employment.

ENROLLMENT

Enrollment is done by completing the appropriate carrier enrollment form(s) and submitting to Human Resources.

In order to complete your enrollment, you need:

- Dates of birth and social security numbers for yourself as well as any family members you are enrolling.
- **Proof of eligibility for your spouse and dependent children (e.g., marriage license, birth certificate).**

NEED TO KNOW UPDATES AND INFO

- What are the benefits for **2026**
- Consider what is new with you... did you have a baby, get married, etc. that may affect your enrollment decisions
- **Please note you should enroll 30 days before the effective date**

MEDICAL INSURANCE

We offer one medical insurance plan option through Premera Blue Cross. Please take the time to understand the features of plan so that you choose the coverage that is best for you and your family.

Your medical plan includes in-and out-of-network benefits, which means you can choose any provider that you would like. However, you will pay less out of your pocket when you choose an in-network provider. at **www.premera.com.**

The table below summarizes the key features of the medical plan. The coinsurance amounts listed reflect the amount you pay for services. Please refer to the official plan documents for additional information on coverage and exclusions.

	In-Network	Out-of-Network
Network	Heritage Signature	
Medicare Part D Creditable Coverage	Yes	
Deductible (individual/family) **Benefit Year Reset**	$200 / $400 Calendar Year	$400 / $800 Calendar Year
Deductible (Embedded/NonEmbedded)[1]	Embedded	Embedded
Out-of-pocket maximum (individual/family)	$2,000 / $4,000	Unlimited
Preventive care	Covered in Full	Not Covered
Office visits (primary care/ specialist)	$15 after deductible	50% after deductible
Emergency Room	$200 copay then 10% after deductible	
Urgent Care	$15 after deductible	50% after deductible
Lab/X-Ray	10%	50% after deductible
Inpatient / Outpatient hospital	10% after deductible	50% after deductible
Rx (generic/preferred/brand/specialty) **Mail-Order**	After deductible: $10 / $20 / $40 / $250 After deductible: $30 / $60 / $120 / $250	

[1] Embedded deductible means each family member has their own individual deductible, up to the family deductible. Non-embedded deductible means the family deductible must be met first when coverage includes family members.

DENTAL INSURANCE

Principal: Dental PPO (DPPO).

The PPO dental plan includes in- and out-of-network benefits, which means you can choose any dentist that you would like. However, you will pay less out of your pocket when you choose an in-network dentist at **principal.com/dentist**.

The table below summarizes the key features of the dental plan. The coinsurance amounts listed reflect the amount you pay for services. Please refer to the official plan documents for additional information on coverage and exclusions.

DO I NEED TO SEE A DENTIST?

A visit to the dentist is about more than just a teeth cleaning. By looking in your mouth, your dentist can tell a lot about your overall health. In fact, he or she may be able to identify early signs of disease, such as diabetes, heart disease, kidney disease, and even some forms of cancer, before you even notice symptoms.

	In-Network	Out-of-Network
Deductible (individual/family)	$50 / $150	
Annual Benefit Maximum	$2,000	
Diagnostic/preventive Services	0%	0%
Basic Services	20%	20%
Major Services	50%	50%

VISION INSURANCE

We offer a vision insurance plan through **VSP Vision Care.** This plan allows you to choose any eye care provider. However, you will maximize the plan benefits when you choose a in-network provider at **vsp.com**.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	In-Network	Out-of-Network
Frequency of Glasses/Lenses/Frames	12 / 12 / 12	
Exams Retinal screening for members with diabetes	$20 copay $0 copay	Up to $45
Lenses Single vision Bifocal Trifocal	$25 copay $25 copay $25 copay	Up to $30 Up to $50 Up to $65
Frames	$200 allowance + 20% discount	Up to $70
Contacts Contact lens exam (fitting and evaluation)	$160 allowance Up to $60	Up to $105
Laser Correction	15% off the regular price or 5% off the promotional price	

DO I NEED AN ANNUAL EYE EXAM IF I HAVE PERFECT VISION?

Your eyes are your windows to the world. They are also your eye doctor's windows into your body. Just by looking in your eyes, a doctor can find warning signs of serious diseases and conditions like high blood pressure, high cholesterol, thyroid diseases, and certain types of cancer. In fact, eye doctors are frequently the first to detect signs of abnormal health conditions.

LIFE AND AD&D INSURANCE – USABLE LIFE

Life and accidental death and dismemberment (AD&D) insurance provides financial protection for those who depend on you for financial support. Upon your death, your designated beneficiary will receive the life benefit. If you die as the result of an accident, your beneficiary will receive both the life and AD&D benefits.

We provide you with basic life and AD&D insurance at **no cost to you.**

DESIGNATE A BENEFICIARY

In the event of your death, your beneficiary would receive your Life and/or AD&D proceeds. Designate your beneficiary for your Basic Life and AD&D insurance. You may change this designation at any time. You are automatically the beneficiary on your Spouse and/or Child Life policy.

GROUP TERM LIFE AND AD&D BENEFIT HIGHLIGHTS	
Employee Life Benefit Amount	$15,000
Employee AD&D Benefit Amount	Same as Life
VOLUNTARY GROUP TERM LIFE BENEFIT HIGHLIGHTS	
Employee Life Benefit Amount	You may purchase coverage in units of $5,000 to a maximum of $100,000 without evidence of insurability. Coverage over these amounts to a maximum of $300,000 is available with evidence of insurability.
PLAN PROVISIONS	
Age Reduction Schedule	• 50% of benefit at age 70 • 30% of benefit at age 75 • 20% of benefit at age 80

LIFE AND AD&D INSURANCE – MUTUAL OF OMAHA

Life and accidental death and dismemberment (AD&D) insurance provides financial protection for those who depend on you for financial support. Upon your death, your designated beneficiary will receive the life benefit. If you die as the result of an accident, your beneficiary will receive both the life and AD&D benefits.

We provide you with basic life and AD&D insurance at **no cost to you.**

If you are eligible for **$50,000** or more in life insurance, you are required to pay income tax on the value of the coverage in excess of **$50,000.**

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BENEFIT HIGHLIGHTS	
Employee Life Benefit Amount	$50,000
Employee AD&D Benefit Amount	Same as Life
PLAN PROVISIONS	
Age Reduction Schedule	• 65% of benefit at age 65 • 50% of benefit at age 70
Basic Life Accelerated Death Benefit	If you become terminally ill and you are insured under Mutual of Omaha, Mutual of Omaha will pay you a portion of your life insurance benefit one time. You may elect 75% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $37,500.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.

DISABILITY INSURANCE

You have the opportunity to purchase long-term disability insurance through **Mutual of Omaha.**

LONG-TERM DISABILITY INSURANCE

A disability income insurance policy can help provide security when you need it most. It pays you cash benefits when you are sick or hurt and can not work.

- Elimination period: **90 days (benefits begin on day 91)**
- Benefit continues up to **Social Security Normal Retirement Age or 3.5 years**
- Benefit amount: **60% of salary up to a maximum of $4,000 per month**
- Pre-existing Condition: **6/24**

EMPLOYEE ASSISTANCE PROGRAM

Business Health Trust

www.businesshealthtrust.com

Expect more from your Health Benefits

At BHT, it is our mission to be a resource for employers. That's why, in response to the growing importance of mental health in the workplace, we've included our Employee Assistance Program (EAP) with all our Industry Health Trust* medical plans.

Product Highlights

Our partner Behavioral Health Systems provides BHT members and their employees with a robust Employee Assistance Program (EAP) including:

BHS BEHAVIORAL HEALTH SYSTEMS

Free, confidential counseling & resources

- Counseling and referrals for personal, marital, family, substance abuse, financial and legal issues
- 6 visits annually for each family member
- Psychiatric consultations included
- Care Coordinators can assist in determining the appropriateness and availability of community resources such as support groups
- MemberAccess online portal with links to self-assessments, work/life articles, tips and resources, and fact sheets
- Use of the EAP is completely confidential

A variety of ways to connect and never any claims to file

- In-person, phone and digital options available. Members can speak with a provider via computer, smartphone, or tablets at their convenience.
- There are never any claims to file, and EAP visits are covered at 100%.

Want to learn more about our EAP program or other products?

Call us at (425) 201-1972 or email us at **info@businesshealthtrust.com**.
Or scan the QR code to request a quote.

**This benefit is offered at no additional cost on Industry Health Trust plans. Kaiser Permanente Small Group plans or non-medical offerings can add the EAP for an additional cost.*

RESOURCES AND CONTACT INFO

- **BENEFITS WEBSITE: https://hohtribe-nsn.org/**
- **FAQS: djohnson@mahoneygroup.com**

BENEFIT	PHONE	WEBSITE / EMAIL
Medical	800-722-1471	www.premera.com
Dental	800-247-4695	principal.com/dentist
Vision	800-877-7195	www.vsp.com
Life and AD&D - USAble Life	800-370-5856	USAbleLife.com
Life and AD&D - Mutual of Omaha	800-775-6000	www.mutualofomaha.com
Disability	800-775-6000	www.mutualofomaha.com
Human Resources	360-775-4659	tracy.gillett@hohtribe-nsn.org
Broker: The Mahoney Group Troy Pitney, Agency Partner / Advisor Denise Johnson, Client Manager	206-419-5040 480-214-2797	tpitney@mahoneygroup.com djohnson@mahoneygroup.com

ANNUAL NOTICES

Each year, employers that offer health care benefit plans are required to provide specific state and federal notices to employees regardless of their participation in the benefit plans offered. Electronic versions of these notices are available at your request or found on **BENEFITS WEBSITE**. If you have any questions, please contact the Human Resources/Benefits Department at **360-775-4659**.

SUMMARY ANNUAL NOTICES

CONSOLIDATED OMNIBUS BUDGET RECONCILATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act gives workers and their families who lose their health benefits the right to choose to continue group health benefits for limited periods of time under certain circumstances, such as, voluntary or involuntary job loss, reduction in hours worked, death, divorce, and other events. Qualified individuals pay the entire premium cost for coverage plus 2% administration fee.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

GINA prohibits discrimination based on genetic information.

Key Points:
Employers cannot request or require genetic information, except in limited circumstances.

- Genetic information includes family medical history, genetic test results, and information about genetic services.
- Employees should avoid providing genetic information unless required by law.

For more information, visit the EEOC's GINA page.

HEALTH INSURANCE MARKETPLACE NOTICE

Even if your employer offers health insurance, you may have other options through the Health Insurance Marketplace. This notice explains how Marketplace coverage interacts with your employer-provided plan.

What is the Marketplace?
The Marketplace is a resource where you can compare and purchase private health insurance. It's designed to help you find coverage that fits your needs and budget.

Can You Save Money in the Marketplace?
You may qualify for savings (like premium tax credits) if:

- Your employer does not offer coverage, or
- The coverage is not affordable (costs more than **9.96% of your income for 2026**), or
- It does not meet minimum value standards set by the ACA.

If your employer offers affordable, minimum value coverage, you likely won't be eligible for Marketplace savings.

Enrollment Periods:

- Open Enrollment runs each year (generally November 1 – December 15).
- You may qualify for a Special Enrollment Period if you experience a life event (e.g., marriage, birth, loss of coverage).
- A temporary Special Enrollment Period is available if you lose Medicaid or CHIP coverage generally run between March 31 – July 31.

Other Coverage Options:
You may be eligible to:

- Enroll in your employer's plan after losing Medicaid/CHIP.
- Apply for Medicaid or CHIP at any time at HealthCare.gov.

Employer Coverage Overview
Your employer offers:

- Health insurance to all eligible employees
- Coverage for spouse and children
- A plan that meets minimum value standard. The affordability rule does not apply due to group size.

Even with employer coverage, you may still qualify for Marketplace savings based on your household income.

Need Help?
Contact your HR department for plan details or visit HealthCare.gov for Marketplace information.

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SUMMARY ANNUAL NOTICES

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Federal law requires employers to notify Medicare-eligible individuals whether their prescription drug coverage is creditable—meaning it is expected to pay, on average, as much as standard Medicare Part D prescription coverage.

Why This Matters:
If you're eligible for Medicare and do not have creditable drug coverage, you may face a late enrollment penalty if you delay enrolling in Medicare Part D and go without creditable coverage for 63 days or more.

What Is Creditable Coverage?
Prescription drug coverage is considered creditable if it is expected to pay, on average, as much as Medicare Part D. Coverage that pays less is non-creditable.

Important for Groups Offering Multiple Plans:
If your employer offers multiple health plans, some plans may be creditable, some non-creditable, or a mix. It is essential to review your specific plan's status each year and choose coverage that aligns with your Medicare needs if you're eligible or nearing eligibility. Below is a list of the plans available and Medicare Part D status:

Premera Blue Cross Titanium 200	Creditable

What You Should Do:
If you are Medicare-eligible (or will be soon), review the notice provided for your specific plan.
Keep the notice for your records — you may need to show proof of creditable coverage to avoid penalties.
Contact HR or your benefits administrator if you're unsure which plan you're enrolled in or need help understanding the creditable status.

For more information about Medicare Part D, visit: https://www.medicare.gov

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

MHPAEA mandates that mental health and substance use disorder benefits cannot have more restrictive limits than general medical/surgical benefits.

Key Points:
- Plans cannot apply higher co-pays, deductibles, or limits on visits for mental health/substance use or disorder treatments.
- For more details about coverage and medical necessity determinations, contact your plan administrator.

For more information please visit:
https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mhpaea

SUMMARY ANNUAL NOTICES

MICHELLE'S LAW

Under Michelle's Law, a dependent child can remain covered by the health plan for up to one year while on a medically necessary leave of absence from a post-secondary institution due to illness or injury.

Key Requirements:
The dependent must provide written certification from a physician confirming that the leave is medically necessary.

For more information, please contact your health plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Federal law prohibits group health plans from limiting hospital stays following childbirth to less than:

- 48 hours after a vaginal delivery
- 96 hours after a cesarean section

For more information please visit - dol.gov/agencies/ebsa/laws-and-regulations/laws/nmhpa

PREMIUM ASSISTANCE UNDER MEDICAID AND CHIP

If you're eligible for Medicaid or CHIP and have employer-sponsored health coverage, your state may offer premium assistance to help with premiums.

Steps to take:

1. **Already Enrolled**: Contact your state Medicaid/CHIP office to inquire about premium assistance.
2. **Not Enrolled**: Visit insurekidsnow.gov or contact your state Medicaid/CHIP office to apply and check eligibility.
3. **Special Enrollment**: If you qualify for Medicaid or CHIP premium assistance, your employer must allow you to enroll in their health plan within 60 days of approval.
4. **For Questions**: The U.S. Department of Labor can be reached at 1-866-444-EBSA (3272), or visit askebsa.dol.gov.

Note: Medicaid and CHIP premium assistance programs vary by state. For more specific details, please contact your state's Medicaid or CHIP office.

PROTECTION AGAINST SURPRISE MEDICAL BILLS

Balance Billing (surprise billing) occurs when you receive care from an out-of-network provider at an in-network facility or in an emergency.

Key Protections:

- **Emergency Services**: You are only responsible for your in-network cost-sharing.
- **In-Network Facility Services**: Out-of-network providers at in-network hospitals cannot balance bill.
- **Written Consent**: You can waive these protections with written consent.

For help with surprise billing, contact the No Surprises Help Desk at 1-800-985-3059 or visit cms.gov/nosurprises/consumers.

SUMMARY ANNUAL NOTICES

NOTICE OF PATIENT PROTECTIONS

You have the right to:

- **Primary Care Provider (PCP)**: Choose any participating PCP in the network, including pediatricians for children.
- **Obstetric and Gynecological Care**: No prior authorization is needed for obstetrics or gynecology services from network providers.

For more information please visit – www.healthcare.gov

NOTICE OF PRIVACY PRACTICES

This notice outlines your rights regarding your medical information:

- **Access to Records**: You can request copies of your health and claims records.
- **Correct Records**: You can request corrections if records are inaccurate.
- **Confidential Communication**: You can request confidential ways to communicate with you.
- **Limit Sharing**: You can restrict sharing your information for treatment, payment, and operations.

For more details or to file a complaint please contact your health plan administrator.

USERRA NOTICE SUMMARY

(Uniformed Services Employment and Reemployment Rights Act)

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), employees who leave their job to perform military service have the right to be reemployed in their civilian job and retain certain benefits upon their return.

Key Rights Under USERRA:

- **Reemployment Rights:** If you leave your job for military service, you are generally entitled to return to your job with the same seniority, status, and pay, provided:
  - You give advance notice of service (when possible)
  - Your cumulative military service is 5 years or less with the same employer
  - You return to work within the required time frame after completing service

- **Health Insurance Protection:**
  - You may elect to continue your employer-sponsored health coverage for up to 24 months while on military leave.
  - If you choose not to continue coverage, your health plan coverage will be reinstated without waiting periods upon your return.

- **Pension and Retirement Plans:**
  - Time spent on military duty is treated as service with the employer for vesting and benefit accrual purposes.

Questions or Claims?

If you believe your USERRA rights have been violated, contact:
U.S. Department of Labor, Veterans' Employment and Training Service (VETS)
1-866-4-USA-DOL (1-866-487-2365)
www.dol.gov/vets

SUMMARY ANNUAL NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

Enrollment & Annual Notice
The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that requires group health plans and insurance issuers that cover mastectomies to also provide reconstructive surgery and related benefits.
What the Law Requires:
If you or a covered dependent receive benefits for a mastectomy, your plan must also cover the following services, as requested by the patient and their physician:

- Reconstruction of the breast removed by mastectomy
- Surgery and reconstruction of the other breast for a symmetrical appearance
- Prostheses (artificial breast devices)
- Treatment of physical complications, including lymphedema

Important Notes:

- These benefits are subject to the same deductibles and coinsurance as other medical/surgical benefits under your plan.
- WHCRA applies to both women and men covered by the plan who undergo a mastectomy.

For more general information, visit the U.S. Department of Labor's WHCRA page:
dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra

REPRODUCTIVE HEALTH CARE PRIVACY ATTESTATION:

Certain states require employers and health plans to provide a notice regarding privacy protections for reproductive health care information.

What This Means:
Your employer or health plan attests that it does not request, collect, or share your reproductive health care information unless required by law or necessary for providing your benefits.
You have privacy rights related to your reproductive health care under applicable state and federal laws.
This attestation confirms the employer's commitment to maintaining the confidentiality of your reproductive health care information.

What You Should Know:
If you have concerns or questions about your reproductive health care privacy, you may contact your Human Resources (HR) department.

Disclaimer:

This summary is intended for informational purposes only and does not include all details of the applicable laws. If you would like a copy of the full legislation or need more detailed information about any of the notices summarized above, please contact your Human Resources (HR) department.

NOTES