# 2024 Benefits Summary
# Hourly Production Partners

## Holidays

| | | |
|---|---|---|
| 7 Paid Holidays | New Year's Day | Memorial Day |
| | Fourth of July | Labor Day |
| | Thanksgiving Day | Christmas Day |
| | Partner's Birthday (or Friday after Thanksgiving, depending upon local policy) | |

## Paid Time Off

| | |
|---|---|
| 0-2 Years | 56 Hours * |
| 3-9 Years | 120 Hours * |
| 10-19 Years | 160 Hours * |
| 20 or more Years | 200 Hours * |

* On June 1, partners will receive credit for the year of service they will achieve during that fiscal year. A year is defined as the Company's 12-month fiscal period, beginning June 1 and ending May 31 each year. For part-time partners, PTO is adjusted based on the partner's standard hours worked. New hires will have PTO prorated based on the length of service employed during their first Fiscal Year.

## Jury Duty

Paid up to 5 days per year (maximum of 40 hours)

## Bereavement Pay

2 Days (maximum of 16 hours)

## Business Travel Accident

MetLife Travel Assistance Program provides partners (traveling more than 100 miles away from home) medical, travel, legal, and financial assistance services when faced with an emergency while traveling

## Commuter Program

Partners who commute to work by public transit (bus, rail, train) or pay for parking, can purchase subway cards, parking permits, etc. with pre-tax dollars

## Employee Assistance Program (EAP)

The program is designed to improve your well-being by helping you resolve a problem before it becomes too overwhelming or costly (i.e., Mental and behavioral health support, relationship or family problems, financial concerns, alcohol or drug issues, legal concerns)

## Short Term Disability (STD)

Eligible after 1 year of service
Begins the 8th day partner is out for illness/injury and 1st day partner is out for an accident, hospitalization or maternity (maternity paid at 100% for first 6 weeks)
Pays up to 13 weeks (including elimination period)
75% of eligible pay up to a maximum of $800/week

## Long Term Disability (LTD)

60% of basic monthly earnings up to a maximum of $2,000/month
Premiums (weekly) based on age and salary

## Basic Life/A.D. & D.

$10,000

## Voluntary Life/A.D. & D.

Choose from 1 x Pay to 10 x Pay (not to exceed $2 million)
Premiums (weekly) vary dependent on age and coverage level

## Spouse Life/A.D. & D.

Choose from $10,000 to $100,000

## Child Life/A.D. & D.

Choose from $5,000 or $10,000 per child

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## Medical ****

### Cost per Weekly Paycheck, *before* the Discount for LiveWell Participation is Applied**

| | Premium PPO* | Basic PPO | Core Choice | Core Value | Essential |
|---|---|---|---|---|---|
| Partner Only | $50.35 | $38.35 | $30.70 | $21.90 | $15.00 |
| Partner + Spouse | $118.70 | $93.40 | $77.80 | $53.45 | $40.80 |
| Partner + Child(ren) | $89.20 | $65.60 | $51.85 | $29.40 | $21.50 |
| Partner + Family | $157.50 | $120.65 | $99.00 | $60.95 | $47.30 |

*The Premium PPO Plan is only available to partners who were benefits-eligible before 1/1/12.
**Tobacco-user surcharge applies to partners and their spouse who are tobacco users. Spousal surcharge applies to partners whose spouse has medical coverage available through his or her employer.

### LiveWell Participation Criteria ***

| LiveWell Activity | Weekly Discount if Completed by: | Partner Only | Spouse Only | Partner + Spouse |
|---|---|---|---|---|
| Complete Biometric Screening Only | | $10 | $10 | $20 |
| Complete Biometric Screening with Health Assessment | | $15 | $15 | $30 |

***Partners who began working at Cintas on or after 7/15/23, will receive the discount outlined above in 2024.
Spouses who were not enrolled in a Cintas medical plan before 7/15/23 will automatically receive the discount if enrolled in a Cintas medical plan in 2024.
Partners on Military leave at any point between 7/15/23 and 8/18/23 will automatically receive the discount if enrolled in a Cintas medical plan in 2024.

**General Medical Expenses**

| | Premium PPO | Basic PPO | Core Choice | Core Value | Essential |
|---|---|---|---|---|---|
| Annual Deductible | **In Network*** $350 Individual; $700 Family** **Out of Network** $700 Individual; $1,400 Family | **In Network** $700 Individual; $1,400 Family** **Out of Network** $1,400 Individual; $2,800 Family | **In Network:** $1,600 Individual applies to Single coverage only; $3,200 Family, for coverage of any combination of a spouse and/or child*** **Out of Network:** $3,200/$6,400 | **In Network:** $3,250 Individual applies to Single coverage only; $6,500 Family, for coverage of any combination of a spouse and/or child*** **Out of Network:** $6,500/$13,000 | **In Network:** $5,850 Individual applies to Single coverage only; $11,700 Family, for coverage of any combination of a spouse and/or child**** **Out of Network:** $11,700/$23,400 |
| Primary doctor office visit | **In Network** $15 copay **Out of Network** 60% covered after deductible met | **In Network** $30 copay **Out of Network** 60% covered after deductible met | **In Network** 80% covered after deductible met **Out of Network** 60% covered after deductible met | **In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met | **In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met |
| Specialist office visit | **In Network** $15 copay **Out of Network** 60% covered after deductible met | **In Network** $30 copay **Out of Network** 60% covered after deductible met | **In Network** 80% covered after deductible met **Out of Network** 60% covered after deductible met | **In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met | **In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met |
| Out-of-pocket maximum | **In Network** $2,300 Individual; $4,600 Family; includes deductible and copays **Out of Network** $4,600 Individual; $9,200 Family; includes deductible and copays | **In Network** $3,400 Individual; $6,800 Family; includes deductible and copays **Out of Network** $6,800 Individual; $13,600 Family; includes deductible and copays | **In Network:** $2,400 Individual applies to Single coverage only; $4,800 Family, for coverage of any combination of a spouse and/or child; includes dedictible*** **Out of Network:** $4,800 Individual; $9,600 Family; as above and includes deductible | **In Network:** $3,250 Individual applies to Single coverage only; $6,500 Family, for coverage of any combination of a spouse and/or child; includes dedictible*** **Out of Network:** $8,500 Individual; $17,000 Family; as above and includes deductible | **In Network:** $5,850 Individual applies to Single coverage only; $11,700 Family, for coverage of any combination of a spouse and/or child; includes dedictible**** **Out of Network:** $13,700 Individual; $27,400 Family; as above and includes deductible |
| Lifetime Limit | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |

* The Premium PPO Plan is only available to partners who were benefits eligible before Jan 1, 2012 or are grandfathered into the Plan.
** Copays do not count toward your deductible.
*** If you have coverage other than Partner Only, you must satisfy the family amount.
**** The Essential Plan for family applies to those partners covering any combination of a spouse and/or child, and the individual limit of $9,100 applies for family coverage.

## Dental

### Cost

| | Basic | Comprehensive |
|---|---|---|
| **Weekly Plan Price** | | |
| Partner Only | $2.86 | $5.98 |
| Partner + Spouse | $7.44 | $15.54 |
| Partner + Child(ren) | $7.30 | $15.24 |
| Partner + Family | $8.45 | $17.64 |

## Dental (continued)

| | |
|---|---|
| **Basic** | **Annual Deductible-PPO/Premier** |
| Individual | $25 |
| Family | $75 |
| **Comprehensive** | **Annual Deductible-PPO/Premier** |
| Individual | $50 |
| Family | $150 |
| **Preventive Services** | **Coinsurance (% Covered)** |
| Basic | PPO - 100%; Premier 70% |
| Comprehensive | PPO - 100%; Premier 90% |
| **Basic Services** | **Annual Deductible-PPO/Premier** |
| Basic | PPO - 80%; Premier 60% |
| Comprehensive | PPO - 80%; Premier 70% |
| **Major Services** | **Annual Deductible-PPO/Premier** |
| Basic | Not Covered |
| Comprehensive | PPO/Premier - 50% |
| **Annual Maximum Coverage** | |
| Basic | PPO/Premier - $1,250 per person |
| Comprehensive | PPO/Premier - $1,250 per person |
| **Lifetime Orthodontia** | |
| Basic | Not Covered |
| Comprehensive | 50% covered; child only; limited to under age 19; limited to $1,500 per lifetime |

## Vision

**Cost**

| | **Vision** |
|---|---|
| **Weekly Plan Price** | |
| Partner Only | $1.29 |
| Partner + Spouse | $3.33 |
| Partner + Child(ren) | $3.21 |
| Partner + Family | $3.72 |
| **Annual Vision Limits** | |
| In Network/Out of Network | Exam, frame, lenses or contact lenses; limited to once every calendar year |
| **Routine vision exams** | |
| In Network | $10 copay; $0 copay if using a PLUS Provider. standard contact lens fit and follow-up up to $40 |
| Out of Network | $35 allowance |
| **Frame benefits** | |
| In Network | $135 allowance, 20% discount thereafter; $185 allowance, 20% discount thereafter if using a PLUS Provider |
| Out of Network | $60 allowance |
| **Single Vision Lens** | |
| In Network | $10 copay |
| Out of Network | $25 allowance |
| **Elective Contact Lens** | |
| In Network | $135 allowance; not including fit and follow-up; conventional and disposable; 15% discount for balance conventional only |
| Out of Network | $60 allowance |

## Profit Sharing/ESOP

| | |
|---|---|
| Company Contribution Determination | 100% made by Cintas. All Company contributions are discretionary, based on factors such as Company performance. |
| Company Contributions Qualifications | Must work 1000 hours of service in the previous calendar year to be eligible<br>Must be employed on the last business day of the fiscal year<br>Point system based on years of service and compensation<br>Company Contributions are made after the end of the fiscal year |
| Vesting | Profit Sharing and ESOP Contributions vest 100% after 3 plan years of service |
| Enrollment | Automatically enrolled once eligibility requirements described above are met |

## 401(k) Tax Deferred Savings

| | | |
|---|---|---|
| Partner Contribution | Portion of salary from 1% to 75% can be saved, up to IRS maximum<br>Eligible after 3 months of service<br>Automatically enrolled at 3% in default fund unless opt out before eligible | |
| Company Match Contribution | Company may match your contributions, as a percentage of every dollar you contribute, up to 10% of your salary | |
| Company Match Qualifications | Must be employed on the last day of the fiscal year<br>Worked at least 1,000 hours in previous calendar year<br>Must contribute a portion of your salary to receive matching from company | |
| Vesting Schedule for Match | Year 0-1 | 0% |
| | Year 2 | 20% |
| | Year 3 | 40% |
| | Year 4 | 60% |
| | Year 5 | 100% |
| Enrollment | Online via Partner Connect at partnerconnect.cintas.com.<br>By phone using the automated telephone system or Cintas Service Center at 1-866-256-6559.<br>Via the Alight mobile app (see QR code below) | |

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