Guide to Employee Benefits

2023

CARLISLE®

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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 page 28 for more details.

CARLISLE cares all about you!

4 years

Carlisle has kept health care costs flat for 4 consecutive years, contributing $2,300 for employees and $6,800 for families during that period

$20 million

Carlisle has contributed over $20 million in employee Health Savings/Reimbursement Accounts over the last 3 years

$1.2 million

$1.2 million reimbursed to employees over the last 3 years for continuing education including industrial skill certification programs

80% appreciation

A nearly 80% appreciation of our 2018 stock grant, plus a new stock option grant for eligible employees on October 3, 2022

$49 million

Carlisle has matched $49 million in 401K contributions over the last 3 years

What's new for 2023

Lower family deductible and out-of-pocket maximums

2 weeks of paid parental leave

Enhanced mental health support through Lyra

What's New for 2023

Carlisle is holding health care costs flat for the FOURTH consecutive year!

Our employees' wellbeing is key to Carlisle's success. Ensuring affordable and accessible health care for our employees and their families is a top priority. While health care costs are expected to increase by nearly 7% across the nation, Carlisle will absorb those costs to keep your premiums at the same rates for the fourth year in a row!

We have added some enhancements to our benefits lineup to bring you even more options.

- Lower family deductible and out-of-pocket maximums. We are moving to a two-tiered medical plan, meaning that the family deductible and out-of-pocket maximums will decrease. Carlisle will adjust contributions to the HSA and HRA plans accordingly.
- Expanded travel and lodging coverage. To make medical care more accessible, our medical plans provide coverage for eligible travel and lodging expenses when health care services are not available close to home.
- Enhanced mental health support through Lyra. Lyra connects you and your dependents to mental and emotional health care that is both convenient and personalized.
- New advocacy services with Health Advocate. Health Advocate provides one-on-one support to help you and your family understand your coverage, find the right medical provider, resolve insurance claims issues, and more.
- Two-weeks of Paid Parental Leave. In conjunction with other leaves programs, Carlisle will now provide two weeks of paid leave to care for a newborn, adopted, or foster child.
- New Commuter/Parking benefits with PayFlex. Set aside pretax dollars to pay for qualified transit and parking expenses related to travel to the workplace.
- Flexible Spending Accounts moving to PayFlex. If you enroll in the dependent or medical care FSA programs, you will receive a new account and debit card to access your funds.

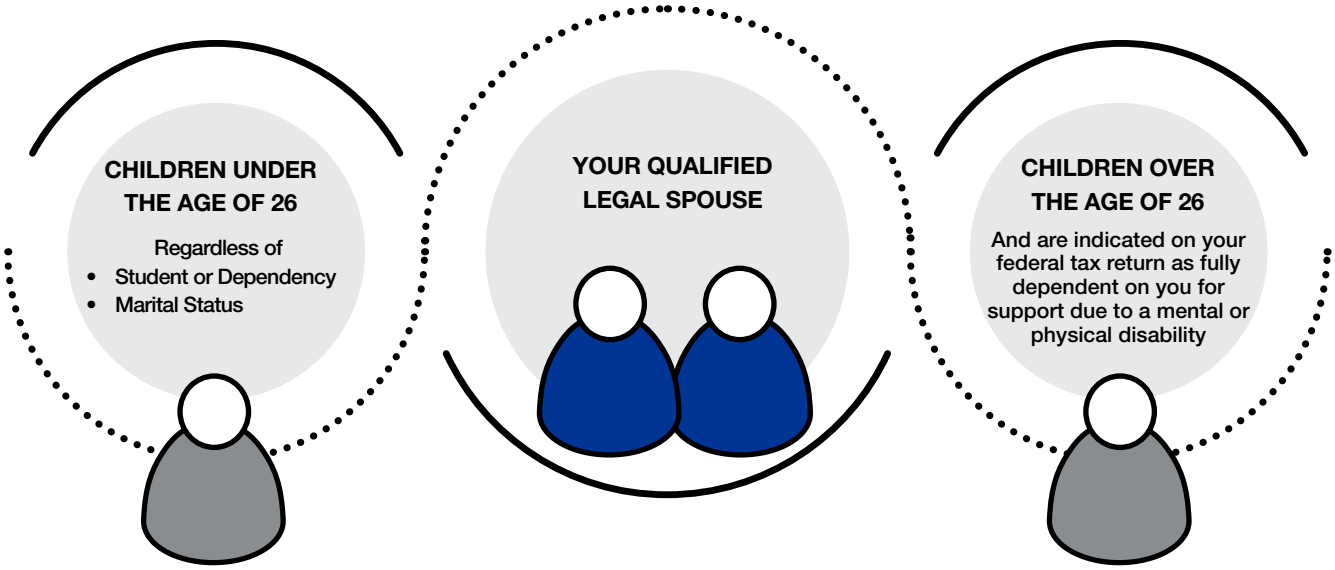
Important Resources

Learn about your Carlisle benefits anytime, any place, using your mobile device. Visit MyBenefits at **carlislebenefits.com**.

Eligibility

You're eligible for benefits if you are a regular, full-time employee. Coverage begins on your date of employment in an eligible class, provided you enroll within 30 days. You may also enroll your eligible dependents. Your cost for dependent coverage will vary depending on the number of dependents you cover and the particular plan you choose. When enrolling dependents, they will be enrolled in the same plans that you select for yourself.

Eligible dependents could be:



Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. If you do not make changes to your benefits within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event		Documentation Needed
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal Separation	Copy of divorce decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full time to part time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

*IMPORTANT: Your spouse is eligible for enrollment in the medical plan only if he/she does not have other group medical insurance available through his/her employer. EXCEPTION: If the employer requires your spouse to pay 100% of the cost of coverage, your spouse will be eligible for the Carlisle medical program.

Medical Plans

Carlisle offers three high-deductible health plans (HDHP). If you are a Medicare recipient or have another first-dollar benefit plan, you are not eligible for the Carlisle HSA Plan as defined by the IRS. However, you may enroll in the Carlisle Medical Plan or Carlisle HRA Plan.

Annual Account Contributions by Plan

	Carlisle HSA Plan	Carlisle Medical Plan	Carlisle HRA Plan
Eligibility	You are enrolled in an HSA-eligible high deductible health plan only	You are covered by a non-HDHP (i.e., spouse's health plan, health care FSA or HRA), Medicare, TRICARE, VA benefits or claimed as a dependent on someone else's tax return	You are enrolled in an HRA-eligible high deductible health plan only
Account Ownership	You decide when to use the funds for eligible **medical, dental, and vision** out-of-pocket. It's yours when you retire or leave the plan	Not Eligible	Funds are held in your name and used to pay medical, dental and vision claims (by the insurance company) while you are in the plan
Annual Carlisle Contributions*	**Individual** – $750 **You + 1 or more Dependents** - $1,500	Not Eligible	**Individual** – $500 **You + 1 or more Dependents** - $1,000 Wellness incentives added to HRA; will be in addition to the amounts above
Your Voluntary Annual Contributions	**Individual** – up to $3,850 less Carlisle contributions and your wellness incentive dollars **You + 1 or more Dependents** – up to $7,750 and your wellness incentive dollars	Not Eligible	Not Eligible
Your Catch-up Contributions	$1,000 at age 55 or older	Not available	Not available
Investment Options	You may invest in mutual funds if you have $1,000 in account; earnings are tax-free	Not available	Not available

Note: HRA account balances will be limited to the calendar year in-network, out-of-pocket maximum.

* Carlisle prorates the annual employer HSA and HRA employer contributions if coverage begins after January 1.

NOTE: In-network deductible and out-of-pocket maximum apply to in-network services only. Out-of-network deductible and out-of-network maximum apply to out-of-network services only.

Medical Plan Comparison

	Carlisle HSA Plan	Carlisle Medical Plan	Carlisle HRA Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible				
Individual	$1,500	$3,000	$1,500	$3,000
+ 1 or more dependents	$3,000	$6,000	$3,000	$6,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible)				
Individual	$3,000	$6,000	$3,000	$6,000
+ 1 or more dependents	$6,000	$12,000	$6,000	$12,000
Lifetime Maximum	Unlimited			
	Carlisle HSA Plan	**Carlisle Medical Plan**	**Carlisle HRA Plan**	
Yearly Employer Contributions				
Individual	$750	Not Eligible	$500	
+ 1 or more dependents	$1,500	Not Eligible	$1,000	
Coinsurance You Pay				
Preventive Care	$0	40%*	$0	40%*
Primary Care Physician	20%*	40%*	20%*	40%*
Specialist	20%*	40%*	20%*	40%*
Diagnostics, X-Ray and Lab	20%*	40%*	20%*	40%*
Urgent Care	20%*	20%*	20%*	20%*
Emergency Room	20%*	20%*	20%*	20%*
Inpatient Hospital Care	20%*	40%*	20%*	40%*
Outpatient Surgery	20%*	40%*	20%*	40%*
Pharmacy You Pay				
Retail Rx (up to 30-day supply)				
Preventive Generic	Preferred Preventive generics are covered at no charge and excluded from the plan deductible.			
Generic	20%*	20% after the 20% member copay	20%*	20% after the 20% member copay
Brand	20%*	20% after the 20% member copay	20%*	20% after the 20% member copay
Specialty	20%*	20% after the 20% member copay	20%*	20% after the 20% member copay
Mail Order Rx (up to 90-day supply)				
Generic	20%*	Not covered	20%*	Not covered
Brand	20%*		20%*	
Members are required to fill a 90-day supply at either CVS Caremark Mail Service Pharmacy or your local CVS pharmacy. You can contact Aetna to opt out of this requirement.				

* After deductible

For Your Protection

The out-of-pocket maximum provides financial protection in the event of a serious illness or injury. The out-of-pocket maximum includes your payments for covered in-network or out-of-network expenses, as applicable, and is withdrawn from your funds. The out-of-pocket maximum includes the deductible. After you reach your out-of-pocket maximum, the plan covers all eligible expenses up to 100% for the rest of the year.

HSA

A Health Savings Account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical, dental, and vision expenses with pretax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP medical plan. **NOTE:** If you're enrolled in Medicare, you are no longer eligible for an HSA account.

How a Health Savings Account Works

Eligibility

You must be enrolled in the High Deductible Health Plan.

Contributions

The Company contributes:
$750 (Employee Only) | $1,500 (Family)

You contribute on a pretax basis and can change how much you contribute from each paycheck up to the annual IRS maximum of $3,850 if you enroll only yourself or $7,750 if you enroll in family coverage. You can make an additional catch-up contribution if you are age 55 or older.

Eligible Expenses

You may use your HSA funds to cover medical, dental, vision, and prescription drug expenses incurred by you and your eligible family members.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

Your HSA is always yours — no matter what.

One of the best features of an HSA is that any money left in your account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the company or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.

HRA

A Health Reimbursement Account (HRA) is an account that you can use to pay for qualified out-of-pocket medical expenses with pretax dollars for yourself and your dependents enrolled in the HRA. HRA's are also a way for an individual or a family to pay for qualified medical expenses without the funds being taxed by the government beforehand. The employee may not contribute to the HRA. Please note: Funds available for reimbursement are limited to the balance in your HRA.

Using the HRA

The Company contributes to your account.
$500 for individual employees | $1,000 for a family

Your expenses are paid by your HRA.
Your HRA pays your eligible deductible and coinsurance amounts.

You can utilize your HRA for payment for eligible expenses.
These payments apply toward your deductible.

You pay your deductible.
After you use all of your HRA funds, you then pay the rest of the deductible amount out of your own pocket.

After that, you pay only coinsurance.
Once you have met your deductible, you share in the cost of the expenses. This is called coinsurance.

Wellness Engagement Program

Carlisle is committed to helping you prevent illnesses and achieve wellness. Participating in the Wellness Program benefits you:

- Physically, mentally, and emotionally through early intervention and maintenance of medical conditions;
- Financially by allowing you to earn incentives to assist with your deductible and eligible out-of-pocket costs; and
- Financially by keeping your share of the premiums lower by reducing medical claims costs.

Covered members will have the opportunity to earn rewards up to $550 for wellness activities.

The Wellness Incentives are available to employees and their spouses enrolled in the Carlisle HSA and HRA plans only. Please follow these steps:

Employee and Spouse Wellness Incentives[1]	
For $50 dollars	
Complete your Health Assessment	Register for aetna.com or download the Aetna Health app to complete your health assessment.
For $200 HSA dollars / HRA credit per member	
Annual preventive/wellness exam	» Complete your annual wellness/preventive exam with your primary care provider » OB/GYN can be the member's PCP; however, OB/GYN visit must be coded as preventive and not a "general" office visit to trigger incentive » Members can only earn the wellness/preventive exam incentive once during the year. They cannot earn an incentive for both an adult physical and well woman exam.
Additional Wellness Incentives	
Age/gender Appropriate[2] Preventive Screenings $100 HSA/HRA credit per test	**Complete one of the incentive actions below:** » Breast Cancer screening, including routine mammogram (adult) or » Colon Cancer screening, including routine colonoscopy, routine sigmoidoscopy, cologuard or » Cervical Cancer Screening or » Prostate Cancer Screening, specifically Prostate-Specific Antigen (PSA) test
Personal Health Goals $100 HSA/HRA credit per goal	Complete 3 calls with an Aetna In Touch Care nurse to work toward your personal health goal; **OR** Work online – Accumulate 3,000 Hearts (Rewards Center digital coaching currency) by completing actions toward your personal health goal. Each action you complete, as part of Your Health Goal activities, will earn you 20 hearts. When you complete a digital coaching program, as part of Your Health Education, you'll earn 100. Hearts accumulate quickly. Call Aetna for details; **OR** Complete 4 free, face-to-face coaching sessions once per year with CVS Minute Clinic Clinician to stop tobacco use; **OR** Enroll in Aetna Maternity Program and complete the Pregnancy Risk survey by the 16th week of gestation; **OR** Complete 4 week or 4 month post-partum assessment, administered by an Aetna Maternity nurse
Self-Reported Activities $50 HSA/HRA credit per activity up to $100	» Did you pay a fee for outdoor hobby, in-person/virtual race or event, gym memberships? » Subscribe to a wellness app or online course » Purchase health/wellness device or equipment » Semiannual Preventive Dental Visits

1 Employees under the Carlisle Medical Plan are not eligible for Wellness Incentives.

2 As defined by the American Cancer Society and U.S. Preventive Service Task Force

FSAs

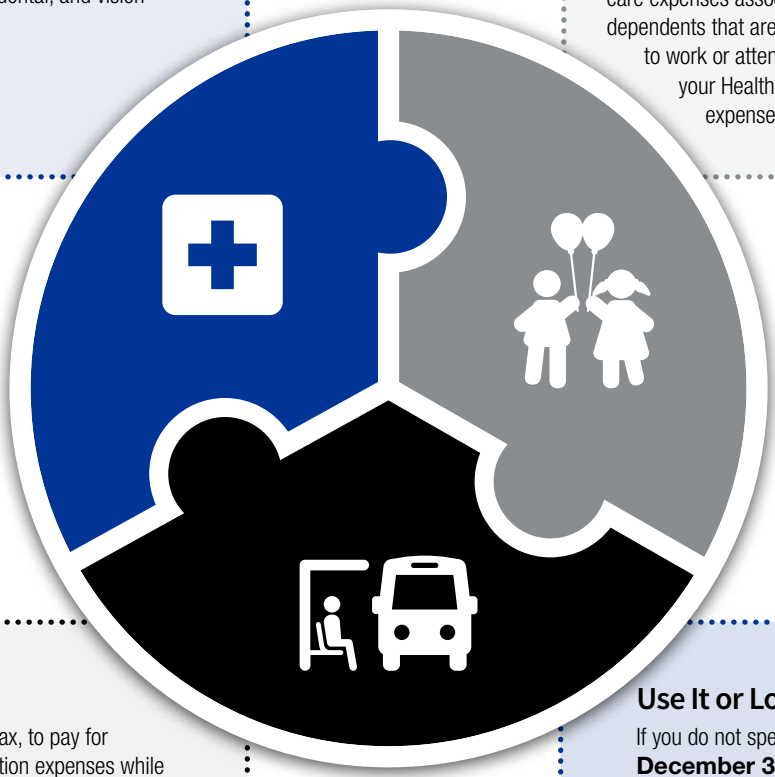
Flexible Spending Accounts (FSAs) allow you to pay for eligible expenses using pretax dollars. You must use all funds in your Health Care and/or Dependent Care account by 12/31 of the current plan year or per IRS regulations the remaining dollars will be forfeited. **For terminated employees:** you will have 90 days from your termination date to submit all reimbursement documents to Pay Flex for any eligible services from the start date of your FSA to the date of your termination (you will not be able to use the FSA funds for anything after your term date).

Health Care FSA

Contribute up to $2,850 per year, pretax, to pay for eligible medical, prescriptions, dental, and vision out-of-pocket expenses.

Dependent Care FSA

Contribute up to $5,000 per year ($2,500 if married and filing separate tax returns), pretax, to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.



Commuter Benefits

Contribute $300 per month, pretax, to pay for your parking or public transportation expenses while commuting to work, including monthly passes, tokens or fare cards. Note: It doesn't include commuting expenses for member's spouse or dependents.

Use It or Lose It

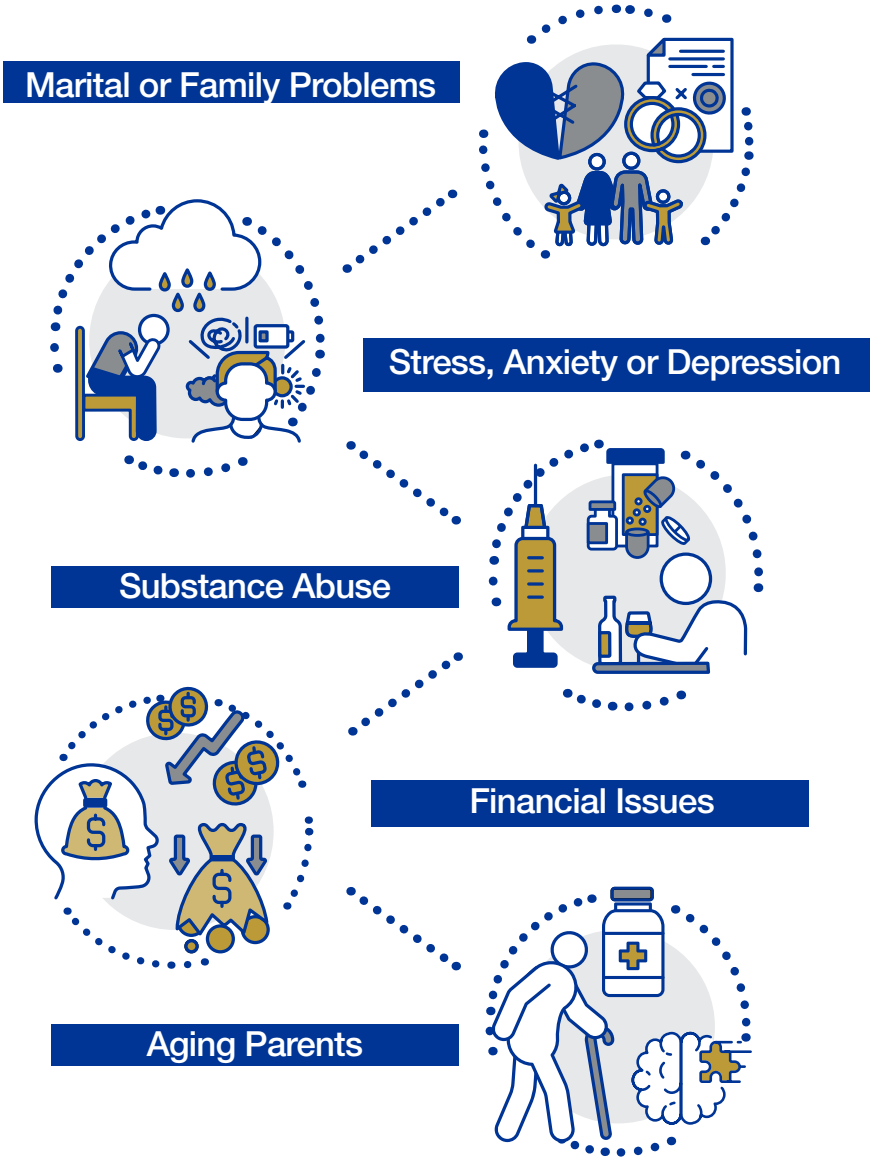
If you do not spend all the money in this FSA by **December 31**, per IRS regulations for pretax contributions, unused dollars will be forfeited. The filing deadline for the previous plan year is **March 31**.

Lyra: Mental and Emotional Health Care

Meet Lyra, your mental health benefit. Lyra provides you with high-quality mental health care designed for you—when and where you need it.

Whether you are experiencing burnout, anxiety, depression, caregiver stress, or racial stress/trauma, or are looking to improve your relationships, Lyra has a care option that's right for you.

We offer our employees and their eligible family members free access to licensed counselors through Lyra, our Employee Assistance Program (EAP), whether or not you have elected other benefit coverage. This coverage program provides support, guidance, assessments and referrals for additional services. You can contract Lyra Health for the following:



Health Advocate

The health care system can be difficult to navigate. That's why Carlisle provides you with 24/7 access to Health Advocate, a health care concierge service, at no cost. Available to you and your family members — including parents and parents-in-law — this service can save you time and money.

Your Personal Health Advocate can:

- Resolve insurance claims and billing issues
- Support medical issues, from common to complex
- Answer questions about diagnoses and treatments
- Research the latest treatment options
- Find the right in-network doctors and make appointments
- Research and arrange expert second opinions
- Facilitate pre-authorizations and coordinate benefits
- Explain benefits and your share of the costs

Personal Health Advocates are highly trained registered nurses backed by a staff of medical directors and administrative experts.

Don't forget to download the Health Advocate mobile app!

Free · Convenient · On-the-Go Help

Your Health Advocate mobile app and member website offer one-click access to health care help.

- Check the status of a case in real time; see your case history
- Send and receive secure messages from your Personal Health Advocate
- Submit a billing or claims issue

Access Health Advocate

Toll-Free: 866-695-8622

Website: www.healthadvocate.com

Email: answers@HealthAdvocate.com

Health Advocate is available 24 hours a day, 7 days a week. Regular hours are 8 AM to 12 AM (midnight) ET on weekdays. After hour calls are handled by the Personal Health Advocate on call.

Supplemental Medical

Just as it sounds, supplemental medical plans can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans are 100% voluntary post-tax.

Accident Insurance

Accident insurance covers qualifying injuries, which might include a broken limb, loss of a limb, burns, lacerations or paralysis. In the event of your accidental death, accident insurance pays out money to your designated beneficiary. While health insurance companies pay your provider or facility, accident insurance pays you directly.

Eligible Expenses	
	**Emergency Room Visits**
	**Hospital Stays**
	**Fractures and Dislocations**
	**Medical Exams** – including major diagnostic exams
	**Physical Therapy**
	**Transportation and Lodging** – if you are away from home when the accident happens

How Accident Insurance Works

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.
- Coverage is available for you, your spouse and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen on the job or off the job unlike workers' compensation, which only covers on-the-job injuries.
- Benefit payments are not reduced by any other insurance you may have with other companies.

Critical Illness Insurance

While major medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, a stroke or a heart attack, major medical insurance may not provide the coverage you need. Critical illness insurance will help ease the financial strain and help you not worry while you recover.

Sample of Covered Conditions	
	**Heart Attack**
	**Multiple Sclerosis**
	**Stroke**
	**Alzheimer's Disease**
	**Parkinson's Disease**
	**Major Organ Failure**

How Will a Critical Illness Claim Get Paid?

After purchasing critical illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things, including:

- Child care costs
- Medical expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Living expenses
- And more

Since the payment is made to you, the money can be used for anything you need while you focus on recovering.

Hospital Indemnity Insurance

Hospital indemnity insurance is a supplemental medical insurance plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury.

Even if your medical insurance covers most of your hospitalization, you can still receive payments from your hospital indemnity insurance plan to cover extra expenses while you recover.

How Does Hospital Indemnity Insurance Work?

You pay monthly premiums for your hospital indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your hospital indemnity plan makes cash payments to you.

And with the payments going directly to you, you can use these emergency funds to pay for costs not covered by your health insurance, health insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of-living expenses as you recover.

Sample of Covered Conditions
Hospital Admission
Hospital Confinement
Hospital Intensive Care
Surgical Care
Medical Diagnostic and Imaging
Transportation and Lodging

Dental Plan

The plan pays benefits for covered preventive and diagnostic services with no need for you to pay a deductible (whether services are obtained in-network or out-of-network). **NOTE:** You may elect dental coverage whether or not you elect medical coverage.

	Carlisle Cigna DPPO Plan	
	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Calendar Year Benefits Maximum		
Per Individual	$1,500 per individual (Basic and Major Services combined)	
	You Pay	
Preventive Care		
Cleanings, exams, X-rays twice per year **Fluoride Treatment under age 19, one per year**	$0	$0 (Up to the maximum allowable amount.)
Basic Services		
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Simple Endodontics, Periodontics, Emergency Exams	20%*	20%* or more if charges are more than maximum allowable charges.
Major Procedures		
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs, Surgical Implants	50%*	50%* or more if charges are more than the maximum allowable charges.
Orthodontia		
24-Month Treatment Fee. Additional fees will apply for pre-ortho visits and treatment, records and retention, and banding.		
Children and Adults	50% up to a lifetime maximum benefit of $1,500 per individual; deductible waived. Out-of-network providers may cost more if charges exceed maximum allowable charges.	

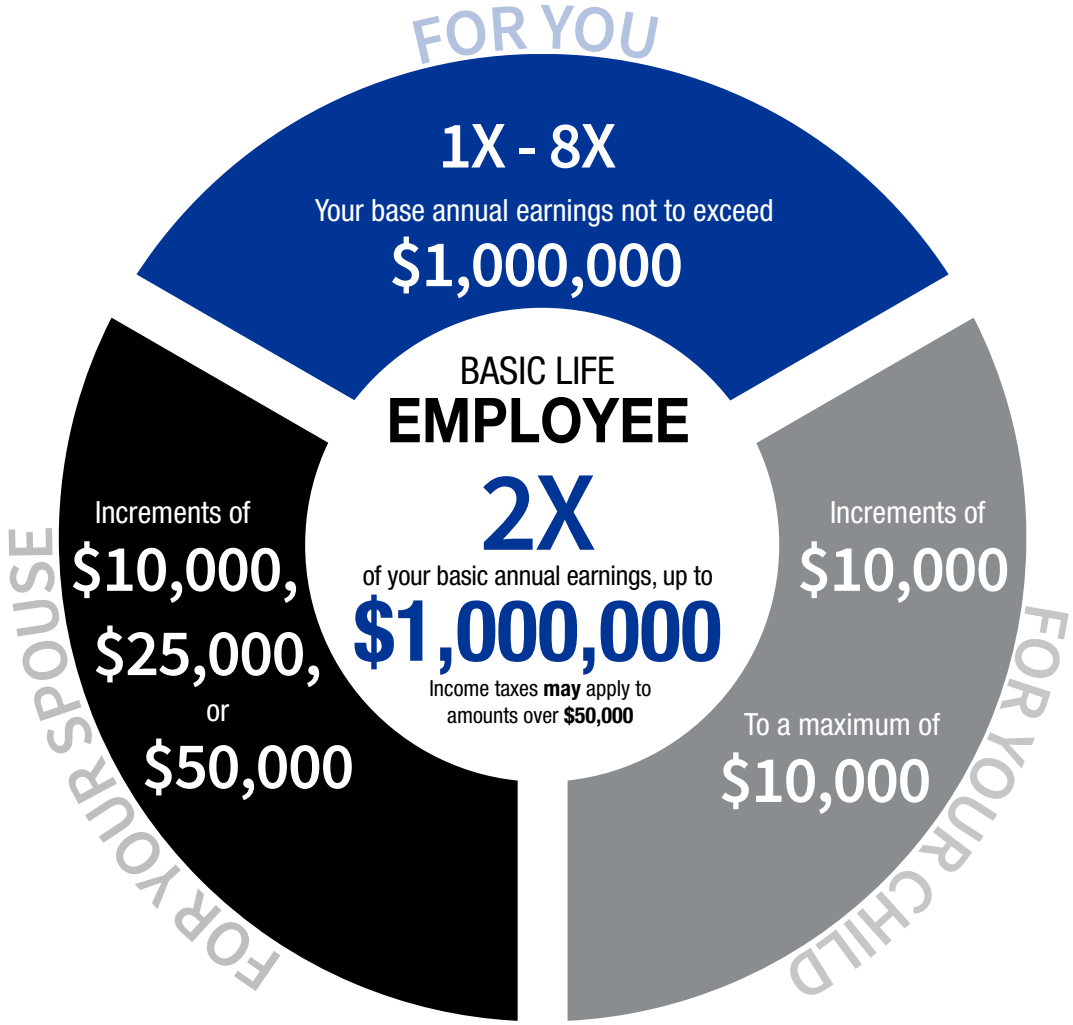
* After deductible

Vision Plan

	Carlisle EyeMed Vision Plan	
	IN-NETWORK	OUT-OF-NETWORK
Exam With Dilation as Necessary	$10 copay	Up to $30
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; 20% off balance over $160 allowance	Up to $75
Standard Plastic Lenses		
Single Vision	$15 copay	Up to $25
Bifocal	$15 copay	Up to $40
Trifocal	$15 copay	Up to $55
Standard Progressive Lens	$80 copay	Up to $40
Premium Progressive Lens	$80 copay +80% of charge less $120 allowance	Up to $40
Lenticular	$15 copay	Up to $55
Lens Options (paid by you and added to the base price of the lens)		
UV Treatment	$15 copay	N/A
Tint (Solid and Gradient)	$15 copay	N/A
Standard Plastic Scratch Coating	$0 copay	Up to $11
Standard Polycarbonate	$40 copay	N/A
Standard Polycarbonate – Kids under 19	$0 copay	Up to $28
Standard Anti-Reflective Coating	$45 copay	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (available once a comprehensive eye exam has been completed)		
Standard	Up to $40	N/A
Premium	10% off retail	N/A
Contact Lenses		
Conventional	$0 copay; 15% off balance over $160 allowance	Up to $120
Disposable	$0 copay; + balance over $160 allowance	Up to $120
Medically Necessary	$0 Copay, Paid-in-Full	Up to $200
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months defined by benefit frequency (Calendar Year)	
Diabetic Diagnostic Vision Services		
TYPE 1 AND TYPE 2 DIABETICS; FREQUENCY: UP TO (2) SERVICES PER BENEFIT YEAR		
Office Visit	Covered 100%	Up to $77
Retinal Imaging	Covered 100%	Up to $50
Extended Ophthalmoscopy	Covered 100%	Up to $15
Gonioscopy	Covered 100%	Up to $15
Scanning Laser	Covered 100%	Up to $33

Life and AD&D

Life and Accidental Death & Dismemberment (AD&D) insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death or in the case of a covered accidental injury. Basic Life is provided for you at no cost, and you have the option to purchase coverage for your dependents.



Guaranteed Issue & Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to 8 times your base annual salary, up to $1,000,000 maximum. Any amounts over 5 times your annual salary or more than $750,000 are subject to EOI. If you elect coverage after your initial enrollment, you will need to provide EOI before any amount becomes effective. If you don't enroll your spouse when first eligible, and coverage is requested at a later date, your spouse will need to provide EOI to be eligible for any amount of coverage. There is no EOI requirement for children.

Disability Income Protection

If you become disabled for an extended period of time and cannot work, no benefit becomes more important to your financial security than disability income protection. Carlisle provides disability coverage for all regular, full-time employees—at no cost to you.

Short-Term Disability (STD)

Short-Term Disability benefits are available when you must be absent from work due to a non-occupational illness or injury.

	Hourly Employees	Salary Employees
Eligible for Benefits	Immediately	Immediately
Benefits Begin » **Accident or Hospitalized** » **Illness**	First day of disability After 3 business days	First day of disability After 3 business days
Benefits while Disabled	75% up to 26 weeks	100% for 8 weeks 75% up to 18 weeks

Salary Continuation benefits are offset by any state disability benefits or Social Security disability benefits. Prudential will assist with information to submit and process claims requests for short-term/long-term disability, family medical leave, or other leave of absence needs at www.prudential.com/mybenefits (click on "Claims and Absence") or at 877-367-7781.

Long-Term Disability (LTD)

Long-Term Disability covers 60% of your base annual earnings to a $25,000 maximum/month. Benefit begins after 180 days of disability and payments will last for as long as you are disabled, depending on your age when disability begins. Certain exclusions as well as pre-existing condition limitations may apply. Prudential will assist with information to submit and process claims requests for short-term/long-term disability, family medical leave, or other leave of absence needs at www.prudential.com/mybenefits or at 877-367-7781.

Paid Parental Leave (PPL)

Eligible employees receive up to two weeks of Paid Parental Leave (PPL) after the birth, adoption or foster placement of a child. PPL must be taken within 12 months of birth, adoption, or placement, and it can be taken in one or two continuous blocks of time. PPL supplements any applicable state benefit programs to provide you with 100% of your base pay for up to two weeks. Prudential can assist with PPL and STD eligibility information. Please contact Prudential at www.prudential.com/mybenefits or at 877-367-7781.

Planning For Retirement

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 401(k) savings plan allows you to save for retirement on a pretax basis. You can begin contributing to the plan at any time once you become eligible and can start making contributions to your account through convenient payroll deductions.

Increase Your Retirement Savings With a 401(k)

Funded with PRE-TAX dollars

Your **ANNUAL** Contribution

+

100% Company Match on the **first 3%** contributed and **50%** on the **next 2%** contributed

can not exceed the IRS limit of

$20,500

If you are **AGE 50+** you can make an additional contribution of **$6,500**

The CEISP is a Safe Harbor Plan. Safe Harbor contributions are fully vested immediately but are subject to restrictions on early withdrawal.

Eligibility

You are eligible for the CEISP if you are a full-time employee. CEISP's service provider, Principal, has your eligibility information. Part time employees are eligible if paid by Carlisle for 1000 hours or more during the first full year of employment or for any calendar year.

Vesting

You are always 100% vested in your pretax, Roth and after-tax contributions, funds you have rolled over from another qualified plan and earnings on these funds. You are also 100% vested in company matching contributions made on or after January 1, 2007.

Employee Deferrals

If you do not elect a deferral percentage and do not elect to opt out of the CEISP within your initial eligibility period, you will be automatically enrolled with a 3% deferral election. You may contribute between 1% and 50% of your eligible pay on a pretax and/or Roth contribution basis, up to the annual IRS limit. You may also contribute on an after-tax basis, but the total deferral percentage of pretax + Roth + after-tax cannot be more than 50%.

Employee Stock Purchase Plan

The Employee Stock Purchase Plan ("The Plan") offers eligible employees the opportunity to purchase Carlisle Companies Incorporated ("Carlisle" or the "Company") Common Stock at market price. Contributions are strictly voluntary and are made through payroll deduction.

Plan Provisions

The Plan provides for monthly purchases and you may enroll at any time, with such enrollment effective the next available pay period ("Purchase Period"). Your participation may be delayed based on the timing of the payroll cycle.

Payroll deductions will accumulate in a non-interest bearing account held by AST Equity Plan Solutions, the Plan Administrator. The accumulated balance will be used to purchase shares on the investment date.

No brokerage fees will be charged for these purchase transactions. You can contact AST Equity Plan Solutions at 866-709-7704 or access your account at www.astepsdiv.com.

Participation

Participation is optional. Once you enroll, the contribution amount you select is deducted automatically from your pay each pay period. You may contribute any whole dollar amount equal to $10 or more.

Buying Stock

After the end of each Purchase Period, your account balance will be used to buy Carlisle Common Stock at market price.
All shares purchased will be held in your name by the Plan Administrator.

Selling Shares

You may sell your shares at any time subject to the terms of the Plan. The tax consequences of selling your shares depend on the length of time that you hold them.

Employee Contributions

Medical Contributions

	Carlisle HSA and Carlisle Medical Plans		Carlisle HRA Plan	
MONTHLY PREMIUMS	YOU PAY	CARLISLE PAYS	YOU PAY	CARLISLE PAYS
Employee Only	$88.42	$558.30	$146.02	$579.95
Employee + Spouse	$218.44	$1,139.70	$343.44	$1,181.14
Employee + Child(ren)	$197.63	$1,031.15	$310.74	$1,068.63
Family	$312.04	$1,628.12	$490.63	$1,687.33

Dental Contributions

Monthly Premiums	You Pay	Carlisle Pays
Employee	$11.12	$15.42
Employee + Spouse	$22.23	$30.83
Employee + Child(ren)	$23.34	$32.37
Employee + Family	$34.45	$47.79

Vision Contributions

Monthly Premiums	You Pay
Employee	$7.01
Employee + Spouse	$13.32
Employee + Child(ren)	$14.02
Employee + Family	$21.57

Life and AD&D Contributions

	Monthly Employee Rate per $1,000		Spouse Monthly Rate per $1,000
AGE	NON-TOBACCO	TOBACCO	
<25	$0.060	$0.060	$0.060
25–29	$0.060	$0.060	$0.060
30–34	$0.080	$0.090	$0.080
35–39	$0.090	$0.111	$0.090
40–44	$0.120	$0.180	$0.128
45–49	$0.214	$0.317	$0.240
50–54	$0.351	$0.514	$0.377
55–59	$0.548	$0.822	$0.599
60–64	$0.882	$1.310	$0.967
65–69	$1.370	$2.020	$1.489
70–74	$2.500	$3.689	$2.714
75–79	$3.946	$5.855	$4.280

Employee AD&D Rate / Family AD&D Rate	$0.033 per $1,000 / $0.035 per $1,000
Child Life Rate / Child AD&D Rate	$0.08 per $1,000

Accident Insurance Contributions

Accident Insurance Monthly Rate	
Employee Only	$7.07
Employee + Spouse	$10.54
Employee + Child(ren)	$10.58
Employee + Family	$16.66

Hospital Indemnity Contributions

Hospital Indemnity Insurance Monthly Rate	
Employee Only	$11.69
Employee + Spouse	$25.71
Employee + Child(ren)	$19.41
Employee + Family	$35.30

Critical Illness Contributions

	Monthly Rate per $10,000	
AGE	EMPLOYEE	SPOUSE
<25	$2.617	$2.460
25–29	$3.400	$3.322
30–34	$4.226	$4.423
35–39	$5.543	$5.720
40–44	$6.775	$7.137
45–49	$10.630	$10.517
50–54	$16.148	$14.967
55–59	$24.339	$21.122
60–64	$34.093	$28.689
65–69	$51.750	$42.972
70–74	$62.729	$52.245
75–79	$62.731	$52.253
80–84	$62.745	$52.248
85+	$62.758	$52.249
Child under age 27	$2.829	

Important Notices

Important notice to employees from Carlisle about creditable prescription drug coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Carlisle medical plans are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2023. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2023 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Carlisle and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Carlisle prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2023. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Carlisle plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Carlisle coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Carlisle plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Carlisle and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Carlisle coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org/.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Corporate Benefits Department at Carlisle
16430 N. Scottsdale Road, Suite 400
Scottsdale, AZ 85254
(O) 480-781-5000
benefits@carlisle.com

Notice of Special Enrollment Rights for Medical Plan Coverage

As you know, if you have declined enrollment in Carlisle's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plans without waiting for the next open enrollment period, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Carlisle will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Carlisle group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (O) 480-781-5000

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (O) 480-781-5000.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

Alabama – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
Alaska – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
Arkansas – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (1-855-692-7447)
California– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
Colorado – Medicaid and CHIP
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
Florida – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
Georgia – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaidgeorgiagov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2

Indiana – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
Iowa – Medicaid and CHIP
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
Kansas – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
Kentucky – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
Louisiana – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
Maine – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
Massachusetts – Medicaid
Website: https://www.mass.gov/info-details masshealth-premium-assistance-pa Phone: 1-800-862-4840
Minnesota – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/ healthcare/health-care-programs/programs-and-services/medical- assistance.jsp Phone: 1-800-657-3739
Missouri – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
Montana – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
Nebraska – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Nevada – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
New Hampshire – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
New Jersey – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/ medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
New York – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
North Carolina – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
North Dakota – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
Oklahoma – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
Oregon – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
Pennsylvania – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462
Rhode Island – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
South Carolina – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
South Dakota - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
Texas – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
Utah – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
Vermont– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

Virginia – Medicaid
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924 Email: HIPPcustomerservice@dmas.virginia.gov
Washington – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
West Virginia – Medicaid
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Wisconsin – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
Wyoming – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Carlisle HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Carlisle health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans Carlisle Medical Plan, Carlisle Corporation Dental Plan and Carlisle Vision Plan. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Carlisle as an employer — that's the way the HIPAA rules work. Different policies may apply to other Carlisle programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment includes** activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Carlisle

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Carlisle for plan administration purposes. Carlisle may need your health information to administer benefits under the Plan. Carlisle agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefits staff are the only Carlisle employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Carlisle, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Carlisle, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Carlisle information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Carlisle cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Carlisle from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2022. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact: Corporate Benefits Department at Carlisle, 16430 N. Scottsdale Road, Suite 400, Scottsdale, AZ 85254 (O) 480-781-5000, benefits@carlisle.com

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Corporate Benefits Department at Carlisle, 16430 N. Scottsdale Road, Suite 400, Scottsdale, AZ 85254 (O) 480-781-5000 benefits@carlisle.com

Wellness Program Notices

NOTICE REGARDING WELLNESS PROGRAM

The Carlisle Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol, LDL, HDL, triglycerides and blood glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive for participating. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives of up to $500 may be available for employees who participate in certain health-related activities. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by Corporate Benefits Department at Carlisle, 16430 N. Scottsdale Road, Suite 400, Scottsdale, AZ 85254, (O) 480-781-5000, benefits@carlisle.com.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as any Aetna condition management programs as listed under the Wellness Engagement Program described in the Carlisle Benefits Guide. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Carlisle may use aggregate information it collects to design a program based on identified health risks in the workplace, the Carlisle Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Corporate Benefits Department at Carlisle, 16430 N. Scottsdale Road, Suite 400. Scottsdale, AZ 85254. (O) 480-781-5000, benefits@carlisle.com.

GINA Spousal Notice and Authorization for Wellness Program

(for Wellness Plans that allow Spouses or Domestic Partners to participate in Disability-Related Inquiries or Medical Examinations)

You are receiving this Notice and Authorization because Carlisle is making a voluntary wellness program available to you as the spouse of an employee. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as applicable, among others. Your spouse who is an employee of Carlisle will receive a separate Notice regarding the wellness program.

Federal law requires that you provide knowing, written, and voluntary authorization prior to Carlisle's wellness program collecting your genetic information, which includes information about your current or past health status. By signing this Notice and Authorization, you are agreeing that you have read and understood it and that you are knowingly and voluntarily providing information about the manifestation of your diseases and certain other conditions – considered genetic information – as part of the wellness program. This may include a medical questionnaire that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a medical examination (e.g., a biometric screening). If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Corporate Benefits Department at Carlisle, 16430 N. Scottsdale Road, Suite 400, Scottsdale, AZ 85254, (O) 480-781-5000, benefits@carlisle.com.

You are not required to complete the questionnaire or the medical examination. You are not required to provide genetic information; however, if you choose not to provide information regarding your own health status, you may not qualify for the full amount of wellness incentives. The wellness program cannot offer you a wellness incentive in return for you providing your own genetic information, including your family medical history, results of your genetic tests, or information about your children's health status or genetic information. Regardless, you and/or your *spouse* will not be denied access to Carlisle's health plan (or any package of health plan benefits), or subjected to Carlisle discrimination or retaliation if you choose not to participate in the wellness program.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The genetic information that you provide will be used to: *help you understand your current health and potential risks, determine whether you met requirements for wellness incentives (or for a reasonable alternative standard), to design a program to address conditions identified with the genetic information, or may be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.*

We are required by law to maintain the privacy and security of your individually identifiable genetic or medical information. Although the wellness program and Carlisle may use aggregate information it collects to design a program based on identified health risks, The Carlisle Wellness Program will never disclose any of your individually identifiable genetic or medical information either publicly or to Carlisle, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as permitted by law.

Genetic or medical information that personally identifies you that is provided in connection with the wellness program will not be provided to Carlisle, including your spouse's or domestic partner's supervisors or managers and may never be used to make decisions regarding your spouse's employment.

Here is a summary of how we will protect your confidentiality and restrict disclosure of your information:

- Carlisle will retain all enrollment and incentive eligibility materials. Information stored electronically *will be protected*, and no information you provide as part of the wellness program will be used in making any employment decision.
- Appropriate precautions will be taken to avoid any data breach. If a data breach occurs involving your information, you will be notified.
- Your individually identifiable genetic or medical information will be provided only to you (or a family member whom you authorize) and licensed health care professionals and staff involved in providing services under the wellness program. Your individually identifiable genetic or medical information will not be accessible to managers, supervisors, or others who make employment decisions for your spouse or to anyone else in their workplace except as permitted by law. Your individually identifiable genetic or medical information will not be disclosed to Carlisle except in aggregate terms that do not disclose the identity of specific individuals. That aggregate information will be treated as a confidential medical record.
- Your information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted or required by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

This Notice and Authorization does not restrict any rights you may have under the Americans with Disabilities Act or the Health Insurance Portability and Accountability Act (HIPAA). If the wellness program provides (directly, through reimbursement, or otherwise) medical care (including genetic counseling) the program may constitute a group health plan subject to HIPAA's privacy rules and you will receive a separate HIPAA privacy notice. If you have questions or concerns regarding this Notice and Authorization, or about protections against discrimination and retaliation, please contact Corporate Benefits Department at Carlisle 16430 N. Scottsdale Road, Suite 400, Scottsdale, AZ 85254, (O) 480-781-5000, benefits@carlisle.com.

I, _____, [Spouse name] hereby acknowledge receipt of this Authorization and that I am knowingly and voluntarily authorizing Carlisle's wellness program to collect the genetic information specifically described herein.

Signature Date

No Surprises Act notice

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

You're protected from balance billing for:

Emergency services

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

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

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

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

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

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

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

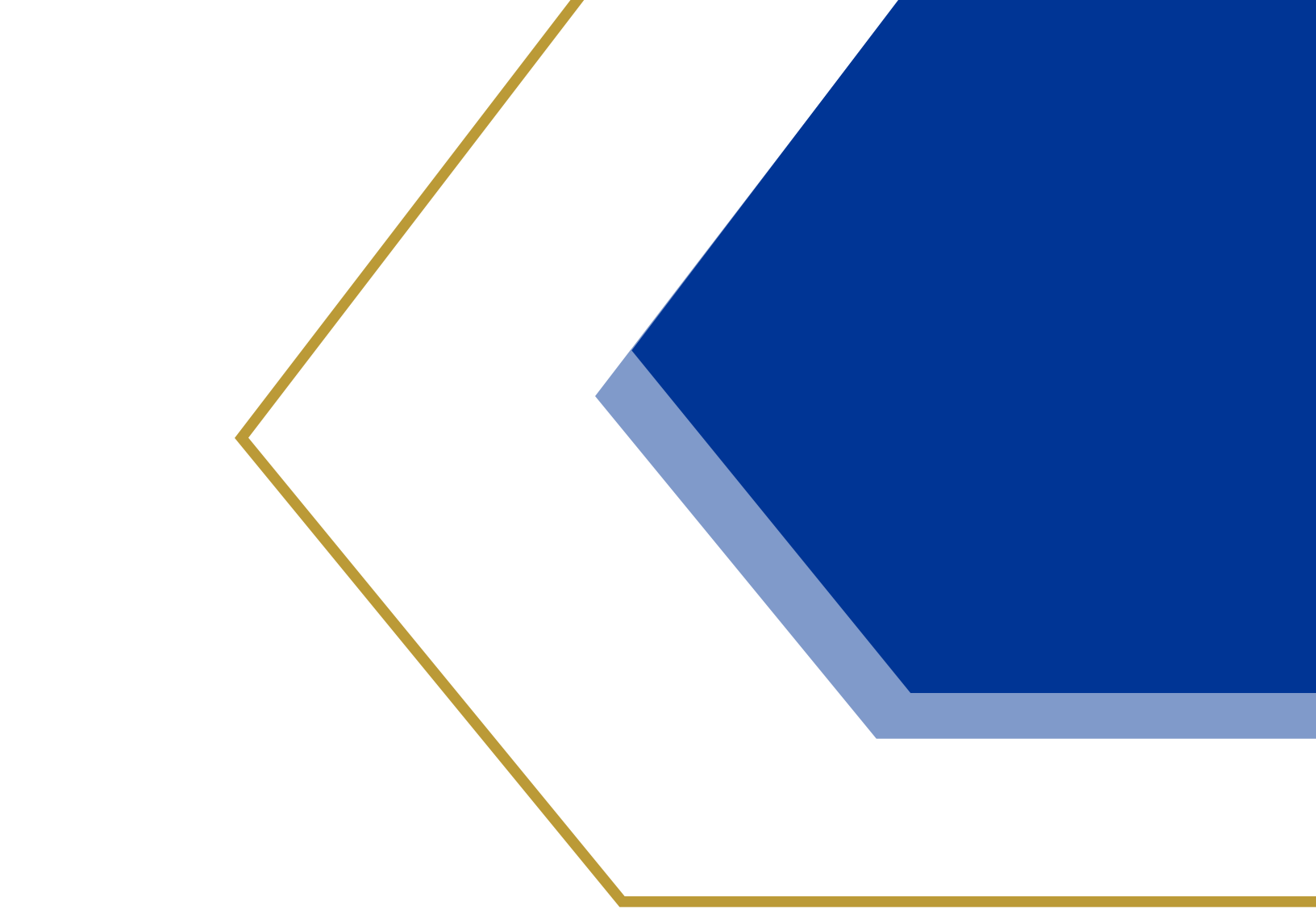
- **Generally, your health plan must:**
- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would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

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

Notes

Important Contacts

Coverage	Contact	Phone	Website
401(k) Retirement CEISP	Principal	800-547-7754	www.principal.com
Business Travel Accident	AIG	866-893-2520	www.aig.com/us/travelguardassistance
Carlisle Benefits Department	Benefits Service Center	855-444-4925	benefits@carlisle.com
COBRA	Payflex	888-678-7835	www.payflex.com
Dental	Cigna	800-244-6224	www.mycigna.com
Employee Stock Purchase Plan	AST Equity Plan Solutions	866-709-7704	www.astepsdiv.com
Health Advocate	Health Advocate	866-695-8622	www.healthadvocate.com
Health Reimbursement Arrangement	Aetna	866-276-5125	www.aetna.com
Life and AD&D	Prudential	877-367-7781	www.prudential.com/mybenefits
Leave and Disability Plans (FMLA, LOA, PPL, STD, LTD)	Prudential	877-367-7781	www.prudential.com/mybenefits
Medical	Aetna	866-276-5125	www.aetna.com
Mental & Emotional Health	Lyra	877-337-3823	https://carlisle.lyrahealth.com
Supplemental Medical (Accident Insurance, Critical Illness, Hospital Indemnity)	Prudential	877-367-7781	www.prudential.com/mybenefits
Spending Accounts (Commuter Benefits, Flexible Spending Accounts, Health Savings Account)	PayFlex	888-678-8242	www.payflex.com
Vision	EyeMed	866-723-0514 For LASIK providers call: 877-558-7376	www.EyeMedvisioncare.com Choose the SELECT Network



This brochure highlights the main features of the Carlisle Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Carlisle reserves the right to change or discontinue its employee benefits plans at any time.