U.S. ANNUAL BENEFITS ENROLLMENT
2026 FREQUENTLY ASKED QUESTIONS

October 2025

This document summarizes important employee benefit plan provisions. Honeywell has the right to modify, change and revise the terms and conditions of Honeywell's employee benefits plans, as well as the right to terminate the plans (subject to applicable collective bargaining agreements). This communication is not a guarantee of the future availability or design of Honeywell's employee benefits. The formal plan documents, as amended from time to time, will govern if there is a conflict between the description of the plans contained here and the plan documents.

When is Annual Benefits Enrollment for U.S. employees?

Annual Benefits Enrollment (AE) for the 2026 plan year begins on October 16, 2025 and ends on October 31, 2025. Eligible employees can enroll online from work or home by visiting HR Direct or **honeywell.com/enrollAE**. Employees without online access should call HR Help at 1-877-258-3699 or access via the site www.benefitcenter.com/honeywell to review plan changes and enroll.

What is the best way to access Annual Enrollment information?

www.benefitcenter.com/honeywell is the best place to find information on Annual Enrollment changes for 2026. Click the AE banner on the homepage to learn more about 2026 Annual Enrollment.

Are there changes to the HON Medical Plan in 2025?

There are rate changes that will affect those enrolled in a high deductible health plan for Cigna and Horizon members for 2026. **Note: Due to Honeywell's fully insured contract with Kaiser Permanente, we are required to follow any state-mandated coverage requirements. This may result in plan design differences. Please refer to the Kaiser Summary of Benefit Coverage (SBC) for your region for further details.**

There will be no change to your medical premiums for the eighth consecutive year, unless you are changing your coverage tier, or a recent salary increase has moved you into a new salary band.

Will I be receiving a new medical insurance identification (ID) card for 2026?

There are no medical plan changes for Kaiser, Cigna or Horizon members in 2026 so there will be no new ID cards issued. Beginning 1/1/2025 Cigna will only provide digital ID cards. You can request a physical card from Cigna directly at any time. Cigna and Horizon members can also access their digital ID on Castlight.

Will I be receiving a new dental insurance identification (ID) card for 2026?

No. If you are enrolled in the MetLife or Cigna dental plan options, you will not be receiving a new dental insurance card.

Are their any conditions not covered when enrolling in LTD coverage during this year's Annual Enrollment?

Pre-existing condition limitations apply to long-term disability. Coverage will not be payable to a condition or injury incurred within the last 3 months prior to obtaining coverage and will not be covered for the first 12 months of disability coverage.

Who is eligible for the $200 Honeywell HSA seed[1]?

To be eligible for the Honeywell $200 HSA seed, you must be enrolled in the Honeywell High Deductible medical plan and earn up to $50,000 in annual base salary. There is no action required on your end to receive the funds.

You are not eligible to contribute to an HSA if you are:

- Enrolled in another medical program that is not a high deductible health plan (for example, through a spouse/domestic partner's employer).
- Enrolled in Medicare Parts A and/or B.
- Enrolled in Tricare (benefits offered to military personnel).
- Covered as a dependent under a Health Care FSA (such as through your spouse/domestic partner's employer).

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Will I see a Biometrics surcharge when reviewing my benefits costs for 2026?

If you completed your biometric screening prior to Oct 10th and did not test positive for nicotine, you should not see an additional surcharge when reviewing your 2026 benefits costs. If you completed the screening after Oct 10th and/or tested positive for nicotine, you will see a surcharge in the Annual Enrollment module. For questions, please reach out to HR Help at 1-877-258-3699.

What if I completed my biometrics screening after Oct 10th, was granted an exception through Healthresource, or had a negative nicotine test result and still see a surcharge?

Due to the timing of getting biometric results to our Annual Enrollment module, you may still see a surcharge applied to your total benefit costs. If any of the above circumstances apply to you, we ask that you carefully review the benefit confirmation statements that will be sent out in December to make sure the surcharge is not applied.

Where do I go to confirm my biometric screening was completed?

You may access your biometric screening results on either the My.QuestforHealth.com website or on the Castlight website.

Are there changes to the dental plan for 2026?

MetLife dental coverage will now allow replacement of a missing tooth if it is extracted prior to being enrolled in Honeywell's coverage.

Are there changes to the vision plans for 2026?

No. Vision plan design and premium contributions will not change for 2026.

Are there changes to the disability plan designs (short- or long-term disability) for 2026?

No. While there are no changes to short- or long-term disability (LTD) plan designs for January 2026, premiums for LTD coverage will be increasing in 2026.

MEDICAL/Rx FAQs

Are there differences in coverage between Cigna, Horizon & Kaiser?

The high deductible health plan design is essentially the same for all 3 medical carriers. The medical carriers offer different provider networks for in-network doctors, hospitals, and facilities. Employees are encouraged to review the provider directories during Annual Benefits Enrollment to find out whether the doctors they plan to see are in-network providers. Also, keep in mind providers participating in the networks can change during the year, so employees should always confirm whether services will be provided on an in- or

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out-of-network basis. **Note: Due to Honeywell's fully insured contract with Kaiser Permanente, we are required to follow any state-mandated coverage requirements. This may result in plan design differences. Please refer to the Kaiser SBC for your region for further details.**

What is a deductible?

This is the flat dollar amount you pay each year before the plan begins paying benefits. The deductible varies based on whether you're covering only yourself or yourself and another family member.

What is an Out-of-Pocket Maximum (OOPM)?

This is the maximum amount you need to pay toward your health care for the plan year. Once you reach your out-of-pocket maximum, the plan pays at 100 percent for eligible expenses. Depending on the plan you choose, deductibles may or may not be included in the out-of-pocket maximum.

Do I pay copays for doctor's office, prescriptions, and/or emergency room visits?

No. The medical plan design includes coinsurance for both in-network and out-of-network covered services. Copays do not apply to any covered services.

Are preventive services covered at 100%?

Certain in-network preventive care expenses are covered at 100%, with no deductible or coinsurance required. Preventive services are not covered out-of-network. To confirm services considered preventive care, please visit your medical plan website or health benefits information through HR Direct.

How does my prescription drug coverage work?

When you enroll in medical coverage, you will also have prescription drug coverage. Under the medical plan design, deductibles and coinsurances apply to covered prescription drugs. You must meet your medical plan deductible before the plan begins to pay for prescription drugs. Once you meet your deductible, coinsurance applies. Some per prescription caps are in place to limit your financial exposure for high-cost prescriptions.

How can I obtain my 90-day maintenance medication that I take regularly for conditions such as high blood pressure or asthma?

You can choose to fill your 90-day supply of maintenance medication at CVS Pharmacy® or through CVS Caremark® Mail Service Pharmacy. By doing so, you're getting your medications at a lower cost and meeting the requirements of your plan.

Are there delivery options for my medication available?

Yes. You can have your 90-day supply of maintenance medication delivered along with short-term medications (such as antibiotics). There are two delivery speeds available:

- On-Demand Delivery - get it on the same day for a small fee. *
- 1–2-day delivery - get it in 1-2 days from USPS, all at no extra cost to you

Savings Account FAQs

What is the maximum annual amount I can contribute to a Health Savings Account (HSA)?

The maximum 2025 HSA contribution limits are:

Individual Coverage	Family Coverage
$4,300	**$8,550**

If you are over age 55 by December 31, an additional $1,000 may be contributed.

It is your responsibility not to exceed the IRS HSA maximum contribution (inclusive of any spousal or other HSA).

*Note the maximum limits above include any employer contributions you may be eligible to receive. If you are eligible to receive employer contributions, please keep this in mind when choosing your savings goal amount for the year.

Will I forfeit the money I contribute to my HSA if I don't use it during the year?

No. You won't lose it if you don't spend it by a certain date or if you change employers.

What is maximum annual amount I can contribute to a Limited Purpose Flexible Spending Account (FSA)?

The maximum employee contribution to the Limited Purpose FSA will be $3,200. Only dental and vision expenses can be submitted for reimbursement from a Limited Purpose FSA.

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What is maximum annual amount I can contribute to a Dependent Care Spending Account?

You can contribute up to $5,000 (up to $2,500 if you are married and file taxes separately) to the Dependent Care FSA each year. To comply with non-discrimination testing requirements, the maximum annual DCSA contribution amount will continue to be $3,200 in 2025, for employees earning more than $150,000 annually.

Can changes be made to my Limited Purpose Flexible Spending Account (FSA) and Dependent Care Spending Account throughout the year?

No. Elections are irrevocable for the duration of the Plan Year. However, following a qualified status change event, an eligible employee may have a limited period of time, to make an election change under the Plan.

Other FAQs

What are salary-based contributions?

Salary-based contributions link the amount you pay for medical coverage to your annual base salary. Employees who earn a higher salary will pay more for medical coverage. If you had a salary increase in 2025, your medical premium contributions for 2026 may increase.

How is salary defined? Does it include bonus or overtime?

Salary is defined as your annual base salary before taxes or other deductions are taken out. Bonuses, commissions, shift differentials, and overtime pay are not included. Your base salary as of September 30, 2025, will be used to determine your salary-based contributions for 2026.

What happens if I do not take action to enroll?

If you do not actively enroll during Annual Enrollment and you have medical, dental, vision coverage today, you will continue to have coverage in 2026. ***Be sure to log into Annual Benefits Enrollment to review your coverage and ensure all costs and coverage for plan year 2026 are correct.***

If you contributed to a Health Savings Account in 2025, you will continue to have the same election in 2026. If you are currently enrolled in a Limited Purpose Flexible Spending Account (FSA) or Dependent Care Spending Account (DCSA), **those elections will not carry over to next year.**

If you have waived healthcare coverage in 2025, and take no action, you will continue to waive coverage in 2026.

Can I cover my domestic partner under the Honeywell medical, dental and vision plans?

Yes, an eligible employee's domestic partner is eligible for medical, dental and vision benefits under the Plan. For this purpose, a Domestic Partner is a person of the same or opposite gender as such employee who has in their personal possession a state or local governmental registration or other documentation of domestic partnership signed by both partners. The document must be dated prior to enrolling for benefits. Employees with Domestic Partners are required to notify HR Help if there is a change in the domestic partnership that would end the state or local governmental registration. The tax consequences of Plan coverage for Domestic Partners will be governed by and determined in accordance with applicable federal, state and local requirements. You may be required to provide proof of dependent eligibility, if requested.

How much will I have to pay for my domestic partner's coverage?

Contributions for domestic partner coverage will be similar in cost to an employee covering their spouse. However, the portion of the contribution allocated to your eligible domestic partner (and their eligible children if applicable) will be withheld on an after-tax basis. In addition, the value of health coverage provided by the plan is considered wages for federal and/or state tax purposes and therefore will be added to your W-2 income.

If you claim your domestic partner as your tax dependent under Internal Revenue Code §152, the value of health coverage provided by the plan may not be considered wages for tax purposes. You will need to notify HR Help at 1-877-258-3699, if this applies to you.

Can I submit my domestic partner's claims for reimbursement under the limited purpose flexible spending account or health savings account?

Generally, claims can only be reimbursed for the employee, the employee's spouse or the employee's tax dependents. However, if you can claim your domestic partner as a tax dependent, under Internal Revenue Code §152, then you may be able to submit your domestic partner's claims for reimbursement. Please consult your tax advisor for guidance.

*Most prescriptions eligible for delivery with qualifying health plans. Orders arrive on the same day by 8pm Monday through Friday, by 4pm on Saturday and Sunday, seven days a week. Orders must be placed by 4 p.m. or four hours before pharmacy closing, whichever is earlier, to ensure delivery within same day. Order cut-off times and delivery fees apply. Delivery is limited to certain locations within a 10-mile radius of CVS Pharmacy locations, and as allowed by and in accordance with state guidelines and regulations. Participating locations only. Either the member or an agent of the member must be present at the delivery address to receive a prescription package. Your delivery is provided at a special rate as part of your prescription benefit plan. You will be notified of the fee before you prepay for your delivery order. Other restrictions apply, see www.cvs.com/RxDelivery or ask pharmacy staff for details.

**Most prescriptions eligible with qualifying health plans. Delivery period does not include Sundays or USPS holidays. Order cut-off times and delivery fees apply. Participating locations only. Delivery not available to every address. Delivery prices may vary from store prices. Coupons/promotions may not be available with delivery orders. Other restrictions apply. Ask pharmacy staff for details. Your delivery is provided at a special rate as part of your prescription benefit plan. You will be notified of the fee before you prepay for your delivery order. Other restrictions apply, see www.cvs.com/RxDelivery or ask pharmacy staff for details.

[1] Excluding employees of FM&T and those covered by a collective bargaining agreement, except to the extent such collective bargaining agreement specifically adopts the provisions of this Policy

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