2026 Benefits Summary
California Production Hourly Partners

Holidays

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

Paid Time Off

0-2 Years	80 Hours *
3-9 Years	120 Hours *
10-19 Years	160 Hours *
20 or more Years	200 Hours *

* PTO accrues on an hourly or weekly basis. Reference Policy C-128 Exhibit A for more details.

Jury Duty

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

Bereavement Pay

2 Days (maximum of 16 hours)

Business Travel Accident

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

Commuter Program

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

Employee Assistance Program (EAP)

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

Short Term Disability (STD)

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

Long Term Disability (LTD)

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

Basic Life/A.D. & D.

$10,000

Voluntary Life/A.D. & D.

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

Spouse Life/A.D. & D.

Choose from $10,000 to $100,000

Child Life/A.D. & D.

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

Medical*****

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

	Premium PPO*	Basic PPO	Core Choice	Core Value	Essential
Partner Only	$53.20	$40.25	$32.00	$22.50	$15.00
Partner + Spouse	$125.95	$98.60	$81.70	$55.40	$41.70
Partner + Child(ren)	$95.25	$69.70	$54.85	$30.60	$22.00
Partner + Family	$167.90	$128.05	$104.60	$63.50	$48.70

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

LiveWell Participation Criteria ***

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

***Partners who began working at Cintas on or after 7/19/25, will receive the discount outlined above in 2026.
Spouses who were not enrolled in a Cintas medical plan before 7/19/25 will automatically receive the discount if enrolled in a Cintas medical plan in 2026.
Partners on Military leave at any point between 7/19/25 and 8/29/25 will automatically receive the discount if enrolled in a Cintas medical plan in 2026.

General Medical Expenses

	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Annual Deductible	**In Network*** $500 Individual; $1,000 Family** **Out of Network** $1,000 Individual; $2,000 Family	**In Network** $850 Individual; $1,700 Family** **Out of Network** $1,700 Individual; $3,400 Family	**In Network:** $1,700 Individual applies to Single coverage only; $3,400 Family, for coverage of any combination of a spouse and/or child*** **Out of Network:** $3,400/$6,800	**In Network:** $3,400 Individual applies to Single coverage only; $6,800 Family, for coverage of any combination of a spouse and/or child*** **Out of Network:** $6,800/$13,600	**In Network:** $6,150 Individual applies to Single coverage only; $12,300 Family, for coverage of any combination of a spouse and/or child**** **Out of Network:** $12,300/$24,600
Primary doctor office visit	**In Network** $15 copay **Out of Network** 60% covered after deductible met	**In Network** $30 copay **Out of Network** 60% covered after deductible met	**In Network** 80% covered after deductible met **Out of Network** 60% covered after deductible met	**In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met	**In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met
Specialist office visit	**In Network** $15 copay **Out of Network** 60% covered after deductible met	**In Network** $30 copay **Out of Network** 60% covered after deductible met	**In Network** 80% covered after deductible met **Out of Network** 60% covered after deductible met	**In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met	**In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met
Out-of-pocket maximum	**In Network** $2,600 Individual; $5,200 Family; includes deductible and copays **Out of Network** $5,200 Individual; $10,400 Family; includes deductible and copays	**In Network** $3,700 Individual; $7,400 Family; includes deductible and copays **Out of Network** $7,400 Individual; $14,800 Family; includes deductible and copays	**In Network:** $2,600 Individual applies to Single coverage only; $5,200 Family, for coverage of any combination of a spouse and/or child; includes dedictible*** **Out of Network:** $5,200 Individual; $10,400 Family; as above and includes deductible	**In Network:** $3,400 Individual applies to Single coverage only; $6,800 Family, for coverage of any combination of a spouse and/or child; includes dedictible*** **Out of Network:** $8,800 Individual; $17,600 Family; as above and includes deductible	**In Network:** $6,150 Individual applies to Single coverage only; $12,300 Family, for coverage of any combination of a spouse and/or child; includes dedictible*** **Out of Network:** $14,300 Individual; $28,600 Family as above and includes deductible
Lifetime Limit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

* The Premium PPO Plan is only available to partners who were benefits eligible before Jan 1, 2012 or are grandfathered into the Plan.
** Copays do not count toward your deductible.
*** If you have coverage other than Partner Only, you must satisfy the family amount.
**** The Essential Plan for family applies to those partners covering any combination of a spouse and/or child, and the individual limit of $9,400 applies for family coverage.

Dental

Cost

	Basic	Comprehensive
Weekly Plan Price		
Partner Only	$3.12	$6.51
Partner + Spouse	$8.10	$16.91
Partner + Child(ren)	$7.94	$16.59
Partner + Family	$9.19	$19.19

Dental (continued)

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

Vision

Cost

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

Profit Sharing/ESOP

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

401(k) Tax Deferred Savings

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

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