2027 Benefits Summary
Full-Time Partners (SSR, Salaried, Office Hourly)

Medical

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

	Clear Choice	Basic PPO	Core Choice	Core Value	Essential
Partner Only	$43.20	$42.25	$33.35	$23.10	$15.00
Partner + Spouse	$108.45	$104.10	$85.85	$57.45	$42.65
Partner + Child(ren)	$76.15	$74.10	$58.05	$31.85	$22.55
Partner + Family	$140.20	$135.90	$110.55	$66.20	$50.20

** $15/week tobacco-user surcharge applies to partners and their spouse who are tobacco users.

Note: Effective October 19, 2026, spouses with access to employer medical coverage are ineligible for Cintas medical coverage for partners hired on or after that date. Grandfathered working spouses pay a $35 per-pay-period surcharge in 2027.

LiveWell Participation Criteria ***

LiveWell Activity	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 7/18/26, will receive the discount outlined above in 2027.

Spouses who were not enrolled in a Cintas medical plan before 7/18/26 will automatically receive the discount if enrolled in a Cintas medical plan in 2027.

Partners on Military leave at any point between 7/18/26 and 8/28/26 will automatically receive the discount if enrolled in a Cintas medical plan in 2027.

General Medical Expenses

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Annual Deductible	**In Network:** $0 Individual; $0 Family	**In Network:** $1,100 Individual applies to Single coverage only; $2,200 Family, for coverage of any combination of a spouse and/or child***	**In Network:** $1,900 Individual applies to Single coverage only; $3,800 Family, for coverage of any combination of a spouse and/or child***	**In Network:** $3,700 Individual applies to Single coverage only; $7,400 Family, for coverage of any combination of a spouse and/or child***	**In Network:** $6,600 Individual applies to Single coverage only; $13,200 Family, for coverage of any combination of a spouse and/or child****
	Out of Network: $0 Individual; $0 Family	**Out of Network:** $2,200/$4,400	**Out of Network: $3,800/$7,600**	**Out of Network: $7,400/$14,800**	**Out of Network: $13,200/$26,400**
Primary doctor office visit	**In Network** $30 Anthem Diamond Provider / $50 Other	**In Network** $40 copay	**In Network** 80% covered after deductible met	**In Network** 100% covered after deductible met	**In Network** 100% covered after deductible met
	Out of Network $100 copay	**Out of Network** 60% covered after deductible met	**Out of Network** 60% covered after deductible met	**Out of Network** 60% covered after deductible met	**Out of Network** 60% covered after deductible met
Specialist office visit	**In Network** $30 Anthem Diamond Provider / $50 Other	**In Network** $40 copay	**In Network** 80% covered after deductible met	**In Network** 100% covered after deductible met	**In Network** 100% covered after deductible met
	Out of Network $100 copay	**Out of Network** 60% covered after deductible met	**Out of Network** 60% covered after deductible met	**Out of Network** 60% covered after deductible met	**Out of Network** 60% covered after deductible met

General Medical Expenses					
	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Out-of-pocket maximum	**In Network** $4,500 Individual; $9,000 Family***	**In Network:** $4,400 Individual applies to Single coverage only; $8,800 Family, for coverage of any combination of a spouse and/or child; includes deductible and copays***	**In Network:** $3,000 Individual applies to Single coverage only; $6,000 Family, for coverage of any combination of a spouse and/or child; includes deductible***	**In Network:** $3,700 Individual applies to Single coverage only; $7,400 Family, for coverage of any combination of a spouse and/or child; includes deductible***	**In Network:** $6,600 Individual applies to Single coverage only; $13,200 Family, for coverage of any combination of a spouse and/or child; includes deductible****
	Out of Network $9,000 Individual; $18,000 Family***	**Out of Network** $8,800 Individual; $17,600 Family; includes deductible and copays***	**Out of Network:** $6,000 Individual; $12,000 Family; as above and includes deductible***	**Out of Network:** $10,000 Individual; $20,000 Family; as above and includes deductible***	**Out of Network:** $14,600 Individual; $29,200 Family; as above and includes deductible***
Lifetime Limit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

** 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 $12,000 applies for family coverage.

Dental			
Weekly Premium			
Partner Only		$3.21	$6.70
Partner + Spouse		$8.34	$17.41
Partner + Child(ren)		$8.18	$17.08
Partner + Family		$9.46	$19.75
Annual Deductible			
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		
Weekly Premium		
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 contribution is made pre-tax
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 Pre-tax and Roth 401k (after-tax) options Automatically enrolled at 3% pre-tax in default target date fund, unless you 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 6% for Highly Compensated Employees (HCE) Company match is made pre-tax

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%
Travel Assistance		
	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)		
	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)	
	60% of eligible pay up to a maximum of $2,500/week	
Long Term Disability (LTD)		
	60% of basic monthly earnings up to a maximum of $5,000/month	
	Premiums (weekly) based on age and salary	
Basic Life/A.D. & D.		
Office Hourly	$10,000	
SSR and Salaried	$20,000	
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

Certain information and/or sections will not appear because this is a summary. If you have questions about a topic that isn't covered in the summary, contact the plan's member services department for additional information. Cintas Corporation is not responsible for the accuracy of this information. If there is a discrepancy between the information displayed on the summary and the official plan documents, the official plan documents will control. Cintas Corporation reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time.