Diversified Logistics
First Coast Pallet
Triple C Enterprise
Southeast Unloading

BENEFIT GUIDE

JULY 1, 2025 - JUNE 30, 2026

Dear Valued Employee,

We are happy to provide you with this Benefit Guide to summarize your employee benefits for the plan year: July 1, 2025 - June 30, 2026.

Diversified Logistics Management, Inc recognizes that benefits are an important part of your life as an employee. Our benefits program will help you choose what works best for your needs and your budget.

This document is not just an enrollment guide; it is a resource for you and your family to use throughout the year. Inside you will find a summary of each benefit plan and helpful tips you may not have known about in the past. This guide is designed to break down the insurance benefits to help you make an informed decision regarding the selection and management of the services and benefits provided to you as an employee of Diversified Logistics Management, Inc.

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 pages 35-36 for more details.

CONTENTS

IMPORTANT NOTICE TO EMPLOYEES:

This Benefit Guide provides a general description of the various benefits available to you through the Diversified Logistics Management, Inc Employee Benefits program. The details of these plans and policies are contained in the official plan and policy documents.

This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

SUMMARY OF BENEFITS & COVERAGE (SBC) NOTICE

Attached are your Federally Mandated Summary of Benefits and Coverage (SBC) documents for all offered medical plan options. In the following pages you will find simpler formatted, easy to understand plan summaries which provide a general description of the various benefits available to you through the Diversified Logistics Management, Inc Employee Benefits Program.

To access your SBCs you may Scan or Click the QR code below with your phone.

If you would prefer a printed copy, please contact your HR department.

ELIGIBILITY

FOR YOU

All full-time employees working an average of 30 hours per week are eligible to enroll in benefits. For specific details, please refer to the plan documents.

New full-time employees' benefits for all lines of coverage will begin on the 1st of the month following 60 days of full-time employment.

FOR YOUR FAMILY

Legislation regulates eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible Dependents includes:

- Legal Spouse
- Dependent children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

DEPENDENT COVERAGE

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

Spouse Verification Documentation:

Marriage Certificate

Child Verification Documentation:

Birth Certificate, court document awarding custody or requiring coverage

You can provide these documents to Human Resources.

The adult child's spouse is not eligible for coverage. In some circumstances and for a limited time period, the newborn of an enrolled adult dependent may be covered. For adult children age 26, the State of Florida has adopted legislation allowing for extended coverage up to age 30, but under more limited conditions such as the child must reside in Florida or be a part-time or full-time student and must be unmarried with no dependent child(ren) of his/her own. In addition, they cannot be covered under another group or franchise plan, student or individual plan, or be Medicare eligible.

2025 Benefits Open Enrollment

June 12 - *June 19*

Visit the Benefits Homepage by using the QR Code or link provided below

1. **Schedule** your personalized appointment with a Benefits Counselor to learn more about your benefit options

2. **Review** the Benefits Guide and other educational tools to learn more about your benefit offerings

3. **Enroll** in Benefits! Be sure to have new dependent and beneficiary SS# and DOB available to complete your enrollment

SCAN ME

SCAN THE QR CODE OR USE THE LINK TO VISIT THE BENEFITS HOMEPAGE

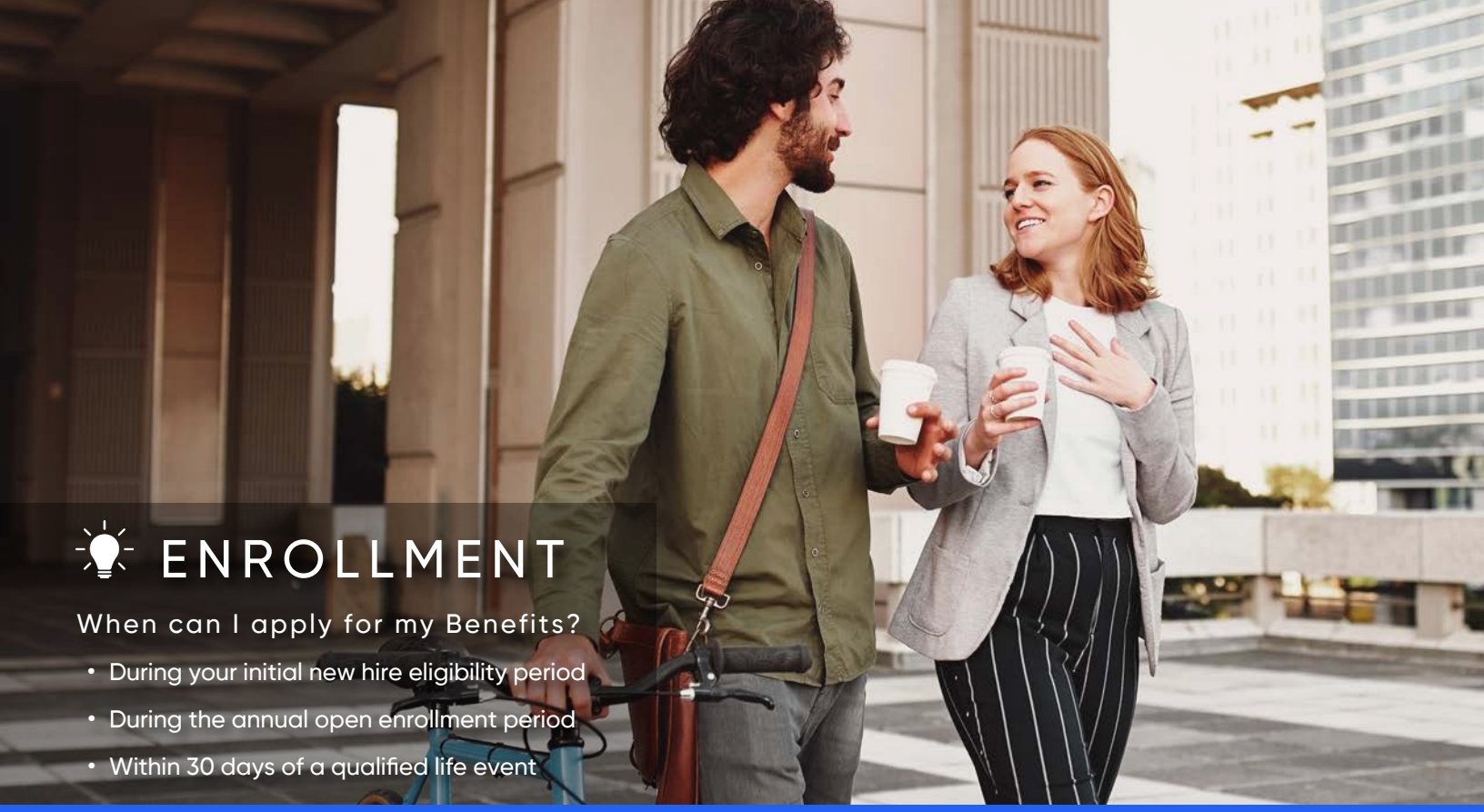
Diversified Logistics | First Coast Pallet | Triple C Enterprise | Southeast Unloading

https://diversifiedlogistics.benefitsinfo.com

Voluntary Benefits

Carrier: Mutual of Omaha

- **Dental:** Access top-notch dental care with Mutual of Omaha's **Mutually Preferred** network. Ortho reset.
- **Vision:** Enjoy comprehensive vision care through **EyeMed**.
- **Voluntary Life Insurance:** Fantastic Opportunity to elect up to the guaranteed issue amount without the need for Evidence of Insurability—no record of past or current health events required.
- New **Long-Term Disability Benefit:** Secure your future with our new long-term disability coverage.



ENROLLMENT

When can I apply for my Benefits?

- During your initial new hire eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event

MID-YEAR ENROLLMENT CHANGES – Section 125 Cafeteria Plan

Employees receive the tax benefits of a Section 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event.

Changes must be reported within 30 days of the actual event.

Some common qualifying events may include:

- Marriage, Divorce or Death of Spouse
- Birth, Adoption or change in Legal Custody
- Loss of other coverage
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

To determine if any of these apply to you, please check with your Human Resources representative.

PLEASE NOTE:

The IRS does not consider financial hardship a qualifying event to drop coverage.

Proliant

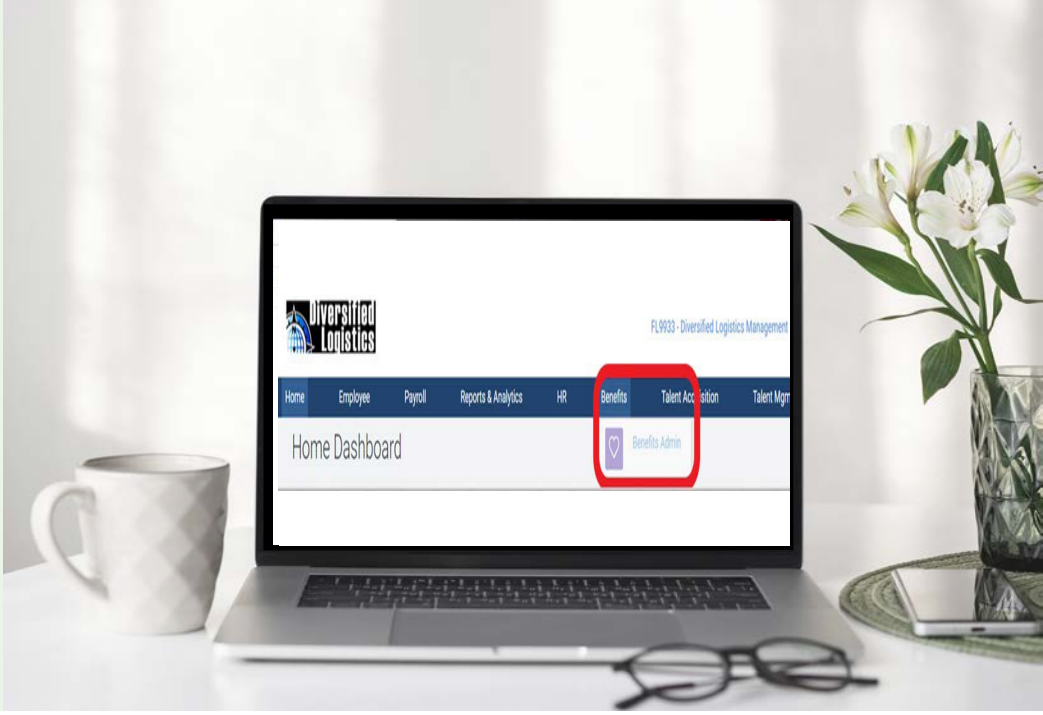
Single Sign-On is available through Proliant

Employees log in to their Proliant

self-service portal

Navigate to the benefits tab on the menu bar

Click on the "Benefits Admin"



employee NAVIGATOR

Diversified Logistics Management, Inc utilizes Employee Navigator as our online benefit platform. We encourage all employees to utilize the system to make benefit elections, demographic and address changes, and other qualifying event elections. Below are the instructions on how to register as a new user and how to access Employee Navigator for Returning Users.

COMPANY ID: DIVLOG

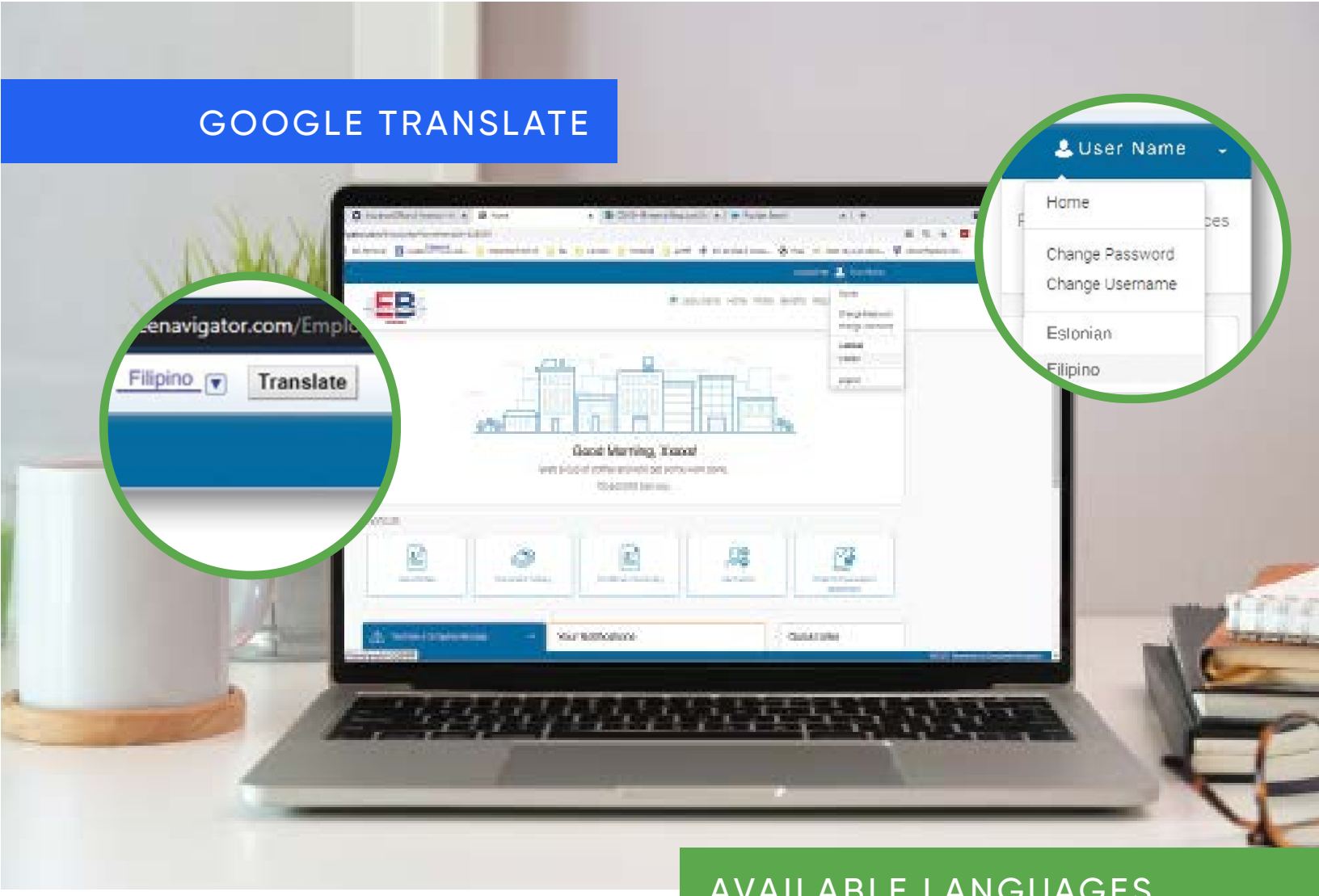
New Users

1. You will receive a Registration Email
2. Use the link in the email to create your Employee Navigator profile
3. Confirm and update personal information
4. Elect OR waive each line of coverage
5. Review Enrollment Summary
6. Click the Agree button

Returning Users

1. You will receive a Welcome Email
2. Login to ioa.employeenavigator.com
3. Confirm and update personal information
4. Elect OR waive each line of coverage
5. Review Enrollment Summary
6. Click the Agree button

GOOGLE TRANSLATE



AVAILABLE LANGUAGES

Afrikaans
Albanian
Amharis
Arabic
Armenian
Azerbaijani
Basque
Belarusian
Bengali
Bosnian
Bulgarian
Catalan
Cebuano
Chichewa
Chinese (simplified)
Chinese (traditional)
Corsican
Croatian
Czech
Danish
Dutch
Esperanto
Estonian
Filipino
Finnish
French
Frisian
Galician
Georgian
German
Greek
Gujarati
Haitian Creole
Hausa
Hawaiian
Hebrew
Hindi
Hmong
Hungarian
Icelandic
Igbo
Indonesian
Irish
Italian
Japanese
Javanese
Kannada
Kazakh
Khmer
Kinyarwanda
Korean
Kurdish (Kurmanji)
Kyrgyz
Lao
Latin
Latvian
Lithuanian
Luxembourgish
Macedonian
Malagasy
Malay
Malayalam
Maltese
Maori
Marathi
Mongolian
Myanman (Burmese)
Nepali
Norwegian
Odia (Oriya)
Pashto
Persian
Polish
Portuguese
Punjabi
Romanian
Russian
Samoan
Scots Gaelic
Serbian
Sesotho
Shona
Sindhi
Sinhala
Slovak
Slovenian
Somali
Spanish
Sundanese
Swahili
Swedish
Tajik
Tamil
Tatar
Telugu
Thai
Turkish
Turkmen
Ukrainian
Urdu
Uyghur
Uzbek
Vietnamese
Welsh
Xhosa
Yiddish
Yoruba
Zulu

employee NAVIGATOR

MEDICAL INSURANCE

MERITAIN AN AETNA COMPANY

Scan or Click the QR code to access the carrier's website >>>

IN-NETWORK MEDICAL BENEFITS	BASE 6500 NETWORK: AETNA CHOICE® POS II (OPEN ACCESS)	MID 2000 NETWORK: AETNA CHOICE® POS II (OPEN ACCESS)	BUY UP 250 NETWORK: AETNA CHOICE® POS II (OPEN ACCESS)
Deductible (Individual / Family)	$6,500/$13,000	$2,000/$6,000	$250/$750
Is Deductible Calendar Year or Policy Year?	Calendar Year	Calendar Year	Calendar Year
Is Deductible Embedded or Non Embedded	Embedded	Embedded	Embedded
Out of Pocket Maximum (Individual / Family)	$9,100/$18,200	$6,350/$12,700	$3,000/$6,000
Coinsurance	30%	30%	None
Prescription Drugs	$15 / < 20% or $50 to $200 max / 100% of negotiated rate	$10 / $50 / $80	$10 / $50 / $80
Mail Order Drugs (90 Day Supply)	$45 / < 20% or $150 to %500 max / 100% of negotiated rate	$30 / $150 / $240	$30 / $150 / $240
PHYSICIAN OFFICE VISITS			
Primary Care Physician	$35	$35	$20
Virtual Visits	$35 PCP / $65 SPC	$35 PCP / $65 SPC	$35 PCP / $65 SPC
Specialist	$65	$65	$45
Referral Needed for Specialist?	No	No	No
PREVENTIVE CARE			
Routine Adult Physical Exams Well Woman Exams Routine Mammograms and Colonoscopy Well Child Exam & Immunizations	Covered 100%	Covered 100%	Covered 100%
DIAGNOSTIC / LABORATORY			
Independent Clinical Lab (Blood Work)	$0	$0	$0
Independent Diagnostic Testing Facility (X-rays)	$0	$50	$50
Advanced Imaging (MRI, PET, CT Scan, Nuclear Medicine)	Deductible + Coinsurance	$300	$200
HOSPITALIZATION / OUTPATIENT SERVICES			
Inpatient Hospitalization (Facility)	Deductible, then Coinsurance	$100 *PAD + Ded, then Coin	$700 Per Admission
Outpatient Surgical Care (Hospital Facility)	Deductible, then Coinsurance	Deductible, then Coinsurance	$300 Per Occurrence
Ambulatory Surgical Center	Deductible, then Coinsurance	$ 250 Per Occurrence	$200 Per Occurrence
Emergency Room	$300 / Professional Fees: Ded + Coin	$300 / Professional Fees: Ded + Coin	$200 / Professional Fees: $50
Urgent Care	Office Visit: $60 / All Other Services: Deductible, then Coinsurance	Office Visit: $70 / All Other Services: Deductible + Coinsurance	Office Visit: $50 / All Other Services: Deductible + Coinsurance
OUT-OF-NETWORK MEDICAL BENEFITS			
Deductible (Individual / Family)	$10,000/$30,000	$6,000/$18,000	$1,000/$3,000
Out of Pocket Maximum (Individual / Family)	$20,000/$40,000	$13,000/$26,000	$6,000/$12,000
Coinsurance	50%	50%	50%
EMPLOYEE BI-WEEKLY (26) PAYROLL DEDUCTIONS			
Employee Only	$80.75	$180.28	$235.09
Employee + Spouse	$471.78	$616.94	$718.74
Employee + Child(ren)	$341.45	$471.40	$557.54
Employee + Family	$704.13	$876.41	$1,006.23

* PAD = Per Admission Deductible

This information summarizes the Diversified Logistics Management, Inc. Medical benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

EMPLOYER-PAID TELEMEDICINE

TELADOC

MERITAIN HEALTH
An Aetna Company

Reach a doctor 24/7
The Teladoc® solution

Teladoc is the on-demand healthcare solution that gives you the medical care you need, when you need it. You can talk to a doctor anytime, anywhere about non-emergent medical conditions.

Benefits of Teladoc $0 copay

- Saves time and money
- Quicker recovery from illness
- Convenient prescriptions
- Choice of consultation method
- Great health means peace of mind

With Teladoc, you can talk to a doctor 24/7/365 by phone, online video or mobile app. Use Teladoc for medical advice and care when:

- Your primary care doctor is not open.
- You are at home, traveling or do not want to take time off work to see a doctor.
- You need a prescription or refills*.

**Please note, there is no guarantee you will be prescribed medication.*

Highly qualified, experienced doctors

When you use Teladoc, your medical questions will be answered by a highly qualified doctor. Teladoc doctors are:

- Experienced—with an average of over 10–15 years in practice.
- Progressive—using the latest technology to provide excellent care.
- U.S. board certified and state licensed.
- Specially trained in telemedicine.

There's more than one way to reach a doctor

By phone. Just call **1.800.362.2667.**

Online. Simply request a video consultation online at **www.MyDrConsult.com.**

On the go. You can download the Teladoc mobile app by visiting the App Store or Google Play.

Common conditions treated:

- Allergies
- Bronchitis
- Cold/flu
- Headaches/migraines
- Eye/ear infection
- Rash/skin infections
- Sinus infections
- Stomachache/ diarrhea
- Urinary tract

Our members love Teladoc

"We had a good experience with the doctor. She called and talked to me, and gave great service. I had no problem picking up my prescription. This is a really good service."

Contact a Teladoc physician at **1.800.362.2667**, or by visiting **www.MyDrConsult.com**.

How to register for Teladoc

You can use Teladoc anywhere you have Internet access. Just:

1. Visit www.MyDrConsult.com and click *Set Up Account*.
2. Enter your name, date of birth, ZIP code, email address, preferred language and gender and click *Continue*. The system will identify you based on this information. If you're unable to be identified, you'll be directed to Teladoc Customer Service.
3. On the next screen, enter the required information and click *Set up my account.* Your registration is now complete!

Then, you can complete your profile by clicking on *My Medical History.* You can enter your history right after registering or you can come back to finish it later. By finishing it when you register, you'll be ready to request a consultation any time and you won't have to fill out your medical history when you're feeling sick.

If you have any questions, or run into any problems when setting up your account, call Teladoc at **1.800.DOC.CONSULT (1.800.362.2667)**.

TELADOC®

MERITAIN HEALTH
An Aetna Company

Your DocFind® Online Directory

Aetna Choice® Point of Service (POS) II

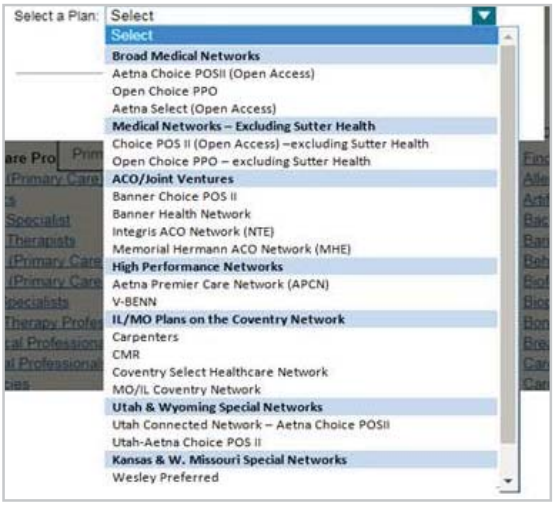
It's easy to find doctors and hospitals in your network

When you and your family need care, you can look for doctors and hospitals in the Aetna Choice POS II network. It's easy when you use the online DocFind directory from Aetna.* With up-to-date listings, you can search for providers by name, specialty, gender, hospital affiliations and more.

Find Aetna providers online in just a few quick steps

You can use the DocFind directory anywhere you have Internet access. Just:

1. Visit **http://www.aetna.com/docfind/custom/mymeritain**
2. Key in the type of provider or provider name, specialty, procedure or condition under *Who or what are you looking for?* and the desired geographical area under *Where?*. Click *Search*.
3. Choose ***Aetna Choice® POS II (Open Access)*** under *Select a Plan*.



Or

4. Click on one of the options listed under *Provider Types, Conditions or Procedures*. You will be prompted to key in the desired geographical area and select your plan (as shown in step three).
5. Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.
6. Narrow your search results by using the filters under *Narrow Your Results*. Choices include *Hospital Affiliations, Group Affiliations, Languages, Gender and Specialty.*
7. For more search tips, you can click on *Search Tips and FAQs* on the home screen.

If you have questions while searching for a doctor or hospital, simply click on the *Contact DocFind* link. It's at the top of any DocFind page. You'll be able to send a quick comment or question.

Find providers by phone

Need a provider when you're not near a computer? No problem. Simply call the Aetna Provider Line at **800.343.3140** from 8:00 a.m.–9:00 p.m. ET, Monday through Friday.

If you need more information, we're here to help. Just call Meritain Health at the number on the back of your ID Card.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates.*

Providers are independent contractors and are not agents of Aetna or Meritain Health. Provider participation may change without notice. Neither Aetna nor Meritain Health provides care or guarantees access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

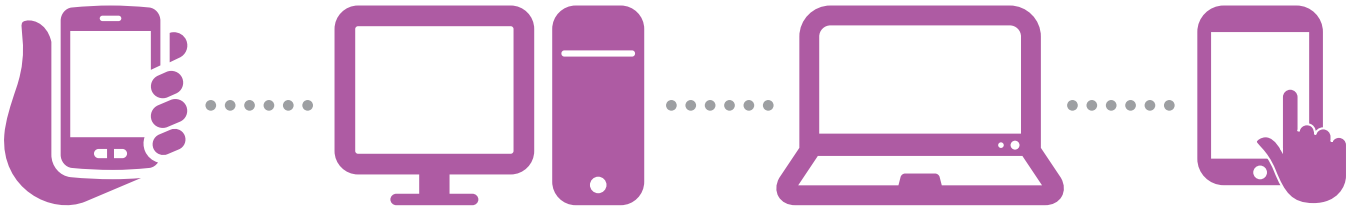
MERITAIN HEALTH
An Aetna Company

Healthcare Benefits Information at Your Fingertips

Introducing Mobile Capabilities for members

On-the-go access to your Meritain Health benefits

You can get benefits information when and where you need it—right from your smart phones and tablets. It's all part of our Mobile Capabilities for members from Meritain Health.



Easy to access and easy to use

1. **First, simply register for your mobile account through www.meritain.com.** (If you've already registered to access your personal information on myMERITAIN—you can skip this step. Simply log in to myMERITAIN through the browser on your smart device to access your account.) *
2. **From any mobile device, just log into myMERITAIN.** Once you do, your mobile features will be ready to use. You'll find quick-to-navigate displays you can easily use with your device's touch screen.

** For best results, we recommend you register for your mobile account using a desktop computer.*

If you have any questions about how to register or use Meritain Health's Mobile Capabilities, we can help. Simply call our customer service department using the phone number on your member ID Card.

Helpful benefits information

You can rely on Meritain Health's Mobile Capabilities for members if:

- You need to quickly find a doctor or hospital in your network.
- You're not near a computer and need to know your deductible or out-of-pocket amounts.
- You need to make a healthcare purchase but don't know your FSA or HRA balance.**
- You want to research a claim or take a look at an Explanation of Benefits (EOB) statement on the go.
- You want to download and view (.pdf) a copy of your ID Card.

You may not always be in front of your computer. But you'll always be able to find the healthcare information you need to help you get the most out of your healthcare benefits. It is one more way Meritain Health is working hard to help you be your healthiest self.

** *If applicable to your plan.*

www.meritain.com

5 Healthcare Options

to help you make the best decision for your medical needs

Virtual Visits $

24/7/365 access to a doctor through the convenience of phone or video consults

You can receive care for:

Cough, cold & flu • Allergies • Skin problems
• Sinus problems • Minor fevers

Convenience Care Clinic $

Your condition is not urgent or an emergency

You can receive care for:

Cough, cold & flu • Pink eye • Urinary tract infections
Ear infections • Head lice • Insect bites
Minor burns, cuts, and scrapes • Sprains and strains

Doctor's Office $$

Routine care or treatment for a current health issue

You can receive care for:

Routine checkups • Immunizations • Preventive services
Manage medications

Urgent Care Center $$$

You need medical care fast for a non-emergent medical issue

You can receive care for:

Migraines • Severe back pain • Vomiting and diarrhea
Minor broken bones • Asthma attacks • Severe cough
Animal bites • Wounds requiring stitches

Emergency Room $$$$

For a true medical emergency that results in serious jeopardy to your health, impairment of bodily functions or organs

You can receive care for:

Head trauma or loss of consciousness • Chest pain
Numbness or difficulty speaking • Severe abdominal pain
Coughing or vomiting blood • Severe bleeding and burns

WHAT IS A PREVENTIVE EXAM?

also called a "Physical," "Wellness Exam" or "Annual Exam"

A Preventive Exam is a scheduled medical evaluation of an individual that focuses on preventive care. It includes age and gender-appropriate history, a physical examination, a review of risk factors and plans to reduce them, and the ordering of appropriate immunizations, screening laboratory tests, ultrasound or diagnostic procedures.

What does this mean?

A Preventive Exam is an annual exam covering all prevention and health maintenance issues related to age, sex, and family history; it is a "Well Exam". A Preventive Exam is NOT a follow-up visit or a problem-based visit; it cannot be expected to deal with everything bothering you since your last visit.

A SECOND Service May Be Necessary

If time and the provider's judgment allow, new problems or chronic disease follow-up issues may be addressed as a SECOND service during a Preventive Exam visit.

NOTE: Your insurance plan may require a co-pay or apply charges to your deductible for a SECOND service provided during a Preventive Exam visit.

For more information on Preventive Health such as free services offered to you, visit www.hhs.gov/healthcare/about-the-aca/preventive-care/index

PRESCRIPTIONS RX

There are other sources to help cover the cost of antibiotics, HBP medicine, cholesterol, or supplies for diabetes.

MARK CUBAN CostPlus DRUG COMPANY

Works with or without insurance

Create an account at CostPlusDrugs.com and have your prescription from your provider submitted to CostPlusDrugs.com.

The prescription will be sent via mail if it is one they carry. You must determine this before submitting your prescription as availability changes frequently.

A complete list of drugs is available at CostPlusDrugs.com/medications

Mail order Rx

amazon pharmacy

Works with or without insurance

$5 per month

(For Prime members only)

You must create an account at amazon.com or use your current Amazon Prime membership. Your provider must submit your prescription to Amazon.

The prescription will be sent via mail if it is one they carry. You must determine this before submitting your prescription as availability changes frequently.

A complete list of drugs is available at pharmacy.amazon.com/how-it-works

Mail order Rx

GoodRx

Outside of Insurance - leverages coupons for your prescription drug up to 50% off.

You must download the app and create an account at GoodRx.com. The app is FREE!

The downfall of GoodRx purchases is they do NOT accumulate toward your deductible or OOP expense as they are not run through the insurance. The upside is you can generally go to local retail merchants that may already have your Rx on file or easily transfer it from another retail pharmacy (e.g. Walgreens to CVS, etc).

A complete list of drugs is available at goodrx.com or the GoodRx app.

Local Rx

DENTAL INSURANCE

MUTUAL OF OMAHA

Scan or Click the QR code to access the carrier's website >>>

BENEFITS SUMMARY Network	VOLUNTARY PPO Mutually Preferred		VOLUNTARY PPO TEXAS ONLY Mutually Preferred	
Annual Deductible(Individual/Family)	$50 / $150		$50 / $150	
Annual Benefit Maximum	$2,000		$2,000	
Orthodontia Lifetime Maximum	$1,000		$1,000	
Waiting Period	None		None	
Rollover	Included		Included	
Out-of-Network is MAC or UCR?	90th% UCR (Usual, Customary, and Reasonable)		MAC (Maximum Allowable Charge)	
	IN-NETWORK	OUT-OF- NETWORK	IN-NETWORK	OUT-OF- NETWORK
PREVENTATIVE SERVICES-DEDUCTIBLE WAIVED				
Oral Evaluations Prophylaxis: Cleanings Fluoride Treatment (child only) Bitewing X-rays, Full Mouth X-rays Sealants Space Maintainers	Plan pays 100%	Plan pays 80% of the 90th % UCR*	Plan pays 100%	Plan pays 100% of MAC**
BASIC SERVICES				
Amalgam Restorations (Silver Fillings) Resin Based Restorations (anterior and posterior) Extractions (routine and surgical) Endodontic Treatments Periodontic Treatments	Plan pays 90%	Plan pays 80% of the 90th % UCR*	Plan pays 90%	Plan pays 90% of MAC**
MAJOR SERVICES				
Crowns Dentures Bridges	Plan pays 60%	Plan pays 50% of the 90th % UCR*	Plan pays 60%	Plan pays 60% of MAC**
ORTHODONTIA SERVICES				
Diagnostics and Treatments	50%	50%	50%	50%

EMPLOYEE BI-WEEKLY (26) PAYROLL DEDUCTIONS		
Employee Only	$11.61	$8.99
Employee + Spouse	$23.76	$18.40
Employee + Child(ren)	$30.45	$22.56
Employee + Family	$42.84	$31.98

This information summarizes the Diversified Logistics Management, Inc. Dental benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

* Out-of-network services are subject to the 90th percentile of usual and customary charges (UCR). This means that the maximum payment for a covered service from an out-of-network provider is determined by the fees that 90% of providers in the given area charge or less.

** TEXAS ONLY - Out-of-network services are subject to the Maximum Allowable Charge (MAC) reimbursement. Both in-network and out-of-network benefits have coinsurance percentages, but all payments are based on the discounted PPO fees. When you use in-network providers, you benefit from PPO savings. However, if you seek out-of-network care, you may have to pay the difference between the discounted PPO fees and the out-of-network provider's regular charges for the services provided.

52536730

DENTAL INSURANCE

IT'S FAST AND EASY TO FIND A DENTIST

With Our Online Provider Directory

With our dental insurance, you have complete freedom to select the dentist of your choice either in network or out of network. However, you'll enjoy greater savings by selecting a dentist who is part of the network. The network currently has thousands of dentists nationwide, so chances are good there's a participating dentist near you.

Online Provider Search

You can find a dentist online quickly and easily.

1. Go to **MutualofOmaha.com/Dental**
2. Click on "**Find a Dentist**"
3. Select your **network**
4. Enter your **ZIP code** or **City and State** to find a provider near you
5. Optional search criteria include:
   - Specialty
   - Provider last name
   - Distance
   - Gender
   - Language
6. Save your results by exporting the provider list via email or print function.

Note: If your provider is listed in the directory and they indicate they are not contracted, please let us know. Contact our Dental Customer Service team at (800) 927-9197.

Contact A Provider

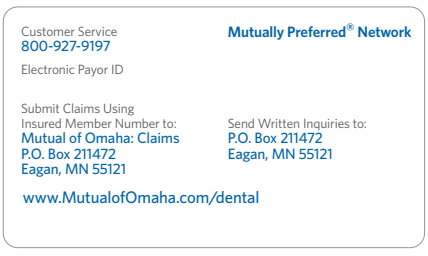
If you choose to call a provider directly, be sure to ask if they accept the Mutually Preferred Network powered by DenteMax Plus.

Dental Customer Service

If you have questions or need additional assistance during business hours, contact our service team at (800) 927-9197.

Your Dental ID Card

The name of your network is displayed in the upper right corner (back-side) of your dental ID card. See sample below.



Mutually Preferred®

MUTUAL of OMAHA

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

605388_0223

VISION INSURANCE

MUTUAL OF OMAHA

Scan or Click the QR code to access the carrier's website >>>

BENEFIT SUMMARY Network	IN-NETWORK EyeMed	FREQUENCY
Eye Examination	$10	12 Months
Materials Copay	$25	
Eyeglass Frames	Up to $130 allowance; 20% off balance	24 Months
STANDARD EYEGLASS LENSES		
Single Vision	Covered 100% after $25 Copay	12 Months
Bifocal	Covered 100% after $25 Copay	
Trifocal	Covered 100% after $25 Copay	
CONTACT LENSES (IN LIEU OF EYEGLASSES)		
Elective	Up to $130 allowance, 15% off balance for conventional lenses.	12 Months
Medically Necessary	Covered 100% after $25 Copay	

EMPLOYEE BI-WEEKLY (26) PAYROLL DEDUCTIONS	
Employee Only	$2.66
Employee + Spouse	$5.34
Employee + Child(ren)	$5.06
Employee + Family	$7.97

This information summarizes the Diversified Logistics Management, Inc. Vision benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

Elective Contact Lenses are in lieu of glasses (lenses & frames). You are not eligible for glasses under our plan until 12 months after you receive contacts and vice versa.

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VISION INSURANCE

Online Reference Guide for Plan Members

You have a great vision insurance plan. Now learn how you can make full use of our vision plan website to ensure proper vision health for you and your family.

With online access you can:

- View benefits information
- View claims history and Explanation of Benefits
- Locate a provider
- Access forms or submit a claim online

Getting Started

- Log on to MutualofOmaha.com/vision
- Click on "View my vision benefits"
- Click the "Need to Register?" button – enter your name, date of birth, member ID number (located on your member ID card) or the last four digits of your Social Security Number (if provided by your employer), zip code and email address and follow the instructions to select your username and password

Logging On

- Go to MutualofOmaha.com/vision
- Click on "View my vision benefits"
- Enter your username and password
- Click the "Login" button

Online Tools and Resources

View your benefits

- Coverage, effective dates, and benefit frequency
- Dependents included in the plan
- Benefits used by you and your dependents
- Print ID cards
- Special Offers
- Know Before You Go cost estimator tool

Access a claim form

If you visit an out-of-network provider, you will have to pay for services out-of-pocket and submit a claim form located in the "Claims" section.

Find a provider

Once you've created an account and signed in, click "Provider Locator." From here, you can search by ZIP code or "use my location" to find a provider near you.

Customer Service

833-279-4358

Download the EyeMed Members App on your iPhone, iPad or Android to view benefit information and ID card.

Mutual of Omaha
Protect Your Kingdom

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A Mutual of Omaha Company

55611041

VISION INSURANCE

MOBILIZE YOUR VISION BENEFIT

Mutual of Omaha has partnered with EyeMed Vision Care to offer an app that helps you get the most from your vision benefit experience — anytime, anywhere.

Features of the EyeMed app include:

- Benefits and eligibility
- Claims tracking
- Special offers to help you save more
- Provider locator to find in-network eye doctors
- Digital ID card
- Upcoming exam reminders
- Contact lens replacement reminders
- Wellness interactives to help you see better and live healthy
- Facial Recognition, Touch ID and Apple Wallet for Apple users
- Helpful FAQs

To access and use the app, simply:

1. Search **EyeMed** in the App store, iTunes or Google Play and download the app to your mobile device.
2. Register using your member ID.
3. If you've already registered an account on the Mutual of Omaha vision member website, log onto the app using the same account information.

Questions?

Call or visit **mutualofomaha.com/vision** to learn more.

POWERED BY EyeMed

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United of Omaha Life Insurance Company
A Mutual of Omaha Company

Vision insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, (800) 769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number G2018MP or state equivalent. Some exclusions and limitations may apply.

631471

EMPLOYER-PAID BASIC LIFE AND AD&D INSURANCE

MUTUAL OF OMAHA

BENEFITS SUMMARY

LIFE BENEFIT AMOUNT
$15,000

AD&D BENEFIT AMOUNT
$15,000

BENEFITS WILL REDUCE BY:
65% at age 65 50% at age 70

Scan or Click the QR code to access the carrier's website >>>

Group Basic Life insurance helps protect your loved ones from financial hardships related to an untimely death.

Cash benefit paid to your beneficiary in the event of your death.

Cash benefit if you suffer a covered loss in an accident, such as losing a limb or eyesight.

You **MUST** designate your beneficiary(ies) in Employee Navigator, your online benefits portal.

Designating your beneficiary ensures your beneficiary will receive the benefit instead of it going into probate.

This information summarizes the Diversified Logistics Management, Inc. Basic Life and AD&D benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

VOLUNTARY LIFE AND AD&D INSURANCE

MUTUAL OF OMAHA

Scan or Click the QR code to access the carrier's website >>>

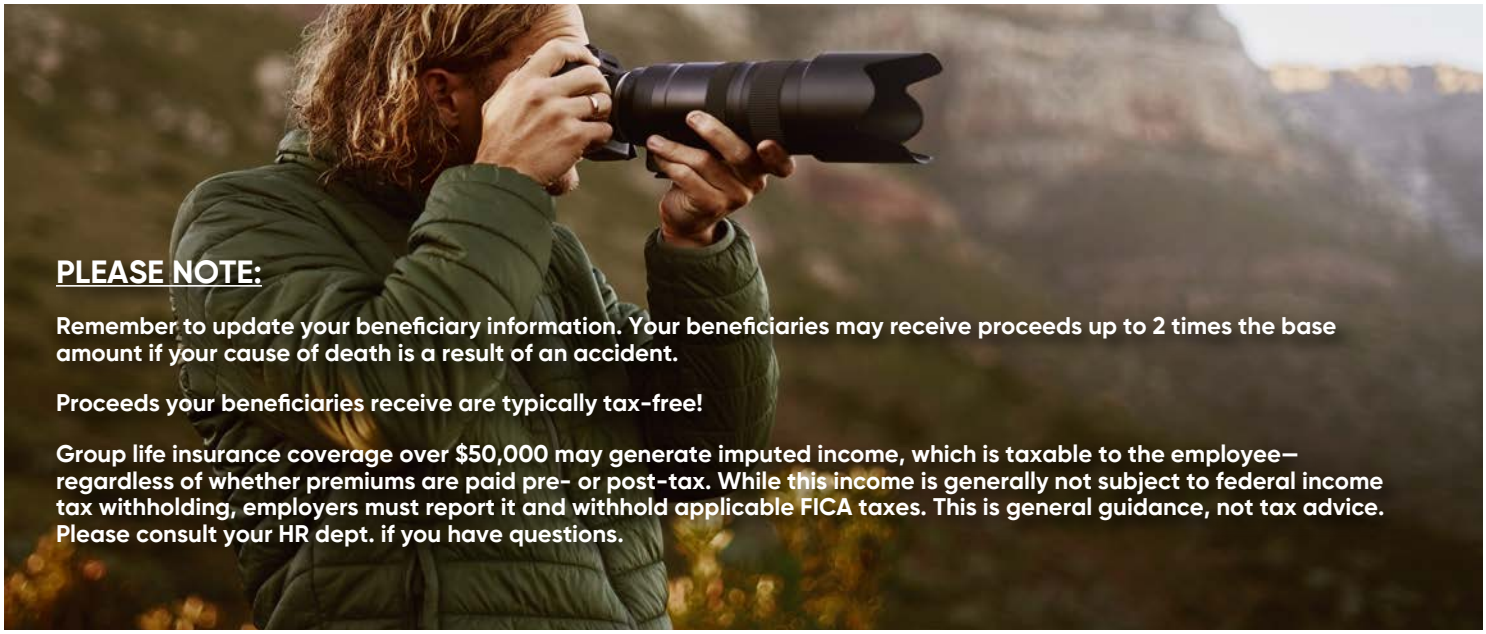
BENEFITS SUMMARY

EMPLOYEE LIFE BENEFIT	SPOUSE LIFE BENEFIT	CHILD LIFE BENEFIT
Benefit Increment: $10,000	Benefit Increment: $5,000	Benefit Increment: $5,000
Minimum Benefit: $10,000	Minimum Benefit: $5,000	Minimum Benefit: $5,000
Maximum Benefit: 10x annual salary, up to $500K	Maximum Benefit: 100% of EE amount up to $250K	Maximum Benefit: $10,000
Guarantee Issue Amount: 10x annual salary, up to $100K	Guarantee Issue Amount: 100% of EE amount up to $25K	Guarantee Issue Amount: $10,000

Payroll Deductions are displayed in Employee Navigator, your online benefits portal

If electing this plan during open enrollment or as a new hire, you may elect up to the guaranteed issue amount without submitting Evidence of Insurability (a record of a person's past and current health events)

BENEFIT REDUCTION
35% at age 65 50% at age 70



*This information summarizes the Diversified Logistics Management, Inc. Voluntary Life benefits and AD&D plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

SHORT-TERM DISABILITY INSURANCE (STD)

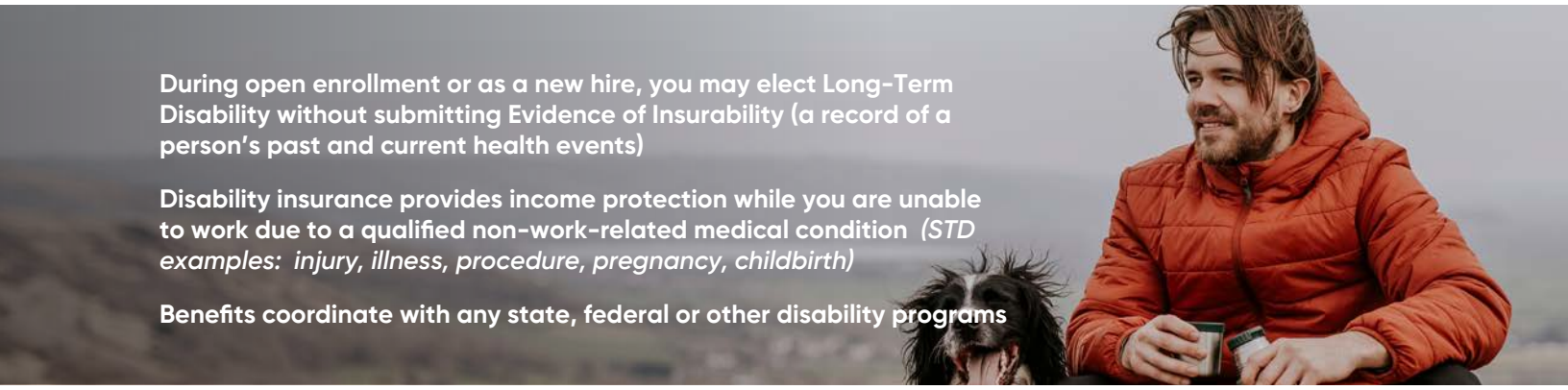
MUTUAL OF OMAHA

Scan or click the QR code to access the carrier's website >>>

Payroll Deductions are displayed in Employee Navigator, your online benefits portal

BENEFITS SUMMARY

Elimination period for accident	7 days
Elimination period for illness	7 days
Benefit duration	13 weeks
Benefit percent	60% of weekly salary
Benefit maximum	Up to $1,000 per week
Pre-existing conditions	3/6 Pre-Existing Condition is an illness or injury for which you have received treatment for a condition within 3 months before your effective date under this policy, until you have been covered under the policy for 6 months



During open enrollment or as a new hire, you may elect Long-Term Disability without submitting Evidence of Insurability (a record of a person's past and current health events)

Disability insurance provides income protection while you are unable to work due to a qualified non-work-related medical condition *(STD examples: injury, illness, procedure, pregnancy, childbirth)*

Benefits coordinate with any state, federal or other disability programs

LONG-TERM DISABILITY INSURANCE (LTD)

NEW

MUTUAL OF OMAHA

Scan or click the QR code to access the carrier's website >>>

Payroll Deductions are displayed in Employee Navigator, your online benefits portal

BENEFITS SUMMARY

Elimination period	90 days
Benefit amount	60% of monthly salary
Benefit maximum	Up to $6,000 per month
Duration of benefits	Social Security Normal Retirement Age as long as you remain disabled
Definition of disability	24 months own occupation
Pre-existing conditions	3/12 Pre-Existing Condition is an illness or injury for which you have received treatment for a condition within 3 months before your effective date under this policy until you have been covered under the policy for 12 months

This information summarizes the Diversified Logistics Management, Inc Disability benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

VOLUNTARY ACCIDENT INSURANCE

MUTUAL OF OMAHA

524578

Accident Insurance

If you broke a leg, would it break your bank account?

Although accidents are unexpected and usually come without warning, you don't have to let an injury catch you off guard. You can be prepared to handle the accompanying medical expenses with the help of an accident insurance policy.

Accident insurance pays a lump-sum cash benefit for injuries you or an insured family member sustain as a result of an accident. Because accident insurance is supplemental, it works in addition to other insurance you may have. The cash benefit can be used to:

- Fill a gap left by other coverage
- Supplement daily living expenses
- Cover lost income from unpaid time off

With accident insurance, you won't have to worry about how you will pay for care, and your savings can be protected.

How Much Accident Insurance Is Enough?

Treating a serious injury usually involves non-covered medical expenses such as deductibles, copays, medical supplies, prescriptions and physical therapy costs, to name just a few.

Consider these expenses:

Medical Example: Broken Leg*

- Emergency Room Visit: $1,000-$2,000 (includes temporary cast)
- Crutches: Up to $100
- Cast Application: $221
- Physical Therapy: $50-$75 per hour for six to eight weeks

**These expenses are for illustration purposes only. Expenses may vary by injury, state or provider.*

Enroll for group accident insurance and gain peace of mind knowing you and your family are protected in the event of an accident.

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VOLUNTARY CRITICAL ILLNESS INSURANCE

MUTUAL OF OMAHA

52457

Critical Illness Insurance

(Specified Disease Insurance in Some States*)

An unexpected critical illness can have a lasting impact on you and your family — physically, emotionally and financially.

An unexpected critical illness such as heart attack, stroke and cancer often comes without warning and may have lasting effects on you and your family. Fortunately, with all the advances in medicine today, your chances of recovering from critical illnesses like these have significantly improved. But could you recover financially?

Even if you have the best health insurance plan available, it will not cover 100 percent of medical expenses. You also need to consider other expenses associated with the recovery process — time off work, travel expenses, home modifications — that may quickly deplete your savings. The financial impact of an illness is real ... and Critical Illness insurance can help.

How does it work?

A Critical Illness insurance policy (known as Specified Disease insurance in some states*) provides a lumpsum cash benefit upon the diagnosis of a critical illness. This benefit can be used to pay out-of-pocket medical expenses or help supplement your daily living expenses. It takes care of your bills so you can focus on what's most important — recovery.

How much is enough?

The amount of Critical Illness insurance you need depends on your current situation and the expenses you may incur if diagnosed with a serious illness. Consider the following:

ANTICIPATED OUT-OF-POCKET EXPENSES	
Home health care needs	$_____
Out-of-pocket medical expenses expected (deductible or out-of-pocket max)	$_____
Travel to treatment centers	$_____
Family travel	$_____
Child or adult care	$_____
Subtotal	$_____
MODIFICATIONS TO ACCOMMODATE LIFESTYLE	
Home alteration	$_____
Car modification	$_____
Other (Estimated cost associated with modifying a home and/or vehicle.)	$_____
Subtotal	$_____
INCOME	
Your lost income (due to time off work)	$_____
Lost income of a spouse or caregiver	$_____
Subtotal	$_____
TOTAL CRITICAL ILLNESS INSURANCE NEEDED	
Out-of-Pocket Expenses + Modifications + Lost Income = Total Need for Critical Illness Insurance	$_____

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Critical Illness insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ 2010 or state equivalent. Known as Specified Disease insurance in CT, NC and NY*. Some exclusions, limitations and reductions may apply. For a list of exclusions, limitations, and reductions, visit www.mutualofomaha.com/disclosure/critical-illness.

619557

VOLUNTARY HOSPITAL INDEMNITY INSURANCE

MUTUAL OF OMAHA

5245785

Hospital Indemnity Insurance

When Hospitalized, Expenses Can Add Up Quickly

When admitted or confined to the hospital not only can it be stressful, but expenses can add up quick and can catch you off guard. With a hospital indemnity insurance policy from United of Omaha Life Insurance Company, you can be better prepared to handle the accompanying medical expenses and daily living expenses.

Hospital indemnity insurance pays a fixed dollar benefit amount when you or an insured dependent are admitted or confined to a hospital. Because hospital indemnity insurance is supplemental and not major medical insurance, it works in addition to other insurance you may have. The cash benefit can be used to:

- Help pay for services your other insurance plans may not cover
- Help you pay for deductibles and copays
- Supplement your daily living expenses
- Cover your lost income from unpaid time off

How Much Hospital Indemnity Insurance Is Enough?

Hospital admission and confinement usually involve noncovered medical expenses such as deductibles, copays, medical supplies, prescriptions and more.

Why United of Omaha Life Insurance Company?

We consistently earn high ratings from leading independent rating agencies. The company holds an A+ (Superior)* rating from A.M. Best Company. The Superior rating is the second highest of 16 ratings and reflects the organization's ability to meet the financial obligations of its policyholders.

**As of 11/23*

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United of Omaha Life Insurance Company
A Mutual of Omaha Company

The information describes some of the features of your group hospital indemnity plan. Benefits may not be available in all states. Please refer to the certificate booklet for a fullexplanation of the plan's benefits, exclusions, and limitations. Should there be any discrepancy between the certificate booklet and this document, the certificate booklet will prevail. Hospital indemnity coverage is not major medical insurance.

The IRS limits the types of supplemental insurance that an individual who participates in a Health Savings Account (HSA) may have, while still maintaining the tax-exempt status of HSA contributions. The IRS allows additional insurance that provides benefits for "a fixed amount per day (or other period) of hospitalization." Anyone who has or plans to open an HSA, should consult tax and legal advisors to determine which supplemental benefits may be purchased by employees with an HSA.

Hospital indemnity insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide except in New York. Policy form number G2018MP or state equivalent (G2018MP NC). Some exclusions, limitations and restrictions may apply and may not be available in all states.

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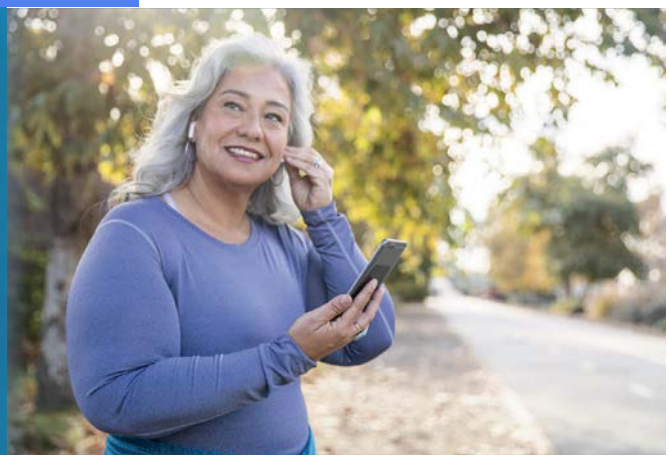
EMPLOYEE ASSISTANCE PROGRAM – EAP

MUTUAL OF OMAHA

435390

Employee Assistance Program

Available Services When You Need Help the Most



Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Continued on back.

Mutual of Omaha

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Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources – legal libraries, tools and forms – available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney • 25% discount for ongoing financial services for same issue
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

EMPLOYEE BENEFITS

Accessing Claims Online Using the Employee Portal

Managing claims shouldn't be difficult. Mutual of Omaha always has our customers in mind, which is why we created our Employee Portal to allow for easy claims access.

Our Employee Portal gives your employees the capability to view current claims, submit new claims, report paid family and medical leave time, and download forms all from one location.

Getting Started

1. Go to www.mutualofomaha.com/my-benefits.
2. Register for an account by filling out the necessary information. Click on Register.
3. Users will be notified when they have completed the first step of creating an account.
4. An email will be sent with the final steps to finish setting up an account.

Already have an account? Log in with your credentials.

How to View Current Claims

- To access current claims, log in and click on the "Claims" icon*
- View a specific claim and its status, along with the claim number for accident, critical illness, hospital indemnity, life, and short-term disability.

***PLEASE NOTE:** The "Claims" icon will only be shown if a claim has been filed. If there are no existing claims, the icon will not appear.

Submitting a Claim Form Online

A claim form can be submitted online by clicking on the "Submit claim" icon on the Employee Portal homepage.

- On the forms page, select "I am a Plan Member (Employee)" and choose the relevant state.
- Select the necessary form, then select "Complete form online."

Forms can be submitted via fax or mail by clicking the "Claims forms" icon and downloading the form.

***PLEASE NOTE:** Microsoft Edge, Google Chrome and/or Firefox are the preferred internet browsers to use when accessing the portal.

Mutual of Omaha

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TERMS TO KNOW

SCAN OR CLICK THE QR CODE TO WATCH A SHORT VIDEO ON THE TERM YOU WOULD LIKE TO KNOW

AD&D: Accidental Death & Dismemberment

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

CREDITABLE: Is the prescription drug coverage offered by an employer plan that pays, on average, the same amount as Medicare pays.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

ELIMINATION PERIOD: This is the time period between injury or illness and the receipt of benefit payments.

EMBEDDED DEDUCTIBLE: An embedded deductible is a system that combines individual and family deductibles in a family health insurance policy. When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible in order for after-deductible benefits to kick in, each individual only needs to meet the individual deductible in order for after-deductible benefits to kick in.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EVIDENCE OF INSURABILITY (EOI): This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

IN-NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAC: Maximum allowable charge

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

NON-EMBEDDED DEDUCTIBLE: A non-embedded deductible is also referred to as an aggregate deductible. Under an aggregate deductible, the total family deductible must be paid out-of-pocket before after-deductible benefits kick in for the health care services incurred by any family member.

OUT-OF-NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

OUT-OF-POCKET MAXIMUM: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

UCR: Usual, customary, reasonable

MANDATORY NOTICES

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

Important Notice:
Medicare Part D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Diversified Logistics Management, Inc** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Diversified Logistics Management, Inc** has determined that the prescription drug coverage offered by the Base 6500, Mid 2000, and Buy Up 250 plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and the group plan will be your primary coverage and Medicare will be your secondary coverage.

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your re-enrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be canceled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage under the group plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Important Notice:
Medicare Part D Creditable Coverage Disclosure

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact your Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if the group plan coverage changes. You also may request a copy of this notice at any time.

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. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Contact Human Resources for more information:

Diversified Logistics Management, Inc

Allen Barcus

1849 S 14th St, Ste. 2 Fernandina Beach, FL 32034

abarcus@div-log.com

904-491-6800

For questions about Medicare prescription drug coverage,

Grace Agency is here to help.

800-791-4840 | info@graceagency.org

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HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact Human Resources.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Model General Notice of COBRA Continuation of Coverage Rights

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit
https://www.medicare.gov/medicare-and-you

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

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KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Plan and COBRA continuation coverage can be obtained on request:

Diversified Logistics Management, Inc

Allen Barcus

1849 S 14th St, Ste. 2 Fernandina Beach, FL 32034

abarcus@div-log.com

904-491-6800

Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.
Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Women's Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

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 (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. Therefore, the deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

Newborns' and Mothers' Health Protection Act

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

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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).

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 March 17, 2025. Contact your State for more information on eligibility –

State Contacts

ALABAMA – Medicaid

Website: myalhipp.com | Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program - dhcs.ca.gov/hipp
Phone: 916-445-8322 | Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: www.in.gov/medicaid
www.in.gov/fssa/dfr
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: www.kancare.ks.gov
Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

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:
www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: mn.gov/dhs/health-care-coverage
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website:
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

Website: 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 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

State Contacts

NEW JERSEY - Medicaid and CHIP

Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK - Medicaid

Website: www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: www.eohhs.ri.gov
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
Website: medicaid.utah.gov/upp
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: medicaid.utah.gov/expansion
Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program CHIP Website: chip.utah.gov

VERMONT– Medicaid

Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: dhhr.wv.gov/bms
mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid

Website: 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 March 17, 2025, 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.

OMB Control Number 1210-0137 (expires 1/31/2026)

CONTACTS

LINE OF COVERAGE	CARRIER	CUSTOMER SERVICE
Medical	MERITAIN HEALTH AN AETNA COMPANY	800-925-2272 www.meritain.com
Telemedicine	TELADOC	800-362-2667 www.MyDrConsult.com
Provider Search (Docfind)	MERITAIN HEALTH	800-343-3140 www.aetna.com/docfind/custom/mymeritain NETWORK: AETNA CHOICE® POS II (OPEN ACCESS)
Dental	MUTUAL OF OMAHA - Mutually Preferred	800-927-9197 www.mutualofOmaha.com/dental
Vision	MUTUAL OF OMAHA - EyeMed	833-279-4358 www.mutualofomaha.com/vision
Employer Paid Basic Life and AD&D	MUTUAL OF OMAHA	800-228-7104 www.mutualofomaha.com
Voluntary Life & AD&D	MUTUAL OF OMAHA	800-228-7104 www.mutualofomaha.com
Short Term Disability (STD)	MUTUAL OF OMAHA	800-228-7104 www.mutualofomaha.com
Long Term Disability (STD)	MUTUAL OF OMAHA	800-228-7104 www.mutualofomaha.com
Voluntary Supplemental Insurance Accident, Critical Illness, Hospital Indemnity	MUTUAL OF OMAHA	800-228-7104 www.mutualofomaha.com
Employee Assistance Program (EAP)	MUTUAL OF OMAHA	800-316-2796 www.mutualofomaha.com/eap

INSURANCE OFFICE OF AMERICA

For assistance with benefits questions, membership card issues, claims, and billing inquiries please contact one of your IOA service team members per the contact information below:

NAME - TITLE	PHONE	EMAIL
Lindsey Malotte *Senior Account Associate*	904-596-2850	Lindsey.Malotte@ioausa.com
Christina Summerell *Account Executive*	904-596-2844	Christina.Summerell@ioausa.com

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