HM CLAUSE

SEASONAL 2025-2026 BENEFIST AT A GLANCE

This summary provides a brief overview of the employee benefits provided to eligible employees, generally Seasonal employees working a minimum of 30 hours per week. These benefits are effective 7/1/2025 – 6/30/2026. Eligible dependents include your spouse or domestic partner and children up to age 26. Disabled dependents age 26 and over are eligible for coverage if approved by Blue Shield.

Refer to the Benefit Summary for additional details on eligibility, benefit coverage details, and plan limits. Summary can be found on **www.ourbenefitsinfo.com.**

BENEFIT	COVERAGE OPTIONS
MEDICAL	· **Blue Shield EPO (California Only)** – Plan pays 100% for most covered services after deductible of $250 per individual / $500 per family. Preventive care is covered at 100% with no deductible. Office Visits, Telemedicine, Chiropractic and Urgent Care are copays only, no deductible.*** **Blue Shield Standard PPO** – Plan pays 90% for most covered services after deductible of $250 per individual / $500 per family. Preventive care is covered at 100% with no deductible. Office Visits, Telemedicine and Urgent Care are copays only, no deductible*** **Blue Shield Choice PPO** – Plan pays 80% for most covered services after deductible of $1,500 per individual / $3,000 per family. Preventive care is covered at 100% with no deductible. Office Visits, Telemedicine and Urgent Care are copays only, no deductible *** · **Blue Shield HSA PPO** – Plan pays 80% for most covered services after deductible of $1,650 employee coverage / $3,300 per family. One or all individuals on Family Plan must satisfy the **entire family deductible** before the plan begins to pay benefits. Deductible can be offset by HSA funds. Preventive care is covered at 100% with no deductible. Office Visits, Telemedicine, Urgent Care, and Prescription Drugs are subject to deductible before the plan begins to pay 80%.*** ****In-network services only*
DENTAL	· **Delta Dental PPO** – Provides services for Preventive, Basic and Major dental care up to $2,000 per individual per year. Includes orthodontia for adults and children up to a lifetime maximum of $1,500. *** *** *In-network PPO Providers only.* · **Delta Dental DHMO (California Only)** – Provides services for Preventive, Basic and Major dental care up to Unlimited per year. Benefits subject to scheduled copays. Includes orthodontia. *** DeltaCare USA network providers must be used.
VISION	· **VSP Vision** – Includes an annual eye exam (100%) *** and lenses once every 12 months from last date of service. Frame and Contacts in lieu of glasses have a $150 allowance and are allowed once every 12 months from the last day of service. .*** *In-network Providers only.*
DISABILITY	· **Short Term Disability (SDI)** – Replaces 60% of covered weekly earnings (maximum $1,500 per week) up to 13th week of disability. Benefits begin after 7 days due to non-work related injury or illness. · Enrollment in company short term disability is automatic in all states **EXCEPT** for CA, HI, NY, RI, and NJ. Employees in these states have access to Short Term Disability through programs outside the company, with benefits varying from state to state.
EMPLOYEE ASSISTANCE PROGRAM (EAP)	The Employee Assistance Program (EAP) provides no-cost, confidential counseling and support for a wide range of personal issues, such as stress and emotional health; substance abuse; parenting and child or elder care; financial coaching; legal consultation; and more. Provided by Health Advocate.

BENEFIT COVERAGE OPTIONS	
HEALTH SAVINGS ACCOUNT (HSA)	· **This account is optional if Blue Shield HSA PPO is elected.** · Individual Coverage – Contribute up to $4,300 for 2025 · Family Coverage – Contribute up to $8,550 for 2025 Enrolled employees age 55+ can contribute an additional $1,000 for both Individual and Family Coverage.
401(k) RETIREMENT SAVINGS PLAN	· Contribute up to 70% into your 401 (k) annually, subject to Federal annual maximums. · Dollar for dollar employer match up to the first 6% of your income. (2-year vesting schedule) · Supplemental employer contribution up to an additional 7%. (4-year vesting schedule)
HOLIDAYS	Eligibility for holiday pay is available only if you work the regularly scheduled workday immediately before and after the holiday. 12 holidays per year + 1 Floating Holiday · New Year's Day (Jan) □ MLK Jr. Day (Jan) · President's Day (Feb) □ Spring Holiday (Apr) · Memorial Day (May) □ Independence Day (Jul) · Labor Day (Sep) □ Veterans Day (Nov) · Thanksgiving (Nov) □ Day After Thanksgiving (Nov) · Christmas Eve (Dec) □ Christmas Day (Dec) · Floating Personal Holiday

YOUR BENEFIT COSTS

DENTAL & VISION

DELTA DENTAL PPO	Per Pay Period	Monthly	Annually
EMPLOYEE ONLY	$7.00	$14.00	$168.00
EMPLOYEE + SPOUSE	$15.00	$30.00	$360.00
EMPLOYEE + CHILDREN	$13.00	$26.00	$312.00
EMPLOYEE + FAMILY	$21.00	$42.00	$504.00

DELTA DENTAL DHMO (CA ONLY)	Per Pay Period	Monthly	Annually
EMPLOYEE ONLY	$3.09	$6.18	$74.16
EMPLOYEE + SPOUSE	$6.18	$12.36	$148.32
EMPLOYEE + CHILDREN	$6.18	$12.36	$148.32
EMPLOYEE + FAMILY	$9.27	$18.54	$222.48

VSP VISION	Per Pay Period	Monthly	Annually
EMPLOYEE ONLY	$2.75	$5.50	$66.00
EMPLOYEE + SPOUSE	$6.50	$13.00	$156.00
EMPLOYEE + CHILDREN	$5.50	$11.00	$132.00
EMPLOYEE + FAMILY	$8.75	$17.50	$210.00

This 2025-2026 Benefits at a Glance is an overview of benefits effective from 7/1/25 through 6/30/26 and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents or summary plan descriptions (SPDs). The plan documents and SPDs determine how all benefits are paid.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify HM.CLAUSE, Inc. if your domestic partner is your tax dependent.

YOUR BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, your wellness rate eligibility. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

Medical

	Wellness Rates			Non-Wellness Rates		
BLUE SHIELD EPO PLAN (CA ONLY)	**Per Pay Period**	**Monthly**	**Annually**	**Per Pay Period**	**Monthly**	**Annually**
EMPLOYEE ONLY	$81.21	$162.43	$1,949.12	$116.02	$232.04	$2,784.53
EMPLOYEE + SPOUSE	$182.98	$365.95	$4,391.40	$261.39	$522.78	$6,273.32
EMPLOYEE + CHILDREN	$167.22	$334.44	$4,013.24	$238.88	$477.76	$5,733.10
EMPLOYEE + FAMILY	$261.77	$523.54	$6,282.51	$373.96	$747.93	$8,975.15
BLUE SHIELD STANDARD PPO PLAN	**Per Pay Period**	**Monthly**	**Annually**	**Per Pay Period**	**Monthly**	**Annually**
EMPLOYEE ONLY	$78.25	$156.50	$1,878.03	$111.79	$223.57	$2,682.84
EMPLOYEE + SPOUSE	$179.52	$359.03	$4,308.38	$256.45	$512.90	$6,154.85
EMPLOYEE + CHILDREN	$163.35	$326.69	$3,920.29	$233.35	$466.70	$5,600.39
EMPLOYEE + FAMILY	$255.98	$511.96	$6,143.52	$365.69	$731.38	$8,776.62
BLUE SHIELD CHOICE PPO PLAN	**Per Pay Period**	**Monthly**	**Annually**	**Per Pay Period**	**Monthly**	**Annually**
EMPLOYEE ONLY	$51.31	$102.62	$1,231.50	$73.31	$146.61	$1,759.33
EMPLOYEE + SPOUSE	$117.04	$234.09	$2,809.05	$167.20	$334.41	$4,012.92
EMPLOYEE + CHILDREN	$106.62	$213.25	$2,558.98	$152.32	$304.64	$3,655.67
EMPLOYEE + FAMILY	$167.67	$335.35	$4,024.14	$239.53	$479.07	$5,748.81
BLUE SHIELD HSA PPO PLAN	**Per Pay Period**	**Monthly**	**Annually**	**Per Pay Period**	**Monthly**	**Annually**
EMPLOYEE ONLY	$41.65	$83.30	$999.60	$59.50	$119.00	$1,428.00
EMPLOYEE + SPOUSE	$97.30	$194.60	$2,335.20	$139.00	$278.00	$3,336.00
EMPLOYEE + CHILDREN	$88.20	$176.40	$2,116.80	$126.00	$252.00	$3,024.00
EMPLOYEE + FAMILY	$130.90	$261.80	$3,141.60	$187.00	$374.00	$4,488.00

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