Benefits Enrollment Guide

2026 Plan Year

WHAT'S INSIDE?

How Your Benefits Work • Your Insurance Plans • Benefits Enrollment

Dear Employee:

Huggin' Molly's, Inc. (Huggin' Molly's) is committed to providing its employees with a comprehensive and market competitive benefits program. Our ongoing goal first and foremost is to maintain an employee benefits program that delivers high quality healthcare at an affordable price both to you and to Huggin' Molly's. Your benefits are a significant and valuable part of your compensation and we believe it is important for you to clearly see the value in the benefits we offer.

Your benefits with Huggin' Molly's will become effective the first of the month following date of hire.

The Huggin' Molly's Benefits Guide has been designed to assist you in determining the coverage levels that will provide you and your family with the protection that gives you peace of mind. You will find explanations for each type of coverage, suggestions on how to effectively use your benefits, and examples to help you determine your benefit and payroll deduction amounts.

Please note it is mandatory that you record your beneficiary information during the enrollment process in UKG.

Thank you for your cooperation.

Human Resources
334-585-2291
hris@yellawood.com

Changing Coverage During the Year

You can change your coverage during the year only when you experience a qualified change in status, such as:

- Marriage, divorce, or legal separation
- Birth, adoption, or a child placed with you for adoption
- Start or stop of adoption proceedings
- Change in your child's dependent status
- Death of your spouse or child
- Change in your spouse's benefit or employment status
- Loss or gain of coverage

Qualifying life events must be entered in UKG within 30 days of the event. Supporting required documentation must be uploaded into UKG within 60 days of event to prevent your coverage from being removed.

Medicare Part D Notice (page 41-42)

Table of Contents

If You are a New Employee

You and your eligible family members can participate in the benefits package first of the month following date of hire.

Who can enroll?

You are eligible to participate in Huggin' Molly's plans if you are an active full-time employee and regularly work 30 or more hours per week. Certain dependents of eligible employees can enroll in the medical, dental, vision, and voluntary life insurance plans.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in Huggin' Molly's medical, dental, or vision plans within 30 days after your other coverage ends.

About Your Payroll Deductions

Your premiums for Medical, Dental, and Vision plans as well as your Flexible Spending Account elections will be deducted on a pre-tax basis because they are covered under Section 125 of the Internal Revenue Service code. This means that once you elect to enroll in any of these plans, you will not be allowed to drop or change your election until the Company's next Open Enrollment unless you have a qualifying event. Your voluntary life insurance premiums will be deducted on an after-tax basis.

Employees who enroll in direct deposit will receive their first check in the form of a paper check delivered to their location. Employees choosing to elect a paycard will have one delivered to their work location. Please contact payroll for any questions.

Employees can contact the HR Team with any questions by emailing HRIS@yellawood.com or calling 334-585-2291.

We have partnered with Prepare Benefits to assist in your benefit enrollment. To schedule an appointment with them, please call 404-369-5317.

Other Benefits

Vacation:
- Vacation days are added on January 1st of each year
- Maximum of 5 days after one year employment

Note: Vacation may be taken in full or half day increments, and vacation requests may be submitted for approval in the UKG app.

Holidays:
You must complete your probationary period prior to receiving paid holidays. There are 7 paid holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving Day, and Christmas Day.

Sick Leave:
- Accrue one sick day per month after your probationary period
- You must be out over 3 days due to sickness
- Begins paying on the 4th day with a maximum of 8 paid days

Bereavement leave:
- Employees are eligible for 3 consecutive days of paid bereavement leave to take time off due to the death of an immediate family member. See manager for details.

Dependent Scholarship Program: Huggin' Molly's now offers an employee dependent scholarship program. For more information, contact Hayley Northey in the Marketing Department.

Please note employees have a probationary period of 90 days from start date for all vacation, holiday pay, sick leave, and bereavement.

401(k) Retirement (Fidelity)

Huggin Molly's offers a 401(K) Plan for all eligible full time and part time employees. **Effective 1/1/2026 new and rehired employees 18 years or older will be automatically enrolled at 1% and contributions will begin the first of the next month. In addition, new and rehired employees effective 1/1/2026 will receive an auto increase annually of 1% up to a maximum of 5%.**

Employees may opt out of auto enrollment and auto increases by contacting Fidelity.

You may rollover 401(K) balances from other plans at any time. **The company will match $1.00 for every $1.00 you contribute to the plan up to 3% of your salary and then $.50 match per $1.00 on your 4th% and 5th%.** New Hires will be eligible for the company match after 6 months of employment. Your contributions are immediately 100% vested and yours to keep. You may contribute your salaried deferrals pre-tax or after tax (401(k) Roth) or both. The company match will apply to pre-tax deferrals or Roth with priority to pre-tax deferrals.

Huggin' Molly's provides the services of a financial advisor to all employees with 401(k) investments at no cost to you.

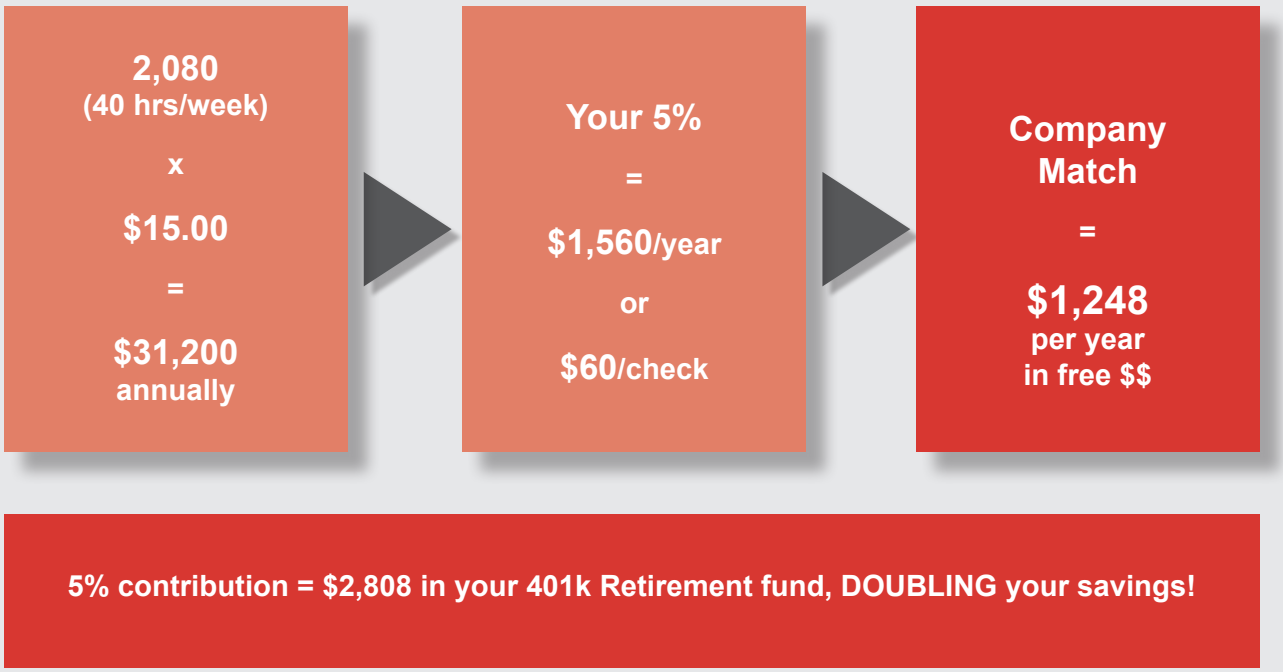
You may manage your account online through Fidelity NetBenefits® at www.401k.com or by calling Fidelity at 800-835-5097.

*Company reserves the right to change the guidelines of the Plan as well as the matching portion of the Plan. Please note employees are required to keep their beneficiary up to date with Fidelity which is separate from the UKG life insurance beneficiary. Please add your beneficiary by contacting Fidelity or by logging into your Fidelity account.

Company Provided Financial Advisor

Contact Matthew Murphy
334-679-4801
matthew@marblewealth.com

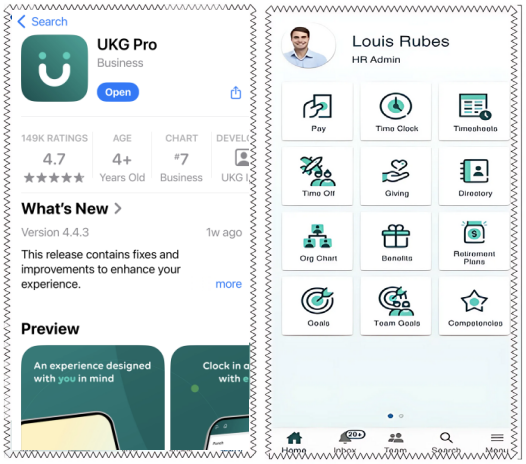
401(k) 5% Contribution Example



DOWNLOAD NOW!

NEW UKG PRO APP

- **COMPANY ACCESS CODE:** yellawood
- **USERNAME: LAST NAME + FIRST INITAL**
  EXAMPLE: CINDY JONES = JONESC
- **PASSWORD: FULL DOB (MMDDYEAR)**
  EXAMPLE: SEPTEMBER 22, 1978 = 09221978



FROM THE APPLE APP STORE OR THE GOOGLE PLAY STORE, SEARCH "UKG PRO" OR SCAN THE QR CODE BELOW.

Have a question?
Contact HR at
334.585.2291 or email
hris@yellawood.com

Apple App Store

Google Play Store

Benefits Enrollment Information

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

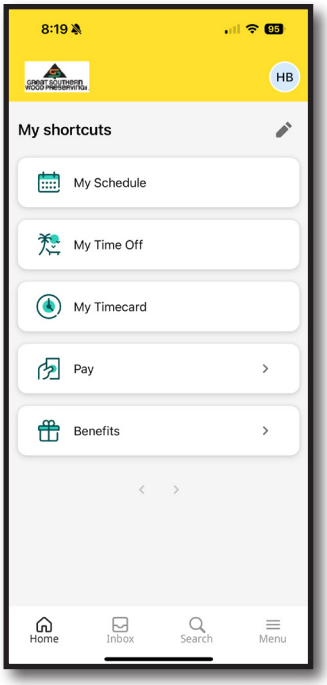
SCAN THE QR CODE OR USE THE LINK TO VISIT THE BENEFITS HOMEPAGE

HUGGIN' MOLLY'S

https://huggin-mollys.benefitsinfo.com

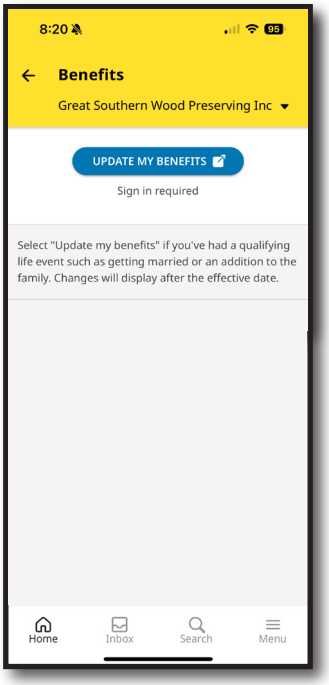
ENROLLING IN YOUR BENEFITS

PLEASE FOLLOW THE STEPS BELOW TO ENROLL IN YOUR BENEFITS.



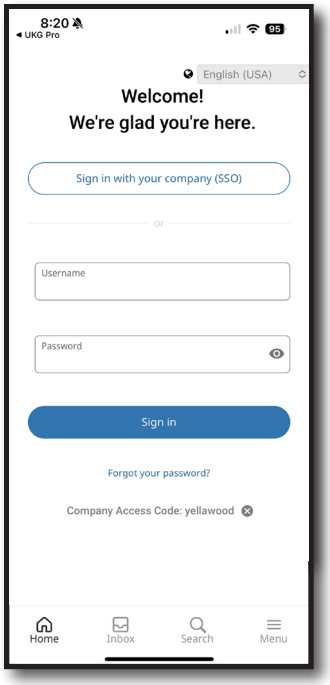
Step 1

Login to the UKG Pro App. Above is the employee's screen upon logging in. The employee will click the benefits icon to enroll.



Step 2

Clicking the benefits icon brings you here. Click "Update My Benefits" to continue.



Step 3

You will be asked to login again. Click "Get Started" to begin enrollment.

Keep your personal information up to date within UKG including but not limited to: phone number, address, email address, direct deposit information, and tax withholdings.

Medical, Dental and/or Vision Plans Dependent Eligibility Matrix

#	Dependent Type	Eligibility Criteria	Documents Required For Verification
1	**Spouse**	The person is currently your legal spouse	A copy of your marriage certificate
2	**Natural Born Child**	Your natural born child **AND** Age 25 or younger	A copy of the child's birth certificate naming the employee as the child's parent
3	**Natural Born Child** Over Age 25 Disabled	Your natural born child, age 26 and older **AND** A child who is physically or mentally incapable of self-support **AND** The incapacity occurred before age 26 as an eligible covered dependent	A copy of the child's birth certificate naming the employee as the child's parent **AND** Statement of Disability verified by insurance provider must be on file with Human Resources
4	**Stepchild**	Your Stepchild **AND** Age 25 or younger	Verification of Spouse (See Spouse) **AND** A copy of the child's birth certificate naming your spouse as the child's parent
5	**Stepchild** Over Age 25 Disabled	Your Stepchild, age 26 and older **AND** A child who is physically or mentally incapable of self-support **AND** The incapacity occurred before age 26 as an eligible covered dependent	Same as for Stepchild **AND** Statement of Disability verified by insurance provider must be on file with Human Resources
6	Legally Adopted Child **OR** Child Placed for Adoption **OR** Permanent Legal Guardianship	Your Legally Adopted Child or Child Placed for Adoption or Child in Permanent Legal Guardianship **AND** Age 25 or younger	A copy of adoption decree naming the employee as the child's adoptive parent **AND** A copy of a legal document showing child's age **OR** Amended Birth Certificate
7	Legally Adopted Child **OR** Child Placed for Adoption **OR** Permanent Legal Guardianship Over Age 25 Disabled	Your Legally Adopted Child/Child Placed for Adoption/Permanent Legal Guardianship, age 26 and older **AND** A child who is physically or mentally incapable of self-support **AND** The incapacity occurred before age 26 as an eligible covered dependent	Same as Legally Adopted Child/Child Placed for Adoption/Legal Guardianship **AND** Statement of Disability verified by insurance provider must be on file with Human Resources
8	**A Child Covered by a QMCSO/NMSN**	A child covered under a National Medical Support Order or a Qualified Medical Support Order	A copy of the NMSN or QMCSO
In all cases, the Summary Plan Description is the governing document with respect to eligibility.			

Documentation for qualifying life events must be uploaded in the UKG app within 60 days or dependent will be automatically terminated.

Medical Coverage

Your Medical Plan Benefits – Open Access

You may seek medical care from any doctor or hospital.

Huggin' Molly's offers a self-funded medical plan. We utilize EBMS to administer medical claims. You have open access so you may use any doctor, hospital, or medical service provider. Present your card when you arrive for your appointment.

Make sure your claims are pre-certified!!

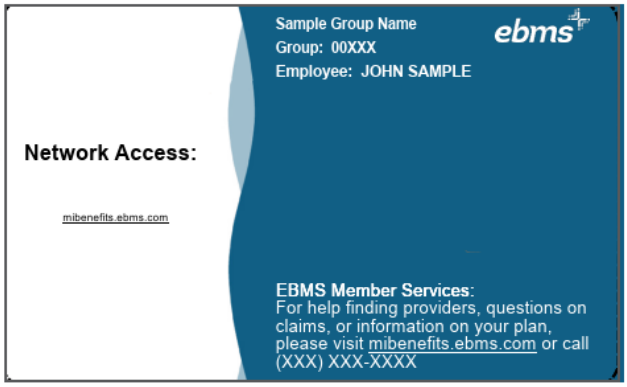
Employees – It is your provider's responsibility to pre-cert your claim before you receive the services, but it has come to our attention that you may need to follow up with your provider to make sure this is completed. Below are the services that will require pre-certification:

- Hospitalizations
- Outpatient surgical procedures which could be considered cosmetic *(examples: breast augmentation or reduction, vein therapy, etc)*
- MRI's
- CAT Scans
- PET Scans
- Sleep studies

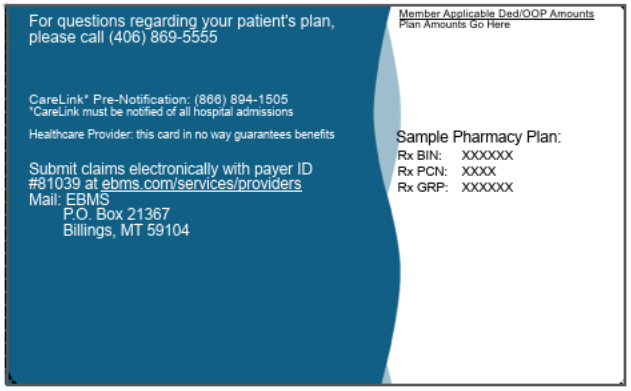
Physical therapy does not require pre-certification but please know that a plan of treatment from your provider will be required in order to pay the claim.

For pre-certification, call Veracity Care Solutions 888.324.1747.

Front:



Back:



Medical Bi-Weekly Payroll Deductions			
	Value Plan	HDHP/HSA	400 Plan
Employee Only	$49.00	$76.00	$111.00
Employee +1	$108.00	$157.00	$275.00
Family	$130.00	$206.00	$354.00

Should you receive a balance-due billing from a medical provider, contact ELAP at 866-326-7340. Balance bills are bills that you receive for amounts that are over what EBMS feels the visit/procedure was worth. You are responsible for any deductible, coinsurance or charges for excluded services.

Medical Plan Options (Effective January 1, 2026)

Medical / Prescription Benefits						
Benefits	**Value Plan**		**HDHP/HSA**		**400 Plan**	
Primary Care Office Copay/ Specialist Copay	$40 / $50		90% after deductible		$30 / $50	
Employee / Family Deductible	$2,000 / $4,000		$3,400 / $6,800		$400 / $1,200	
Employee / Family Out-of-Pocket	$4,000 / $8,000		$4,000 / $8,000		$3,000 / $6,000	
Coinsurance	70%		90%		90%	
Wellness Services	100% no copay or deductible		100% no copay or deductible		100% no copay or deductible	
Inpatient Services	70% after deductible		90% after deductible		$200 copay, then 90%	
Outpatient Services *(Including Ambulatory Surgical Centers)*	70% after deductible		90% after deductible		$250 copay, then 90%	
Emergency Room *(Medical Emergency) Non emergency use not covered by the plan*	70% after deductible		90% after deductible		$250 copay, then 90%	
Spinal Manipulation/ Chiropractic Care Visit Limit *(25 visits per member per plan year)*	70% after deductible		90% after deductible		70% after deductible	
Physical Therapy	70% after deductible		90% after deductible		70% after deductible	
Prescription Drugs	**Value Plan**		**HDHP/HSA**		**400 Plan**	
Deductible	$0		Shares Medical Deductible		$0	
Preferred Pharmacy Options	**Preferred**	**Non Preferred**	**Preferred**	**Non Preferred**	**Preferred**	**Non Preferred**
Retail *(34 day supply)*						
Generic Drugs	$0	$15	$0 after deductible	$15 after deductible	$0	$15
Formulary Brand Drugs	$40	$50	$20 after deductible	$30 after deductible	$25	$35
Non-Formulary Brand Drugs	$65	$75	$40 after deductible	$50 after deductible	$50	$60
Specialty	$100	$100	$100 after deductible	$100 after deductible	$100	$100
90 Day Supply Maintenance Medication	A 90 day supply of maintenance medications may be available at the 34-day benefit amount at retail pharmacy.		A 90 day supply of maintenance medications may be available at the 34-day benefit amount at retail pharmacy.		A 90 day supply of maintenance medications may be available at the 34-day benefit amount at retail pharmacy.	

Medical Plan Financial Details:	**Yearly Max Cost = Out of Pocket Max + Annual Premiums**		
Employee Cost:	**Value Plan**	**HDHP/HSA***	**400 Plan**
Employee Only	$5,274.00	$5,476.00	$5,886.00
Employee + 1	$10,808.00	$11,082.00	$13,150.00
Family	$11,380.00	$12,356.00	$15,204.00

Cost Definitions:

Yearly Max Cost = the maximum amount you may be required to pay for the Medical Plan you choose if you have a" Major Health Issue" that requires you to meet your Benefit Plan Out-of-Pocket maximum + this amount includes your Employee Annual premiums.

***Employer contributions subtracted from total out of pocket max ($500 EE/$1,000 Employee +1 / Family)**

***Please Note: The information listed in the chart above is provided as a summary of the plan designs and cost for illustrative purposes. Additional details regarding plan specifics are provided in the official plan documents.*

Save money on covered prescriptions by using a Preferred Pharmacy! You can save money if you choose Preferred over the Non-preferred Pharmacies. **Preferred Pharmacies are typically your private or family, locally owned pharmacies and any Walmart, Publix, or Sams. Some Non-Preferred Pharmacies are Target, CVS, Walgreen's, and Rite-Aid.** To download the Prescription Drug Formulary which is a full list of covered drugs under your plan, visit: https://veracity.procarerx.com. For additional information, contact ProCare at 888-388-8228 this information can also be found on your medical ID card.

The benefit plan outline above is a general summary of the plans offered. For additional details please refer to the Medical Plan Document which is available upon request in the Human Resources Department.

Understanding what it means

What is Deductible

A deductible is the amount of money you pay each year for healthcare before your insurance company starts to pay.

Until you meet your deductible, you are responsible for paying for your doctor's visits or treatments, with some exceptions. Once you reach your deductible, your insurance company starts paying your bills or splitting this cost with you.

Your deductible can be high or low, depending on the type of plan you have. Your health plan's deductible starts over each year, and the amount you owe may change annually.

What is Coinsurance

Coinsurance is the amount, generally expressed as a fixed percentage, that an insured must pay toward a covered claim after the deductible is satisfied.

What is OOP (Out-of-Pocket)

OOP, or out-of-pocket, refers to the costs that individuals must pay for healthcare services that are not covered by their health insurance plan.

Understanding Out-of-Pocket Costs

Out-of-pocket costs in health insurance include various expenses that you are responsible for when receiving medical care. These costs can encompass:

- **Deductibles:** The amount you pay for healthcare services before your health insurance begins to pay.
- **Copayments (Copays):** A fixed amount you pay for a specific service or prescription, usually at the time of service.
- **Coinsurance:** The percentage of costs you pay for covered services after you've met your deductible.

Out-of-Pocket Maximum

The out-of-pocket maximum (OOP max) is the most you will have to pay for covered healthcare services in a plan year. Once you reach this limit, your health insurance will cover 100% of your healthcare costs for the remainder of the year. Key points about the OOP max include:

- **Annual Cap:** The OOP max serves as a financial safety net, preventing excessive healthcare costs in a given year.
- **In-Network Services:** Typically, only costs for in-network services count toward your OOP max. Out-of-network services may incur additional costs that do not contribute to this limit.
- **Exclusions:** Not all expenses count toward the OOP max. For instance, monthly premiums and certain non-covered services are excluded.

For example, Peg is on the HDHP plan and is having a baby. After delivery, she receives a bill for Childbirth Professional and Facility services along with Diagnostic Testing such as blood work as well as for the Anesthesiologist in the amount of $10,000. She would be responsible for her deductible of $3,400 and Coinsurance of $600. The total she would pay would be $4,000.

Prescription Medical Coverage

International and Specialty Drugs are managed though the **Pharmacist Concierge Services**. Members that use this program for applicable international and specialty medications are eligible to receive covered medications at little to no cost. Please log onto veracity-rx.com initially to get started and/or contact: 888-388-8228 by phone for more information.

VERACITYRx

Personal Importation Medications VeracityRx Program

How to Enroll in the Program

1. Please check the list below of **commonly prescribed medications that can be sourced internationally**.
2. If you or a covered member of your household are on any of the drugs listed, please start by going to **www.veracity-rx.com** and completing the **"Enrollment Form".**
3. Be on the look out for an email from a VeracityRx Personal Importation Team member with next steps.
4. Contact your healthcare provider to have a new prescription sent into our pharmacy partner. **Instructions will be included in email on how to send in new prescription.*

Commonly Prescribed Personal Importation Medications		
Drug	**Drug**	**Drug**
Anoro Ellipta	Invokamet	Silenor
Apidra	Isentress	Skyrizi
Apidra Solostar	Janumet	Spiriva Respimat
Arnuity Ellipta	Janumet XR	Symbicort
Atripla	Januvia	Tivicay
Basaglar Kwikpen	Jardiance	Toujeo Solostar
Biktarvy	Juluca	Tradjenta
Breo Ellipta	Levemir Flextouch	Trelegy Ellipta
Combivent Respimat	Omnaris	Trintellix
Dulera	Orencia	Trulicity
Eliquis	Ozempic	Victoza
Entresto	Prezcobix	Xarelto
Farxiga	Qvar	Xeljanz
Fiasp	Rexulti	
Flovent HFA	Rinvoq	
Invokana	Rybelsus	

**List is only a sample of the top personal importation drugs and is subject to change without notice. Additional personal importation drugs can be pursued beyond this list.*

VERACITYRx

Specialty Medications VeracityRx Program

How to Enroll in the Program

1. Please check the list below of **commonly prescribed specialty drugs**.
2. If you or a covered member of your household are on any of the drugs listed or any other specialty medication, please start by going to **www.veracity-rx.com** and complete the **"Enrollment Form"**
3. Be on the look out for an email from a VeracityRx Specialty Team member with next steps.
4. Complete the patient assistance application included in the email and return with any additional required documentation (i.e., 1st two pages of your most recent 1040).

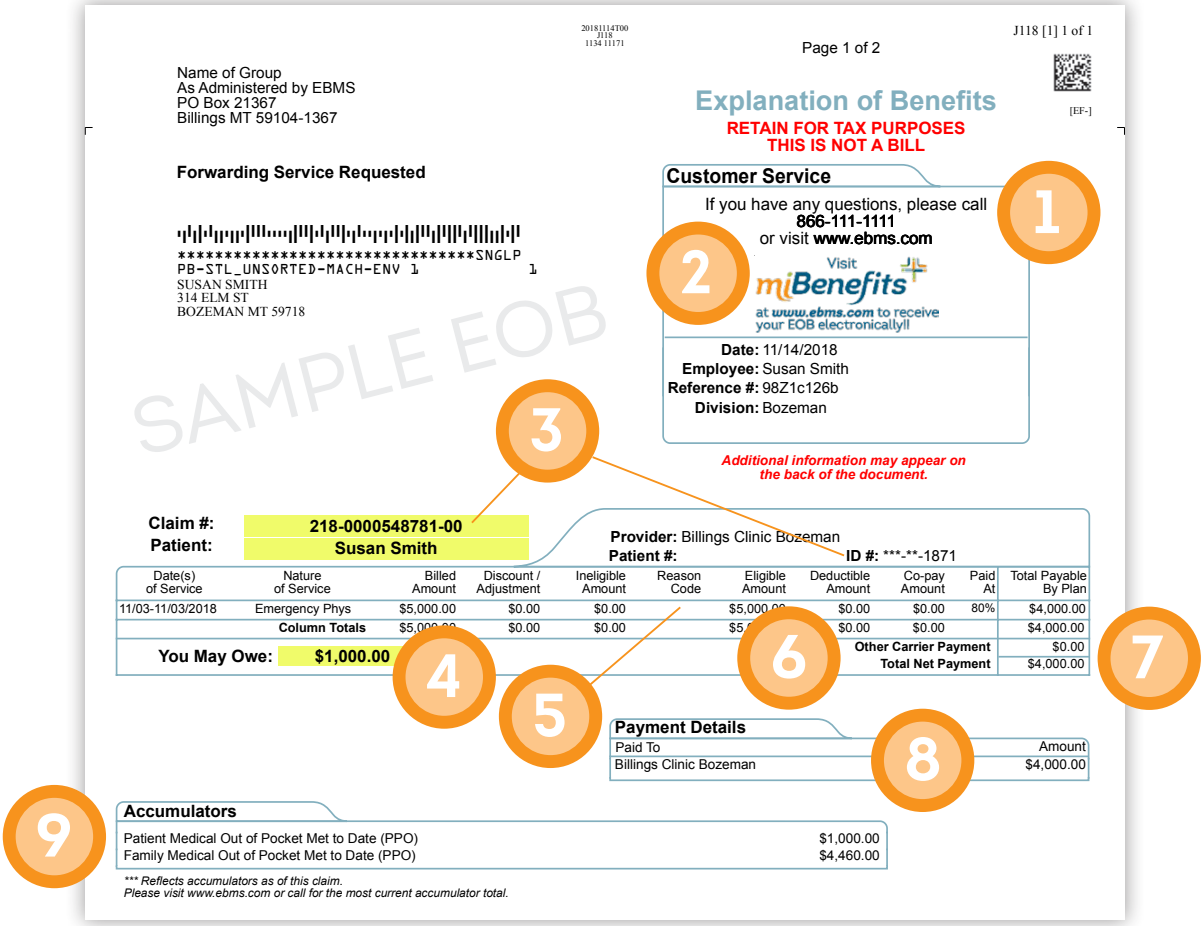
Commonly Prescribed Specialty Medications	
Drug	**Drug**
Actemra	Promacta
Adempas	Pulmozyme
Afinitor	Rebif
Aubagio	Stelara
Cimzia	Strensiq
Cosentyx	Tagrisso
Dupixent	Taltz
Enbrel	Tobi Podhaler
Envarsus XR	Tremfya
Firazyr	Tyvaso
Gilenya	Vumerity
Haegarda	Xolair
Kuvan	Zelboraf
Lenvima	
Norditropin AQ	
Opsumit	
Otezla	

**List is only a sample of the top specialty drugs and is subject to change without notice. Additional specialty drugs can be pursued beyond this list.*

rev 20232707

MEMBERS

Understanding Your Explanation of Benefits



20181114T00
J118
1134 11171

J118 [1] 1 of 1

Page 1 of 2

Name of Group
As Administered by EBMS
PO Box 21367
Billings MT 59104-1367

Forwarding Service Requested

**********SNGLP
PB-STL_UNSORTED-MACH-ENV 1 1
SUSAN SMITH
314 ELM ST
BOZEMAN MT 59718

SAMPLE EOB

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

[EF-]

Customer Service

If you have any questions, please call
866-111-1111
or visit **www.ebms.com**

Visit miBenefits at www.ebms.com to receive your EOB electronically!

Date: 11/14/2018
Employee: Susan Smith
Reference #: 98Z1c126b
Division: Bozeman

Additional information may appear on the back of the document.

Claim #: 218-0000548781-00
Patient: Susan Smith

Provider: Billings Clinic Bozeman
Patient #: **ID #:** ***-**-1871

Date(s) of Service	Nature of Service	Billed Amount	Discount / Adjustment	Ineligible Amount	Reason Code	Eligible Amount	Deductible Amount	Co-pay Amount	Paid At	Total Payable By Plan
11/03-11/03/2018	Emergency Phys	$5,000.00	$0.00	$0.00		$5,000.00	$0.00	$0.00	80%	$4,000.00
	Column Totals	$5,000.00	$0.00	$0.00		$5,000.00	$0.00	$0.00		$4,000.00
You May Owe: $1,000.00								**Other Carrier Payment**		$0.00
								Total Net Payment		$4,000.00

Payment Details

Paid To	Amount
Billings Clinic Bozeman	$4,000.00

Accumulators

Patient Medical Out of Pocket Met to Date (PPO)	$1,000.00
Family Medical Out of Pocket Met to Date (PPO)	$4,460.00

**** Reflects accumulators as of this claim.*
Please visit www.ebms.com or call for the most current accumulator total.

1. **EBMS phone number**
2. **24/7 access to all current and historical claims information through miBenefits**
3. **Important information for you to have when calling EBMS (claim number and patient ID number)**
4. **Amount you may be billed by your provider. If your provider bills more than the amount listed here, you may receive a Balance Bill.**
5. **Reason code information and description**
6. **Deductible information**
7. **This is the payment amount the plan will make to you or your provider**
8. **If there is no check, please refer to the "payment" field. The check may have been sent directly to the provider**
9. **Accumulators show how much of your deductible and out-of-pocket have been met**

Introducing EBMS Services – Your Health Plan's Affordability Partner

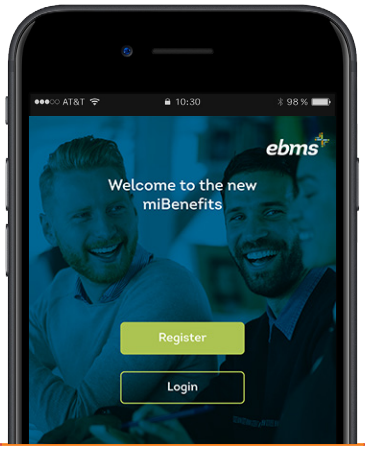
EBMS' Mobile App – miBenefits – is Here!

Need to check a claim or review benefits on the go? With the new miBenefits app, your benefit plan is one touch away. Now you can manage your benefits anywhere, anytime! EBMS' miBenefits mobile app was designed for instant, complete, and secure access.

- Access digital ID cards for medical, dental or vision
- Receive real-time updates with push notifications
- Stay updated on claims, deductibles, out-of-pocket maximums, and more!
- Find a provider or pharmacy and search for benefit details

Questions? Contact us at 1-866-462-9054.

Download on the App Store | GET IT ON Google Play



How Can a Healthcare Navigator Help?

We hope you never have a problem with your health plan! If you do have an issue, ELAP can step in to advocate for you in certain situations.

BEFORE a medical procedure, call a healthcare navigator to discuss your options if:

- A hospital or doctor asks for payment up front
- A hospital or doctor turns you away based on your health plan
- You need to travel outside your primary location to receive care (our navigators can coordinate all aspects of travel and care, when medically appropriate)

AFTER your medical procedure, call a healthcare navigator for assistance if:

- You receive a medical bill for an outstanding balance that is different from what your explanation of benefits (EOB) shows you owe
- You receive a collection notice from the hospital or doctor

Let ELAP advocate for you!

Contact a Healthcare Navigator now:

Call: 1-866-326-7340
Email: navigator@ebms.com

Health Savings Account

Effective immediately – changes to your Health Savings Account elections will need to be communicated through UKG.

If you are enrolled in the HDHP Plan, you will automatically be enrolled in a Health Savings Account. You do not have to contribute your funds to receive the company match.

The High Deductible Health Plan (HDHP) is intended to cover an illness or injury after the deductible has been met. The Health Savings Account is owned by and funded with pre-tax contributions. The HSA pays for out-of-pocket expenses incurred before and after the deductible is met. If you leave, you can take it with you. Employer HSA Contributions will be done bi-weekly through UKG.

Employees who enrolls in the Employee Only H.S.A. plan receive $500 and $1,000 for every Employee who enrolls in the Employee + Dependents H.S.A. plan. You will receive information in the mail which will require you to activate your account to utilize the funds. Don't let this money pass you by as it is yours to use and roll over each year.

What is a High Deductible Health Plan (HDHP)?

A High Deductible Health Plan is an insurance plan that does not cover first dollar medical expenses (except for preventive care). It is a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually by the Internal Revenue Service (IRS) and are subject to change.

What is a Health Savings Account?

A Health Savings Account (HSA) is an account that can be funded with your tax-exempt dollars to help pay for eligible medical, prescription, dental, and vision expenses not covered by an insurance plan, including the deductible, coinsurance, copays, and even in some cases, health insurance premiums.

Who is eligible for an HSA?

Anyone who is:

- Covered by a High Deductible Health Plan (HDHP)
- Not covered under another medical plan that is not a HDHP
- Not enrolled in Medicare benefits; or
- Not eligible to be claimed on another person's tax return
- Tax covered dependents even if not covered on the health plan

2026 HSA Contributions Limits

2026	Contribution Limit	55+ Contribution
Single	$4,400	$1,000
Family	$8,750	$1,000

Note: *When allocating funds to your HSA, make sure the contribution does not exceed the 2026 limits.*

New Hires: If you are hired within the plan year, your HSA contribution will be prorated.

Key Benefits to an HSA

- **Tax Savings:** Money taken out of your paycheck before taxes are calculated, thus reducing your reported taxable earnings.
- **Portability:** The money in your account is yours to keep, so you can take it with you if you change employers, health plans, or retire.
- **Savings:** Let the funds in your account grow tax-deferred. After age 65, you may make withdrawals from your HSA for any reason without penalty.
- **Individual:** Your HSA is your individual account, setup in your name, with your listed beneficiary. It is completely your responsibility, very similar to a checking account. You are responsible for making sure funds are used for qualifying expenses and that your account is not funded beyond the annual maximum amount. You are also responsible for ensuring your demographic information, such as your address, is up to date on your account.
- **Control:** You decide when to use your savings to pay for medical expenses.

Employer Contributions

If you elect to enroll in the High Deductible Health Plan, Huggin' Molly's will make a deposit into your HSA account as follows:	Total for Year
Employee Only	$500
Employee + 1 / Family	$1,000

Please Note: *Deposits will be made quarterly. Participants must have a HSA established in order to receive the deposit.*

Health Savings Account
HSA Bank
Customer Service 1-800-357-6246
Website: www.hsabank.com

Flexible Spending Account

What is a Flexible Spending Account?

Through our Flexible Spending Accounts (FSA's), you are able to set aside money, before it is taxed, to pay for eligible out-of-pocket costs for dependent and medical care expenses.

How Do FSA's Work?

Once you calculate your annual FSA contribution, it will be deducted from your paycheck in equal amounts over the year. You will receive a card in the mail and can use this card for payment and/or reimbursement of eligible expenses.

What Expenses are Eligible?

Expenses are eligible for reimbursement from your FSAs, provided:

- They are incurred during your FSA plan year
- Dependent care expenses must be for children in daycare up to age 13 and adult family members who need daily care so that the employee and spouse can both work
- They are not reimbursable from any other source
- You have available documentation from the provider of the services or supplies which shows the amount of each expense and the date it was incurred

Some Eligible Health Care Expenses Examples:

- Acupuncture
- Alcoholism and drug treatment center
- Artificial limbs and teeth
- Chiropractic care
- Copays and coinsurance
- Cosmetic surgery to correct a medical condition
- Deductibles
- Dental expenses
- Dermatology
- Eye exams, lenses, frames and contacts
- Hearing aids
- Laser eye surgery
- Over-the-counter medications accompanied by a physician's written prescription
- Prescription drug copays
- Wheelchairs
- X-rays

A Tax Break on Expenses

- **Dependent Care FSA:** A sizable amount of a family's income is used for day care expenses for children or a disabled spouse or parent. You may elect to contribute a maximum of $7,500 if you are single or if you are married and filing a joint tax return. If you are married and filing separate returns, you may elect to contribute a maximum of $3,750 for the calendar year.

- **Health Care FSA:** We all spend money every year for deductibles, copayments, and other out-of-pocket expenses our health plan doesn't pay. You may contribute a maximum of $3,300 for the calendar year. If limit is updated prior to 1/1/26 the group will match the IRS confirmation maximum. The Healthcare FSA will pay for your expenses as they occur, up to your elected contribution. For example, if you elect to contribute $50 per month and incur a $200 expense after only one month, the FSA will pay the total $200.

Keep these Important Rules in Mind

Filing deadlines have been extended. Typically expenses incurred during the plan year (January 1 - December 31) are required to be submitted no later than 90 days after the plan year ends. **Please note: Huggin' Molly's will no longer extend the filing deadline by 2½ months. Instead of the grace period, you will now be allowed to rollover $660 of your unused Health Care Only FSA balance into the 2026 plan year.** The run out date 4/15 is for manual claims to be submitted for the prior plan year. Rollover funds are distributed on 5/1 and after 5/1 so you can see your new balance with rollover funds included.

Please note you must re-enroll in the FSA benefit each year in UKG regardless of whether it's a passive or mandatory enrollment.

Questions? We have the answers.

Call 1-833-232-4673 Live customer support 24/7

Or email to: HASinfo@voya.com

relyMD

Provided by

Huggin' Molly's

Welcome to **RelyMD**

24/7 on-demand doctor visits, no appointment necessary.

As a RelyMD member, you and your family will receive 24/7/365 access to U.S. board-certified physicians who can diagnose common illnesses and injuries regardless of time and location. Register for your secure account today, we'll be ready when you need us.

Copay Plan

Your Co-Pay is

$0

Employer Code:

MYIDR1394

HDHP Plan

Your Co-Pay is

$38

Employer Code:

MYIDR1395

Medical conditions **we commonly treat:**

- Allergies
- Arthritic pain
- Bronchitis
- Cold & flu
- Constipation
- Cough
- Diarrhea
- Eye infections
- Fever
- Gout
- Headache
- Insect bites
- Mild asthma
- Muscle pains
- Rashes
- Sinus infection
- Sore throat
- UTI
- Nausea/vomiting
- and more!

When to use **RelyMD**

If you're considering the ER or urgent care for a non-emergency medical issue.

When leaving home to see a licensed physician just isn't possible.

You or your family are traveling or in need of medical care.

How to **access your account as a previous MYidealDOCTOR user:**

1. Go to **patient.relymd.app** and click **"Log In"**
2. Log in **using your existing username and password**. All existing data is being securely transferred to the new website.
3. **Review your demographics and medical history** to ensure everything is correct before starting your visit.
4. That's it! **You're ready to see a doctor!**

**If you need assistance, please call 855-879-4332.

How to **access your account as a NEW member:**

1. Go to **patient.relymd.app** and click **"Sign Up"**
2. When asked **Do you have RelyMD services through your employer or insurance provider?** Click **Yes** and type in your employer's name.
3. **Click Continue** to validate and access your patient account.
4. You're now registered! **You're ready to see a doctor!**

**If you need assistance, please call 855-879-4332.

relymd.com | support@relymd.com | (855) 879-4332

DIABETES CARE

Join the Diabetes Care Rewards Program to Live Well and Get Rewards.

If you, a spouse, or child are one of our health plan members and are 1 of the 34 million Americans living with diabetes or have pre-diabetes, join the Diabetes Care Rewards Program at **GoodHealthGateway.com**.

Get Unlimited Access to Diabetes Educators
for diabetes care support any time you need it.

Get $0 Copays
on covered diabetes medications and supplies after completing your diabetes care activities.

Participation is voluntary and confidential.

Member Story

The Diabetes Care Rewards Program has helped me gain a better understanding of what affects my sugar levels and better ways to cope with the disease.

The program sends me reminders about my doctor's visits and eye exams to help me stay ahead. When meeting the program deadlines, all of my diabetes medications and supplies are at NO CHARGE! Diabetes educators are also available to answer my questions.

This is an awesome program to help deal with and better understand my diabetes.

Great Southern Wood Preserving, Inc. Teammate from Virginia

Scan Me..

Join Today!

800.643.8028 Hablamos español.
GoodHealthGateway.com

Good Health GATEWAY®
Diabetes Care Rewards Program

Dental Coverage

Ameritas

A dental plan is available to you and your covered dependents for routine dental care such as exams, x-rays, and cleanings, as well as fillings, dentures, bridge work and periodontal care.

The PPO Plan allows you to receive benefits when using dental providers of your choice. However, the highest level of benefits will be received by in network dentists. If you see an in network dentist, they have agreed to accept discounted fees for service and not to balance bill you.

If you see a non-network dentist, you could be balance-billed as they are subject to Usual, Reasonable and Customary (UCR) charges. This means that if your non-network dentist charges more than the majority of dentists in the same geographic location, you would be responsible for paying the difference between what the non-network dentist charges and the UCR charge for the area.

To find a provider, go to www.ameritas.com. Click "Find a Health Provider", "Find a Dental Provider", enter zip code or city and state, then choose "Classic Network."

For Example: A non-network dentist charges $150 for teeth cleaning and the majority of dentists in the area charge $130 for the same service. You would be responsible to pay the $20 difference.

Dental Bi-Weekly Payroll Deductions		
	Basic Plan	Plus Plan
Employee Only	$9.30	$13.10
Employee + 1	$18.60	$24.06
Family	$30.66	$41.22

Dental Summary of Benefits		
	Basic Plan	**Plus Plan**
Annual Deductible: Waived for Preventive Services	$25/$75	$25/$75
Preventive Services Include: Routine Exam (2 per benefit period) Bitewing X-rays (2 per benefit period) Cleaning (2 per benefit period) Fluoride for children under 18 (2 per benefit period) Sealants (age 13 and under) Space Maintainers	100% *(Does NOT Apply to Calendar Year Max)*	100% *(Does NOT Apply to Calendar Year Max)*
Basic Services Include: Oral Surgery, General Anesthesia, Root Canals, Fillings, Denture Repairs	90%	90%
Major Services Include: Crowns, Bridges, Dentures, Inlays, Treatment of Gums	70%	70%
Calendar Year Maximum *(The maximum benefit you will receive from the plan in a calendar year. You will be responsible for anything additional.)*	$1,250	$2,000
Network- Passive PPO	Passive PPO	Passive PPO
Out of Network- Allowance	95th U&C	95th U&C
Schedule of Benefits		
Orthodontia Coverage	No Orthodontia Coverage	50% *(Dependent Children Up to Age 26)* No Waiting Period
Orthodontia Lifetime Maximum	No Orthodontia Coverage	$2,000

Important Note: Please refer to the detailed plan summary for additional information on the plan limitations and exclusions.

Vision Ameritas

It is important to preserve your eye health and receive regular eye exams. The EyeMed insight vision network is nationwide including private practice and retail providers. To obtain a list of network vision care providers go to www.EyeMed.com. Click on “Find a Provider”, enter the zip code, click on “Select Network”, click on “Insight” then click on “Get Results”. A list of providers and their addresses, phone numbers, and mileage to their locations will be displayed.

If you prefer to speak to a customer service representative, call 1-866-289-0614.

EyeMed Vision Summary of Benefits	In-Network	Out-of-Network
Deductibles	$10 Exam/ $10 Eye Glass Lenses	No deductible
Annual Eye Exam	Covered in full	Up to $35
Lenses (per pair)		
Single Vision	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $55
Lenticular	20% discount	No benefit
Progressive	See lens options	N/A
Contacts		
Fit & Follow Up Exams		
Standard	Standard: Member cost up to $40	No benefit
Premium (Allowance)	Premium: 10% off of retail	No benefit
Elective	Up to $130	Up to $104
Medically Necessary	Covered in full	Up to $200
Frames	$130	Up to $65
Frequencies (months)		
Exam/Lens/Frame	12/12/12 (Based on date of service)	12/12/12 (Based on date of service)
Lens Options (member cost)		
Progressive Lenses		
Standard	Standard: $65 + lens deductible	No benefit
Premium	Premium: lens cost - 20% discount - $120 allowance + Standard Progressive cost	No benefit
Standard Polycarbonate	$40	No benefit
Tint (solid and gradient)	$15	No benefit
Scratch Resistant Coating	$15	No benefit
Anti-Reflective Coating	$45	No benefit
Ultraviolet Coating	$15	No benefit
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers	No benefit
Vision Bi-Weekly Payroll Deductions		
Employee Only	$2.69	
Employee + 1	$5.38	
Family	$6.18	

Short Term Disability

Lincoln Financial Group

Short Term Disability provides a weekly benefit to replace a portion of your income in the event you are disabled.

Short Term Disability premiums are based on the employee's salary and applicable rate. Premiums are provided to newly hired employees and also available in UKG. During Open Enrollment, employees may enroll in Short Term Disability without an EOI and are subject to the pre-existing limitation periods per the plan design.

How to Report a Disability Claim

Notify your supervisor and Human Resources to complete the required Short Term Disability claim form. The claim form will require:

- Your name, address, phone number, birth date, date of hire, and Social Security Number as well as your employer's name, address and phone number.
- The date and cause of your disability and when you plan to return to work. If you are pregnant, give your expected delivery date.
- The name, address and phone number of each doctor you are seeing for this absence.

Short Term Disability Summary of Benefits	
Benefits Begin	15th day of injury or illness*
Benefit Amount	60% of weekly earnings
Maximum Weekly Benefit	$500
Maximum Benefit Period	26 weeks

**1st day for hospitalization*

If you have to be out for more than 3 days, be sure to notify your supervisor and HR.
"Note: Claims can take up to 3-5 days for review and approval once the required paperwork is received.

Personalized

When you log in to *My Lincoln Portal*, you can quickly navigate to your personalized group benefits information. Plus, you can easily manage your portal profile and preferences.

Company Code to Register : LF130GRE

Basic Life and AD&D Insurance

Lincoln Financial Group

Huggin' Molly's automatically provides Basic Term Life insurance and Accidental Death and Dismemberment coverages equal to **1 x basic annual earnings with a minimum of $10,000 to a maximum of $250,000 at no cost to you.** The Life Insurance also provides a Living Care Benefit. If you are diagnosed with a terminal illness with a life expectancy of less than 12 months, you may collect 75% of your life insurance benefit prior to your death. At death, the Living Care benefit will be deducted from the original life insurance benefit.

Please note that your Basic Life and AD&D benefit will reduce by 35% of the inforce amount at age 65 and by 50% at the inforce amount at age 70.

Please keep beneficiaries up to date at all times. Beneficiaries can be added/updated any time within UKG.

Optional Life Insurance and AD&D

Lincoln Financial Group

Optional Life Insurance provides extra protection for your family in the event of your untimely death.

New Hires may elect up to $300,000 Employee Life and $20,000 Spouse Life with no Evidence of Insurability Forms (EOI).

During Annual Enrollment each year employees and their spouses are able to elect/increase coverage in the amount of 2 Increments ($20,000 - Employee and $10,000 - Spouse) without Evidence of Insurability Forms (EOI) up to the plan maximums and subject to the regular terms of the life enrollment. Please Note: Employees and Spouses are eligible for this incremental increase only IF they have NOT been previously declined EOI or withdrawn their EOI for or/by Lincoln.

Please note that your voluntary life benefit will reduce by 35% of the inforce amount at age 65 and by 50% at the inforce amount upon attainment of age 70. Premiums will be billed based on the reduced amount.

If you elect Optional Life, you may also elect Accidental Death & Dismemberment (AD&D) insurance in an amount equal to your Optional Life. Optional AD&D is available to employees only and pays your beneficiary a benefit for loss of life or other injuries resulting from a covered accident – 100% for loss of life and a lesser percentage for other injuries. Injuries may include loss of sight or speech, paralysis, and dismemberment of hands or feet.

Please note you have the option to port or convert policies if you decided to leave Huggin' Molly's.

Optional Life Summary of Benefits			
	Employee	**Spouse**	**Child(ren)**
Benefit Amount	Increments of $10,000	Increments of $5,000	$10,000 *(not to exceed 50% of employee's benefit)*
Benefit Maximum	$300,000 *(not to exceed 5x annual earnings)*	$150,000 *(not to exceed 50% of employee's benefit)*	
Guarantee Issue*	$300,000	$20,000	$10,000
New Hire Guarantee Issue: The amount of coverage permitted by Lincoln Financial without completing an Evidence of Insurability form.			

Monthly Rates per $1,000			
Age	**Rates**	**Age**	**Rates**
Under 30	$0.073	**55-59**	$0.837
30-34	$0.087	**60-64**	$1.250
35-39	$0.114	**65-69**	$1.910
40-44	$0.177	**70-74**	$3.806
45-49	$0.287	**75+**	$6.514
50-54	$0.471		

Monthly Payroll Deductions for Child(ren)	
$10,000	$1.53
**One premium covers all eligible children.*	

Optional AD&D

Monthly Rates per $1,000	
Employee Only	$0.033

Life Insurance premiums are based on the employee's age and volume selected. Spouse's Rate is calculated based on the spouse's age. Premiums are provided to newly hired employee and also available on UKG.

Please keep beneficiaries up to date at all times. Beneficiaries can be added/updated any time within UKG.

Accident

Lincoln Financial Group®

Accidents happen. Accident Insurance can help. Accident coverage is one of the more common benefits people choose to elect. Any guesses why? It's because accidents are a leading cause of injury for people under age 40, and because they occur more randomly than sickness. Accident insurance pays you with cash benefits for expenses that may not be fully covered by your comprehensive health insurance.

Accident Bi-Weekly Payroll Deductions	
Employee Only	$7.76
Employee + Spouse	$12.68
Employee + Child(ren)	$16.47
Employee + Family	$21.39

Health Assessment/Wellness Benefit	Plan Benefit
Health assessment benefit Receive a cash benefit every year you and any of your covered family members complete a single covered exam, screening, or immunization	$100

Emergency Treatment	Your Cash Benefit
Ambulance	$300
Air ambulance	$900
Emergency care/treatment	$150
Initial care visit	$150
Major diagnostic exam	$150
X-ray	$30

Fractures	Your Cash Benefit
Ankle	$1,250
Arm (shoulder to elbow)	$1,375
Arm (elbow to wrist)	$1,050
Coccyx	$425
Collarbone	$1,250
Elbow	$375
Bones of the face	$1,125
Fingers	$200
Foot (except toes)	$1,025
Hand (except fingers)	$1,025
Hip	$3,250

Dislocations*	Your Cash Benefit
Ankle	$1,250
Collarbone (acromio and separation)	$975
Collarbone (sternoclavicular)	$1,250
Elbow	$1,250
Fingers	$350
Foot (except toes)	$950
Hand (except fingers)	$700
Hip	$3,000

Note: HR can only provide payroll deductions for this benefit. To file claims or for any questions, please reach out to Lincoln Financial by calling 800-487-1485.

Hospital Indemnity

Lincoln Financial Group®

Hospitalization is unplanned. Even with your employer's medical insurance, the cost of a hospital stay can be overwhelming. According to HealthCare.gov, the average price for a three-day hospital stay is $30,000. Hospital Indemnity reimburses hospital usage and stays based on the care received.

Hospital Indemnity Bi-Weekly Payroll Deductions	
Employee Only	$10.20
Employee + Spouse	$18.61
Employee + Child(ren)	$15.17
Employee + Family	$23.58

Core Hospital Benefits	Plan Benefit
Hospital admission For the initial day of admission to a hospital for treatment of a sickness/an injury	$1,000 per day for one day per calendar year
Hospital confinement For each day of confinement in a hospital as a result of a sickness/an injury	$150 per day for 30 days per calendar year starting on the second day of confinement
Hospital intensive care unit (ICU) admission For the initial day of admission to an ICU for treatment as the result of a sickness/an injury	$1,000 per day for one day per calendar year
Hospital ICU confinement For each full or partial day of confinement in an ICU as a result of a sickness/an injury	$150 per day for 30 days per calendar year starting the second day of confinement

Additional Confinement Benefits	Plan Benefit
Newborn care For each day of confinement to a hospital for routine post-natal care following birth	$100 per day for two days per calendar year

Health Assessment/Wellness Benefit	Plan Benefit
Health assessment benefit Receive a cash benefit every year you and any of your covered family members complete a single covered exam, screening, or immunization	$50

Enhanced Benefits	Plan Benefit Percentage
Hospital NICU Admission Increases the hospital ICU admission benefit for a newborn child's ICU or NICU admission by the percentage shown in the schedule of benefits	25%
Hospital NICU Confinement Increases the hospital ICU confinement benefit for a newborn child's ICU or NICU confinement by the percentage shown in the schedule of benefits	25%

Note: HR can only provide payroll deductions for this benefit. To file claims or for any questions, please reach out to Lincoln Financial by calling 800-487-1485.

Critical Illness

Lincoln Financial Group®

Critical Illness can affect any one at any time. Critical Illness insurance pays a benefit upon the diagnosis and/or treatment of a named Critical Illness or certain category of major surgery. Plan options let you choose the amount of coverage you need.

The reasoning behind a Critical Illness policy is that someone with employer provided health care coverage and disability coverage could still incur a large amount of costs in copayment, deductibles, coinsurance, and non-covered items in the event of a Critical Illness.

Critical Illness policies help to pay these expenses and assist someone during their recovery by paying the insured a cash benefit.

Monthly Premium rate per $1,000 of Insured's Critical Illness Insurance	
Age	**Rate**
17-19	$0.648
20-29	$0.648
30-39	$1.008
40-49	$1.841
50-59	$3.494
60-69	$6.489
70+	$6.489

Supplemental Conditions	Benefit Percentage
Advanced ALS/Lou Gehrig's disease	100%
Advanced Alzheimer's disease	25%
Advanced Parkinson's disease	25%
Benign brain tumor	100%
Loss of sight, hearing and/or speech	100%

Supplemental Conditions	Benefit Percentage
Cerebral Palsy	100%
Cleft lip, cleft palate	100%
Cystic Fibrosis	100%
Down Syndrome	100%
Muscular dystrophy	100%
Spina bifida	100%
Type 1 Diabetes	100%

Health Assessment/Wellness Benefit	Your Cash Benefit
You receive a cash benefit every year you and any of your covered family members complete a single covered exam or screening	$50

Covered Conditions	Benefit Percentage
Heart Attack	100%
Sudden cardiac arrest resulting in death	100%
Stroke	100%
Invasive Cancer	100%
End Stage Renal (Kidney) Failure	100%
Major organ failure (heart, lung, liver, pancreas, or intestine)	100%
Arterial/Vascular Disease	25%
Noninvasive cancer (in situ)	100%

Note: HR can only provide payroll deductions for this benefit. To file claims or for any questions, please reach out to Lincoln Financial by calling 800-487-1485.

ATLANTIC AMERICAN
Employee Benefits

GROUP WHOLE LIFE INSURANCE
and Living Care Benefits

Give yourself protection for a lifetime

Many people buy life insurance to provide financial protection for those left behind. What if your life insurance could also provide benefits if you suffer from a permanent health condition and you require ongoing care from a family member or professional caregiver?

Value of Whole Life insurance

- **Permanent Life insurance**
- **Living Care benefits for chronic illnesses**
- **Guaranteed premiums and death benefits**
- **Accumulates cash value[1]**
- **Payroll-deducted premiums**
- **Coverage can be taken with you if you change jobs or retire, billed directly to you at home**

Atlantic American's Whole Life & Living Care plan combines the guarantees of permanent life insurance with the benefits of living care protection. Our living care benefits can assist you when you need to take care of ongoing expenses that arise from a chronic medical condition.

This hybrid life product is ideal if you want to:

- Leave a death benefit to loved ones after you die
- Provide benefits for the costly expenses associated with care, particularly over long periods of time
- Lifelong coverage through retirement with no increase in premiums

How can Living Care benefits help?

- Adult daycare
- Assisted living or nursing home
- Prescription drugs
- Gas for transportation (to and from treatment)
- Cash to a family member to assist in your care

[1]Access to cash values through borrowing or partial surrenders will reduce the policy's cash value and death benefit, increase the chance the policy will lapse, and may result in a tax liability if the policy terminates before the death of the insured.

AAEB 21803 EEG22 2183 GWL EE EIS

[GSWP] (9-23)

Understanding

permanent and term insurance

Whole Life Insurance
Coverage you "Own"

- Provides coverage for your entire life, as long as you pay the premiums and don't cancel your policy
- Ideal for people who value predictability and security
- Builds cash value at guaranteed rate
- Premiums never increase and are based on the age when you buy the policy.
- A stable financial asset on your balance sheet that will never lose value year to year
- Cash value can be accessed over the lifetime through a policy loan to supplement retirement, college tuition, down payment on a home, a business, and emergency funds or pay the policy itself
- Guaranteed death benefit, generally free from federal income tax*
- Coverage is portable without premium increases

Term Life Insurance
Coverage on "Loan"

- Provides temporary coverage for a particular length of time and expires when you reach the maximum age limit
- A good fit for people in their young adult years before a family is dependent on their income
- Essential protection while you're working
- Premiums can change over time based on the age of the policyholder, typically every 5 years
- Death benefit generally free from federal income tax*
- Option to convert to whole life insurance later without evidence of insurability, premiums can increase
- Portability is available, but may continue at a higher cost

*These statements are not intended as tax advice.

[1]https://nfda.org/news/statistics - National Federal Directors Association

AAEB MKT SS23 BRKR 1618 (5-23)

GROUP WHOLE LIFE INSURANCE

The ABC's of **Living Care[1] benefits**

Long-term chronic illnesses can have a significant impact on an individual's quality of life, both physically and financially. These types of illnesses often require ongoing medical treatment and care, which can be costly and financially devastating for individuals and their families. Atlantic American's Whole Life plan allows you to access a portion of your life insurance benefits while living. We call this Living Care.

You may not have a long-term illness now, but let's consider how you may use a hybrid life plan.

Living Care[1] ABC's

Example Election: Whole LIfe $70,000 ▶ Living Care 6.25% up to 32 months ▶ **Death Restoration**

A

What if you need care for a long-term illness?

You are able to use our Living Care benefit with a maximum **monthly benefit $4,375,** for up to **32 months.**

When you pass away, your beneficiary still receives a **Death Benefit of 50%,** or **$35,000.**

Use it all and get restored

B

What if you need care for a brief period of time?

You could have a serious illness that leaves you needing care for a brief period. **You use only $28,000** for your care, before passing away.

The remainder of your policy, **$42,000,** is paid to your beneficiary as a **death benefit.**

Use some and leave some

C

You could pass away, without ever needing care

The entire **$70,000** face amount of your policy will be paid as a **death benefit** to your beneficiaries.

Keep it all as a legacy

Exclusions, Limitations and Other Plan Information
GROUP WHOLE LIFE

EXCLUSIONS – No Benefits are provided for the following, nor will We pay any expenses incurred as a result of any Loss which is caused by, or sustained while, or incurred for, directly or indirectly:1) suicide – If the Insured, whether sane or insane, dies by Suicide, within two (2) years* from the Effective Date, Our liability will be limited to an amount equal to the premiums paid for this Certificate.

* 1 year in CO, MO, ND.

OTHER LIMITATIONS AND EXCLUSIONS – The policy and riders have other elimination periods, exclusions and limitations that may affect coverage. Please refer to your certificate for full details.

DELAYED EFFECTIVE DATE PROVISION – Atlantic American Employee Benefits will postpone the Effective Date of an eligible Spouse/Dependent, other than a newborn child's coverage if, on that date, he or she is: 1) confined to a hospital or other health care facility; 2) home confined; or 3) unable to perform two or more daily living activities. In that case, we will postpone the Effective Date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more activities of daily living. If a Spouse/Dependent was covered under a prior plan at replacement, this language will not apply to the amount of coverage that was in force with the prior plan.

QUALIFYING CHRONIC ILLNESS – a Chronic Illness: 1) that was Diagnosed no more than twelve (12) months prior to the date We received a claim for benefits under this Rider; 2) that has continued while this Rider has been In Force for at least ninety (90) consecutive Days; 3) which was not caused by a mental or nervous disorder (except organically demonstrable disorders, such as Alzheimer's or senile dementia), alcoholism or drug addiction; and 4) which is expected to be Permanent.

PORTABILITY OPTION – If you, an employee, lose eligibility for this insurance, coverage can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue coverage.

COVERED CHILDREN AND GRANDCHILDREN – Children are covered if the child is a natural, step, or legally adopted child and dependent of the employee. A grandchild is covered if the child is a dependent of the employee and filed as such on their federal tax returns. Children/grandchildren must reside in the U.S. to receive coverage.

CONVERSION – Within the 31-day period after the expiration date of the term insurance on each Dependent Child, such term insurance may be converted to a new whole life policy without evidence of insurability up to 5x the term rider coverage amount.

EXPIRATION OF CHILDREN TERM INSURANCE – The term insurance on each Dependent Child will expire on the earlier of 1) the end of the month of the child's 26th birthday; or 2) the date the Certificate matures or becomes paid up for its full Face Amount.

Lincoln Financial Group®

Your employer offers this service at no additional cost to you! Available to you, your spouse and your dependents.

You get

Unlimited phone access to legal, financial and work-life services

In-person help with short-term issues

Up to six in-person sessions per person, per issue, per year

Help and support for personal and work-life matters

EmployeeConnect Plus℠ gives you and your loved ones the support, resources and information you need to handle life's demands.

GuidanceConsultants℠

When going through a difficult time, having someone to talk to can make a big difference in your state of mind. You and your loved ones have access to confidential counseling from trained counselors for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Parenting questions
- Job pressures
- Grief and loss
- Substance abuse

GuidanceResources® Online

Whenever you need guidance on important life matters, visit GuidanceResources.com or download the GuidanceNow℠ mobile app. You'll find help on relationships, work, school, children, legal, financial concerns and more. You have access to:

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches
- Pet insurance discounts and care locator

Financial services

Everyone needs a bit of financial advice now and then. With *EmployeeConnect Plus*, you can speak with a ComPsych® financial expert to discuss:

- Managing personal financial challenges
- Credit card and debt management
- Budgeting
- Tax questions
- Financing for college
- Estate planning
- Investment options
- Mortgages, loans and refinancing
- Retirement planning

EmployeeConnect Plus℠

EMPLOYEE ASSISTANCE PROGRAM SERVICES

24 hours a day, 7 days a week. Call 855-327-4463, or visit us online at www.GuidanceResources.com (Web ID = Lincoln)

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

Lincoln Financial Group®
You're In Charge®

GROUP BENEFITS

Answers when you need them most

EmployeeConnect Plus℠ legal services

When you need legal help...

You can turn to *EmployeeConnect Plus* for guidance.[1] Simply call *EmployeeConnect Plus* to speak to a GuidanceConsultant℠ who will talk with you about your specific situation and schedule a phone appointment for you with a ComPsych® staff attorney. If you need more immediate help, you can be put in a queue to talk to a staff attorney as soon as one becomes available.

If you also need in-person representation, you can receive a referral to a qualified attorney in the *EmployeeConnect Plus* network.

Your *EmployeeConnect Plus*℠ legal services include:

Unlimited phone access to a ComPsych® staff attorney

One free, 30-minute consultation with a local network attorney, per legal issue

25% off network attorneys' customary legal fees

Get help with:

- Family law matters, including divorce, custody, child support and adoption
- Bankruptcy and credit issues
- Landlord/tenant issues, including eviction and lease questions
- Civil actions and small claims court issues
- Immigration concerns
- DUI/DWI
- Wills and living wills
- Trusts
- Name changes
- Contracts
- Probate matters

[1]Employment-related issues are excluded.

Call or click anytime to access your services

Call: 1-855-327-4463
TDD: 1-800-697-0353
Go to: GuidanceResources.com
Your company Web ID: Lincoln

Lincoln Financial Group®
You're In Charge®

GROUP BENEFITS

Resources and solutions for everyday challenges

EmployeeConnect Plus℠ work-life services

Work-life specialists at your service

Everyone has issues they need to resolve, at home and at work. *EmployeeConnect Plus* services can help. When you call *EmployeeConnect Plus*, you'll be connected to a GuidanceConsultant℠ who will talk with you about your specific needs. Work-life specialists will research your question and in just a few business days will send you a packet of practical information, including prescreened referrals (if needed), HelpSheets℠ on your subject and much more. You can receive these materials via email, fax or second-day air.

Are you:	You can get information on and help with:	
A parent looking for answers to parenting questions?	• Child care • Nanny services • Before- and after-school care	• Camps • Financial assistance • Adoption
A family member of an elder?	• Home health care • Respite care • Community services • Help determining the right level of care	• Screened referrals for assisted living and nursing homes • Hospice
Looking for a place to live?	• Finding an apartment • Finding movers • Relocating to another city	• Choosing a realtor • School and neighborhood • Housing and utility assistance
A pet owner?	• Dog walkers • Kennels and pet care • Veterinarians	• Obedience classes • Pet insurance
Sending a child off to school?	• Choosing schools, from preschool through college and beyond • Financial aid	• Scholarships • Tutors • Special needs
Planning a major project?	• Weddings and other events • Home improvement projects	• Vacation planning • Making a big purchase, such as a home or a car

Lincoln Financial Group®
You're In Charge®

GROUP BENEFITS

Objective and impartial financial advice

EmployeeConnect Plus℠ financial services

When you need financial guidance...

You can turn to *EmployeeConnect Plus* for guidance. Simply call *EmployeeConnect Plus* to speak to a GuidanceConsultant℠ who will talk with you about your specific situation and schedule a phone appointment for you with a ComPsych® financial expert. You'll have access to an in-house staff that includes certified public accountants (CPAs), certified financial planners (CFPs) and other professionals who are exclusively dedicated to providing financial information by phone.

And because our experts are not associated with any financial institution, you are assured that they will provide impartial and objective information on your money topics.

On-staff financial experts can help you with:

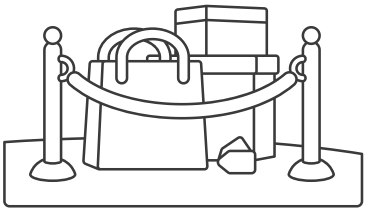
- Managing personal financial challenges
- Credit cards and debt management
- Budgeting
- Tax questions
- Financing for college
- Retirement planning
- Estate planning
- Real estate questions
- Investment options
- Mortgages, loans and refinancing

Call or click anytime to access your services

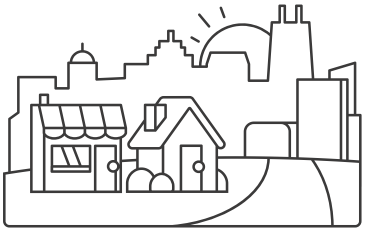
Call: 1-855-327-4463
TDD: 1-800-697-0353
Go to: GuidanceResources.com
Your company Web ID: Lincoln

YellaWood®
Pressure Treated Pine

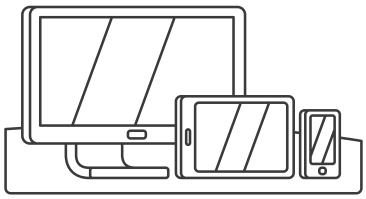
Welcome to Your YellaWood Discount Program



Exclusive Discounts from Your Favorite Brands



30,000 National and Local Offers



Designed for Your Device of Choice

Start by signing up or logging in at yellawood.perkspot.com with access code:
YellaPerks

Access at work, home, or on the go and browse thousands of discounts!

Keep an eye out for new featured discounts in your weekly email.

TRAVEL GYMS CELL PHONES RESTAURANTS AUTO APPAREL ELECTRONICS

Get Started Today!

yellawood.perkspot.com

Take Advantage of Your Learning Partner Tuition Discount

COLUMBIA SOUTHERN UNIVERSITY

Learning Partner 10% Tuition Discount

GREAT SOUTHERN WOOD PRESERVING INC.

Why CSU?

At Columbia Southern University, we bring the classroom to you. Progress through assignments completely online when it's convenient for you. No required login times and you can access your course 24/7.

CSU Offers

- Complimentary Evaluation of Prior Education and Training
- eTextbooks Provided at No Cost
- Flexible Learning
- Math and Writing Assistance
- No Application Fee
- No ACT, SAT, GRE, GMAT Required
- Multiple Course Schedule Options
- Career Services

Graduate & Undergraduate Tuition Rates

	Tuition *Per Credit Hour*	Learning Partners† *Per Credit Hour*
Undergraduate Courses*	$278.00	$250.20
Graduate Courses*	$359.00	$323.10
Doctoral Courses	$561.00	$504.90

Tuition rate effective July 1, 2025. Rates are per credit hour. Most courses are three (3) credit hours. Tuition and fees are payable in U.S. funds. Tuition Rates are subject to change. For the most current tuition information, visit www.ColumbiaSouthern.edu/Financial.

**The undergraduate and graduate tuition rate for all active-duty military using military tuition assistance is $250 per credit hour. (Discount not applicable for Learning Partners.). The lower rate is offered to keep the tuition rate at the DoD cap of $250.*

†CSU Learning Partners receive a tuition discount that is applied to the full tuition rate.

A technology fee of $35 per undergraduate course, $45 per graduate course and $60 per doctoral course will be applied to tuition. Technology fees do not apply to active-duty U.S. service members.

Online Degree Programs

Columbia Southern University offers **online associate**, **bachelor's**, **master's** and **doctoral degree programs** in a variety of majors and concentrations including:

- Accounting
- Business
- Criminal Justice
- Cyber Security
- Education
- Emergency Management
- Emergency Medical Services
- Environmental Management
- Fire Science
- Forensic Investigation
- Health Care
- Homeland Security
- Human Resources
- Human Services
- Information Technology
- Military Studies
- Nursing
- Occupational Safety & Health
- Organizational Leadership
- Psychology
- Public Administration
- Public Health

For a complete listing of online degree programs, concentrations, certificates and micro-credentials, visit **ColumbiaSouthern.edu**.

ACCREDITED INSTITUTION

For more information about your Learning Partner benefits or our online degree programs, contact your dedicated learning partner representative.

Jim Forsythe

Jim.Forsythe@ColumbiaSouthern.edu

800.977.8449 ext. 1860

ColumbiaSouthern.edu/Partners

Multiple factors, including prior experience, geography and degree field, affect career outcomes. CSU does not guarantee a job, promotion, salary increase, eligibility for a position, or other career growth. Any reference to United States Department of Defense (DoD) personnel, products or services does not constitute or imply endorsement by the DoD.

5/13/2025

Employee Benefit Assistants You Can Count On

Marsh McLennan Agency provides you and your family members a complimentary member claims service to help with claims, billing, missing ID cards and more!

Give Member Claims Advocate a call if:

- You received a provider bill or EOB but do not feel the claim was processed correctly.
- You are at the doctor or pharmacy and having trouble with your coverage.
- You need to confirm if a provider is In-Network.
- You are missing your ID card.

You can reach the Member Claims Advocate team by phone or email.

Monday through Friday, 8:15 AM EST – 5:15 PM EST
Email: mmajslbenefitclaims@MarshMMA.com
Toll Free: (800) 226-4518

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 July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

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

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

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

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://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: https://www.in.gov/medicaid/
http://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:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://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:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://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: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) (continued)

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

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

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

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

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

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://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

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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

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

PENNSYLVANIA – Medicaid
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://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: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program
Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

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

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

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

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

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://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 July 31, 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

Important Healthcare Notices

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services are subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Fixed Indemnity Policy Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Medicare Part D Notice: Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Huggin' Molly's, It's Affiliates and Subsidiaries 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:

- 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.
- Huggin' Molly's has determined that the prescription drug plans administered by EBMS are, 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 current Huggin' Molly's coverage will not be affected. However, if you do decide to join a Medicare drug plan and drop your current Huggin' Molly's coverage, be aware that you and your dependents may not be able to get this coverage back.

Medicare Part D Notice: Prescription Drug Coverage and Medicare

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 with Huggin' Molly's 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.

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 our office 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 this coverage through Huggin' Molly's 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).

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

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."

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

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 TBD.

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. Any Disability Extension needs to be sent to Admin America.

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.

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

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/agencies/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.

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

EBMS
406-869-5555

Huggin' Molly's Welfare Benefit Plan Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Huggin' Molly's Welfare Benefit Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on September 22, 2013.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Huggin' Molly's, It's Affiliates and Subsidiaries requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Huggin' Molly's, It's Affiliates and Subsidiaries for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Huggin' Molly's Welfare Benefit Plan Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Human Resources
Huggin' Molly's
P.O. Box 610
Abbeville, Alabama 36310
Phone: 1-334-585-2291

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Huggin' Molly's		4. Employer Identification Number (EIN) 63-0594831
5. Employer address Highway 431, P.O. Box 610		6. Employer phone number 334-585-2291
7. City Abbeville	8. State AL	9. ZIP code 36310
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

⊡ Some employees. Eligible employees are:

Full-time employees who are regularly scheduled to work 30+ hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses and children up to age 26

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Carrier Contact Information

Medical (EBMS)
Customer Service: 406-869-5555
Toll Free: 866-326-7618
Website: https://mibenefits.ebms.com

Pharmacy (VeracityRx)
Customer Service: 888-388-8228
Website: https://veracity.procarerx.com

Pre-Certification (Veracity Care Solutions)
Customer Service: (888) 324-1747

ELAP Member Services
Phone: 800-977-7381
Hours: 9am-7pm EST
Fax: 888-560-2447
Mail: ELAP
1550 Liberty Ridge
Suite 330
Wayne, PA 19087

Health Savings Account
HSA Bank
Customer Service 1-800-357-6246
Website: www.hsabank.com

Dental (Ameritas)
Customer Service: 1-800-487-5553
Website: www.ameritas.com

Vision (Ameritas – EyeMed Insight Network) Customer Service: 1-866-723-0514
Website: www.eyemedvisioncare.com

Life, Disability, and Voluntary Benefits (Lincoln Financial)
Customer Service: 1-800-487-1485
Website: www.lfg.com

Employee Assistance Program (EAP) (Lincoln Financial)
Customer Service: 1-888-628-4824
Website: www.lfg.com

Flexible Spending Accounts (Voya)
Customer Service: 1-833-232-4673
Website: myHealthAccountSolutions.voya.com

401(k) Plan (Fidelity)
Customer Service: 1-800-835-5097
Website: www.401k.com

Human Resources
Phone: 1-334-585-2291
Email: hris@yellawood.com

Financial Advisor
Matthew Murphy
Customer Service: 334-679-4801
Email: matthew@marblewealth.com

Member Claims Advocate, Marsh McLennan Agency
Phone: 800-226-4518
mmajslbenefitclaims@MarshMMA.com

Insurance Agent/Broker Marsh McLennan Agency
Ellen Flynn
Phone: 706-596-4654
Email: ellen.flynn@marshmma.com

Sara Franks
Phone: 706-645-8221
Email: sara.franks@marshmma.com