National Management Resources Corporation

Benefits Enrollment Guide

2025 Plan Year

WHAT'S INSIDE?

Medicare Part D Notice (pages 25-26)

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Dear Employee:

Each year, employers are faced with tough decisions regarding employee benefits. The rising cost of healthcare services, along with the mandated plan changes set forth by Healthcare Reform, have greatly impacted the cost of group health plans. National Management Resources Corporation is not immune to these changes. We are committed to providing our employees with a comprehensive benefit program, and we have selected the most preferable options for our group based on our review of carrier proposals.

This enrollment guide is designed to assist you in making benefit decisions for you and your family as well as enrolling for your benefits for the 2025 plan year. It explains each type of coverage, gives suggestions about how to effectively use your benefits, and provides examples to determine your benefit and payroll deduction amount. Please review this guide prior to completing your enrollment.

Susan Carson
Chief People Officer

This communication represents a brief summary of the various benefits available to you and is provided for reference only. The actual policies issued by the Insurance Carrier determine coverage and contain exclusions, limitations, full coverage terms, conditions and requirements. Any notices included in this document do not replace an Employer's requirement for communication.

If You're a New Employee

If you aren't currently enrolled, you and your eligible family members can participate in the benefit package on the 1st day of the month following 60 days of employment. Just keep in mind that if you are a new employee who is disabled and away from work on the date that your coverage would become effective, you'll have to wait until you return to work before your coverage goes into effect. If a family member is confined in a hospital or confined to the house because of an illness or injury, they would also have to wait for coverage to begin.

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

When a qualifying change occurs, you must notify your Human Resource Department and provide supporting documentation within 30 days of the event (in most circumstances), and your benefit changes must be consistent with the event. If you do not do so within 30 days, you must wait until the next open enrollment to make benefit plan changes.

About Your Deductions

Your premiums for medical, dental, and vision coverage will be deducted on a pre-tax basis because it is covered under your Cafeteria Plan under Section 125 of the Internal Revenue Service Code. Once you elect to enroll in this plan, you will not be allowed to drop or change your election until the Company's next Annual Enrollment unless you have a Qualifying Event.

Should you prefer to opt out of the Cafeteria Plan, and have your benefits deducted on a post-tax basis, please notify Human Resources.

Information You'll Need to Enroll

In order to make the enrollment process as smooth as possible, it will help if you have the following information ready.

- Your name, date of birth and Social Security Number
- The name(s), date(s) of birth and Social Security Number(s) of your dependent children up to age 26. Dependent children include your natural children, adopted children, stepchildren and children for whom you have legal guardianship.
- The name, date of birth and Social Security Number of your spouse (if applicable).
- Your current address, so that we can update our records. This will also ensure that both your ID cards and other important benefit information are sent to the correct address.

Eligible Dependent

Please make note of the definition of an eligible dependent. You may be asked to produce documentation as proof of the dependent's current eligibility status. It will be your responsibility to notify Human Resources of any changes in eligibility status.

- Employee's legal spouse (please note that "Common Law" spouses are not eligible for coverage)
- Employee's biological children up to the age of 26
- Employee's mentally or physically handicapped children who are totally dependent on employee for support
- Employee's or employee's spouse's legally adopted children from the date of adoption
- Dependent children for whom the employee assumes court appointed legal guardianship
- Employee's stepchildren as long as employee remains married to the natural parent of the child
- Children for whom employee or employee's spouse has legal responsibility resulting from a valid court decree
- Foster children for whom employee assumes legal responsibility

HOW TO ENROLL

alight worklife

How to Enroll by Phone

You may enroll by telephone through e-sMMArt, Monday through Thursday, 8:30 am - 6:00 pm and Friday, 8:30 am - 5:00 pm EST. To speak with a trained Enrollment Specialist, please call **1-866-688-9727**.

How to Enroll Online

Alight Worklife is our online enrollment tool. The site is accessible 24 hours a day, 7 days a week. The following tips will help you prepare and complete the online enrollment process.

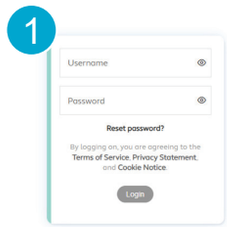
What You'll Need to Enroll

- Social Security Number and Date of Birth for any spouse or dependents you plan to cover
- Beneficiary contact information for any applicable benefits

Step 1

Log on to **https://worklife.alight.com/teamnational/** and enter your user-name: First 4 letters of last name (ALL caps) + Last 4 digits of SSN and password: 8 digit DOB

• Example: John Smith SSN: 123444678 DOB: January 7, 1976
John's Username: SMIT4678
John's Password: 01071976

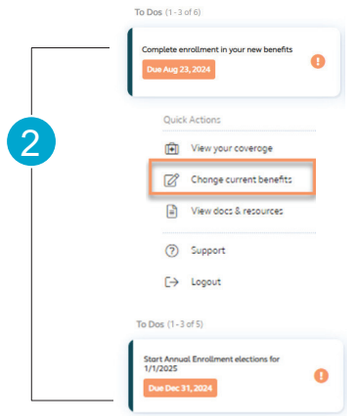


Step 2

On the home page, your applicable type of enrollment can be accessed as follows:

New Hire/Acquisition
Select the To Do titled "Enroll in your new benefits". The To Do contains the due date to complete your newhire enrollment.

Annual Enrollment
Select the To Do titled "Start Annual Enrollment". The To Do contains the due date to complete your annual enrollment.



Step 3

Review and Elect Benefits: The Benefit Summary page lists all benefits you are eligible to enroll in. To enroll or make changes to a benefit, click the View/Change button on each benefit you wish to update.

Step 4

Once within the benefit, select the desired level of coverage based on **Who is being covered**:

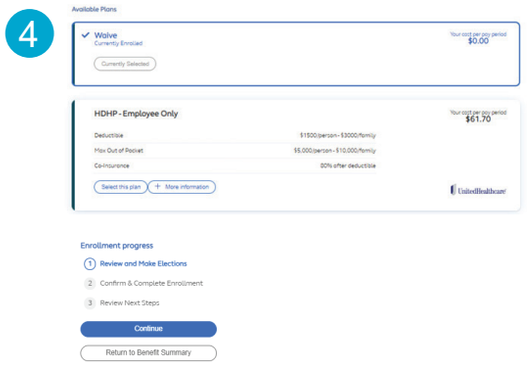
a. The plan and costs will update automatically based on the tier level selected.

i. To select a plan, select the "Select this plan" button in the lower left-hand corner of the plan option.

ii. The election will be highlighted

b. To keep the current coverage option, click the **Continue** button on the right side of the page.

c. To waive current coverage, click the **Decline This Coverage** button at the bottom of the screen. Decline This Coverage



HOW TO ENROLL

Step 5

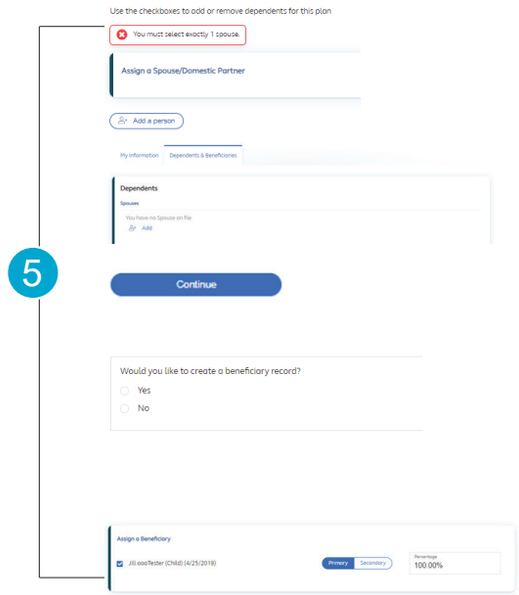
If spouse/dependent/beneficiary assignments are required, Alight Worklife will prompt you automatically to add these new records. You can review all dependents and beneficiaries at any time by clicking on the Dependents and Beneficiaries button.

a. Dependents and Beneficiaries page:

i. Select the + button under the appropriate record type (spouse/ dependent/beneficiary)
ii. Update all required demographic fields and click **Save**
iii. Once all records have been added, select the **Continue** button. This will resume the enrollment process to assign the applicable dependents.

b. **TIP**: The last question when creating the record is whether you would like to create a beneficiary record. By selecting "Yes," this will automatically create the beneficiary record for that dependent for you. If you select "No," and the dependent will act as a beneficiary, you will need to create the beneficiary record separately.

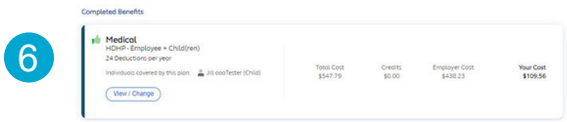
c. **Beneficiary**: If you are eligible for a benefit that requires a beneficiary you will be prompted to add one. Multiple beneficiaries can be added. During enrollment, you may designate your beneficiary as primary or secondary and you may also select the percentage allocation for each beneficiary.



NOTE: Adding spouse/dependent/beneficiary records to this section does NOT assign them to applicable coverage. Once all records have been added, select Continue. Official assignments to coverage will occur within the benefits as you are making your desired elections.

Step 6

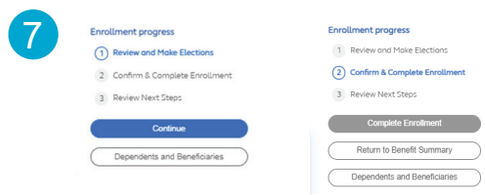
After all required information is captured, the benefit will move to the completed benefits section of the benefit summary page.



Step 7

Complete the process for any remaining benefits in the Incomplete Benefits section.

- Once all elections have been completed, the Continue button on the right side of the Benefit Summary page will turn blue and can be clicked.
- Follow the prompts and any confirmations on the following screens.
- Initial confirmation of enrollment.
- Select the **Complete Enrollment** button

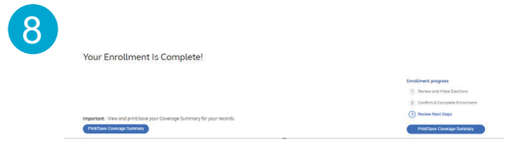


Step 8

Once enrollment is complete, you will reach the "Your Enrollment is Complete" screen and be prompted to print a confirmation page.

Next Steps:

- You will receive notice that your enrollment has successfully completed.
- You can then print your **Confirmation Page** for your records.
- Back on your home page, you may view your confirmation, review plan documents, etc.
- Once complete, click the logout on the left-hand side.



Medical Coverage (EBMS)

Your Medical Plan Benefits Partners Direct Health (PDH)

In order to receive the highest level of medical benefits and pay the least amount out of your pocket, you should seek care from Partners Direct Health (PDH) in-network providers.

National Management Resources Corporation offers a self-funded medical plan. We utilize EBMS to administer medical claims, and EBMS partners with Partners Direct Health (PDH) providers to apply discounts on medical services. In-network providers can be found by logging on to https://partnersdirecthealth.com/providers.

You will be able to choose between two medical plan options. Please review the medical plan summary for each option on the following pages.

- Premier
- Core

Plan Summary of Benefits (EBMS)

Benefit Features	Premier In-Network	Core In-Network
Calendar Year Deductible		
Individual	$1,800	$4,500
Family	$5,400	$9,000
Coinsurance	Member pays 20%	Member pays 10%
Lifetime Maximum	Unlimited	Unlimited
Out-of-Pocket Calendar Year Maximum		
Individual	$4,500	$7,500
Family	$9,000	$15,000
Office Visit Copays		**Copays apply after deductible**
Primary Care Physician	$35 copay	$30 copay
Specialist	$70 copay	$60 copay
Urgent Care	$75 copay	$60 copay
Maternity Services *(prenatal, delivery, postpartum)*	Member pays 30% after deductible	Member pays 20% after deductible
Preventive Care		
Well child care, immunizations	Plan pays 100%	Plan pays 100%
Periodic health exams	Plan pays 100%	Plan pays 100%
Annual gynecology exams	Plan pays 100%	Plan pays 100%
Prostate screenings	Plan pays 100%	Plan pays 100%
Emergency Room Copay *(waived if admitted)*	$350 copay; then member pays 20%	Member pays 10% after deductible
Hospital Services		
Inpatient	Member pays 20% after deductible	Member pays 10% after deductible
Outpatient	Member pays 20% After deductible; $150 copay freestanding	
Pharmacy		
Rx Deductible	No Rx Deductible	Medical Deductible Applies
Generic Drugs	$5 (30 days) / $15 (90 days)	$5/$15 after deductible
Formulary Brand Name Drugs	$60 (30 days) / $90 (90 days)	$40/$100 after deductible
Non-Formulary Brand Name Drugs	Not Covered	$80/$200 after deductible

Note: All covered services, including deductible, copays, and prescriptions apply towards the out-of-pocket maximum. Once the out-of-pocket maximum has been reached, the play pays 100% for all covered services.

Pharmacy Program – Preferred Pharmacies

We are always looking for ways to save our members money. Here are just a few ways our Pharmacy Program strives to meet that goal.

Save with one of our Preferred Pharmacies!

Choose to fill your prescriptions at one of our many Preferred Pharmacies and start saving. Save money by skipping the “big box” pharmacies like Target, CVS, Walmart & Walgreen’s and get your prescription filled at your neighborhood grocery store or local independently owned pharmacy.

Skip the mailbox and get your 90-day RX filled right at your favorite Preferred Pharmacy!

Once you are on the same medication and dosage for 90 days you can elect to get a 90-day fill at the pharmacy and receive mail order discounts without the wait.

Go Generic and Save!

When you choose the generic prescription versus the brand name RX you can save on your member cost/copay. Think of it like getting the drug store brand of ibuprofen instead of the name brand of Motrin. Same pain relief without the expensive label. You still have the option of a brand name RX. You just pay the difference in cost.

Access to our Pharmacy Advocate Concierge!

When your provider prescribes a Specialty Drug, our Pharmacy Concierge will contact you to find out how we can help obtain your prescription at a discounted cost to you and your health plan.

Health Savings Account (HSA Bank)

If you elect the "Core" High Deductible Health Plan (HDHP), you are eligible to also establish a Health Savings Account (HSA) which allows you to pay for qualified expenses with pre-tax dollars. For questions on your account, receipts, general, legal, or plan questions, you may go online to www.hsabank.com to access your account.

The High Deductible Health Plan (HDHP) is intended to cover serious illness or injury after the deductible has been met. You can have a HDHP without an HSA account. In this case, all medical expenses incurred prior to meeting the deductible are paid out of your pocket with after-tax dollars. The Health Savings Account is owned by and funded with pre-tax contributions. The HSA pays for out-of-pocket expenses incurred before the deductible is met. If you leave, you can take it with you.

How to setup your HSA

Your enrollment information will be provided to HSA Bank and a new account link will be sent directly to you. After your information has been entered into the system, National Management will receive your account number in order to set up your account. Please watch for notifications from HSA Bank.

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.

2024 HSA Contribution Limits		
	Contribution Limit	**55+ Contribution**
Single	$4,300	$1,000
Family	$8,550	$1,000
Note: When allocating funds to your HSA, make sure the contribution does not exceed the 2024 limits.		

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 entitled to Medicare benefits; or
- Not eligible to be claimed on another person's tax return.

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, are up to date on your account.
- **Control:** You decide when to use your savings to pay for medical expenses.
- **Dependents:** HSA funds can be used to pay health expenses for dependent children if they meet the definition of a dependent set by the IRS. A qualifying child:
  - Has the same principal place of abode as the covered employee for more than one-half of the taxable year.
  - Has not provided more than one-half of his or her own support during the taxable year.
  - Is not yet 19 (or, if a student, not yet 24) at the end of the tax year or is permanently and totally disabled.

Introducing ELAP Services – Your Health Plan's Partner for Fairness & Affordability

Overinflated hospital bills cause health plans to raise rates and members to pay more. ELAP eliminates this problem so that everyone pays only what's fair.

When life takes you here...

- Hospital
- Emergency Room
- Outpatient Surgery
- Doctor Visits

...ELAP eases the financial pain.

- **Supporting claim limits:** ELAP helps your plan set fair limits on what it will pay for healthcare services to avoid wasteful spending.
- **Reviewing every hospital and facility bill:** ELAP examines every bill line-by-line to catch overcharging.
- **Resolving billing issues:** If your plan is overcharged, we will let you know that we're reducing payment. That's when we need you to look out for **balance billing**.

Know What You Owe

Make sure your EXPLANATION OF BENEFITS (EOB)...

From your health plan (not a bill)

Shows you what your plan covered and what you'll owe. If you owe money, you'll get a bill from the hospital/provider.

...Matches your BILL

From the hospital/facility

If this does not match your EOB, **simply contact ELAP**. They'll take care of it.

Most of the time, you'll never have a reason to contact ELAP about a bill. But if you do, the ELAP advocacy team is here to support you.

ELAP Services – Your health plan's affordability partner.

Telephone: 1-800-977-7381, 9 am - 7 pm ET | Fax: 1-888-560-2447 | balancebills@elapservices.com

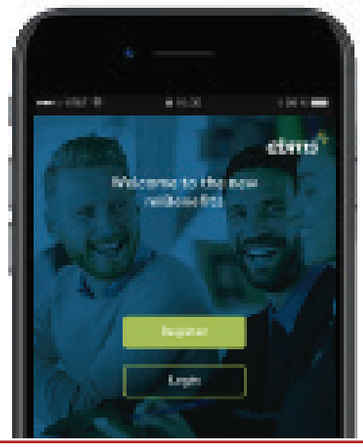
Introducing EBMS Services – Your Health Plan's Affordability Partner

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
- 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.



Frequently Asked Questions

How can I find doctors and hospitals who accept my insurance?

Online Option:

1. Go to https://partnersdirecthealth.com/providers.
2. Click on "Provider Search" (at the top of page).
3. Search by name, specialty, or location.

Telephonic Option:

1. Customer Service: 888-573-3186
2. Make sure to have your ID card on hand when calling.

What exactly does ELAP do? ELAP partners with your company to ensure hospital and facility payments do not exceed your health plan's limits and that they are for services rendered and nothing more. We do this by auditing all hospital and facility claims. ELAP Services will ensure the hospital makes a fair and reasonable profit on all services provided, but we greatly reduce excessive markups that are often seen on facility bills.

What types of medical bills does ELAP review? We review all medical bills with the exception of retail and mail order prescription drug claims. Your prescription drug claims are handled by VeracityRx.

How do I know ELAP reviewed my claim? You will receive a notice from EBMS notifying you that ELAP has audited a claim for services rendered to you. The letter will list the date of service and facility. If you receive a bill for money outside of your member responsibility, this is called "balance billing" and you must submit the bill to ELAP.

What if the hospital or doctor denies care due to an outstanding billing issue? If the facility will not perform treatment without additional funds outside of your normal copay, then you should contact EBMS immediately and request to speak with a representative.

How does ELAP make my health plan better? Overinflated hospital bills cause health plans to raise rates and members to pay more. ELAP eliminates this problem so that everyone pays only what's fair and reasonable.

What should I do if a facility requests payment up front? The only out-of-pocket expense that you should pay to the facility in advance of or at the time of service is a copay (if applicable). You can contact your plan to confirm copay and/or deductible amounts. Since ELAP will often reduce the amount you owe after auditing a bill, you could overpay by paying up front and the facility will not reimburse you.

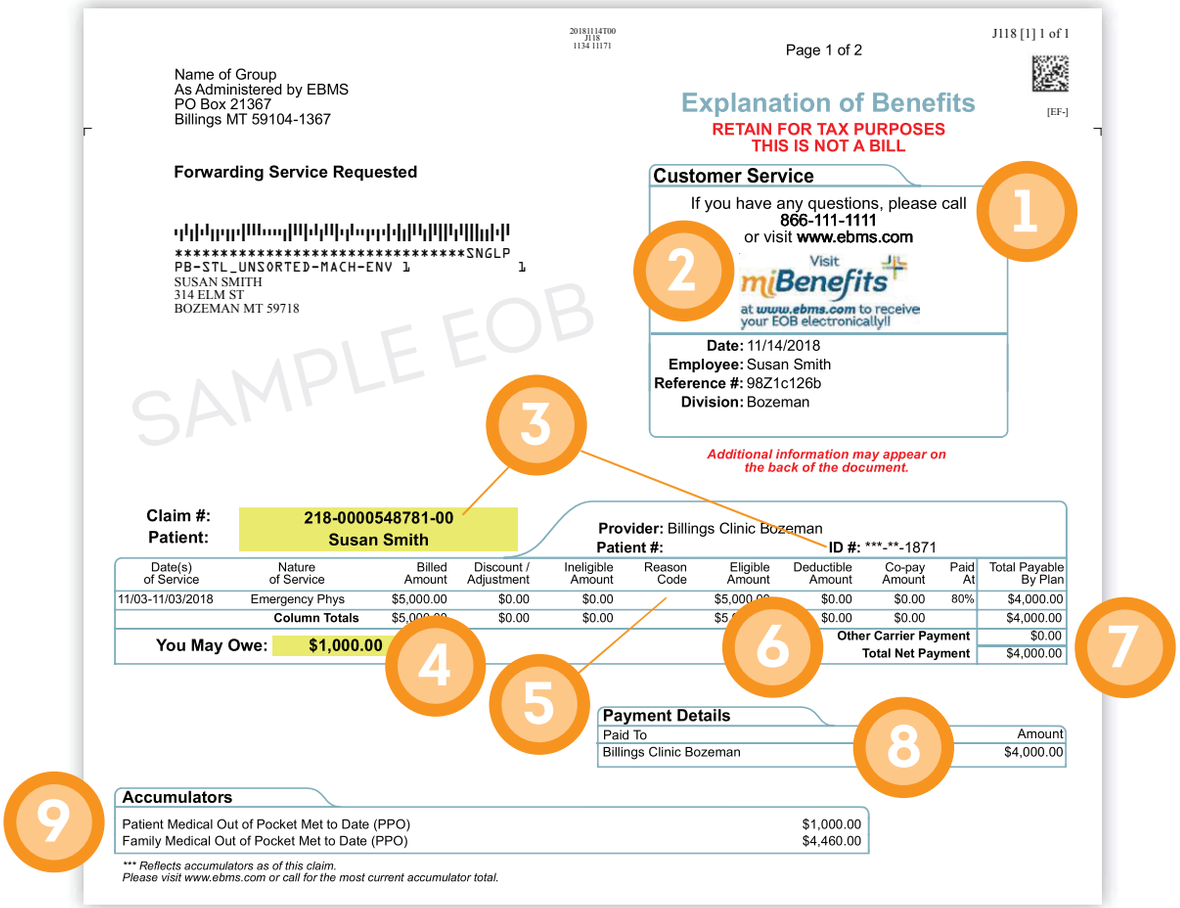
When do I have to contact ELAP? Sometimes a hospital or other facility does not accept the payment that we approve as fair and reasonable. In this case, they may bill you for the balance. This is called "balance billing" and when it happens, you need to contact us and send us your bill via fax, email or mail…

Email: balancebills@elapservices.com
FAX: 888.560.2447 ATTN Balance Bill Response Team
Mail: 1550 Liberty Ridge Drive, Suite 330 Wayne, PA 19087

What happens when I contact ELAP about balance billing? You will receive assistance from a Member Services Advocate throughout the balance billing process. ELAP's legal team will also go to work right away to handle the billing issue with healthcare facilities and collection agencies. It is **very important** that you send ELAP any bills or notices as you receive them.

Questions about a medical bill? Contact ELAP right away!
Telephone: 1-800-977-7381, 9 am - 7 pm ET
Fax: 1-888-560-2447
balancebills@elapservices.com

Understanding Your Explanation of Benefits



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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
									Other Carrier Payment	$0.00
									Total Net Payment	$4,000.00

You May Owe: $1,000.00

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**
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 ELAP's Navigation Services Program

Occasionally, you may run into a challenge with your healthcare plan. ELAP Services is ready to support you with the Navigation Services program, staffed by high-level specialists known as healthcare navigators. You can call on ELAP Services if you experience a problem either before you access a health service or afterward.

Reference-based pricing can:

- Promote price transparency and counteract the wide variation in prices across providers
- Set the fair price for a health service based on pre-determined benchmarks (for example, the Medicare rate plus a fair profit margin)
- Allow you to more easily shop for care based on both price and quality, without being limited to a list of preferred doctors and hospitals

How Can a Healthcare Navigator Help?

We hope you never have a problem with your health plan! But if you do, ELAP Services 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 Services advocate for you!

Contact a Healthcare Navigator now:

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

SwiftMD is now revive

Welcome to revive

Eligible employees can talk to a doctor 24/7 by phone or video-chat. Cost of service is $45 and applies to the Core medical plan only.

- 24/7 nationwide access to Board-Certified physicians
- Consults available anytime, anywhere
- Prescriptions sent to your preferred local pharmacy
- Avoid overcrowded waiting rooms and long wait times
- Fee for service cost: $45

Getting Started:

You can use SwiftMD anytime by calling our toll free number 833-SWIFTMD (833-794-3863).

To use Swift MD online, go to SwiftMD.com member login and click "Get Started."

Login with credentials provided.

Enter your email, cell phone, and pharmacy information to facilitate your telemedicine consults.

Please take a few minutes to enter your medical history before talking to a Swift MD doctor.

After a consulation you can review your visit note in your account online.

Each adult family member (age 18 and over) has an individual online account and can retrieve their login credentials at SwiftMD.com member login.

Access care via our mobile app!

Download on the App Store

GET IT ON Google Play

Conditions we treat:

Allergies and Rashes, Arthritis Pain, Back Pain or Injury, Cold Sores, Diarrhea, Earache, Conjunctivitis or Pink Eye, Fever and Flu, Headache, Insect Bites and Stings, Lyme Disease, Sinusitis, Sore Throat, Stomach Ache and Nausea, Upper Respiratory Infections, Urinary Tract Infections, Vomiting, Your Individual Concerns

Revive does not replace your PCP managing chronic conditions. Revive health doctors don't prescribe controlled or psychiatric medications, and certain other medications subject to abuse.

Dental Coverage (Ameritas)

Dental benefits are available to you and your eligible family members to cover routine care such as exams, x-rays and cleanings, as well as fillings, dentures, bridgework and periodontal care. In order to pay the least amount out of your pocket, you will want to use network providers because of the PPO discounts associated with these providers. Visit https://ameritas.com for an in-network provider directory. Select FIND A PROVIDER, then DENTAL. Enter your criteria to search by location or for a specific dentist or practice. You may also call Customer connections at 1-800-487-5553. Your provider network is Ameritas Classic and Plus Network.

There are two plans to choose from:

- Plan 1
- Plan 2

Please review the summary of benefits for each plan below.

Dental Summary of Benefits				
PPO Network	**Plan 1**		**Plan 2**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$50 Lifetime Basic, Waived Preventive		$50 Lifetime Basic & Major, Waived Preventive	
Preventive Services Routine exams Routine cleanings (two per year) Fluoride X-rays Sealants Space maintainers	100%	80th percentile; U &C*	100%	90th percentile; U &C*
Basic Services Fillings Simple extractions Repair of dentures Re-cement crowns/bridges Occlusal guards	80%	80th percentile; U &C*	80%	90th percentile; U &C*
Major Services Inlays Crowns Bridges Dentures Denture rebase or reline Repair of fixed bridge Endodontics (root canal) Periodontics (gum treatment)	Not Covered	Not Covered	50%	90th percentile; U &C*
Annual Maximum	$1,000 per person		$1,250 per person	
Note: Deductible is waived for Preventive Services.				

**We determine the Usual and Customary (U&C) allowance listed on the plan summary page using information including data from a nationally recognized independent data source. Plan members are reimbursed based on the appropriate charges in the dentist's ZIP Code area. We review our U&C allowances annually. 80th/90th U&C means 8/9 out of 10 dentists in a specific ZIP Code area charge at or below the plan allowance for a procedure.*

Vision Coverage (Ameritas)

Vision benefits are available to you and your eligible dependents to cover lenses, frames, contacts and routine care such as exams. The VSP Choice network is nationwide including private practice and retail providers. To obtain a list of in-network vision care providers, go to https://vsp.com or call 1-800-877-7195.

Ameritas - VSP Choice	Vision Summary of Benefits	
	In-Network	Out-of-Network
Annual Eye Exam	$10 deductible, then covered in full	Up to $45
Lenses (per pair)		
Single	$10 deductible, then covered in full	Up to $30
Bifocal	$10 deductible, then covered in full	Up to $50
Trifocal	$10 deductible, then covered in full	Up to $65
Lenticular	$10 deductible, then covered in full	Up to $100
Frame allowance	$130**	Upt to $70
Frequencies Exam/Lens/Frames	12/24/2024	
**The Costco and Walmart Allowance will be the wholesale equivalent.		
Deductibles		
	$10 Exam	$10 Exam
	$10 Eye Glass Lenses or Frames	$10 Eye Glass Lenses or Frames
Contact lenses		
Fit & Follow Up Exams	Member cost up to $60	No benefit
Contacts		
Elective	Up to $130	Up to $105
Medically Necessary	$10 deductible, then covered in full	up to $210
Note: Contact lenses are in lieu of eyeglass lenses.		

Voluntary Life (Anthem)

Voluntary group life insurance is available to you during your New Hire enrollment in the amount of $30,000 at a low cost per paycheck. Contact Human Resources to confirm your cost for this coverage.

There are several benefit provisions that you need to be aware of regarding this coverage:

- The Guarantee Issue Limit is $30,000 for all employees regardless of age. Newly eligible employees can enroll without medical underwriting.
- If you become totally disabled before age 60, after 6 months of disability, you no longer will need to pay premiums for this coverage. The Waiver of Premium provision terminates when you turn 65 or prior retirement.
- You may receive Accelerated Death Benefits if you are diagnosed with a terminal illness with life expectancy of less than 12 months. This provision allows you to receive up to 75% of the face amount of the policy to assist you and your family. The remaining face amount of the policy would become payable upon your death.
- This Voluntary Group Life coverage reduces in value as you age. It reduces by 35% at age 65; 50% at age 70. Benefits terminate at retirement.

Voluntary Life Summary of Benefits	
Life Benefit	$30,000
Accidental Death & Dismemberment	$30,000
**Make sure to designate your beneficiaries during your enrollment on SmartBen.*	

Value Added benefits including Resource Advisor and Travel Assistance are included when this benefit is purchased.

Resource Advisor provides services such as identity theft victim recovery services; beneficiary services; legal/financial services, savings center, and relocation services. The services available to members are vast. Be sure to visit the www.anthem.com website to learn more about these services available to you.

Travel Assistance also offers a vast array of Value Added services. This includes, however is not limited to, medical evacuation and/or repatriation; prescription replacement or refill assistance; emergency cash advance; emergency message relays; return of dependent children; vehicle return; legal assistance. To learn more about Travel Assistance, call 240-330-1000.

Disability Coverage (Lincoln)

Accidents and illnesses happen every day. How long would your money last if your paycheck suddenly stopped? Thankfully, there is insurance that pays you an income if you become temporarily or permanently disabled.

Short Term Disability and Voluntary Long Term Disability provides income protection in the event of inability to work due to an accident or illness. Short Term Disability is provided by National Management Resources at No Cost to you! Long Term Disability cost is based on your age and increases as you enter into a new age band. Coverage is available only while employed by National Management Resources.

Employer-Paid Short Term Disability

Short Term Disability, STD, provides you with a specified percentage of your pre-disability income on a weekly basis. Conditions that can trigger Short Term Disability are usually temporary in nature, such as pregnancy, broken bones, sprains, or minor surgery. The coverage begins on the 8th day of an accident or illness. Most people use accumulated sick time to cover the waiting period.

Voluntary Long Term Disability

Long Term Disability, LTD, provides you with a specific percentage of your pre-disability income on a monthly basis. This type of policy provides protection for a longer period of time, sometimes to age 65. LTD is often used in situations of a catastrophic disease or illness.

These policies usually start when a short term policy ends. In a long term policy, you are usually defined as disabled if you cannot complete the duties of your own occupation for a first initial period. After the initial period, you are defined as disabled if you cannot complete the duties of any occupation to which you are suited by education, training, or experience, for the remainder of the benefit period.

Disability Summary of Benefits	Short Term Disability	Long Term Disability
Elimination Period	7 days	90 days
Duration of Benefit	12 weeks	Later of Age 65 or SSNRA
Percentage of Income Replacement	60%	60%
Maximum Benefit	$1,500	$10,000
Pre-Existing Conditions	3 / 12	3 / 12

What does “elimination period” mean?

The elimination period is a period of time an employee must be disabled before benefits are paid.

What are “pre-existing conditions”?

A pre-existing condition is one that you have previously received consultation, medical treatment, care or medicine for.

Please Note: If you elect Voluntary LTD coverage after your initial eligibility period you will be required to submit an Evidence of Insurability Form to Lincoln for approval. The coverage will not become effective until approval from Lincoln is received.

ADDITIONAL BENEFITS

CRITICAL ILLNESS | ACCIDENT | HOSPITAL INDEMNITY

AC^G | ACCIDENT

Accidents happen to all kinds of people every day.

38 million people – about 1 out of 8 – sought medical attention for an injury in 2012.*

What would the financial impact of an injury mean to you? Are you prepared for high medical costs in addition to everyday household expenditures and lost wages? Out-of-pocket expenses associated with an accident are unexpected, but an accident's impact on your finances and your well-being certainly can be reduced.

Aflac is here to help. If you have an accident, major medical insurance will help with many medical expenses, but you could be left with out-of-pocket expenses. You could also lose pay while you're out of work. And you can be sure that the bills will keep coming.

IT'S INSURANCE FOR DAILY LIVING:

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group accident insurance plans** are designed to provide you with cash benefits throughout the different stages of care, such as the following:

- Emergency treatment
- Hospital admission
- Intensive care unit
- Ambulance transportation
- Travel expenses to distant treatment centers
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more

DEDICATED LOCAL SERVICE

Ask your Aflac agent how group accident insurance can help you. Remember, we're always by your side. And you're always under our wing.

**Injury Facts*, 2014 Edition, National Safety Council.

**This is a brief product overview only. Products and benefits vary by state and may not be available in some states. Plan design and optional benefits are selected at the employer level. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

In Arkansas, Policy CAI7800AR and CA7700-MP-AR. In New York, Policy AF7700NY. In Oklahoma, Policy CAI7800OK and CA7700-MP(OK). In Oregon, CAI7800OR and CA7700-MP(OR). In Pennsylvania, CAI7800PA and CA7700-MP(PA) 07. In Texas, CAI7800TX and CA7700-MP-TX. In Virginia, CAI7800VA and CA7700-MP(VA).

Continental American Insurance Company is not aware of whether any employees receive benefits from Medicare, Medicaid, or a state variation. If any employees or dependents are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that any such employees may not receive any of the benefits in the plan. As a result, employees should please check the coverage in all health insurance policies those employees already have or may have before such employees buy this insurance to verify the absence of any assignments or liens.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

Aflac

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situsedin California, group coverage is underwritten by Continental American Life Insurance Company. For groups situsedin New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • Columbia, South Carolina

AGC01041G R2 IV (2/16)

SHI[G] | HOSPITAL INDEMNITY

Hospital care and physician/clinical services combined account for over half (52%) of the nation's health expenditures*

As health care costs continue to rise, employees realize they are responsible for paying more and more out-of-pocket costs with every accident and illness. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

How will you help protect your savings when you have a covered accident or sickness?

If you are confined to the hospital, major medical insurance will help with many medical expenses, but you could be left with out-of-pocket expenses. You could also lose pay while you're out of work. And you can be sure that the bills will keep coming. Aflac is here to help.

IT'S INSURANCE FOR DAILY LIVING:

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group hospital indemnity insurance plans** are designed to provide you with cash benefits to help with the following:

- Hospital admission
- Hospital confinement
- Intensive care unit
- Ambulance transportation
- Surgery and anesthesia
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more

ENROLL TODAY

Ask your Aflac agent how group hospital indemnity insurance can help you. Remember, we're always by your side. And you're always under our wing.

*National Center for Health Statistics. Health, United States, 2013: With Special Feature on Prescription Drugs. Hyattsville, MD. 2014.

**This is a brief product overview only. Products and benefits vary by state and may not be available in some states. Plan design and optional benefits are selected at the employer level. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

In Arkansas, Policy CA8500-MP(AR). In New York, Policy AF8500NY. In Oklahoma, Policy CA8500-MP(OK). In Oregon, CAI8500OR. In Pennsylvania, CA8500-MP-PA. In Texas, CA8500-MP. In Virginia, CA8500-MP (VA).

Continental American Insurance Company is not aware of whether any employees receive benefits from Medicare, Medicaid, or a state variation. If any employees or dependents are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that any such employees may not receive any of the benefits in the plan. As a result, employees should please check the coverage in all health insurance policies those employees already have or may have before such employees buy this insurance to verify the absence of any assignments or liens.

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Aflac®

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AGC01384G R2 Continental American Insurance Company • Columbia, South Carolina IV (2/16)

Group Critical Illness Insurance

You can count on Aflac to help ease the financial impact of surviving a critical illness.

Chances are you know someone who's been diagnosed with a critical illness such as cancer, a heart attack (myocardial infarction), or stroke. You can't help but notice the strain it's placed on the person's life–both physically and emotionally. What's not so obvious is the impact on that person's personal finances. While the person is busy getting well, the bills may continue to pile up.

Would you have the money to cover the out-of-pocket expenses such as:

- Transportation to a distant medical facility.
- Specialized treatment costs.
- Living expenses like rent, mortgage, and utility bills.

It's insurance for daily living:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group critical illness insurance plans are designed to provide you with a lump sum benefit for a covered critical illness such as: cancer, heart attack, or stroke.

Enroll Today

Learn how group critical illness insurance can help you.

Aflac®

This is a brief product overview only. The plan has limitations and exclusions that may effect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

In Oklahoma, Policy CAI2800OK or C21100OK. In Idaho, CAI2800ID and C21100ID.

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Continental American Insurance Company • Columbia, South Carolina

AG28802 R5 IV (2/20)

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: 1-800-226-4518

ARE YOU ELIGIBLE FOR MEDICARE?

National® Management Resources Corporation

- Are you over the age of 65?
- Are you a U.S. Citizen?
- Are you under 65, but disabled?

Explore your options and get your questions answered....

There is a lot of information available, we want to make sure you are able to make an informed decision during this benefit enrollment season!

REACH OUT TO OUR MEDICARE SPECIALIST TO REVIEW YOUR OPTIONS...

For more information, contact Medicare Specialist:
Barbara H. Smith - Account Executive
Marsh & McLennan Agency, LLC
706-660-2208 (direct)
Barbara.H.Smith@MarshMMA.com

know your options

HEALTHCARE.GOV

ARE YOU ELIGIBLE FOR MARKETPLACE HEALTHCARE COVERAGE?

VISIT HEALTHCARE.GOV, ENTER YOUR STATE, AND ANSWER A FEW ADDITIONAL QUESTIONS TO SEE WHAT MARKETPLACE OPTIONS ARE AVAILABLE TO YOU. (COST ESTIMATES ARE AVAILABLE ON CURRENT CARE PROVIDERS AND PRESCRIPTIONS.)

WHAT'S BEST FOR YOU...

Healthcare costs are rising across the country. We want to do our part and help you make an informed decision about your healthcare options during our 2024 open enrollment season.

NATIONAL MANAGEMENT RESOURCE CORPORATION OPEN ENROLLMENT DATES ARE MAY 5TH THROUGH MAY 15TH, 2025.

National Management Resources Corporation

Medicare Part D Notice: Prescription Drug Coverage and Medicare

Premier and Core Medical Plans

This notice has information about your current prescription drug coverage with NMRC and 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.

Please note: If you are not Medicare eligible, and none of your covered family members are Medicare eligible, no action is required on your part.

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.
- NMRC has determined that the prescription drug coverage offered by EBMS for the Premier and Core medical plans 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 through 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 NMRC coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have

Medicare Part D Notice: Prescription Drug Coverage and Medicare

Premier and Core Medical Plans

available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current NMRC coverage, be aware that you and your dependents will be able to get this coverage back.

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 NMRC 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: 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 NMRC 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).

General Notice Of Cobra Continuation Coverage Rights

** Continuation Coverage Rights Under Cobra**

Introduction

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"

When is COBRA 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 Human Resources within 60 days after the qualifying event occurs.

General Notice Of Cobra Continuation Coverage Rights

** Continuation Coverage Rights Under Cobra**

How is COBRA 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 continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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.

If you have questions

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

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. To update your address, contact your Human Resources Department.

Plan Contact Information

COBRA Administrator
American Benefits Services
1-866-826-6554

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

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
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)

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: Children's Health Insurance Program (CHIP) (pa.gov)
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 March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notices about Medical Coverage

Women's Health and Cancer Rights Act Notice

Under the Women's Health and Cancer Rights Act of 1998, 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 lymph edemas. 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.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Summary Plan Descriptions (SPD)

As required under the Employee Retirement Income Security Act (ERISA), all employees and their covered dependents must be given access to a copy of the Summary Plan Description (SPD) for the employee welfare benefit plans.

The SPD outlines the eligibility, schedule of benefits and covered/excluded items of the benefit plans offered by National Management Resources.

Employees and/or their covered dependents are given 2 options to access/obtain a copy of an SPD.

1. SPD's are known as Certificate Booklets. A copy of the medical SPD/Certificate Booklet can be requested by contacting EBMS member services at 1-866-326-7618.
2. A copy of the dental or vision SPD/Certificate Book can be requested by contacting Ameritas member services at 800-659-2223.
3. You may also request a paper copy of a SPD from the Human Resources Department.

Privacy Rights under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that your private health information is protected and confidential. This Plan, the Plan Administrator and the Plan Sponsor will not disclose information that is protected by HIPAA, as required by law. To obtain a copy of your HIPAA Privacy Rights, contact your Human Resources Department.

Summary of Benefits and Coverage (SBC) & Uniform Glossary

As required by the Patient Protection and Affordable Care Act (Healthcare Reform), the Summary of Benefits and Coverage (SBC) for the medical plan(s) offered and the Uniform Glossary are available to all eligible employees. You may request a paper copy from your Human Resources Department.

Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify Human Resources and enroll in the plan.

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

Carrier Contact Information

Medical (EBMS)
Customer Service: 406-869-5555
Toll Free: 866-326-7072
Website: https://mibenefits.ebms.com

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

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

Ameritas

Dental Benefits
Dental Customer Service: 1-800-487-5553

Dental Claim Mailing Address:
Ameritas Dental Claims
Attn: Claims
P.O. Box 82520 Lincoln, NE 68501

Vision Benefits
VSP Customer Service: 1-800-877-7195
Website: https://vsp.com

Vision Claims Mailing Address:
VSP Out of Network Claims
P.O. box 385018 Birmingham, AL 35238
1-800-877-7195

Aflac

Additional Benefits:
Critical Illness
Accident
Hospital Indemnity

Aflac Customer Service: 1-800-433-3036
Website: www.aflacgroupinsurance.com

Anthem

Life Benefits
Customer Service: 800-851-8544
Website: www.anthem.com

Resource Advisor
Customer Service: 888-209-7840
Website: www.anthem.com

Travel Assistance
Customer Service: 240-330-1000

Disability

Lincoln Financial
Website: www.lfg.com
Phone: 1-800-487-1485 (Option 4)

HSA Bank

Health Savings Account
Website: www.hsabank.com
Phone: 1-800-357-6246

esMMArt

Marsh McLennan Agency
Phone: 1-866-688-9727
Fax: 1-866-597-2157
Website: teamnational.smartben.net
Company ID: nmrc (all lowercase)

Marsh McLennan Agency Member Claims Advocate

Toll free #: (800) 226-4518
Email: mmajslbenefitclaims@MarshMMA.com

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employmentbased health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Amy Weatherford; aweatherford@teamnational.com; 706-884-7489

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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 National Management Resource Corporation		4. Employer Identification Number (EIN) 84-0755858
5. Employer address 113 Corporate Park Drive East		6. Employer phone number 706-884-7489
7. City LaGrange	8. State GA	9. ZIP code 30241
10. Who can we contact about employee health coverage at this job? Amy Weatherford		
11. Phone number (if different from above) 706-884-7489	12. Email address aweatherford@teamnational.com	

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:

    All full-time employees working 30 or more hours per week
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Your eligible spouse, children under age 26, and children beyond age 26 if incapable of self-support due to mental or physical handicap.
  - ☐ 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.

National Management Resources Corporation

This communication represents a brief summary of the various benefits available to you and is provided for reference only. The actual policies issued by the Insurance Carrier determine coverage and contain exclusions, limitations, full coverage terms, conditions and requirements. Any notices included in this document do not replace an Employer's requirement for communication.