

TydenBrooks®
SECURING THE WORLD

Brooks Utility Products

2027 Benefits Guide







At E.J. Brooks, we are dedicated to supporting all aspects of your well-being — both at work and at home — and your benefits are a big part of that. We're committed to creating a culture that prioritizes the well-being of our team members and their families by providing a comprehensive and competitive benefits package.

We encourage you to prioritize your well-being by focusing on preventive care and utilizing the tools and resources available to help you live your best life.

Before you make your benefit elections, take the time to review this guide so you can make an informed decision on which plans are the right fit for you and your family. Remember to choose wisely; the choices you make during Annual Enrollment cannot be changed until the following year unless you have a qualifying life event.

Thank you for all that you do.

Welcome to Your 2027 Benefits Guide

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

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Disclaimer: This guide highlights the main features of many of the benefit plans sponsored by E.J. Brooks. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. E.J. Brooks reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Eligibility

It's important to understand what benefits you are eligible for so you can make an informed decision about coverage.

Full-time team members who work a minimum of 30 hours or more per week are eligible for benefits. Benefits go into effect on the first of the month following 30 days of full-time employment.





COVERING YOUR DEPENDENTS

- Legal spouse
- Child(ren), up to age 26, including biological, adopted, stepchildren, legal guardianship, and disabled children if disabled prior to age 26 and are dependent on you for support

QUALIFYING LIFE EVENTS

The benefits you elect during enrollment are in effect through December 31, 2027, so choose your coverage carefully.

You can only make changes outside of annual enrollment if you have a qualifying life event, such as:

- Marriage
- Divorce
- Birth of a child
- Adoption
- Loss of coverage

In most cases, you must make changes within 30 days of the event, including the day of the event. Contact Human Resources for more information.



Body and Mind

Medical Benefits

It's important to have choices when it comes to healthcare. That's why E.J.Brooks offers three medical plan options—a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) and two Point of Service (POS) plans—designed to give you choice in cost, control, and coverage level. All plans are offered by Anthem.



CONSIDER YOUR COVERAGE

When choosing between the HDHP and POS plans, it all comes down to how much you want to spend from your paycheck and whether you are comfortable with lower or higher out-of-pocket expenses and deductibles when you need care.

- If you prefer to pay less out of your paycheck and are OK with higher out-of-pocket costs and a higher deductible when you need care, then the HDHP might be the right fit. The HDHP comes with a HSA. E.J. Brooks will contribute to the account to help pay for your qualifying medical, dental, and vision expenses.
- If you prefer to pay more out of your paycheck and have a lower out-of-pocket expense and deductible when you need care, you might prefer one of the POS plans.

No matter which option you choose, both plans:

- Provide preventive care at 100%
- Provide prescription drug coverage
- Use the same nationwide network of doctors and pharmacies
- Provide access to virtual care, mental health services, and additional care resources

All three of our plans operate on the same national network of providers. You do not need to select a Primary Care Physician (PCP) and you do not need a referral to see a specialist.

By choosing in-network physicians, hospitals, and lab facilities, you will receive a higher level of coverage and reduce your out of pocket cost. By going out-of-network you will pay a higher cost for services, including the amount above the insurance carrier's negotiated rates.



FIND IN-NETWORK PROVIDERS

1. Go to https://www.anthem.com/find-care/
2. Click "Select a plan for basic search"
3. Choose the following:
   - Plan type: Medical Plan or Network
   - State: Georgia (even if you reside outside Georgia)
   - Coverage type: Medical (Employer-Sponsored)
   - Network:
     - If you live in Georgia: Blue Open Access POS
     - If you live outside Georgia: National PPO (BlueCard PPO)

Terms to Know

Benefits can be confusing! Here's a quick reference to help you navigate commonly used terms:

- **High Deductible Health Plan:** E.J. Brooks offers one High Deductible Health Plan (HDHP). A High Deductible Health Plan (HDHP) is a medical plan with minimum deductibles and out-of-pocket maximums set annually by the IRS. These plans do not and cannot have copays, but still provide full coverage for most preventive care with the deductible waived and still provides comprehensive coverage for catastrophic events. Premiums on the HDHP are less, leaving more money in your paycheck.
- **Health Savings Account:** Otherwise known as an HSA, a health savings account can be funded with your tax-exempt dollars to help pay for eligible medical expenses not covered by an insurance plan, including the deductible, coinsurance, and even in some cases, health insurance premiums. **You must participate in the HDHP medical plan to be eligible for the HSA.**
- **Deductible (Calendar Year Deductible):** The annual amount that must be satisfied before coinsurance is applied. The deductible resets annually on January 1.
- **Coinsurance:** After the deductible has been satisfied, the health plan will pay according to the percentage/coinsurance shown in the chart and according to the benefits for in and out-of-network coverage. Your coinsurance will continue to apply until you have reached the out-of-pocket maximum for the health plan. After the out-of-pocket maximum has been met, the plan will pay at 100%.
- **Out-of-Pocket Maximum:** The Out-of-Pocket Maximum is the maximum amount a member will have to pay during the plan year. The Out-of-Pocket Maximum includes the deductible, coinsurance and copays. For out-of-network benefits, the member is also responsible for any balance billing from the provider above the Anthem contracted rate for services. The Out-of-Pocket Maximum resets annually on January 1.
- **Copay:** Participants will pay a copay for many levels of service including physician office visits, emergency room and pharmacy.





MEDICAL PLANS AT A GLANCE

	POS $1,000	POS $2,500	HDHP $3,500 with HSA
PLAN FEATURE	IN-NETWORK	IN-NETWORK	IN-NETWORK
Employer Annual HSA Contribution	N/A		$750 individual $1,500 family
Deductible	$1,000 individual $2,000 family	$2,500 individual $5,000 family	$3,500 individual $7,000 family
Coinsurance	80% carrier 20% individual	90% carrier 10% individual	90% carrier 10% individual
Out-of-Pocket Maximum	$3,000 individual $6,000 family	$5,000 individual $10,000 family	$4,000 individual $8,000 family
YOU PAY			
Preventive Care	100% covered	100% covered	100% covered
Primary Care Visits	$25 copay	$25 copay	10% after deductible
Specialist Visits	$50 copay	$50 copay	10% after deductible
Virtual Care Sydney Health	No charge for Primary & Acute Care $50 copay for Specialty Care	No charge for Primary & Acute Care $50 copay for Specialty Care	No charge after deductible
Urgent Care	$75 copay	$75 copay	10% after deductible
Emergency Room	$500 copay	10% after deductible	10% after deductible
Inpatient Hospital Services	20% after deductible	10% after deductible	10% after deductible
Outpatient Services	20% after deductible	10% after deductible	10% after deductible

OUT-OF-NETWORK COVERAGE

Your medical plan includes out-of-network benefits. If you use an out-of-network provider, you'll pay more out-of-pocket and may be balance billed for charges above the plan's allowed amount. To avoid unexpected costs, always confirm your provider is in-network before receiving care.

Prescriptions

All medical plans include prescription drug coverage. The Rx Choice Network offers high-quality healthcare services while keeping copays affordable. You can choose to fill prescriptions at either a level 1 or level 2 pharmacy, but will pay less out-of-pocket at a level 1 pharmacy. Level 1 pharmacies offer competitive pricing and convenient locations so you have plenty of choices. Login to your Sydney Health App to find a level 1 pharmacy near you.

In the HDHP plan, you pay the full cost of all non-preventive prescriptions until you meet your deductible, then the plan begins paying a portion of the costs.

In the POS plans, they pay a portion of your prescription drug costs whether you've met the medical deductible or not.

YOU PAY	POS $1,000		POS $2,500		HDHP $3,500	
IN-NETWORK RETAIL PHARMACIES (UP TO A 30-DAY SUPPLY)						
	Level 1	**Level 2**	**Level 1**	**Level 2**	**Level 1**	**Level 2**
Preventive	No Charge					
Generic (Tier 1)	$15 Copay	$25 Copay	$15 Copay	$25 Copay	10% after Deductible	
Preferred (Tier 2)	$40 Copay	$50 Copay	$40 Copay	$50 Copay		
Non-Preferred (Tier 3)	$70 Copay	$80 Copay	$70 Copay	$80 Copay		
Specialty	20% up to $300					
HOME DELIVERY MAIL ORDER (90-DAY SUPPLY)						
	Level 1	**Level 2**	**Level 1**	**Level 2**	**Level 1**	**Level 2**
Tier 1, 2, and 3	**$30/$80/$140 Copay**				10% after Deductible	



Maintenance Drugs

If you take maintenance drugs (like those used to treat chronic conditions such as high blood pressure or high cholesterol) on a regular basis, be sure to have your physician write a 90-day prescription instead of a 30-day prescription. You can:

- **Have your medication delivered** straight to your door by using Carelon Rx's convenient mail order service.
- **Pick up your prescriptions** at any in-network pharmacy.

Preventive Drugs

All three medical plans offer preventive drugs at no charge. This includes medicines for diabetes, asthma, heart health, high cholesterol, high blood pressure, and more. Contact member services on the back of your ID card for more information.

Virtual Care Options

Get the care you need, when you need it — without leaving home. Your E.J. Brooks medical plan gives you access to two convenient virtual care services

1. **Anthem 24/7 Virtual Care via the Sydney Health app**
2. **Virtual Primary Care Scheduled Visits via LiveHealth Online**

1. ANTHEM 24/7 VIRTUAL CARE VIA THE SYDNEY HEALTH APP

When you have a minor illness, the last thing you want to do is leave the comfort of home to sit in the doctor's office. Anthem's Virtual Care is available to team members enrolled in a medical plan and their covered family members. You can see a doctor 24 hours a day, seven days a week, 365 days a year.

Appointments can take place by webcam or a camera-equipped mobile device. Most visits take only 10 minutes and, in most cases, doctors can write a prescription for pick up at your local pharmacy.

The best part is that Virtual Visits are paid at 100% under the POS and cost approximately $55 under the HDHP plan (covered at 100% once the deductible is met). This is a big cost saving over the average Primary Care visit.

Symptoms treated:

- Allergies
- Cold or flu
- Fever
- Minor skin conditions
- Nausea
- Sinus infections
- Stomachache
- UTI
- And more

Request 24/7 Virtual Care

To request a virtual care visit, log in to your Anthem account and choose Care, then select Virtual Care.

You can also download the SydneySM Health mobile app. The Sydney app will connect you to a healthcare professional through a virtual chat or video visit

2. VIRTUAL PRIMARY CARE SCHEDULED VISITS VIA LIVEHEALTH ONLINE

Choose your doctor and see them every time...online. You can see the same primary care provider (PCP) on an ongoing basis through scheduled video visits on your computer or mobile device. Get regular personal health visits and checkups with LiveHealth Online Virtual Primary Care. It's like an office visit with your PCP — without the office. Choose from board-certified, in-network PCPs, and the same board-certified, in-network PCP can take care of you over time for treatment including: chronic conditions, preventive care, referrals, and acute care.

With LiveHealth Online Virtual Primary Care you can get:

- Care for diabetes, the flu, and other health issues.
- Referrals for X-rays, blood work, and specialists.
- Prescriptions sent to your local pharmacy.
- Appointments 8 a.m. – 6 p.m. (Mon – Fri).

Request Virtual Primary Care

Virtual primary care visits are available through the LiveHealth Online app and LiveHealthOnline.com.

SYDNEY HEALTH MOBILE APP

Access personalized health and wellness information wherever you are.

Use SydneySM Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.



FIND CARE: Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.



MY HEALTH DASHBOARD: Use My Health Dashboard to find news and tips on health topics that interest you and personalized action plans that can help you reach your goals. It offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.



CHAT: Use If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.



COMMUNITY RESOURCES: This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.



MY HEALTH RECORDS: See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.



VIRTUAL CARE: Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

¿PREFIERES OBTENER INFORMACIÓN EN ESPAÑOL?

Choose Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el menú dentro de la aplicación Sydney Health y elige el idioma de la aplicación. También puedes visitar anthem.com/es.

Download the Sydney Health App Today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.

Download to your mobile device using the QR code or set up an account at anthem.com/register to access most of the same features from your computer.

Know Before You Go

Staying in network is the best way to keep your medical costs low. But did you also know that deciding where to go for care based on the type of treatment you need and how quickly you need it can also save you money?

If you're enrolled in one of the medical plans, the chart below can help you decide where to go for care based on the type of treatment you need, how much you can expect to spend, and how quickly you need it.

TYPE OF SYMPTOMS	BEST PATH FOR CARE	YOUR VISIT COST	AVERAGE WAIT TIME	HOURS OF OPERATION
Common cold, flu, sinus or ear infections, mild Covid-19, allergies, UTI	**Anthem 24/7 Virtual Care via the Sydney Health app**	$0 or $	A few minutes	24/7
Basic health problems, chronic conditions, persistent joint pain	Virtual Primary Care Scheduled Visit via LiveHealth or Primary Care Physician (PCP)	$	Wait times vary	Traditional office hours (appointment often required)
Minor cuts, burns, or sprains, ear or sinus pain, minor allergic reactions, animal bites, broken bones	Urgent Care Clinic	$$	About an hour	Extended hours (includes evenings, weekends, and holidays)
Sudden numbness, uncontrolled bleeding, difficulty breathing, seizure or loss of consciousness, chest pain or pressure	Emergency Room	$$$$	A few hours	24/7





Wellness Program

E.J. Brooks offers all team members enrolled in one of our medical plans and their enrolled spouses the opportunity to participate in a wellness program and reduce your monthly medical premium.

How it Works

- Available to: Team members and enrolled spouses in our medical plan
- Incentive: Each enrolled person can earn $50/month. That's up to $100/month off your medical premiums for you and your spouse

To earn a monthly wellness discount, complete the following by the deadline:

- Complete Annual Physical with Biometric Screening
- Health Risk Assessment Survey
- Complete Two (2) Preventive Screenings

Employee Login	Spouse Login
Your username will be: TB + First Initial + Last Name + MMDD Example: TBjdoe1001	Your username will be: TB + First Initial + Last Name + MMDD + S Example: TBjdoe1001S
Your temporary password will be: Date of Birth (MMDDYYYY) Example: 10011975	Your temporary password will be: Date of Birth (MMDDYYYY) Example: 05151978

How to Complete Your Wellness Steps

STEP 1: COMPLETE YOUR BIOMETRIC SCREENING

Choose from one of the three options:

1. **On-site Screening:** Sign up through your HR contact. Dates and times vary by location.
2. **Primary Care Physician Visit:** Schedule your appointment and have your provider complete and fax the Wellworks physician form.
   Download form at www.wellworksforyoulogin.com.
3. **LabCorp Walk-in Clinic:** Download and bring the LabCorp voucher from www.wellworksforyoulogin.com. You can visit any LabCorp location.

STEP 2: COMPLETE YOUR HEALTH RISK ASSESSMENT

Visit www.wellworksforyoulogin.com.

1. **To Access Your Account:**
   Log in to the Wellness Portal > Select My Program, then click Know Your Number > Complete all questions. If your waist measurement was not provided, enter it manually. Exclude metrics uploaded from the Physician Results Form > Your health metrics will be added once you have submitted your Physician Results Form > Your full report will appear once both are complete.

   Your results will also be stored in your Forms & Documents, and your participation will be recorded.
2. **To Take the Survey:**
   Log in and select "Access Survey and Results"
   Click "Take Survey Now."
   After completing, your results will be available 7–10 days after your screening.
3. Complete two preventive screenings between November 1, 2026, and October 31, 2027, and **submit the required forms by October 31, 2027**, to earn credit.

Reminders & Eligibility

Programs are voluntary, but all steps must be completed to qualify for the monthly discount.

Fitness Reimbursement Program

E.J. Brooks is committed to supporting your health and well-being. Our Fitness Reimbursement Program helps cover eligible fitness-related expenses to encourage an active lifestyle.

How it Works

- Available to: All active full-time team members.
- Eligibility begins the first of the month following your hire date.
- Receive up to $25 per month, or $300 annually, for eligible fitness expenses.
- Reimbursements are paid in your next paycheck following approval.
- Unused funds do not carry over to the next calendar year.

What's Covered?

Eligible Expenses

- Gym or fitness club memberships
- Fitness classes (yoga, aerobics, martial arts, etc.)
- Approved fitness programs

Not Eligible

- Fitness equipment
- Supplements or medications
- Personal training sessions (not part of gym membership)

How to Submit Expenses for Reimbursement

1. Complete the Request Form: Scan the QR code to complete.
2. Provide Proof of Payment: Receipt must show your name and the facility/program name.
3. Meet the Deadline: Submit requests by the 15th of the following month.

Submit each month—late submissions will not be accepted. All reimbursements are subject to approval by HR. E.J. Brooks reserves the right to modify or discontinue this program at any time.

Questions?

Reach out to your HR Team with any questions or for assistance.





Dental

You have two dental plan options, both administered by Unum. Here's a breakdown of how the plans compare.

PLAN FEATURES	BUY-UP PPO	BASE PPO
Deductible	$50 individual $150 family	$50 individual $150 family
Annual Benefit Maximum	$1,500 per person	$1,000 per person
Non-Network Reimbursement	80th% R&C	MAC
YOU PAY		
Preventive services (exams, bitewing x-rays, cleanings, fluoride, sealants)	100% covered, deductible waived	100% covered, deductible waived
Basic services (fillings, simple tooth extractions, root canals, gum treatment)	**20%** after deductible	**20%** after deductible
Major services (crowns, inlays, bridges, dentures)	**50%** after deductible	**50%** after deductible
Orthodontia (up to age 19)	$1,500 lifetime limit	**Not covered**

Reasonable & Customary Limits (R&C): This term is used to define the amount most frequently charged for a service in a geographic area. When using non-network dental providers with the PPO plan, Unum reimburses claims based upon the 80th percentile R&C. Because the non-network provider is not contracted with Unum, the provider can balance bill you for any amount they charge above 80th R&C. The balance bill amount is in addition to the percentage that you are responsible for based upon Unum's schedule of benefits.

Maximum Allowable Charge (MAC): In this case, the reimbursement schedule from Unum to your dentist is capped at the maximum allowable charge which is set regardless of geography. The rates charged per procedure are negotiated between in-network dental providers and Unum. Unum uses these negotiated in-network fees to determine the reimbursement if you visit an out-of-network provider for treatment. This means Unum will only pay a set dollar amount to your dentist, and you will be responsible for the remainder.

In-Network Dentist

You can see any dentist you choose, but in-network dentists have agreed to provide services at discounted rates. Use the **Find a Provider** tool at **https://unum.go2dental.com/member/dental_search/searchprov.cgi** to locate an in-network dentist.

Vision

The vision plan is administered by Unum, utilizing the EyeMed network. It includes eye exams, frames, lenses, and contacts every 12 months. You'll save money if you go to a network provider.

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Eye Exam (one every 12 months)	**$10** copay	Up to $40 allowance
Prescription Lenses (one set every 12 months): Single Lenses	**$10 copay**	Up to $30 allowance
Bifocal Lenses	**$10 copay**	Up to $50 allowance
Trifocal Lenses	**$10 copay**	Up to $70 allowance
Lenticular Lenses	**$10 copay**	Up to $70 allowance
Standard Progressive Lenses	**$10 copay**	Up to $50 allowance
Frames (one set every 12 months)	$150 retail allowance, then 20% discount	Up to $105 allowance
Contact Lenses (one set every 12 months in lieu of glasses) • Elective • Medically Necessary • Standard Fitting & Exam	• **$150 allowance, then 15% discount paid in full** (lenses) • **Up to $40 allowance** (fitting and evaluation)	• Up to $150 allowance • Up to $210 allowance • Not covered

EyeMed Providers

You can use any eye doctor you choose, but using EyeMed in-network providers will save you money. Use the **Find a Provider** tool by **visiting** **www.eyemedvisioncare.com/unum** to locate an in-network eye doctor.





Funding Accounts

When it comes to saving money on healthcare and dependent care expenses, a Health Savings Account (HSA), Healthcare Flexible Spending Account (HFSA), and Dependent Care Flexible Spending Account (DFSA) are options. The HSA is administered by HSA Bank, and both FSAs are administered by Medcom. All three accounts help you save money for eligible expenses and lower your taxable income through pre-tax contributions.

Health Savings Account (HSA)

To participate in the HSA, you must enroll in the HDHP. You cannot:

- Be enrolled in Medicare or Medicaid
- Be able to be claimed under someone else's taxes
- Be covered by a traditional-style (PPO, POS, HMO, etc.) health plan
- Participate in a Healthcare Flexible Spending Account (HFSA)

The HSA allows you to set aside pre-tax dollars into an account you own to pay for eligible healthcare expenses now, in the future, and even into retirement. Because you own the account, it's portable, so you can take it with you if you leave the company. HSA funds are completely yours and 100% vested. If unused, the money rolls over or carries forward from one year to the next.

You will elect your contribution limit during enrollment and can change it any time during the year. The company contributions and yours will be deposited into your HSA each pay period. Funds will be available for use as they are deposited. You'll earn interest on your HSA funds and also have the opportunity to invest your funds as long as you keep a minimum balance of $2,000 in your HSA.

HSA AT A GLANCE

	2027 IRS LIMIT	E.J. BROOKS CONTRIBUTION	YOUR CONTRIBUTION LIMIT
Team Member Only	$4,500	$750	$3,750
All Other Coverage Levels	$9000	$1,500	$7,500
"Catch Up" Contributions (age 55+)			Additional $1,000

Triple Tax Savings

Your HSA offers triple tax savings*

- **Before-tax contributions:** Any money you contribute lowers your federal taxable income.
- **Tax-free growth:** The money in your account earns interest, and the investment earnings are tax-free, too.
- **Tax-free withdrawals:** HSA money you use to pay for eligible expenses is withdrawn tax-free. Visit hsabank.com/QME for a full list of HSA eligible expenses.

*Withdrawals for non-eligible expenses are subject to a tax



Flexible Spending Accounts (FSAs)

When you choose an FSA, it's important to know how it works. FSAs are use-it-or-lose-it plans. The funds you set aside must be used to pay for eligible expenses incurred during the plan year — between January 1 and December 31. When deciding how much to allocate to the Flexible Spending Account(s), it is important to estimate as accurately as possible because IRS regulations require that team members will forfeit any unused money above $700.

FSAs AT A GLANCE

	HEALTHCARE FSA	DEPENDENT CARE FSA
Eligibility	POS enrollees	Any benefits-eligible team member
Contribution Limits*	$3,500	$7,500 ($3,750 if married and filing taxes separately)
Fund Availability	January 1	Available as funds are deposited
Eligible Use	Qualified medical, prescription, dental, and vision expenses, copays, and deductibles	Eligible day care expenses from licensed daycare providers for children aged under 13 or disabled dependents of any age

*Once elected, FSA contributions cannot be changed during the plan year.





Life Insurance

No one can predict the future, but you can plan for it. That's why E.J. Brooks offers you Life and Accidental Death & Dismemberment coverage, administered by New York Life, to help protect your income and give you peace of mind.

Basic and Voluntary Life Insurance

Each full-time team member has a 100% company-paid basic life policy equal to two times your annual salary up to a maximum of $500,000. You are able to convert your life insurance to an individual policy without evidence of insurability within 31 days of the termination of coverage.

Team members must elect team member voluntary life before they can elect the benefit for their spouse and/or child(ren). You pay for Voluntary Life Insurance on an after-tax basis through payroll deductions. Monthly rates are based on age and calculated when enrolled.

VOLUNTARY LIFE AND AD&D AMOUNTS			
	Team Member	**Spouse**	**Child (Up to Age 26)**
Minimum	$10,000	$5,000	$10,000
Maximum	$10,000 increments up to $500,000	50% of Team Member Benefit up to $250,000 in $5,000 increments	$10,000
Guarantee Issue	$250,000	$25,000	$10,000
Age Reduction	Benefit reduces to 65% of original life benefit at age 65 and then to 50% of original amount at age 70		

Beneficiary Designation

You must designate a beneficiary for Basic and Voluntary Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.





Disability

E.J. Brooks offers disability coverage to protect your income if you miss work due to an illness or non-work-related injury. Disability plans are administrated through New York Life.

Short-Term Disability (STD) and **Basic Long-Term Disability (LTD)** are automatically provided at no cost to full-time eligible team members.

	STD	BASIC LTD
Waiting Period	1st day of accident 8th day of sickness or pregnancy	180 days
Coverage Provided	• **Up to 60% of pre-disability earnings*** • **Maximum $3,462 per month (dependent on team member class)**	• **Up to 60% of pre-disability earnings*** • **Maximum $10,000 per month**
Maximum Duration	26 weeks	Until you can return to work or reach the maximum benefit period
Taxable Benefit	Yes	Yes

***excludes bonuses, stipends, and other incentive payments**

WHEN ARE YOU DISABLED?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to do your job at E.J. Brooks, and
- You must have lost 20% or more of your pre-disability income due to your illness or injury

Voluntary Products

These voluntary benefits, provided through New York Life, offer additional financial protection when you experience a covered accident, critical illness, or hospital stay. Benefits are paid directly to you and can help with medical and everyday expenses not covered by your medical plan. Coverage is available on a post-tax basis.

ACCIDENT COVERAGE

Accident insurance provides fixed benefits for covered accidental injuries, such as fractures and dislocations, as well as related services, including emergency room visits and physical therapy. The plan also includes daily hospital and ICU benefits, an Accidental Death and Dismemberment benefit, and a $50 annual wellness benefit for each covered person.

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance pays cash benefits directly to you following a covered hospital admission or stay. Benefits can help with medical and everyday expenses associated with hospitalization.

CRITICAL ILLNESS

Critical Illness insurance provides financial protection for expenses that medical insurance may not cover, such as deductibles, copays, mortgage or rent payments, childcare, and income replacement during recovery. Coverage through New York Life includes a $50 annual wellness benefit per covered person and benefit amounts of $10,000, $20,000, or $30,000 for employees and spouses, with dependent child coverage available at 50% of the elected amount. This coverage is available on a post-tax basis.

Wellbeing Resources

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Available to all team members, our EAP partner New York Life helps you and your family manage life's challenges with in-person, phone, and video counseling sessions, all at no cost to you. You can also get referrals to household services related to child/elder care, financial and legal help, and much more.

All counseling calls are answered by a Master's or PhD-level counselor who will collect some general information and will discuss your needs. The Life Assistance Program provides a maximum of three sessions, per issue, per year. In addition, you have access to five telephonic sessions with a well-being coach.

Licensed counselors can help with issues such as:


Mental health concerns


Emotional difficulties


Domestic abuse


Substance abuse


Financial worries


Grief and loss


Relationship support


Self-esteem and personal development


Stress management


Work-life balance

When you need in-the-moment emotional well-being support, counselors are here to help 24/7. You can call **1.800.344.9752 or visit guidanceresources.com | Web ID: NYLGBS**

SMOKING CESSATION SUPPORT

Wellworks provides a digital support program at no cost to you to support you on your journey to quit tobacco.

To learn more, login to your Wellworks account and access the digital learning center or call. Your Guide to going tobacco free, on the Learning Center for help with tobacco cessation. Begin with the Pre-Module Survey and your first video, then complete each quiz with a score of 70% or higher to unlock the next module each week. Wrap up by completing the Post-Module Survey.

Access to Mobile App: Keep track of your progress anytime, anywhere.

JOINT & MUSCLE SUPPORT (HINGE HEALTH)

Hinge Health's digital musculoskeletal program, led by physical therapists and health coaches, is available at no extra cost to Anthem members. This personalized, remote care provides members with a customized curriculum for preventive, acute, and chronic joint and muscle pain. This program uses mobile and wearable technology to improve strength and mobility with real-time feedback and tracking. For program qualifications and enrollment information, visit hinge.health/enroll-today or call the number on the back of your Anthem ID card.

Medicare Education & Support

FREE Medicare Guidance & Support

Turning 65 or already Medicare-eligible? We've partnered with licensed Medicare specialists to provide you with personalized guidance—at no cost to you.

One-on-One Consultations

Compare Medicare options to your current plan

Enrollment Support

Expert help with all paperwork and deadlines

Ongoing Service

Annual reviews and year-round support

Why Consider Medicare?

Many employees find Medicare offers **lower costs, better coverage,** and **additional benefits** like dental, vision, and hearing—often at a fraction of what you're paying now.

Important!

This is completely voluntary and confidential. Our specialists educate—you decide. No pressure, ever.

Ready to Learn More?

Contact Avant Senior Market Solutions

Book Online Now

For additional information regarding your benefits, please contact Laura Siler at 816-307-2115 or LSiler@avantsb.com.

Tuition Reimbursement Program

We support your continued growth and development through our Tuition Reimbursement Program. If you're pursuing job-related education, you may be eligible for reimbursement.

Eligibility

- Full-time team member
- At least 1 year of service
- Coursework must be job-related

Repayment Obligation

If you voluntarily resign within 12 months of receiving tuition reimbursement, you must repay any reimbursement received during that period.

Reimbursement Amounts

EDUCATION LEVEL	ANNUAL MAX	LIFETIME CAP
Associates/ Certificates	$3,000	$10,000 per degree
Bachelors	$7,250	$25,000
Masters	$10,000	$30,000

Request Form

Submit your request using the official Tuition Reimbursement Jotform, available in the full policy document or from your HR representative.

Note: Tuition reimbursement over $5,250 per calendar year is considered taxable income and will be reported on your W-2.

How to Apply

1. Pre-approval is required at least 10 days before your course begins.
2. Submit documentation (grades, proof of payment, etc.) within 10 days after course completion.
3. Reimbursement will be processed via payroll within 1–2 pay cycles after final approval.





Contacts

PLAN	CARRIER	WEBSITE	PHONE
Medical and Prescriptions	Anthem CarelonRx	www.anthem.com Download Anthem's Sydney App by scanning the QR code	1.855.397.9267
Wellness Program	Wellworks	www.wellworksforyoulogin.com	1.800.425.4657
Dental	Unum	www.unumdentalcare.com	1.800.400.9304
Vision	Unum	www.eyemedvisioncare.com/unum	1.855.652.8686
Health Savings Account (HSA)	HSA Bank	www.hsabank.com	1.800.357.6246
Flexible Spending Accounts (FSAs)	MedCom	www.medcombenefits.com/resources/for-employees	1.800.523.7542
Employee Assistance Program (EAP)	New York Life	www.guidanceresources.com WebID: NYLGBS	1.800.344.9752
Voluntary Products	New York Life	www.newyorklife.com	1.800.362.4462
Disability	New York Life	www.newyorklife.com	1.800.362.4462
E.J. Brooks Benefits Department	Contact is Crystal Handley	crystall.handley@tydenbrooks.com	845.689.3004

Required Notices

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, 2026. Contact your State for more information on eligibility –

State	Website/Email	Phone
Alabama (Medicaid)	http://www.myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	Premium Payment Program: http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx E-mail: CustomerService@MyAKHIPP.com	1-866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
California (Medicaid)	www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	Medicaid: https://www.healthfirstcolorado.com/ CHIP: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	1-800-221-3943 1-800-359-1991 1-855-692-6442
Florida (Medicaid)	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia (Medicaid)	GA HIPP: medicaid.georgia.gov/health-insurance-premium-payment- program-hipp GA CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-healthinsurance-program-reauthorization-act-2009-chipra	GA HIPP: 678-564-1162, press 1 GA CHIPRA: 678-564-1162, press 2
Illinois (Medicaid)	Illinois Medicaid Premium Assistance Information Medicaid applicaiton website: abe.illinois.gov HIPP Email: mhfs.boc.hipp@illinois.gov	217-524-8268
Indiana (Medicaid)	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	Family & Social Services: 800-403-0864 Member Services: 800- 457-4584

State	Website/Email	Phone
Iowa Medicaid and CHIP (Hawki)	Medicaid: **hhs.iowa.gov/programs/welcome-iowa-medicaid** Hawki: **hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki** HIPP: **hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp**	Medicaid: 800-338-8366 Hawki: 800-257-8563 HIPP: 888-346-9562
Kansas (Medicaid)	Website: **kancare.ks.gov**	Medicaid: 800- 792-4884 HIPP: 800-967-4660
Kentucky (Medicaid and CHIP)	KI-HIPP: **chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** KI-HIPP **Email: KIHIPP.PROGRAM@ky.gov** KCHIP: **kynect.ky.gov** Medicaid: **chfs.ky.gov/agencies/dms**	KI-HIPP: 855-459-6328 KCHIP: 877- 524-4718
Louisiana (Medicaid)	Medicaid website: **ldh.la.gov/healthy-louisiana** Medicaid email: **healthy@la.gov** LaHIPP website: **www.ldh.la.gov/lahipp** LaHIPP email: **La.HIPP@la.gov** LaHIPP Mailing Address: **100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084**	Medicaid: 888- 342-6207 LaHIPP Phone: 877-697-6703 LaHIPP Fax: 888-716-9787
Maine (Medicaid)	Enrollment: **www.mymaineconnection.gov/benefits/s/?language=en_US** Private health insurance premium: **maine.gov/dhhs/ofi/applications-forms**	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY: Maine Relay: 711
Massachusetts (Medicaid)	Website: **www.mass.gov/masshealth/pa** Email: **masspremassistance@accenture.com**	800-862-4840 TTY: 711
Minnesota (Medicaid)	**https://mn.gov/dhs/health-care/**	800-657-3672
Missouri (Medicaid)	**https://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana (Medicaid)	Website: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Email: **HHSHIPPProgram@mt.gov**	800-694-3084
Nebraska (Medicaid)	**https://dhhs.ne.gov/Pages/CHIP-State-Plan.aspx**	855-632-7633 Lincoln: 402-473-7000 Omaha: 402- 595-1178
Nevada (Medicaid)	**https://www.nevadamedicaid.nv.gov/**	800-992-0900
New Hampshire (Medicaid)	Website: **dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program** Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**	Phone: 603-271-5218 Toll Free HIPP: 800-852-3345, ext. 15218
New Jersey (Medicaid and CHIP)	Medicaid: **https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/** CHIP: **njfamilycare.org/index.html**	Medicaid: 800- 356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800- 701-0710
New York (Medicaid)	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina (Medicaid)	**https://medicaid.ncdhhs.gov/**	919-855-4100
North Dakota (Medicaid)	**https://www.hhs.nd.gov/healthcare**	1-844-854-4825

State	Website/Email	Phone
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp CHIP: https://www.dhs.pa.gov/chip/pages/chip.aspx	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS(5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/ health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	UPP Website: https://medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website:https://medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	1-877-222-2542
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select HIPP Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/ famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/ health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/http://mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095. htm	1-800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/ programs-and-eligibility/	1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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 10.22% 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 10.22% of the employee's household income.

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.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit healthcare.gov/medicaid-chip/getting-medicaid-chip for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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. Indexed annually; see 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% 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.

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage 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 dependentsin 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

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

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: Human Resources, Crystal Handley at 845-689-3004.

Your Information. Your Rights. Our Responsibilities.

• HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
• YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
• HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION
YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH HUMAN RESOURCES AT 845-689-3004 IF YOU HAVE ANY QUESTIONS. **Please review it carefully.**

YOUR RIGHTS

You have the right to:

- Consent to most uses and disclosures of your health information
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

In these circumstances, we must protect your information and limit how we use and share it.

YOUR RIGHTS

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly upon such request.

Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

For your Medical Emergencies

We may use or share your health information with health care providers or emergency personnel when needed to provide you with emergency treatment or to respond to a serious and immediate threat to your health or safety, even when you are unable to consent. This is allowed under HIPAA's rules for treatment and emergency disclosures.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Legal Proceedings and Lawful Process

We may use or share your health information as permitted or required by law when responding to legal proceedings. This includes disclosures in response to a valid court order, warrant, subpoena, or other lawful process, consistent with HIPAA's rules for judicial and administrative proceedings (45 CFR §164.512(e)) and law enforcement requests (45 CFR §164.512(f)). When responding to legal requests, we disclose only the information required and follow all conditions and limitations imposed by HIPAA.

Communicate within our program and with contractors

We may use and disclose your information within our health plan and with organizations that help us administer our program, including contractors and business associates who perform services for us. These disclosures occur only as permitted by HIPAA for health care operations.

Respond to audits and program oversight

We may use and share your information for health oversight and health care operations. This includes sharing with government agencies that are authorized by law to conduct audits, inspections, and licensure activities, and with accrediting organizations to support accreditation, quality assessment and improvement, and program evaluation of our health plan. We share only the minimum necessary information as required by law.

Disclosure to Law Enforcement

We may disclose information to law enforcement if we believe, in good faith, that it is evidence of a crime that occurred on our premises, or to report certain crimes during a medical emergency that did not occur on our premises. In these situations, we will disclose only what the law allows in these situations.

OUR RESPONSIBILITIES

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

With Your Written Consent (42 CFR Part 2)

If you provide written consent, we may use or disclose your Substance Use Disorder (SUD) information in the following ways:

- To the person or organization you name in your consent. Part 2 allows you to decide who may receive your SUD information through a written consent.
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs. Part 2 permits disclosures for this purpose when authorized by your consent or as otherwise allowed by law.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- To report prescribed SUD treatment medications to a state Prescription Drug Monitoring Program when required by law. Part 2 allows this type of disclosure only when a state statute mandates such reporting.

Additional Protections for SUD Information (42 CFR Part 2)

For records related to Substance Use Disorder (SUD) treatment, we will not disclose your information in any civil, criminal, administrative, or legislative proceeding without your written consent or a court order that meets the requirements of 42 CFR Part 2.

Respond to audits and program oversight

For Substance Use Disorder (SUD) records protected by 42 CFR Part 2, organizations performing audits or evaluations must agree in writing not to redisclose your information and must destroy or return identifying information when the audit or evaluation is complete.

Redisclosure Rules for Substance Use Disorder (SUD) Information

If you authorize us to disclose your SUD records to other health care providers or health plans for treatment, payment, or health care operations, those recipients may redisclose your information as permitted by the HIPAA Privacy Rule. However, your SUD information may not be used or disclosed in any civil, criminal, administrative, or legislative proceeding against you without your 6 written consent or a court order that meets the requirements of 42 CFR Part 2. We will include the required Part 2 notice prohibiting unauthorized redisclosure with every disclosure of SUD information.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Name of Entity/Sender: E.J. Brooks Company
Contact--Position/Office: Crystal Handley
Address: 2727 Paces Ferry Road Southeast, Atlanta, GA
Phone Number: 260-624-4805

Important Notice from E.J. Brooks Company About Your 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 E.J. Brooks Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

When Can You Join A Medicare Drug Plan?

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

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 coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current E.J. Brooks' plan 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 E.J. Brooks Company 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 the person listed below 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 E.J. Brooks Company 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).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/15/2026
Name of Entity/Sender: E.J. Brooks Company
Contact--Position/Office: Crystal Handley
Address: 2727 Paces Ferry Road Southeast, Atlanta, GA 30339
Phone Number: 260-624-4805

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?

You're getting this notice because you are enrolled in the Plan or eligible for enrollment in the Plan.

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's 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

- 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 CONTINUATION COVERAGE AVAILABLE?

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

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

IF YOU HAVE QUESTIONS

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs.

Disability Extension of 18-month Period of COBRA Continuation Coverage

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. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Name of Entity/Sender: E.J. Brooks Company

Contact--Position/Office: Human Resources

Address: 2727 Paces Ferry Road Southeast, Atlanta, GA

Phone Number: 260-624-4805

1. https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Women's Health and Cancer Rights Act ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: deductibles and coinsurance dependent on the medical plan which you are enrolled. If you would like more information on WHCRA benefits, call your plan administrator at 260-624-4805.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomyrelated services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 260-624-4805 for more information.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the Frequently Asked Questions (FAQs) About the Newborns' and Mothers' Health Protection Act.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - » Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - » Cover emergency services by out-of-network providers.
  - » Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - » Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the member services number on the back of your medical ID card. Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Wellness Program Notices

E.J. Brooks Company wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $50 per month wellness incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Wellworks at 800-425-4657.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and E.J. Brooks Company may use aggregate information it collects to design a program based on identified health risks in the workplace, E.J. Brooks Company wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) qualified health professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

ACCOMMODATIONS

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Wellworks at 800-425-4657 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notes

Notes

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2027 BENEFITS GUIDE

NOVEMBER 2027