neighborly®

2026

BENEFITS GUIDE

BE WELL. STAY WELL.

IMPORTANT CONTACTS

Benefit	Administrator	Phone	Website / Email
Medical	BCBS of Texas	800-521-2227	www.bcbstx.com
Prescription Drugs	RxBenefits / Express Scripts	800-334-8134	**Email:** RxHelp@RxBenefits.com www.express-scripts.com
HSA	Empower HSA	800-331-5455	www.empowermyretirement.com
FSA	Wex	866-451-3399	www.wexinc.com
Dental	MetLife	800-942-0854	www.mybenefits.metlife.com **Organization for login:** Neighborly
Vision		855-638-3931	
Life		800-438-6388	
Disability		866-729-9201	
Accident		800-438-6388	
Critical Illness		800-438-6388	
Hospital Indemnity		800-438-6388	
Employee Assistance Program (EAP)		888-319-7819	www.one.telushealth.com
HealthJoy	Healthcare Guidance and Telehealth	877-500-3212	www.healthjoy.com/members **Email:** Support@healthjoy.com
401(k) Savings Plan	Empower Retirement	800-338-4015	www.empowermyretirement.com
Investment Advisor	Russell Livesay Disciplined Investors LLC	254-755-8622	www.dinvestors.com **Email:** rl@dinvestors.com
Benefit Advocate Center (BAC)	Gallagher	833-775-2147	**Email:** bac.neighborly@ajg.com

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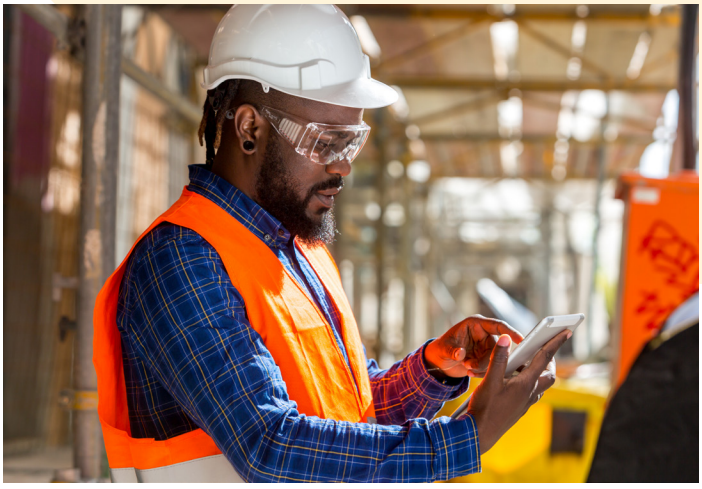
WELCOME TO YOUR BENEFITS!

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement. This brochure was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this brochure to make sure you understand the benefits that are available to you and your family.

This brochure highlights the main features of our associate benefits program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Neighborly reserves the right to change or discontinue its associate benefits plans at any time.



Scan here to access Workday

ELIGIBILITY

If you are a full-time associate scheduled and working at least 30 hours per week, you are eligible for benefits. Benefits are effective on the first day of the month, following 30 full days of employment. You may also enroll your eligible dependents for coverage. Eligible dependents could be:

Children Under the Age of 26

Regardless of

- Student Status
- Marital Status

Your Legal Spouse* or Your Qualified Domestic Partner

- If Spouse* / Domestic Partner does not have access to other coverage

Children Over the Age of 26

- A child of any age who is mentally or physically incapable of self-care, lives with you, and is claimed as a dependent on your IRS tax return

*Spouse can't be covered on medical if they have access to other coverage but can be covered for all other benefits.

Qualifying Life Event

During the year, you cannot make changes to your benefits unless you have a Qualifying Life Event. If you do not make changes to your benefits within 30 days of the Qualifying Life Event, you will have to wait until the next annual Open Enrollment period to make changes.

Qualifying Life Event		Documentation Needed
Change in Marital Status	Marriage	Copy of marriage certificate
	Divorce / Legal Separation	Copy of divorce decree
	Death	Copy of death certificate
Change in Number of Dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Step-child	Copy of birth certificate plus a copy of the marriage certificate between associate and spouse
	Death	Copy of death certificate
Change in Employment	Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

MEDICAL + RX

Medical insurance is essential to your well-being, and our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

Neighborly offers two medical plan options through Blue Cross Blue Shield of Texas.

BCBS PPO Plan – Covers some items and services even if you haven't yet met the deductible. You pay a fixed-dollar co-pay for office visits, specialist visits, prescription drugs, emergency room services, and diagnostic testing.

BCBS HSA Plan – A High Deductible Health Plan (HDHP) allows you to pay lower premiums and save pre-tax dollars for health care expenses, now or in the future, using a Health Savings Account. Generally, you pay all costs from providers up to the deductible amount before this plan begins to pay. In-network preventive care is covered before you meet your deductible.

Parts of Your Medical Plan

- **Preventive care** – Always 100% covered when you use in-network providers and includes things like physical exams, flu shots and screenings.
- **Annual deductible amounts** – The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Annual out-of-pocket maximums** – The most you will pay each year for eligible in-network and out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.
- **Co-pays** are a fixed amount you pay for a health care service. Co-pays do not count toward your deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurance** – Once you've met your deductible, you and the plan share the cost of care, called coinsurance.

MEDICAL PLAN COMPARISON

Administered by Blue Cross Blue Shield of Texas (BCBSTX)

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs.

In-network providers charge members reduced, contracted fees instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits. We use the nationwide Blue Cross Blue Shield of Texas (BCBSTX) provider network for all medical plan options. To determine if your current provider is in the network or to locate providers near you, call BCBSTX Member Services at **800-521-2227** or visit **www.bcbstx.com**. For more details on our 2026 benefit plans — how they work, what they cover, what they cost, and the Summary of Benefits and Coverage (SBC) documents — go to **https://myneighborlybenefits.com**.

	BCBS PPO Plan		BCBS HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	YOU PAY			
Annual Deductible (Individual / Family)	$1,500 / $3,000	$3,000 / $6,000	$3,500 / $7,000	$8,000 / $16,000
Annual Out-of-Pocket Max (Individual / Family)	$6,250 / $12,500	$12,000 / $24,000	$5,000 / $10,000	$12,000 / $24,000
Preventive Care	$0	40% after deductible	$0	30% after deductible
Regular Office Visit	$25 copay	40% after deductible	20% after deductible	30% after deductible
Specialist Office Visit	$70 copay	40% after deductible	20% after deductible	30% after deductible
Urgent Care	$70 copay	40% after deductible	20% after deductible	30% after deductible
Emergency Room Visit	$350 copay		20% after deductible	
Coinsurance	20% after deductible		20% after deductible	

Medical Contributions

Benefit Tiers	BCBS PPO Plan*	BCBS HSA Plan*
	Bi-Weekly Deduction	Bi-Weekly Deduction
Associate Only	$72.04	$46.38
Associate + Spouse/DP**	$256.13	$184.93
Associate + Child(ren)	$232.84	$168.12
Associate + Family	$392.86	$266.97

*Neighborly Wellness is a voluntary wellness program available to all employees. Please see notices on page 27 for reasonable alternatives.
**By law, if a domestic partner does not qualify as a tax dependent, the cost for their benefits cannot be paid pre-tax, and the "value" of associate and employer-provided domestic partner contributions is taxable.

RX PLAN COMPARISON

When you enroll in Medical coverage, you will also receive prescription benefits through Express Scripts. Here you can see the basics, be sure to check the **formulary** for a full list of the prescriptions that are covered by the plan.

	Prescription Drugs (Express Scripts) In-Network			
	BCBS PPO Plan		BCBS HSA Plan	
	30-day supply	90-day mail-order	30-day supply	90-day mail-order
	YOU PAY			
Retail Generic	$15 copay	$37.50 copay	0% after deductible	0% after deductible
Retail Preferred Brand	$30 copay	$75 copay		
Retail Non-Preferred	$60 copay	$150 copay		
Specialty	$120 copay	$300 copay		

Out-of-Network not covered.

Save on Prescription Drugs

Ask for Generics

Generic and brand-name drugs have the same active ingredients, which means they have the same efficacy for treating your condition. The main difference is the cost to you.

Brand-name drugs tend to be more expensive because of the lengthy drug development process. Manufacturers charge more to recoup costs. When a patent expires, other manufacturers can produce the medication, and competition drives the price down.

RxBenefits Member Services

Get access to RxBenefits Member Services representatives who can help you, your physician, and your pharmacy with questions about your network, prescriptions coverage, mail order medications, prior authorization, and more.

You can stay on track and manage your medications anytime, anywhere using the Express Scripts mobile app available in the App Store and Google Play. After downloading, first-time visitors must register using their member ID number found on their BCBS medical card or Social Security number (SSN).

RxBenefits Member Services
800-334-8134
Monday through Friday
7:00 a.m. – 8:00 p.m. Central
customercare@rxbenefits.com

ESI Member Login Page - https://www.express-scripts.com/login

HEALTH SAVINGS ACCOUNTS

When you enroll in the BCBS HSA Medical Plan, you may be eligible to open a Health Savings Account (HSA) through Optum Bank. Both Neighborly and you can contribute money to your HSA, up to the IRS limit. Note, the IRS limit includes both employer and associate contributions.

A Health Savings Account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pre-tax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can be used for you and your dependents, even if your dependents are not covered by the HSA medical plan.

How a Health Savings Account Works

Eligibility

You must enroll in the BCBS HSA Medical Plan and have no other non-HDHP medical coverage. This includes coverage through a spouse, traditional FSAs/HRAs, Medicare, TRICARE, or certain clinic benefits. Limited-purpose FSAs/HRAs, dental, vision, and accident coverage do not affect HSA eligibility.

Contributions

If enrolled in the BCBS HSA medical plan, Neighborly will provide an employer contribution, based upon your plan enrollment. $1,000 annually ($38.46 biweekly) for associate only | $2,000 annually ($76.92 biweekly) for family.*Employer funding will be pro-rated each paycheck.

You contribute on a pre-tax basis and can change how much you contribute from each paycheck up to the annual IRS maximum of $4,400 if you enroll only yourself or $8,750 if you enroll in family coverage. You can make an additional catch up contribution of $1,000 if you are age 55 or older.

Eligible Expenses

You may use your HSA funds to cover medical, dental, vision and prescription drug expenses incurred by you and your eligible family members.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future health care expenses

Your HSA is always yours — no matter what.

One of the best features of an HSA is that any money left in your account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the company or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.

DENTAL INSURANCE

Administered by MetLife

Taking care of your oral health is not a luxury — it's a necessity to long-term optimal health.

With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will pay only a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill. To find a provider, visit **www.MetLife.com/dental**. Select Find a Dentist on the homepage.

New for 2026, an additional dental plan without ortho coverage.

	Dental Plan #1 (with ortho)		Dental Plan #2 (without ortho)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (90% UCR*)	$50 individual $150 family	$50 individual $150 family	$75 individual $225 family	$75 individual $225 family
Annual Maximum	$1,500 per person	$1,500 per person	$1,000 per person	$1,000 per person
	YOU PAY		**YOU PAY**	
Preventive Exams, Cleanings (every 6 months)	$0	$0	$0	$0
Basic Fillings, Extractions, Repairs	20%	20%	20%	20%
Major Single Crowns, Bridges, Dentures	50%	50%	50%	50%
Orthodontia	50%	50%	Not covered	Not covered
Orthodontia Lifetime Maximum	$1,250 per person	$1,250 per person	Not covered	Not covered

*90% UCR means that there is a 10% chance that your non-network provider charges would be higher than MetLife's usual and customary reimbursement for that service and you could be balance billed for the difference.

Dental Contributions

Benefit Tiers	Dental Plan #1 (with ortho)	Dental Plan #2 (without ortho)
	Bi-Weekly Deduction	**Bi-Weekly Deduction**
Associate	$15.34	$14.16
Associate + Spouse/DP*	$31.11	$28.71
Associate + Child(ren)	$42.37	$39.11
Associate + Family	$62.32	$57.52

*By law, if a domestic partner does not qualify as a tax dependent, the cost for their benefits cannot be paid pre-tax, and the "value" of associate and employer-provided domestic partner contributions is taxable.

VISION INSURANCE

Administered by MetLife

Healthy eyes and clear vision are an important part of your overall health and quality of life.

You may enroll yourself and your eligible dependents, or you may waive Vision coverage. You do not have to be enrolled in Medical coverage to elect Vision coverage or cover the same dependents under Medical and Vision.

You may go to any eye doctor you prefer, but you will save money when you use a participating MetLife provider. To locate a participating provider, contact MetLife at **855-638-3931** or visit the web site at **www.MetLife.com/vision**.

The table below summarizes the key features of the Vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	Vision PPO	
	In-Network	**Out-of-Network**
	YOU PAY	**REIMBURSEMENT**
Eye Exam	$0	Up to $45
Single Lenses	$0	Up to $30
Bifocal Lenses	$0	Up to $50
Trifocal Lenses	$0	Up to $65
Frames	Up to $120 (then 20% discount)	Up to $55
Necessary Contacts	$0	Up to $210
Elective Contacts	Up to $120	Up to $105
FREQUENCY		
Exam, Lenses, Frames	Every 12 months	Every 12 months

Vision Contributions

Benefit Tiers	Bi-Weekly Deduction
Associate	$3.12
Associate + Spouse/DP*	$6.26
Associate + Child(ren)	$5.30
Associate + Family	$8.74

*By law, if a domestic partner does not qualify as a tax dependent, the cost for their benefits cannot be paid pre-tax, and the "value" of associate and employer-provided domestic partner contributions is taxable.

FLEXIBLE SPENDING ACCOUNT – DEPENDENT CARE

Dependent Care FSA

Contribute up to $7,500 per year ($3,750 if married and filing separate tax returns), pre-tax, to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time.

Use It or Lose It

If you do not spend all the money in your FSA by March 31, 2027, per IRS regulations for pre-tax contributions, unused dollars will be forfeited.

Plan details are available at **https://myneighborlybenefits.com** and **www.wexinc.com**. For a list of qualified expenses, visit **www.irs.gov** and look for Publication 502.

LIFE AND AD&D

Life and Accidental Death & Dismemberment (AD&D) insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death or in the case of a covered accidental injury. Basic Life and AD&D is provided for you at no cost, and you have the option to purchase coverage for your dependents.

Basic Life and AD&D

For You – 1x your basic annual earnings, to a maximum of $300,000, with a minimum of $25,000.

If your company-paid life insurance coverage is more than $50,000, the IRS requires the value above that amount to be added to your taxable income. This means you may see a small amount included in your paycheck for tax purposes. You're not paying extra for the coverage—it's simply how the IRS treats the value of this benefit.

Voluntary Life and AD&D

For You – 1, 2, 3, or 4x your earnings, to a maximum of $1,000,000. Guaranteed Issue amount of $250,000.

For Your Spouse – $10,000, $25,000, $50,000, or $100,000. Guaranteed Issue amount of $50,000.

For Your Child – $5,000 or $10,000 from birth to age 26. Guaranteed Issue is the full amount.

Guaranteed Issue and Evidence of Insurability

Associates and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

Please note: Guaranteed issue amounts are only available during your initial eligibility period. If you are an existing associate, any new election or change to voluntary life coverage will require evidence of insurability.

If you elect Voluntary Life and Voluntary AD&D, those benefit amounts must be equal.

ACCIDENT

Accident insurance pays out a lump sum if you become injured because of an accident. It allows you to claim benefits even if the injuries you incur do not keep you out of work. It may also complement health insurance if an accident causes you to have medical expenses that your health insurance doesn't cover.

How Does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.
- Coverage is available for you, your spouse and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen on the job or off the job — unlike workers' compensation, which only covers on-the-job injuries.
- Benefit payments are not reduced by any other insurance you may have with other companies.
- Please note, you are responsible for filing claims with the provider.

Examples of Covered Expenses

- Emergency Room Visits
- Hospitals Stays
- Fractures and Dislocation
- Medical Exams
- Physical Therapy
- Transportation and Lodging

Accident Contributions

Benefit Tiers	Bi-Weekly Deduction
Associate	$3.60
Associate + Spouse/DP	$7.11
Associate + Child(ren)	$8.56
Family	$10.10

CRITICAL ILLNESS

While medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, Medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

How Will a Critical Illness Claim Get Paid?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:

- Child care costs
- Medical and living expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Please note, you are responsible for filing claims with the provider.

Examples of Covered Expenses

- Heart Attack
- Multiple Sclerosis
- Stroke
- Alzheimer's Disease
- Parkinson's Disease
- Major Organ Failure

Critical Illness Contributions

AGE RANGE*	$5,000		$10,000	
BI-WEEKLY	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
<34	$0.95	$1.02	$1.89	$2.03
35 – 44	$1.64	$1.96	$3.28	$3.92
45 – 54	$3.67	$5.52	$7.34	$11.03
55 – 64	$7.43	$13.32	$14.86	$26.63
65+	$13.18	$26.31	$26.35	$52.62
Child Coverage	Included in Associate Election			

*Age as of 1/1/26.

HOSPITAL INDEMNITY

MetLife is pleased to offer you an opportunity to provide financial protection through Hospital Indemnity insurance as part of our voluntary products portfolio. Hospital Indemnity insurance provides benefits, including:

- Benefits available due to hospitalization and associated treatment.
- Portability through Continued Insurance with Premium Payment which gives associates the ability to keep their existing coverage when their employment status with the employer changes.
- No coordination with other insurance benefits.
- Associates are paid a lump-sum benefit that they can use as they feel necessary.
- Associates and their families will have access to discounts or services that will provide them actionable tools and resources to help them navigate life's twists and turns.

MetLife Hospital Indemnity insurance can supplement existing medical coverage and help provide financial support to pay for out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to covered associates to spend as they choose.

Covered Benefits

Please contact MetLife for detailed definitions of covered benefits.

Subcategory	Benefit Limits (Applies to Subcategory)	Benefit	Benefit Amounts
Hospital Benefits			
Admission Benefit	4 time(s) per calendar year	Admission	$1,000
		ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	$1,000
Confinement Benefit	31 days per confinement ICU Supplemental Confinement will pay an additional benefit for 31 of those days	Confinement	$200
		ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU)	$200
Confinement Benefit for Newborn Nursery Care	3 day(s) per confinement	Confinement Benefit for Newborn Nursery Care	$200
Inpatient Rehabilitation Benefit	15 days per calendar year	Inpatient Rehabilitation (For Injury or Sickness)	$200
Additional Care Benefits			
Ambulance Benefit	1 time(s) per calendar year	Ground Ambulance Transport	$100
Nursing Care	10 days per calendar year 20 days per lifetime	Nursing Care Facility	$100
		Home Care	$100
Other Benefits			
Health Screening Benefit	1 time(s) per calendar year per covered person	Health Screening	$50

Hospital Indemnity Contributions

Benefit Tiers	Bi-Weekly Deduction
Associate	$6.76
Associate + Spouse/DP	$15.81
Associate + Child(ren)	$14.39
Family	$19.53

DISABILITY

Disability insurance can keep you financially stable should you experience a qualifying disability and become unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive an income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

STD Coverage

This plan is sponsored by Neighborly and is a self-insured disability plan. You pay nothing out-of-pocket for this coverage.

LTD Coverage

You pay the cost of LTD coverage with after-tax dollars, so that any benefits you may receive are not taxed as income. The monthly cost is $0.460 per $100 of monthly covered pay.

Voluntary Long-Term Disability	All Associates
Rate per $100 of Bi-Weekly Covered Salary	$0.2123 (rounded)

Disability Benefits at a Glance

The STD Plan benefits begin after day 0 of accident or day 7 of illness.

Next 12 Weeks

STD replaces 60% of your weekly earnings to a $1,250 maximum for 12 weeks. Maternity STD is paid at 100%.

Benefit begins after 7 days of illness or immediately after an accident.

After 12 Weeks

LTD replaces 60% of your monthly earnings to an $8,000 maximum.

Benefit begins after 12 weeks of disability and payments will last for the remainder of the disability, up to 24 months (or longer with approval from MetLife) after STD benefits end.

PLANNING FOR RETIREMENT

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 401(k) savings plan allows you to save for retirement on a pre-tax or after-tax basis. You are eligible to start contributions to your Neighborly 401(k) plan at 60 days of employment. You are automatically enrolled at a rate of 6% effective the first payroll following 60 days of employment, unless you opt out or designate a contribution amount. You may opt out at any time.

To enroll in the 401(k) plan, visit **www.empowermyretirement.com** or call the Empower Retirement at **800-338-4015**. If you have a 401(k) from a previous employer and are interested in a rollover to our plan, the Empower Retirement service center can advise you through the process.

INCREASE YOUR RETIREMENT SAVINGS WITH A 401(K)

Funded with Pre-Tax or After-Tax Dollars

For associates under age 50: The elective annual deferral limit is expected to increase to $24,500.

Standard catch-up contributions (for ages 50+): The additional annual catch-up contribution limit is projected to increase to $8,000, making the total potential associate contribution $32,500.

Enhanced catch-up contributions (for ages 60–63): A higher annual catch-up limit of $11,500 is projected. This would bring the total potential associate contribution to $36,000.

Looking for guidance on investments, finances, or associate retirement planning? As a participant in the Neighborly 401(k) plan, you have access to personalized support from our 401(k) fiduciary—completely free of charge. Disciplined Investors are available to help you make informed financial decisions.

To schedule a one-on-one session, contact:

- Russell Livesay – **rl@dinvestors.com** | **254-755-8622**
- Sabrina Moore – **sabrina@dinvestors.com** | **254-754-9102**

Vesting

Vesting is at 20% each year, which means you are fully vested after completing 5 years of service.

Neighborly Contributions and Earnings Vesting Schedule	
Years of Service	**Percentage**
Less than 1 year	0%
1 year	20%
2 years	40%
3 years	60%
4 years	80%
5 years	100%

EMPLOYEE ASSISTANCE PROGRAM

We offer our associates and their eligible family members free access to licensed counselors through our Employee Assistance Program whether or not you elect other benefits coverage. Through this coverage, associates and their families receive immediate support and guidance and referrals for other services. You and your family members have unlimited telephone access to qualified counselors and up to 5 face-to-face visits per year based on need. You can contact the EAP for help with the following:

- Marital or Family Problems
- Stress, Anxiety or Depression
- Substance Abuse
- Financial Issues
- Aging Parents

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your Medical plan.

Call **888-319-7819** for more information.

You may also access resources online at **www.one.telushealth.com**

- **Username:** metlifeeap
- **Password:** eap

ADDITIONAL BENEFITS

HealthJoy

HealthJoy is the virtual access point for all your health care navigation and benefits needs. This resource is provided at NO COST to help you understand and make the most of your benefits.

HealthJoy offers 24/7 access to a dedicated health care concierge team, telemedicine visits, and care navigation tools. Easily locate in-network doctors, find extra savings on your prescriptions, and spot errors in your medical bills. HealthJoy's mobile app and dedicated member support team are always on hand to help make it easier to stay healthy and well. Learn more about HealthJoy at **https://myneighborlybenefits.com**.

- **JOY:** JOY is your virtual AI-powered assistant. It's available anytime, anywhere to help explain how HealthJoy works, provide personalized guidance, send reminders and alerts, and answer any questions.
- **Benefits Wallet:** Access all your benefits in one place in the digital benefits wallet. You can personalize your wallet to fit your life. One click gets you the information and assistance you need.
- **On-Demand Health Care Concierge:** Chat with a live health care concierge in seconds. Simply send a request and quickly receive assistance on anything related to your benefits or health care needs such as questions, claim issues, clinical issues, appointment setting, research, provider and facility recommendations, cost estimation, medical device help, and more. Phone: **877-500-3212**

HealthJoy Behavioral Health

Online: **https://healthjoy.com/members/**
Email: **support@healthjoy.com**

Spot Pet

Get reimbursed on eligible vet bills for accidents, illnesses, and more. It is EASY!
Visit **https://myneighborlybenefits.com** for more details.

How Spot Pet Insurance Works

- Visit any licensed vet or specialist in US / Canada
- Submit your claim online
- Get reimbursed fast and easily for eligible expenses
- Associates can elect this benefit at any time. This benefit is not available through a payroll deduction with Neighborly.

Neighborly Recognition Program

Bravo is a social media style platform which allows Associates to actively recognize others on a job well done. Associates have the ability to earn award points through recognition which can be cashed in from a catalog featuring hundreds of name brand products.

If you're not connected to Neighborly network, enter:

Username: @dwyergroup.com email
Password: Neighborly network password

HEALTH COVERAGE NOTICES

Marketplace Notice

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

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

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

1 Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.
2 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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.**

Marketplace-eligible individuals who live in states served by **HealthCare.gov** and either submit a new application or update an existing application on **HealthCare.gov** between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP 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 **800-318-2596**. TTY users can call **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 **https://www.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 **benefits@nbly.com**.

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.

Medical Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the Neighborly Health Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 1/1/2026.

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

Protected Health Information

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

How We May Use Your Protected Health Information

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

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

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

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

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

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

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

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

To the Plan Sponsor. We may disclose protected health information to certain employees of Neighborly for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures.

Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

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

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

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

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

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

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

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

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

Our Legal Responsibilities

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

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

If you have any questions or complaints, please contact:
benefits@nbly.com.

Complaints

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

Important Notice From Neighborly 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 Dwyer Franchising, LLC dba Neighborly 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. **Neighborly has determined that the prescription drug coverage offered by Neighborly 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 15th to December 7th.

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Neighborly coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Neighborly coverage, be aware that you and your dependents may not 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 Neighborly 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 Neighborly 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 "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:	1/1/2026
Name of Entity/Sender:	Dwyer Franchising, LLC dba Neighborly
Contact:	benefits@nbly.com
Address:	1020 North University Parks Drive Waco, TX 76707
Phone Number:	254-651-3404

OTHER NOTICES

Wellness Program and Reasonable Alternatives Notice

Neighborly Wellness 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 tobacco-free affidavit or a tobacco-cessation program.

However, employees who choose not to participate in the wellness program will incur a $40 per month penalty for tobacco use.

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 Dwyer Franchising, LLC dba Neighborly may use aggregate information it collects to design a program based on identified health risks in the workplace, Neighborly Wellness 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.

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.

Reasonable Alternatives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under the Neighborly wellness program, you might qualify for an opportunity to earn the same reward by different means.

Contact **benefits@nbly.co**m 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.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact **benefits@nbly.com**.

Expanded Coverage For Women's Preventive Care

Under the Affordable Care Act, Neighborly provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.

Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit **https://www.healthcare.gov/preventive-care-women/**.

60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in Dwyer Franchising, LLC dba Neighborly medical coverage 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 no more than 30 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in Neighborly medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact **benefits@nbly.com**.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Women's Health and Cancer Rights Act of 1998

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 consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the Dwyer Franchising, LLC dba Neighborly or your medical plan administrator.

Gallagher

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have question regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

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