HMG HEALTHCARE LLC



2027 Benefits Open Enrollment

November 16 - November 27, 2026

Benefits effective January 1, 2027

Corporate

Welcome

At HMG Healthcare, we are committed to your health and well-being. We are proud to provide you and your family with valuable and significant benefits.

This Guide is an overview of the benefits available to you and their impact on your compensation as a whole. Please read it carefully in order to make the best choices for you and your family in the 2027 plan year.

You can also visit our online benefits library to access all of your 2027 benefit information in one place. Scan the QR code or visit **HMGHealthcare.MyBenefitsLibrary.com**.

SCAN ME

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Eligibility and Enrollment

You and your family have unique needs, which is why HMG Healthcare offers a variety of benefit plans from which you may choose. Consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

If you are a full-time employee of HMG Healthcare who is regularly scheduled to work at least 30 hours a week, you are eligible to participate in the medical, dental, vision, life and disability plans, and additional benefits.

When Does Coverage Begin?

Your elections are effective on the first of the month following 30 days of full-time employment. You won't be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

Eligible Dependents

Dependents eligible for coverage in the HMG Healthcare benefits plans include:

- Your legal spouse (or common-law spouse where recognized).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

See **page 22** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to HMG Services, LLC. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Enroll Now. You've Got One Shot!

What are **Qualifying Life Events?**

Most people know you can change your benefits when you start a new job or during Open Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual open enrollment period.



When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Keep in mind your change in coverage must be consistent with your change in status.

Questions regarding specific life events and your ability to request changes should be directed to the Benefit Call Center.

Preparing to Enroll

HMG Healthcare provides its employees the best coverage possible. As a committed partner in your health, HMG Healthcare absorbs a significant amount of your benefit costs. Your contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

You may select any combination of medical, dental and/or vision plan coverage. For example, you could select medical coverage for you and your entire family, but select dental, and vision coverage only for yourself. The only requirement is that you, as an eligible employee of HMG Healthcare, must elect coverage for yourself in order to elect any dependent coverage.

Be sure to have the Social Security numbers and birth dates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

Enrollment Process

Professional benefits counselors will be available over the phone to help you complete enrollment. During your confidential meeting, the counselor will:

- Review your benefits and help you understand the programs available to you
- Answer your questions and provide additional information
- Help you customize a benefits package to best meet your individual needs
- Complete the enrollment process for yourself and your dependents

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For your convenience, you may pre-schedule your appointment with a benefits counselor by scanning the QR code, visiting **HMGHealthcare.mybenefitsappointment.com,** or calling **855-658-0073**, Monday - Friday, 9 a.m. - 5 p.m. Central.

You also have the option to **enroll online:**

- Go to **HMGHealthcare.bswift.com**
- Enter your username and password

  Username = First Initial + Last Name + Last four of SSN. Default Password will be last 4 of SSN
- Follow the prompts to complete your enrollment



Medical Benefits

Medical benefits are provided through Leading Edge with Anthem, **a BCBS Network**. We chose a plan that we felt brought the best value and service for our employees. The plan offers the flexibility to see any doctor you wish; however, you will pay less out-of-pocket when you see an in-network provider. Keep in mind your choice is effective for the entire 2027 plan year, unless you have a Qualifying Life Event.

Medical Plan Summary

This chart summarizes the 2027 medical coverage provided by Anthem, a BCBS Network. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

Medical Plan Features	
Plan Options	**Premier**
Annual Deductible (In-Network / Out-of-Network)	
Individual	$2,000/$4,000
Family	$4,000/$8,000
Annual Out-of-Pocket Maximum, Includes Deductible (In-Network / Out-of-Network)	
Individual	$5,000 / $12,000
Family	$10,000 / $24,000
Coinsurance (In-Network / Out-of-Network)	
	80% / 50%
Services (In-Network / Out-of-Network)	
Preventive Care	100%
Virtual Visit	$10 copay
Physician Office Visit	$30 copay
Specialist Visit	$50 copay
Hospital Benefit	80% after deductible / 50% after deductible
Emergency Room	$500 copay
Urgent Care	$75 copay
Pharmacy (Generic / Preferred Brand / Non-Preferred Brand)	
Retail 30-Day	$15/$50/$85
Mail 90-Day	$37.50/$125/$212.50
Biweekly Contributions	
Employee Only	$161.01
Employee + Spouse	$341.19
Employee + Children	$298.75
Employee + Family	$495.08

Medical Premiums

The table above shows the per-pay (26 biweekly deductions per year) employee cost. Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your biweekly contributions.

Medical Benefits Continued

Rising Costs of Healthcare

The cost of healthcare in the U.S. has been steadily growing each year. Why? Some of the factors include an aging population, increased demand for care (resulting in higher prices for premiums and prescription drugs), and an increase in chronic illnesses. The Company wants to help keep you healthy, so we do what we can to keep your healthcare costs reasonable. Make sure you're informed about your options so you can make the best healthcare choices for you and your family. Placing an importance on preventive care, making healthy choices, and managing costs will help keep your health — and wallet — in control in the long run.

Healthcare Cost Transparency

Healthcare cost transparency tools are online services available through most health insurance carriers that allow consumers to compare costs for medical services, from prescriptions to major surgeries, to make choices easier.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

Thoughts & Tips:

Most preventive care offered by an in-network physician is covered at 100%.

How to Find a Provider

Visit **mesa.leadingedgeadmin.com** and register as a member to seach or you can search as a guest on **anthem.com/find-care** and select **National PPO (BlueCard PPO)**.

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option, so here's the skinny: Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, a generic version costs 80% to 85% less than the brand-name equivalent. To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Note: Apps such as GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. If you use these tools, make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. As a result, if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

Home Delivery Pharmacy

Skip the trip to the pharmacy by having your ongoing medications delivered to your home through CarelonRx Pharmacy. Home delivery offers convenient 90-day supplies, free standard shipping, refill reminders, and automatic refill options. Pharmacists are available by phone, text, or chat 24/7 to answer questions.

To get started, log in at anthem.com and go to Prescriptions Home, or open the Sydney Health app and select Pharmacy. Choose View Prescriptions and follow the steps to switch eligible prescriptions to home delivery. CarelonRx can contact your doctor if a new prescription is needed.

For help, call the number on the back of your member ID card or use the live chat feature through Sydney Health or anthem.com.

Understanding Out-of-pocket Costs

Deductible

The amount you must pay for covered services before your insurance starts paying its portion.

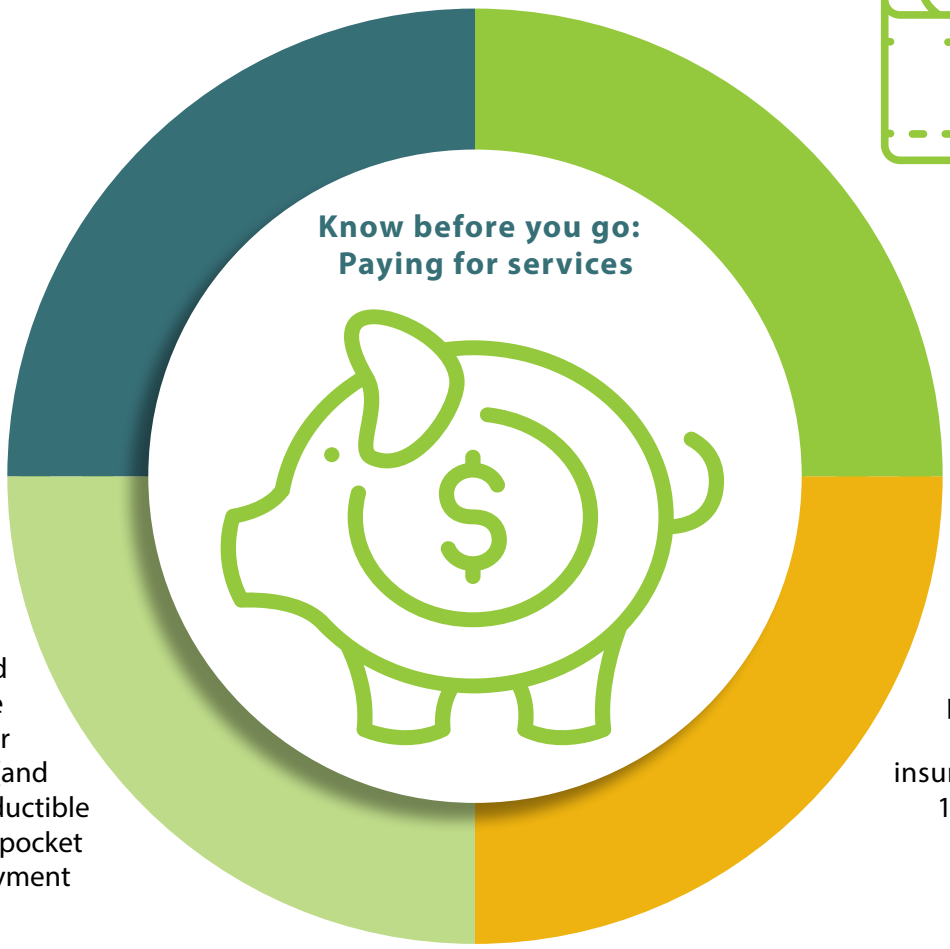
UP TO DEDUCTIBLE

YOU PAY **100%**

Copay

The fixed amount you pay for healthcare services at the time you receive them.





Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

% YOU PAY

% PLAN PAYS

AFTER DEDUCTIBLE IS REACHED

UP TO THE OUT-OF-POCKET MAXIMUM

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

AFTER OUT-OF-POCKET MAXIMUM IS REACHED

PLAN PAYS **100%** THROUGH END OF PLAN YEAR

Preventive Care

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

- Wellness visits, physicals, and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes
- Pediatric screenings for hearing, vision, obesity, and developmental disorders

- Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Where to Go for Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

PRIMARY CARE CENTER

When would I use this?

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

What are the costs and time considerations?**

- Often requires a copay and/ or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment.

NURSE LINE

When would I use this?

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

What type of care would they provide?*

Answers to questions regarding:

- Symptoms
- Medications and side effects
- Self-care home treatments
- When to seek care

What are the costs and time considerations?**

- Nurse lines are usually available 24 hours a day, 7 days a week.
- This service is usually free as part of your medical insurance.

TELEMEDICINE

When would I use this?

You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?**

- There is usually a first-time consultation fee and a flat fee or copay for any visit thereafter.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

URGENT CARE CENTER

When would I use this?

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

What are the costs and time considerations?**

- Often requires a copay and/ or coinsurance that is usually higher than an office visit.
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first.

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

EMERGENCY ROOM

When would I use this?

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

What are the costs and time considerations?**

- Often requires a much higher copay and/or coinsurance.
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

**This is a sample list of services and may not be all-inclusive.*
***Costs and time information represent averages only and are not tied to a specific condition or treatment.*

AllyHealth

Virtual Care. Anytime. Anywhere. Don't Forget to Register!

With AllyHealth, you can visit with a doctor 24/7 from your home, office, or on the go, with no copays or consultation fees for you or your family! Plus, you'll have access to our Rx and medical bill savings programs - helping you save time, money, and frustration.



YOUR ALLYHEALTH
VIRTUAL CARE SERVICES INCLUDE

Virtual Urgent Care: $0 Copay
877-283-3777 ext 1

24/7/365 On-demand access to licensed physicians for common illnesses and medications when appropriate.

Savings Tools: FREE

Save big on your prescriptions and medical bills with our in-app healthcare savings tools.

Visit https://allyhealth.app/, scan QR to download the AllyHealth app, or call the phone number listed above.

SCAN HERE

THIS PLAN IS NOT INSURANCE and is not considered a Qualified Health Plan under the Patient Protection and Affordable Care Act. Copays and usage limitations may apply (review detail pages that follow for more information). If you have any questions about your plan, please contact your HR manager or AllyHealth customer support at support@allyhealth.net



Doctors can be hard to reach, illness can occur in the middle of the night, and sometimes you just have a question. In all of those circumstances – and many more – AllyHealth is a convenient and affordable solution.

HOW IT WORKS

Log into your account or call AllyHealth anytime, 24/7/365, to connect directly with a licensed physician by phone or video call within minutes at no cost to you and your family.

FEATURES INCLUDE

- ☑ No copays, deductibles, or per-call charges
- ☑ Prescriptions called into your local pharmacy
- ☑ Plan covers the entire family
- ☑ Fast and easy access, 24/7/365
- ☑ Avoid germ-filled waiting rooms
- ☑ Flexible and easy to use (available via web, mobile app, or simply by phone)

COMMON CONDITIONS WE TREAT

- Sore Throat
- Sinus Infection
- Cough
- Allergies
- Urinary Tract Infections
- Skin Rash/ Infections
- Fever/Headache
- Covid-19/Flu
- Rx Refill
- Pink Eye
- Constipation/ Diarrhea
- Stomach Pain
- Stress and Anxiety
- Ear Pain
- And More

WHEN TO USE ALLYHEALTH

- ☑ Instead of going to the ER or urgent care center for a non-emergency medical issue
- ☑ During or after normal business hours, nights, weekends, and even holidays
- ☑ If your primary care doctor or pediatrician is not available
- ☑ To request prescriptions or refills (when appropriate)
- ☑ If traveling and in need of medical care



Savings and Transparency Tools

Registration Steps Available on Page 1

Tired of paying full price for prescriptions and out-of-pocket medical bills? Through the AllyHealth app, you have access to two incredible tools focused on saving you money.

FREE RX DISCOUNT PROGRAM

- ☑ 10-85% prescription discounts versus cash price on most short-term and acute care medications
- ☑ Online drug price lookup tool helps you find the price of prescriptions at participating locations by zip code
- ☑ Over 65,000 participating pharmacy locations, including independent, national and regional chain pharmacies nationwide
- ☑ No cost, membership, or personal information is required

MEDICAL BILL SAVER

- ☑ Save 20-50% on most out-of-network bills of $500 or more
- ☑ No up-front fee - Save or the service is free and only pay fee if your negotiation is successful (success fee is equal to 35% of the negotiated discount)
- ☑ Gain control over your medical spending without feeling the need to become a health care expert
- ☑ Reduce your medical bills regardless of your insurance status or procedure
- ☑ Track your annual savings

HOW TO USE RX DISCOUNT PROGRAM

1. In the AllyHealth app, click the "Prescription Savings" tile.
2. Search our network of pharmacies for your prescription.
3. Select the best price and the most convenient location for you.
4. Present the savings information to your pharmacist to save!

HOW TO USE MEDICAL BILL SAVER

1. In the AllyHealth app, click the "Medical Bill Review" tile.
2. If this is your first time using the service, then click the "Get Started" button and then follow the instructions to get started and submit your bill for review. Make sure to use the code "ALY100" to get access to your benefits.
3. If you've used the service before, click the "Access Portal" button any time to visit the online portal to see the status of your negotiation or to submit additional bills.
4. We will alert you when the process is complete. If your negotiation is successful, then you will pay the discounted amount, plus the success fee.

Supplemental Health Benefits

HMG Healthcare offers several ways for you to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and is offered at discounted group rates.

Voluntary Accident Insurance - *Includes a $100 Health Screening Benefit!*

Voluntary Accident Insurance through MetLife helps with the unexpected costs of a covered accident, whether it happens on or off the job. Benefits are paid directly to you, regardless of what your medical insurance pays. You can use the money for medical bills, household expenses, or other needs.

Choose from three coverage options: Base, Enhanced, or Premium. You pay the full cost of coverage through payroll deductions.

Covered Benefit	Base Plan	Enhanced Plan	Premium Plan
Accidental Death			
Employee	$25,000	$50,000	$75,000
Spouse	$12,500	$25,000	$37,500
Child	$5,000	$10,000	$15,000
Emergency Care and Treatment			
Emergency Room	$150	$200	$250
Urgent Care	$75	$100	$125
Ground Ambulance	$300	$400	$500
Air Ambulance	$1,000	$1,250	$1,500
X-rays	$150	$200	$250
Physician Follow-Up Visit	$75	$100	$125
Hospital Benefits			
Hospital Admission	$1,000	$1,500	$2,000
Hospital Confinement, per Day	$200	$300	$400
Additional Benefit			
Health Screening, Once per Calendar Year	$100	$100	$100
Biweekly Rates	**Base Plan**	**Enhanced Plan**	**Premium Plan**
Employee Only	$2.48	$4.66	$8.46
Employee + Spouse	$5.28	$10.00	$15.20
Employee + Child(ren)	$5.24	$9.60	$18.26
Employee + Family	$6.40	$11.88	$24.98

The benefits shown are a summary only and do not include all covered benefits, exclusions, or limitations. Please refer to your MetLife benefit summary and certificate of insurance for complete coverage details. If there is a discrepancy, the policy documents will govern.

Voluntary Critical Illness - *Includes a $100 Health Screening Benefit!*

Critical Illness insurance through MetLife pays a lump-sum benefit in the event that you or a covered family member is diagnosed with a covered illness and meets the policy requirements. This benefit can be used any way you choose, and benefits are paid regardless of any other insurance coverage you may have.

Employees may purchase coverage in $5,000 increments, up to $50,000. Spouse coverage is available at 50% of the employee's elected benefit amount. Coverage for eligible dependent children from birth to age 26 is also available at 50% of the employee's elected benefit amount. You must elect employee coverage to cover your dependents.

Illnesses Covered

- Heart attack and stroke
- Cancer
- Kidney failure and major organ transplant
- Coma and paralysis
- Certain neurological and progressive diseases
- Certain childhood conditions
- Certain infectious diseases
- Severe burns

Biweekly Rates

Coverage is 100% employee paid. Rates are based on the employee's attained age, elected benefit amount, and coverage tier. Rates increase when the employee enters a new age band. ***Please speak with a benefits counselor for your personalized quote and coverage options.***

How the Coverage Works

Joe meets with a counselor and elects $30,000 of coverage.

Three months after his annual wellness exam, Joe suffers a heart attack.

Three years later, he is diagnosed with invasive cancer.

Joe's Critical Illness policy provided the following benefits:

Wellness Benefit:	$100
Heart Attack Benefit:	$30,000
Invasive Cancer Benefit:	$30,000
Total Benefits:	**$60,050**

The benefits shown are an example only and do not include all covered benefits, exclusions, or limitations. Please refer to your MetLife benefit summary and certificate of insurance for complete coverage details. If there is a discrepancy, the policy documents will govern.



Voluntary Hospital Indemnity - *Includes a $50 or $100 Health Screening Benefit!*

A trip to the hospital can be costly—and most people are surprised to learn that they are responsible for a good portion of the bill. Hospital Indemnity insurance through MetLife provides a direct benefit in the event of a covered hospitalization, regardless of treatment costs or other insurance coverage. It's a way for employees to protect themselves from rising healthcare costs.

- Choose from Base, Enhanced, or Premium plan options.
- Coverage is available for employees, spouses, and eligible children from birth to age 26. You must elect employee coverage to cover your dependents.
- Coverage is offered on a guaranteed-issue basis, subject to actively-at-work requirements and dependent medical restrictions.
- Portability is available. Eligible employees may continue coverage through direct billing with MetLife if they lose eligibility under the group plan, subject to plan requirements.
- ICU supplemental benefits pay in addition to the corresponding hospital admission and confinement benefits.
- Provides coverage for covered injuries and illnesses, including routine childbirth and complications of pregnancy. The Premium Plan's pre-existing condition limitation applies to sickness benefits, including pregnancy.
- No sickness waiting period applies. The Base and Enhanced Plans have no pre-existing condition limitation; the Premium Plan has a six-month look-back and 12-month exclusion period for new entrants, subject to takeover provisions and state variations.

Covered Benefit	Base Plan	Enhanced Plan	Premium Plan
Hospital Benefits			
Hospital admission	$500	$1,000	$1,500
Additional ICU admission	$500	$1,000	$1,500
Hospital confinement (per day)	$100	$200	$350
Additional ICU confinement (per day)	$100	$200	$350
Newborn nursery care (per day)	$100	$200	Not Covered
Additional Benefit			
Health Screening, Once per Calendar Year	$100	$100	$50
Biweekly Rates	**Base Plan**	**Enhanced Plan**	**Premium Plan**
Employee Only	$3.56	$7.14	$8.94
Employee + Spouse	$7.06	$13.96	$15.26
Employee + Child(ren)	$6.26	$12.96	$12.94
Employee + Family	$9.94	$19.56	$22.58

The benefits shown are a summary only and do not include all covered benefits, exclusions, or limitations. Please refer to your MetLife benefit summary and certificate of insurance for complete coverage details. If there is a discrepancy, the policy documents will govern.

Dental Benefits

Routine preventive care such as regular dental checkups can help protect your oral health. HMG Healthcare's dental coverage will provide you and your family affordable options for overall health. Coverage is available from MetLife.

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs may be higher, and you are responsible for charges above the plan's allowed amount.

The Low Plan bases out-of-network benefits on the Maximum Allowable Charge (MAC). The High Plan bases out-of-network benefits on the 90th percentile of Reasonable and Customary (R&C) charges. Even though the coverage percentages are the same in and out of network, your costs may differ.

To find a network dentist, visit www.metlife.com and select Find a Dentist.

Dental Premiums

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your plan and tier of coverage determine your biweekly premium.

	Low Plan	High Plan
Calendar Year Deductible		
Individual	$50	$25
Family	$150	$75
Calendar Year Maximum		
Per Person - Base Maximum	$1,000	$2,000
Covered Services		
Preventive Services	80%	100%
Basic Services	60%	80%
Major Services	30%	50%
Orthodontics - Dependent Child(ren) Only	N/A	50%
Orthodontic Lifetime Maximum	N/A	$1,500
Biweekly Rates	**Low Plan**	**High Plan**
Employee Only	$0.00	$1.17
Employee + Spouse	$8.66	$15.00
Employee + Child(ren)	$12.57	$20.10
Employee + Family	$22.44	$38.82

Thoughts & Tips:

Only 60% of adults ages 20 to 64 have been to the dentist in the past year. Take advantage of your dental coverage to keep your smile healthy.

Vision Benefits

If you wear glasses or contacts, chances are you already have a steady appointment with an eye doctor. But even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, HMG Healthcare offers a comprehensive vision benefit provided by Superior Vision by MetLife.

Network Providers

If you use a vision provider who doesn't participate in your plan's network, your out-of-pocket costs may be higher. Out-of-network services are reimbursed up to the plan's scheduled amounts, and you are responsible for charges above those amounts.

To find a network provider, visit www.metlife.com/mybenefits and search for providers in the Superior Vision network. Confirm your provider's participation before scheduling an appointment.

Vision Premiums

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your biweekly premium.

Benefit	In-Network	Out-Of-Network Reimbursement	Frequency
Copays			
Examination	$10 Copay	Up to $45	Once every 12 months
Materials	$10 Copay	See below	Based on the applicable eyewear benefit
Lenses			
Single Vision	Covered in full after materials copay	Up to $30	Once every 12 Months
Lined Bifocal	Covered in full after materials copay	Up to $50	Once every 12 Months
Lined Trifocal	Covered in full after materials copay	Up to $70	Once every 12 Months
Frames			
Allowance	$130 Allowance; 20% Off Amount Over Allowance	Up To $90	Once Every 24 Months
Contacts—In Lieu Of Glasses			
Elective	$130 Allowance	Up To $130	Once Every 12 Months, In Lieu Of Glasses
Medically Necessary	Covered In Full	Up To $300	Once Every 12 Months, In Lieu Of Glasses
Contact Lens Fitting And Follow-Up	$30 Copay; Standard: Covered In Full After Copay; Specialty: $50 Allowance After Copay	Applied To Contact Lens Allowance	Subject To Contact Lens Benefit
Biweekly Rates			
Employee Only	$0.00		
Employee + Spouse	$2.22		
Employee + Child(ren)	$2.47		
Employee + Family	$4.79		

Thoughts & Tips:

More than 150 million Americans use corrective eyewear to compensate for refractive errors.

Survivor Benefits

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Survivor benefits provide financial protection and security in the event of an unexpected death. Securing Life insurance now can help protect your family's financial future.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

HMG Healthcare provides employees with Basic Life and AD&D insurance through Prudential. Life insurance pays a benefit to your designated beneficiary in the event of your death. AD&D insurance provides benefits for a covered accidental death or certain covered losses.

Your Basic Life and AD&D insurance benefit is $15,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage

What's a Beneficiary? Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by HMG Healthcare. You receive the benefit payment for a covered dependent's death under the Prudential insurance.

Name a primary and contingent beneficiary to make your intentions clear. Provide the beneficiary information requested during enrollment, including your intended distribution percentages. Keep your designations up to date as your circumstances change. Special arrangements may be necessary when naming a minor as beneficiary. If you need assistance, contact Human Resources or your own legal counsel.

Voluntary Life and AD&D Insurance

Life and AD&D benefits are an important part of your family's financial security. The basic benefits provided to you by HMG Healthcare may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible employees may purchase additional Voluntary Life and AD&D insurance through Prudential. Premiums are paid through post-tax payroll deductions.

During this enrollment period, employees already enrolled in Voluntary Life insurance may increase their existing employee coverage by up to $40,000 without answering medical questions, subject to plan limits. Coverage is also available for your spouse and eligible children. ***Please speak with a benefits counselor for your personalized quote and coverage options.***

Voluntary Life And AD&D Insurance	
Monthly Rates Per $1,000 Of Coverage	
Age (As Of January 1, 2027)	**Employee/Spouse**
24 Or Younger	$0.08
25–29	$0.08
30–34	$0.09
35–39	$0.12
40–44	$0.19
45–49	$0.30
50–54	$0.43
55–59	$0.74
60–64	$1.07
65–69	$1.78
70–74	$2.79
75 Or Older	$4.71
Voluntary Child Life And AD&D Insurance	
$0.202	

To Calculate Your Monthly Premium: Benefit Elected ÷ 1,000 × Applicable Rate = Monthly Premium

Rates shown are monthly and are not your biweekly payroll deduction. Please see a benefits counselor for your customized quote.

Term Life Insurance with Long-Term Care Benefits

HMG Healthcare offers Term Life Insurance through The Standard, with premiums that remain level to age 100 unless coverage changes. Eligible insureds can access a portion of their death benefit while living to help pay for qualified long-term care expenses. The Life insurance death benefit provides money your beneficiaries can use any way they choose, including mortgage or rent, education, family debt, and final expenses. ***During this enrollment period only, enroll up to the guaranteed issue amount without answering medical questions! Please speak with a benefits counselor for your personalized quote and coverage options.***

Guaranteed Life Insurance with Long-Term Care Benefits

HMG Healthcare offers Chubb Guaranteed Life with Long Term Care, which provides a death benefit guaranteed through age 121 and Life insurance premiums that will never increase, as long as required premiums are paid. Living benefits can help pay for qualifying long-term care, including home health care, assisted living, adult day care, and nursing home care. The Life insurance death benefit provides money your beneficiaries can use any way they choose, including mortgage or rent, education, family debt, and final expenses. Using living benefits can reduce the death benefit, subject to the plan's restoration provisions. ***During this enrollment period only, enroll up to the guaranteed issue amount without answering medical questions! Please speak with a benefits counselor for your personalized quote and coverage options.***

Income Protection

HMG Healthcare offers disability coverage through Prudential to protect you against an unfortunate or debilitating injury or illness. This insurance protects a portion of your income until you can return to work, subject to the plan's maximum benefit period.

Voluntary Short-Term Disability (STD) Insurance

Short-Term Disability (STD) benefits are available for purchase on a voluntary basis. STD insurance replaces 66.67% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents for details. ***Please speak with a benefits counselor for your personalized quote and coverage options.***

Voluntary Short-Term Disability (STD) Insurance	
Benefit	**Coverage**
Weekly Maximum Benefit	$1,250
Elimination Period	7 days
Maximum Benefit Period	12 weeks

Long-Term Disability (LTD) Insurance

Long-Term Disability (LTD) benefits are available at no cost to you. LTD insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents for details.

Long-Term Disability (LTD) Insurance	
Benefit	**Coverage**
Monthly Maximum Benefit	$10,000
Elimination Period	90 days
Maximum Benefit Period	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Additional Benefits

HMG Healthcare knows the value of well-rounded, balanced employees, which is why we offer additional benefits to help you manage your life.

Voluntary Advantage DNA Cancer Program

HMG Healthcare offers Chubb Advantage DNA, which combines cash benefits with personalized cancer support services to help you navigate a covered cancer diagnosis. Coverage is available for eligible employees and spouses.

The plan pays a $5,000 cash benefit for a covered cancer diagnosis, with separate benefits of $1,250 for carcinoma in situ and $250 for skin cancer. The skin cancer benefit is payable once per insured per year. Cash benefits can help with medical bills, household expenses, or other needs. Through Kadance, you also have access to services such as:

- Oncology nurse advocacy and cancer education.
- Expert medical review and genetic testing to help inform treatment.
- Clinical trial search and enrollment support.
- Genetic-based cancer recurrence monitoring.

Please speak with a benefits counselor for your personalized quote and coverage options.

Voluntary Norton LifeLock Identity & Digital Protection

HMG Healthcare offers Norton LifeLock protection to help safeguard your identity, finances, and digital life. This voluntary benefit provides monitoring, alerts, and support to help you respond to identity theft and online threats. Coverage is available for yourself or your family. The plan includes:

- Identity and one-bureau credit monitoring.
- Identity theft restoration support and reimbursement for eligible losses and expenses, subject to policy limits.
- Device security with Secure VPN for up to three devices, or six devices with family coverage.
- Scam protection, a password manager, and privacy monitoring.
- Financial and credit insights.

Please speak with a benefits counselor for your personalized quote and coverage options.

Legal Plan

MetLife Legal Plans gives you easy, direct access to a national network of more than 18,000 attorneys that provide telephonic advice and office consultations and access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft or caring for aging parents.

Please speak with a benefits counselor for your personalized quote and coverage options.

Voluntary Home & Auto Insurance

HMG Healthcare is providing a group Home and Auto policy from MetLife. To receive your personalized quote, please call 844-569-3607.

Pet Insurance

MetLife Pet Insurance helps you manage the cost of veterinary care for covered accidents and illnesses. Customizable coverage options allow you to choose a plan that fits your pet's needs and your budget. To learn more, get a personalized quote, or enroll, visit **quote.metlifepetinsurance.com/pet**.

Enrollment is completed directly through MetLife. You are responsible for paying premiums directly to MetLife; payments will not be deducted from your paycheck.

Additional Benefits Continued

Employee Assistance Program

We know life is complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP), provided through TELUS Health, offers professional support and guidance for you and your eligible household members. Available at no additional cost, the program can help you manage everyday challenges at home and at work.

Through this program, you have access to confidential counseling, legal and financial guidance, and resources to support your well-being. Your benefit includes up to five phone or video consultations per issue, per year, with licensed counselors for you and your eligible household members. You can call 888-319-7819 anytime, 24 hours a day, seven days a week.

You can also access educational materials, self-guided programs, and a chat feature for help finding resources or scheduling counseling. Visit **one.telushealth.com** or download the TELUS Health app from the App Store or Google Play. Log in using the username metlifeeap and password eap.

The program provides support and guidance for:

- Emotional health, stress, anxiety, and depression
- Marriage, family relationships, and caregiving
- Workplace challenges and relationships
- Budgeting, retirement planning, and tax questions
- Legal matters, including family law and estate planning
- Identity theft prevention and recovery
- Grief, loss, and other life changes
- Healthy habits, sleep, and quitting smoking

Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher co-payments.

Reasonable and Customary Allowance (R&C) – Also known as the UCR (Usual, Customary, and Reasonable) amount. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) - The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.



Required Notices

Important Notice From HMG Services, LLC 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 HMG Services, LLC 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. HMG Services, LLC has determined that the prescription drug coverage offered by the BCBS plan(s) 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 HMG Services, LLC coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current 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 HMG Services, LLC 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 at the end of these notices 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 HMG Services, LLC 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.

Remember: Keep this Medicare Part D 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:	**January 1, 2027**
Name of Entity/ Sender:	**HMG Services, LLC**
Contact—Position/ Office:	**Human Resources**
Address:	**1780 Hughes Landing Blvd, Suite 500 The Woodlands, TX 77380**
Phone Number:	**281-419-5520**

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).

Women's Health and Cancer Rights Act

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. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 281-419-5520.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 281-419-5520.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

- Loss of eligibility includes but is not limited to:
- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact Human Resources at 281-419-5520.

Benefit Contact Information		
Plan	**Provider/Contact**	**Phone Number / Website**
Medical	Leading Edge	
Virtual Medicine	AllyHealth	888-565-3303 allyhealth.app
Hospital Indemnity	MetLife	800-438-6388 mybenefits.metlife.com
Accident	MetLife	800-438-6388 mybenefits.metlife.com
Critical Illness	MetLife	800-438-6388 mybenefits.metlife.com
Dental	MetLife	800-438-6388 mybenefits.metlife.com
Vision	MetLife	800-438-6388 mybenefits.metlife.com
Basic & Voluntary Life and AD&D	Prudential	800-842-1718 prudential.com/mybenefits
Term Life Insurance with Long-Term Care Benefits	The Standard	800-521-3535 mybenefits.standard.com
Guaranteed Life Insurance with Long-Term Care Benefits	Chubb	855-241-9891 chubb.com
Short-Term Disability	Prudential	800-842-1718 prudential.com/mybenefits
Long-Term Disability	Prudential	800-842-1718 prudential.com/mybenefits
Advantage DNA Cancer Program	Chubb	833-542-2013 chubb.com/WorkplaceBenefitsClaims
Home and Auto	MetLife	800-438-6388 mybenefits.metlife.com
Identity & Digital Protection	Norton LifeLock	800-607-9174 Norton.com/BenefitEssential
Legal Plan	MetLife	800-248-9000 www.legalplans.com
Pet Insurance	MetLife	quote.metlifepetinsurance.com/pet
Employee Assistance Program (EAP)	TELUS Health	888-319-7819
HMG Healthcare Human Resources		281-419-5520
Open Enrollment Suppport Benefits counselors	EOI Service Company	855-658-0073 HMGHealthcare.mybenefitsappointment.com