Transamerica - 2024 Online Benefits Decision Guide

Medical

Overview

To support you in living your best life, Transamerica provides valuable benefits that help you and your family stay healthy and pay for care in the event of illness or injury.

2024 medical plans

Transamerica offers you a choice of medical plans[1] with a range of coverage levels and costs, so you have the flexibility to select the option that's best for you.

The following information provides an overview of your medical plan options. For complete details on coverage and for more information on how to enroll, visit the Mercer Marketplace 365+ website.

Please note: Deductibles in the medical plan names reflect Self Only coverage; deductible amounts are double for all other coverage tiers.

Medical Plan	Description
$4,500 Deductible Plan[2] Administered by: • Wellmark Blue Cross Blue Shield or United Healthcare, based on the state where you live.	A high deductible health plan (HDHP) that offers the lowest premiums and highest deductibles, along with a tax-advantaged Health Savings Account (HSA) to put you in charge of your spending. You have the opportunity to earn Reward Dollars for participating in the wellness program if you elect an HSA.
$3,200 Deductible Plan Administered by: • Wellmark Blue Cross Blue Shield or United Healthcare, based on the state where you live. • Kaiser may be available as a carrier option for participants living in California, Colorado, the District of Columbia, Georgia, Maryland and Virginia. You will only be offered Kaiser as a medical option if it is available for your home ZIP code. You can see a list of ZIP codes where Kaiser is available on mytabenefits.com.	A high deductible health plan (HDHP) that offers lower premiums and higher deductibles, along with a tax-advantaged Health Savings Account (HSA) to put you in charge of your spending. You have the opportunity to earn Reward Dollars for participating in the wellness program if you elect an HSA.
$1,850 Deductible Plan Administered by:	A high deductible health plan (HDHP) that offers lower premiums and high deductibles, along with a tax-advantaged Health Savings Account (HSA) to put you in

• Wellmark Blue Cross Blue Shield or United Healthcare, based on the state where you live. • Kaiser may be available as a carrier option for participants living in California, Colorado, the District of Columbia, Georgia, Maryland and Virginia. You will only be offered Kaiser as a medical option if it is available for your home ZIP code. You can see a list of ZIP codes where Kaiser is available on mytabenefits.com.	charge of your spending. You have the opportunity to earn Reward Dollars for participating in the wellness program if you elect an HSA.
$900 Deductible Plan Administered by: • Wellmark Blue Cross Blue Shield or United Healthcare, based on the state where you live. • Kaiser may be available as a carrier option for participants living in California, Colorado, the District of Columbia, Georgia, Maryland and Virginia. You will only be offered Kaiser as a medical option if it is available for your home ZIP code. You can see a list of ZIP codes where Kaiser is available on mytabenefits.com.	A low deductible plan that offers the highest premiums and lowest deductibles to reduce your out-of-pocket responsibility when you need care. This plan is not HSA-eligible, but you can contribute to a Health Care Flexible Spending Account (FSA).
Compare the plans in the Plan Comparison section below	

[1]Number of medical plan options varies by location and eligibility. If you live in Hawaii, you are only eligible for the Platinum Be Fit Plan offered by Kaiser-Hawaii.
[2]The $4,500 Deductible Plan with HSA is not offered by Kaiser.

Key features

All of Transamerica's medical plans offer:

- Comprehensive, affordable coverage that also fulfills the requirements of the federal health care law. Tip: If you want extra protection from large or unexpected medical expenses, you may also choose to enroll in one of the supplemental health insurance plans.
- In-network preventive care, with services such as annual physicals, recommended immunizations and routine cancer screenings covered at 100%. View a complete list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
- Prescription drug coverage included with each medical plan. Prescription benefits are provided by Express Scripts if you enroll in a Wellmark Blue Cross Blue Shield or United Healthcare plan, and by Kaiser Pharmacy if you enroll in a Kaiser plan.
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year.

Plan Comparison

The chart below provides a comparison of the medical plans' key features. For more information, including out-of-network coverage details, visit the Mercer Marketplace 365+ website. See the how to enroll section for more details.

	$4,500 Deductible Plan	$3,200 Deductible Plan	$1,850 Deductible Plan	$900 Deductible Plan
HSA-eligible	Yes	Yes	Yes	No
Reward Dollars (if participating in the wellness program)	Up to $500 for Self Only coverage; Up to $800 if you cover your spouse and/or child(ren)	Up to $500 for Self Only coverage; Up to $800 if you cover your spouse and/or child(ren)	Up to $500 for Self Only coverage; Up to $800 if you cover your spouse and/or child(ren)	N/A
In-network care: Your costs				
Preventive care	Covered at 100% in-network			
Annual deductible (individual/ family)	$4,500/$9,000[1]	$3,200/$6,400[1]	$1,850/$3,700[2]	$900/$1,800[1]
Annual out-of-pocket maximum (individual/ family)	$6,550/$13,100[3]	$5,500/$11,000[3]	$3,500/$6,500[4]	$3,000/$6,000[3]
Coinsurance (after meeting deductible)	You pay 30%, plan pays 70%	You pay 30%, plan pays 70%	You pay 20%, plan pays 80%	You pay 20%, plan pays 80%
Retail prescriptions (30-day supply)				
Tier 1 (most generics)	You pay 30% after meeting deductible	You pay 30% after meeting deductible	You pay 20% after meeting deductible	You pay 30% (min. $10/max. $20)[5]
Tier 2 (formulary)	You pay 30% after meeting deductible	You pay 30% after meeting deductible	You pay 20% after meeting deductible	You pay 30% (min. $25/max. $50)[5]
Tier 3 (non-formulary)	You pay 30% after meeting deductible	You pay 30% after meeting deductible	You pay 20% after meeting deductible	You pay 45% (min. $40/max. $80)[6]
Mail order prescriptions (up to a 90-day supply[6])				
Tier 1 (most generics)	You pay 30% after meeting deductible	You pay 30% after meeting deductible	You pay 20% after meeting deductible	You pay 30% (min. $25/max. $50)[5]
Tier 2 (formulary)	You pay 30% after meeting deductible	You pay 30% after meeting deductible	You pay 20% after meeting deductible	You pay 30% (min. $62.50/max. $125)[5]

Tier 3 (non-formulary)	You pay 30% after meeting deductible	You pay 30% after meeting deductible	You pay 20% after meeting deductible	You pay 45% (min. $100/max. $200)[5]

[1]With the $900, $3,200 and $4,500 Deductible Plans, coinsurance will begin for a covered family member if that family member's individual deductible is met; coinsurance begins for all covered family members once the family deductible has been met.
[2]With the $1,850 Deductible Plan (excluding the Kaiser California $1,850 Deductible Plan), the family deductible must be met before the plan will begin to pay coinsurance for any covered family member. The Kaiser California $1,850 Deductible Plan has, as required by state law, a three tier deductible consisting of a $1,850 individual deductible for Self Only coverage, a $2,800 individual-within-family deductible for employees electing dependent coverage and a $3,700 overall family deductible
[3]With the $900, $3,200 and $4,500 Deductible Plans, the plan will begin to pay 100% of the cost of a covered family member's covered expenses if that family member's individual out-of-pocket maximum is met; the plan begins to pay 100% of covered expenses for all covered family members once the family out-of-pocket maximum has been met.
[4]With the $1,850 Deductible Plan (excluding the Kaiser California $1,850 Deductible Plan), the family out-of-pocket maximum must be met before the plan will begin to pay 100% of the cost of covered services for any covered family member. With the Kaiser California $1,850 Deductible Plan, the plan will begin to pay 100% of the cost of a covered family member's covered expenses if that family member's individual out-of-pocket maximum is met; the plan begins to pay 100% of covered expenses for all covered family members once the family out-of-pocket maximum has been met.
[5]Deductible does not apply.
[6]If you take a long-term or "maintenance" medication to manage a health condition like high blood pressure, diabetes or high cholesterol, you have the option to pick up a three-month supply of your medication at a CVS or Walgreens, or have your medication shipped to your home using Express Scripts mail-order pharmacy.

$4,500 Deductible Plan ($9,000 family deductible)

The $4,500 Deductible Plan is a high deductible health plan, or HDHP. It offers the lowest premiums and highest deductibles, along with the option to elect a tax-advantaged Health Savings Account (HSA) that helps you save pre-tax money to cover eligible medical expenses. When participating in the wellness program, you and your covered spouse (if applicable) can earn Reward Dollars that will be deposited automatically into your HSA within six weeks of reaching certain point levels. Employees can earn up to $500, and a covered spouse has the opportunity to earn an additional $300. Employees covering themselves and child(ren) only can earn up to $800 (only the employee is required to complete the activities).

You have until November 30 of each year to earn Reward Dollars. Money in your HSA can be carried forward from year to year and is always yours to keep.

How it works

- Your in-network preventive care is covered in full – the deductible does not apply.
- You pay for your initial medical and prescription costs until you meet your annual deductible. Your pre-tax HSA contributions and any earned Reward Dollars from Transamerica can help you pay your out-of-pocket costs.
- Once you meet the deductible, you'll pay 30% of your covered medical expenses; this amount is called your coinsurance.
- If you choose a coverage tier other than Self Only, there is an embedded individual deductible, which means that coinsurance will begin for a covered family member if that person's individual deductible is met; coinsurance begins for all covered family members once the family deductible has been met.
- If your share of medical expenses reaches $6,550/$13,100 (individual/family), the plan's out-of-pocket (OOP) maximum, the plan pays 100% of your eligible expenses for the rest of the year. An individual

OOP maximum applies for each covered family member; once the family OOP maximum is met, 100% payment begins for all covered family members.

$3,200 Deductible Plan ($6,400 family deductible)

The $3,200 Deductible Plan is a high deductible health plan, or HDHP. It pairs lower-premium, higher-deductible coverage with the option to elect a tax-advantaged Health Savings Account (HSA) that helps you save pre-tax money to cover eligible medical expenses. When participating in the wellness program, you and your covered spouse (if applicable) can earn Reward Dollars that will be deposited automatically into your HSA within six weeks of reaching certain point levels. Employees can earn up to $500, and a covered spouse has the opportunity to earn an additional $300. Employees covering themselves and child(ren) only can earn up to $800 (only the employee is required to complete the activities).

You have until November 30 of each year to earn Reward Dollars. Money in your HSA can be carried forward from year to year and is always yours to keep.

How it works

- Your in-network preventive care is covered in full – the deductible does not apply.
- You pay for your initial medical and prescription costs until you meet your annual deductible. Your own pre-tax HSA contributions and any earned Reward Dollars from Transamerica can help you pay your out-of-pocket costs.
- Once you meet the deductible, you'll pay 30% of your covered medical expenses; this amount is called your coinsurance.
- If you choose a coverage tier other than Self Only, there is an embedded individual deductible, which means that coinsurance will begin for a covered family member if that person's individual deductible is met; coinsurance begins for all covered family members once the family deductible has been met.
- If your share of medical expenses reaches $5,500/$11,000 (individual/family), the plan's out-of-pocket (OOP) maximum, the plan pays 100% of your eligible expenses for the rest of the year. An individual OOP maximum applies for each covered family member; once the family OOP maximum is met, 100% payment begins for all covered family members.

$1,850 Deductible Plan ($3,700 family deductible)

The $1,850 Deductible Plan is a high deductible health plan, or HDHP. It pairs lower-premium, high-deductible coverage with the option to elect a tax-advantaged Health Savings Account (HSA) that helps you save pre-tax money to cover eligible medical expenses. When participating in the wellness program, you and your covered spouse (if applicable) can earn Reward Dollars that will be deposited automatically into your HSA within six weeks of reaching certain point levels. Employees can earn up to $500, and a covered spouse has the opportunity to earn an additional $300. Employees covering themselves and child(ren) only can earn up to $800 (only the employee is required to complete the activities).

You have until November 30 of each year to earn Reward Dollars. Money in your HSA can be carried forward from year to year and is always yours to keep.

How it works

- Your in-network preventive care is covered in full – the deductible does not apply.

- You pay for your initial medical and prescription costs until you meet your annual deductible. Your own pre-tax HSA contributions and any earned Reward Dollars from Transamerica can help you pay your out-of-pocket costs.
- Once you meet the deductible, you'll pay 20% of your covered medical expenses; this amount is called your coinsurance.
- Important note: With this plan, there is a true family deductible, which means that if you choose a coverage tier other than Self Only, the family deductible must be met before the plan will begin to pay coinsurance for any covered family member.
- If your share of medical expenses reaches $3,500/$6,500 (individual/family), the plan's out-of-pocket (OOP) maximum, the plan pays 100% of your eligible expenses for the rest of the year. For coverage tiers other than Self Only, the entire family OOP maximum must be met before the plan begins paying for covered expenses at 100%.

Use the High Deductible Health Plans Wisely

With lower premiums, the $4,500, $3,200 and $1,850 Deductible Plans give you more opportunity to take control of your health care spending. Here's how you can make the most of your plan all year long.

- Track your stats. Log in to your carrier's website to see how much of your deductible you've met, review claims, use helpful tools and more. Likewise, keep tabs on your HSA by logging in to Transamerica's website at transamerica.com/portal to view your balance, manage claims, etc.
- Be cost-conscious. Visit your carrier's website to search for in-network providers and use the tools to compare costs for medical services.
- Plan for your expenses. You pay lower premiums in exchange for assuming more financial responsibility when you receive care, so it's smart to plan ahead. Try to contribute enough to your HSA to cover your expected out-of-pocket costs, such as your annual deductible and coinsurance.
- Change your HSA contributions anytime. Adjust your contributions as necessary during the year to make sure you have money available when you need it. Keep in mind: With an HSA, you can only spend up to the amount that's actually been deposited into your account.
- Look long term. You will never forfeit any money left in your HSA; it rolls over year after year. If you know about future expenses, or if you want to save for your health care costs in retirement, set aside a little extra each paycheck so your balance can grow over time. Once your account reaches a certain balance, there are investment options to help your money grow.

$900 Deductible Plan ($1,800 family deductible)

The $900 Deductible Plan offers the lowest out-of-pocket costs when you need care, but has the highest premiums of all your plan options. With this plan, your costs are more predictable, but you'll likely still have out-of-pocket expenses.

How it works

- Your in-network preventive care is covered in full — the deductible does not apply.
- You pay your medical costs in full until you meet the plan's annual deductible.
- Once you meet the deductible, you'll pay 20% of your covered medical expenses; this amount is called your coinsurance.
- If you choose a coverage tier other than Self Only, there is an embedded individual deductible, which means that coinsurance will begin for a covered family member if that person's individual deductible is met; coinsurance begins for all covered family members once the family deductible has been met.

- The deductible does not apply to prescription drugs with this plan — you pay a coinsurance amount with a minimum and maximum out-of-pocket cost for prescriptions.
- If your share of medical expenses reaches $3,000/$6,000 (individual/family), the plan's out-of-pocket (OOP) maximum, the plan pays 100% of your eligible expenses for the rest of the year. An individual OOP maximum applies for each covered family member; once the family OOP maximum is met, 100% payment begins for all covered family members.

Use the $900 Deductible Plan wisely

Here are ways to make the most of your plan all year long.

- Track your stats. Log in to your carrier's website to see how much of your deductible you've met, review claims and more.
- Pair it with a Health Care FSA. If you enroll in the Health Care FSA, you can set aside pre-tax dollars to help pay for your out-of-pocket costs. Keep in mind, you can only carry over up to $640 of unused money in your FSA to the next year; you will forfeit amounts above $640.
- Be cost-conscious. Visit your carrier's website to search for in-network providers and use the tools to compare costs for medical services.

Understanding Your Deductible

- In the $1,850 Deductible Plan (excluding the Kaiser California $1,850 Deductible Plan), there is a family deductible of $3,700. The combined family unit must meet the $3,700 deductible before coinsurance begins. This deductible can be met by any combination of family members (including only by one of them), but the only way for coinsurance to begin for any family member is when the entire $3,700 family deductible is satisfied.
- In the $900, $3,200 and $4,500 Deductible Plans, there is an embedded individual deductible. As an example, let's use the $3,200 plan, which has a $6,400 family deductible. If the combined family unit meets this $6,400 deductible, then coinsurance begins for the entire family. In addition, the embedded individual deductible provides that if one family member's expenses on their own reach the $3,200 amount, then coinsurance will begin for that family member only. This means there are two ways for coinsurance to kick in for these plans – either on a combined family basis or also on an individual basis.

Find a Doctor

Using in-network providers saves you money. It is your responsibility to ensure providers are in-network. It's especially important to check when your primary care physician is referring you to a specialist or for lab/x-ray procedures. Here's how to find doctors in your medical plan network.

Additional Network Option for Iowa Residents

If you live in Iowa, you have an additional option for medical coverage: the Narrow Network (Iowa only). This plan offers the same range of deductibles as the National Network – $900, $1,850, $3,200 or $4,500 – but the premiums are much lower because the network is Iowa-only. The online Doctor On Demand and many of the same providers are part of the Narrow Network (about 98%); the biggest differences are you can't receive care out of state (except for emergencies, pre-approved referrals, and dependents that live out of state); you must designate a Primary Care Physician; and the number of chiropractic care providers is substantially less.

1. First, determine the medical carrier in your area.
You will have either Wellmark Blue Cross Blue Shield or United Healthcare as your medical plan carrier, based on the state where you live. Aligning a medical carrier to each state gives you access to the best service, most competitive discounts and an extensive network of providers and facilities available.

Medical plan carrier by state	
Wellmark Blue Cross Blue Shield	United Healthcare
Alabama	Alaska
Arizona	Arkansas
California*	Florida
Colorado*	Georgia*
Connecticut	Illinois
District of Columbia*	Kansas
Delaware	Maryland*
Idaho	Minnesota
Indiana	Missouri
Iowa**	Nebraska
Kentucky	New Hampshire
Louisiana	New Jersey
Maine	New Mexico
Massachusetts	North Carolina
Michigan	Oklahoma
Mississippi	Oregon
Montana	Tennessee
Nevada	Texas
New York	Washington
North Dakota	Wisconsin
Ohio	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Utah	
Virginia*	
Vermont	
West Virginia	
Wyoming	

*If you live in California, Colorado, the District of Columbia, Georgia, Maryland or Virginia, Kaiser may be an additional medical carrier option that provides in-network coverage only (availability depends on your home ZIP code). Kaiser is an HMO, and all your care must be coordinated by your Primary Care Provider (PCP).

**If you live in Iowa, you can also choose the Wellmark Narrow Network Plan, utilizing the Wellmark Blue HMO network.

2. Second, go to your carrier's website to find in-network providers.

Wellmark Blue Cross Blue Shield

- Visit Wellmark at wellmark.com.
- Under Member Resources, click on "Find a Provider."

- Click “Search Now,” then click on “Continue to New Site” when the “You are now leaving Wellmark.com” box appears.
- Click on “Choose a location and plan” when the “Hi there, let’s get started!” box appears.
- Enter your ZIP code. The city, state and zip code will appear, then if correct, click “Yes, this is correct.”
- When the “Find your plan by prefix” box appears, click on “Browse a list of plans” at the bottom of the box.
- For the “National network” plans: Select “Wellmark Blue PPO,” and then click “Confirm selection.”
- For the “Narrow network (Iowa only)” plans: Select “Wellmark Blue HMO,” and then click “Confirm selection.”
- You can click on “Search all” then enter a name or phrase, or click on one of the categories to search by a doctor’s name, specialty, facility name or type of facility.

United Healthcare
- Visit United Healthcare at myuhc.com.
- Click on “Find a Provider."
- Select either "Medical Directory" or “Behavioral Health Directory" as appropriate.
- Select “Employer and Individual Plans," followed by “Shopping Around," then “Choice Plus."
- Enter your ZIP code to continue your search. (The UHC site might already show a ZIP code based on your location; you can change this.)
- Search for providers or services in the search bar, or click on one of the icons in the “Find Care by Category" section.

Kaiser
- Visit Kaiser at kp.org.
- Click on “Doctors & Locations” along the top menu.
- Choose your region.
- Use the fields under “What can we help you find?” to select your search criteria.
- You can search Doctors or Locations, by Region or Specific Location, and you can search by Hospital, Doctor’s Name, Medical Specialty or Other Keywords.

Don’t have a personal doctor? You should. Here’s why.
- Better health. Having a personal relationship with a doctor ensures you’re getting the right health screenings each year, which can reduce your risk for many serious conditions. Preventive care is free, so there’s no excuse for skipping it.
- A healthier wallet. Having a doctor you can call helps you avoid costly trips to the emergency room and determine when you really need to see a specialist.
- Peace of mind. Advice from someone you trust ... it means a lot when you’re healthy, but it’s even more important when you’re sick. Your personal doctor gets to know you and your health history and can help coordinate any care you need.

Keep in mind: If you choose a Kaiser plan in California, Colorado, the District of Columbia, Georgia, Maryland or Virginia, you are required to select a Primary Care Provider (PCP), who will manage your care. Employees in Iowa who newly enroll in the Wellmark Narrow Network Plan must assign a Primary Care Physician. You’ll receive an email with instructions for adding your PCP after the first of the year. The online Doctor On Demand and many of the same providers (about 98%) are part of the Narrow Network; the biggest differences are you can't receive care out of state (except for emergencies, pre-approved referrals, and dependents that live out of state); you must designate a Primary Care Physician; and the number of chiropractic care providers is substantially less.

Prescription Drugs

When you enroll in a Transamerica medical plan, you will automatically receive prescription drug coverage. Benefits are provided by Express Scripts for Wellmark Blue Cross Blue Shield and United Healthcare plans, and by Kaiser Pharmacy for Kaiser plans.

Once you enroll for medical coverage, you will receive a prescription drug ID card from Express Scripts or Kaiser Pharmacy within 30 days of enrollment.

Drug tiers

The cost of your prescription drugs under each medical plan depends on the "tier" of the medication:

- Tier 1 drugs include most generics; these drugs contain the same active ingredients as their brand-name equivalents and meet the same federal standards for safety, but typically cost significantly less.
- Tier 2, or formulary drugs, are brand-name medications that are preferred by a prescription plan based on drug effectiveness and cost.
- Tier 3, or non-formulary drugs, are brand-name medications that are not on a prescription plan's preferred list (or formulary) based on drug effectiveness and cost. They may still be covered, but may require prior authorization and cost more.

Filling your prescription

The cost of prescription drugs is rising faster than many other health care services and supplies. But there are ways for you to save money when you're filling prescriptions:

- Retail or mail order? For short-term medication needs, such as antibiotics, a retail pharmacy is your best and most convenient option.

  Long-term medications are prescriptions you take for an ongoing condition such as high blood pressure. After three retail prescription fills for long-term medications, you need to either use Express Scripts mail-order pharmacy or pick up a three-month supply of your medication at CVS or Walgreens. If you don't use one of these options, you'll pay 100% of the prescription cost at a retail pharmacy.

- Generic or brand name? Generic medications are generally just as effective as brand-name medications, yet the cost of generics is substantially lower — they typically cost between 30% and 75% less than brand-name drugs.

  If you choose a brand-name drug when a generic is available, you will pay the cost of the generic drug plus the difference in cost between the generic and the brand name. Although you may use any available HSA or FSA funds to pay for the brand-name prescription, the difference in cost is not a covered expense under the Plan, and will not apply to your deductible or out-of-pocket maximum.

- Certain compound medications are not covered under the prescription drug plan. To be covered under the drug plan, a medication must be approved by the Food and Drug Administration (FDA). While certain ingredients in the compound may be FDA approved, the resulting medication after compounding may not be. The FDA does not verify the quality, safety or effectiveness of compound medications.

- Specialty medications are drugs used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. If you take a specialty medication, you should purchase it through the specialty pharmacy offered by your medical plan.
    - Accredo is the specialty pharmacy for United Healthcare and Wellmark Blue Cross Blue Shield plans.
    - Kaiser's specialty pharmacy will vary by location. Please contact Kaiser for more information.

  Please note: If you receive manufacturer coupons, discount cards or copay assistance for specialty medication, the amount applied to your annual deductible and out-of-pocket maximum will equal the amount you pay for your prescription drug after the coupon or discount is applied.

Prescription management programs

We have partnered with Express Scripts to offer prescription drug management programs to help you use your prescription drugs safely and effectively, as well as save money. These programs automatically apply to all participants who choose either a Wellmark Blue Cross Blue Shield or United Healthcare medical plan. (Note: These programs do not apply to Kaiser plans.)

Specialty Deductible/Out-of-Pocket Protection Program

Provides copay assistance toward the purchase of certain specialty medications. However, only the amount you pay towards your specialty prescriptions will be applied to your deductible and out-of-pocket maximum.

Safeguard Rx: Diabetes Care Value Program

If you have diabetes, this program helps you monitor and control your glucose levels. With Diabetes Remote Monitoring, you will receive a free smart glucose meter that synchronizes with your smartphone and securely sends data to specialist pharmacists who are available to support you. You can also access Mango Health, which offers a mobile app with games and rewards for healthy habits, such as taking medication on time.

Advanced Opioid Management Program

Opioids are a highly effective treatment for pain when taken correctly, but they can also be addictive. If you take prescription opioids for pain, Express Scripts will send you a letter and a short guide with important guidelines and tips to help you stay safe, as well as a number you can call with any questions or concerns.

Maintenance Medications

If you take a long-term or "maintenance" medication to manage a health condition like high blood pressure, diabetes or high cholesterol, you have the option to pick up a three-month supply of your medication at a CVS or Walgreens, or have your medication shipped to your home using Express Scripts mail-order pharmacy.

With a three-month supply of your medicine on hand, you're less likely to miss a dose, which can keep you healthier and save money.

With Express Scripts, you can:

- Get prescriptions delivered to your door with free standard shipping, or pick up a three month supply at a CVS or Walgreens near you
- Transfer prescriptions easily online, by phone or via Express Scripts® mobile app
- Set up auto-refills and refill reminders
- Talk with a pharmacist by phone 24/7

	To get started, log in to esrx.com review your 90-day options. If this is your first time visiting the site, take a minute to register (be sure you have your member ID number handy). You can also use the Express Scripts mobile app on your digital device to locate a participating pharmacy or call Express Scripts at the number listed on the back of your member ID card. If you choose to use Express Scripts home delivery for your 90-day supply of your maintenance medication, you can either have your doctor send the prescription directly to Express Scripts or use the Express Scripts website to initiate the transfer to home delivery. If you'd prefer to get a 90-day supply at a CVS or Walgreens, you can have your doctor provide CVS or Walgreens with a 90-day prescription, ask the pharmacist to contact your doctor if you already have a prescription on file at the pharmacy, or to transfer your current 90-day prescriptions from another pharmacy.

Tools & Resources

You have access to a wealth of resources and helpful tools through your medical plan provider. From tracking claims to improving your health, information that puts you in charge of your spending and your well-being is just a click away. Each medical plan provider provides a wide variety of tools and resources, in addition to those listed below. Visit your provider's website or call the number on your medical plan identification card for more information.

TouchCare

You have access to TouchCare. If you need assistance understanding your coverage, you have a personal health assistant to help answer all of your healthcare and benefit questions.

TouchCare can help you and your family:

- Compare Transamerica's benefit plan with your existing coverage
- Resolve claims issues with your insurance company
- Find the right doctor and/or get an appointment scheduled
- Make the right decisions while keeping costs down
- Understand your benefits and cost share

TouchCare also offers a 30-minute consultation during open enrollment. To get started, visit www.touchcare.com or call 866-486-8242. This benefit is available to all benefit-eligible employees.

Wellmark Blue Cross Blue Shield

The following programs are available to those enrolled in a Wellmark BlueCross Blue Shield medical plan:

2nd.MD Expert Second Opinions
The 2nd.MD program gives you access to board-certified doctors across the country for an expert second opinion, enabling you to connect with a top specialist by video or by phone at a time that's convenient for you.

Doctor on Demand
With Doctor On Demand, you and your family members can connect face-to-face with a board-certified doctor on your schedule. You can get treatment for conditions including cold and flu, allergies, fever and other conditions, such as mental health. To get started, download the Doctor On Demand® app or visit www.DoctorOnDemand.com.

Blue365

Just by being a Wellmark member, you have access to Blue365. When you sign up, you get exclusive discounts for wellness products and services you use every day, such as fitness trackers, eyeglasses and athletic shoes. Visit Wellmark.com/Blue365 for a full list of deals and discounts available to you.

IDX Identity
Your Wellmark health insurance coverage keeps you safe, secure and protected from more than the cost of health care. Just by being a member, you and your dependents have exclusive, free access to identity protection services called IDX Identity. With IDX Identity, you can monitor your credit record, keep track of your online activity 24/7, and have access to complete identity recovery if fraudulent activity is found. Register or sign in to myWellmark® at myWellmark.com to get started.

BeWell 24/7
BeWell 24/7 is here for you, when you need it — connecting you with a real person who can help with a variety of health-related concerns. Whether you need help discussing care options, determining if a fever warrants a trip to the doctor or even finding elder care, you can call 24 hours a day, 7 days a week at 844-84-BeWell.

Blue
Each issue of Blue features health and wellness articles, consumer tips and health plan news. It provides resources on living a fulfilling and healthy life. Find it online at Wellmark.com/Blue.

Health support programs
Wellmark has three different programs — case management, pregnancy support and rare condition management — that can help improve outcomes when there is a significant health need.

UnitedHealthcare

The following programs are available to those enrolled in a UnitedHealthcare medical plan:

2nd.MD Expert Second Opinions
The 2nd.MD program gives you access to board-certified doctors across the country for an expert second opinion, enabling you to connect with a top specialist by video or by phone at a time that's convenient for you.

Virtual Visits
When you are sick and need care quickly, a Virtual Visit is a convenient way to start feeling better faster. With Virtual Visits, you have access to United Healthcare's network of virtual doctors who can provide care using live audio and video technology. Visits typically take less than 20 minutes and will typically cost you $50 or less. To get started, go to www.uhc.com/virtualvisits and register today.

Mercer Health Advantage
If you have a complex or chronic condition, Mercer Health Advantage provides a special support team with your own "nurse in the family" approach, along with various health services at your fingertips. In the event that you or a covered family member are diagnosed with a health condition that requires complex care, or requires follow-up care after a recent hospital stay, you and your family will receive support from a dedicated team of nurses, clinicians and other specialized professionals to help you improve your health.

Mercer Health Advantage provides specialized support for things such as:

- Managing a chronic condition, such as diabetes, coronary artery disease, asthma, COPD or heart failure;
- Dealing with a complex condition such as cancer or chronic kidney disease;
- Treating back pain and musculoskeletal conditions; and
- Maternity support.

Kaiser Permanente

The following programs are available to those enrolled in a Kaiser Permanente medical plan:

Video Visits & Chat with a Doctor

Kaiser offers two ways to get care that are secure, convenient and personalized. If your Kaiser provider determines the care you need can be provided in a video visit, this is a great alternative to making a trip for an in-person visit. Kaiser also offers an online chat feature. "Chat with a Doctor" is on demand, real-time messaging with a doctor to receive medical advice and triage. These services are available 8 a.m. – 10 p.m., seven days a week.

Wellness Coaching

Health Solutions offers an invitation-only coaching program which provides tools and guidance to empower you to effectively manage your health and to ultimately achieve a better quality of life. If you qualify, you will receive an invitation via email to this free, confidential program, and your health coach will help you develop and implement a personal wellness plan to address any high-risk areas, with help from a licensed Health Solutions clinical pharmacist.

You will work with your Health Solutions Care Team to:

- Review health screening results and understand areas of risks;
- Receive education specific to your conditions and risks;
- Develop goals and action plans to reduce risk;
- Coordinate care with your doctor; and
- Get support in overcoming obstacles, tracking progress and celebrating success.

Prescription Tools

Order or refill prescriptions, sign up for mail order and more on your prescription websites:

- Express Scripts at esrx.com
- Kaiser Pharmacy at kp.org

HSA/FSA Tools

Manage your Health Savings Account and Health Care Flexible Spending Account online with Transamerica at Transamerica.com/portal.

Supplemental Health Insurance

Overview

Supplemental health insurance provides cash payments in the event of a significant unexpected medical expense. You are responsible for the premiums that are paid through pre-tax payroll deductions.

You can choose from four different supplemental health insurance policies. For cost and benefit details and to enroll, visit the Mercer Marketplace 365+ website.

Keep in mind

These policies don't provide the minimum level of medical coverage needed to meet federal health care law requirements. Rather, they're intended to supplement the coverage provided by your medical plan.

Accident Insurance

Accident insurance, available through Transamerica Life Insurance Company, helps protect you from unexpected financial stress if you or an insured family member has an accident. It supplements your major medical plan by providing cash benefits in cases of accidental injuries. You can use this money to help pay for expenses not paid by your medical plan (such as your deductible or coinsurance) or for anything else (such as everyday living expenses). This policy also includes a wellness benefit that allow you or your insured spouse to receive an annual benefit of $50 each for having a covered wellness exam. For cost and benefit details and to enroll, visit the Mercer Marketplace 365+ website.

Benefits are paid:

- Directly to you, unless you assign them to someone else
- In addition to any other insurance, like your major medical plan or an Accidental Death & Dismemberment (AD&D) plan

Note: You can take your policy with you if you leave Transamerica.

You receive a cash benefit up to a specific amount for:

- Accidental death
- Dismemberment
- Dislocation or fracture
- Initial hospital confinement
- Intensive care
- Ambulance
- Medical expenses
- Outpatient physician's treatment

The actual benefit amounts depend on the type of injuries you have and the medical services you need.

This is a brief summary of AccidentAdvance®, Accident Insurance underwritten by Transamerica Life Insurance Company (TLIC), Cedar Rapids, IA. TLIC is not an authorized insurer in New York. Policy form series CPACC100 and CCACC100. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

See limitations and exclusions in the Appendix — Supplemental Health Insurance.

Critical Illness Insurance

When a serious illness strikes, critical illness insurance — available through Transamerica Life Insurance Company — can provide financial support to help you through a difficult time. It can help protect against the financial impact of certain illnesses, such as a heart attack, cancer or stroke.

You receive a lump-sum benefit to help pay for out-of-pocket expenses for your treatment, to help pay your coinsurance or to help take care of your everyday living expenses such as housekeeping services, special transportation services and child care. This policy also includes a wellness benefit rider that allows you, your covered spouse and your covered children to receive an annual benefit of $50 each for having a wellness exam. For cost and benefit details and to enroll, visit the Mercer Marketplace 365+ website.

Choose from three benefit amounts:

- $10,000

- $20,000
- $30,000

Benefits are paid:
- Directly to you, unless you assign them to someone else

Note: You can take your policy with you if you leave Transamerica.

This is a brief summary of CriticalEvents® Critical Illness Insurance underwritten by Transamerica Life Insurance Company (TLIC), Cedar Rapids, IA. TLIC is not an authorized insurer in New York. Policy form series CPCI0500 and CCCI0500. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

See limitations and exclusions in the Appendix — Supplemental Health Insurance.

Hospital Indemnity Insurance

A trip to the hospital can be stressful, and so can the bills. Even with a major medical plan, you may still be responsible for deductibles, coinsurance and other out-of-pocket costs. Offered through Transamerica Life Insurance Company, hospital indemnity insurance can help offset your share of the cost associated with a covered sickness or accident.

You can use the money you receive to help cover hospital stays, ambulance service, surgery and certain inpatient or outpatient treatments. The policy pays benefits in addition to any other insurance. For cost and benefit details and to enroll, visit the Mercer Marketplace 365+ website.

Choose from two benefit options:
- Standard, which includes a $1,500 hospital admission and $150 daily hospital confinement benefit
- Enhanced, which includes a $1,500 hospital admission and $250 daily hospital confinement benefit

Benefits are paid:
- Directly to you, unless you assign them to someone else
- As a lump sum or on a benefit schedule

This is a brief summary of Hospital Select® II Group Hospital Indemnity Insurance underwritten by Transamerica Life Insurance Company (TLIC), Cedar Rapids, IA. TLIC is not an authorized insurer in New York. Policy Form Series CPGHI400 and CCGHI400. Forms and numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details. THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.

See limitations and exclusions in the Appendix — Supplemental Health Insurance.

Cancer Insurance

Cancer insurance is designed to provide benefits to help pay for the costs of cancer treatment. Offered through Transamerica Life Insurance Company, this policy can help pay a variety of expenses associated with cancer care, including chemotherapy and radiation, surgery, hospital confinement, transportation and lodging.

	With this supplemental benefit, you'll not only have more resources to help cope with any future diagnosis of cancer, but you'll also have wellness benefits to help you detect cancer early, when it's most treatable. For cost and benefit details and to enroll, visit the Mercer Marketplace 365+ website. *This is a brief summary of CancerSelect® Plus, Group Cancer Insurance underwritten by Transamerica Life Insurance Company (TLIC), Cedar Rapids, IA. TLIC is not an authorized insurer in New York. Policy form series CPCAN200 and CCCAN200. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.* See limitations and exclusions in the Appendix — Supplemental Health Insurance. EB2 264951R2 S 08/23

Dental

Overview

You have a choice between two dental plans. Both are designed to help you maintain healthy teeth and gums, which are important to your overall health.

Learn about the dental plans available to you through Delta Dental of Iowa. For complete cost and coverage details and to enroll, visit the Mercer Marketplace website 365+.

2024 dental plans

- Basic Plus Plan
- Enhanced Plan

Key features

- Free in-network preventive and diagnostic care
- Affordable coverage that helps you manage the cost of dental treatment
- Extensive network of providers that have agreed to negotiated rates, which helps you save money

Find a network dentist
All Delta Dental PPO and Premier network providers are considered to be in-network (the PPO network is a subset of the broader Premier network). Although your plan pays the same benefits for either network of providers, if you use a PPO provider, the discounts for services will be greater. You can search for PPO and Premier providers by visiting the Delta Dental of Iowa website at deltadentalia.com.

If you enroll in dental coverage, Delta Dental will mail you an ID card. You can also print your ID card on the Delta Dental of Iowa website at deltadentalia.com after you register.

Coverage details

Below is an overview of the coverage provided by the 2024 dental plans available to you. Please refer to the plan summaries on the Mercer Marketplace 365+ website for more information, including out-of-network coverage details.

	Basic Plus Plan	Enhanced Plan
In-network coverage		
Individual/family deductible	$50/$150	$50/$150
Individual annual maximum benefit*	$1,000	$2,000
Services		
• Preventive – includes services such as oral evaluations, routine cleanings, X-rays, fluoride treatments and sealants	• You pay $0; deductible does not apply	• You pay $0; deductible does not apply
• Enhanced preventive services** – includes additional cleanings if you have gum disease or kidney failure or if you are pregnant, have a high risk of a	• Not covered	• You pay $0; deductible does not apply

cardiac event, or have a medical condition, such as diabetes or cancer.		
• Basic – includes services such as basic restorations, some oral surgery, endodontics and periodontics	• After meeting the deductible, you pay 30%, plan pays 70%	• After meeting the deductible, you pay 20%, plan pays 80%
• Major – includes services such as crowns, dentures, implants, general anesthesia/intravenous sedation and some oral surgery	• After meeting the deductible, you pay 50%, plan pays 50%	• After meeting the deductible, you pay 50%, plan pays 50%
• Orthodontia coinsurance/ lifetime maximum – includes services such as straightening misaligned teeth and/or jaws with braces and/or surgery	• Not covered	• You pay 50%, plan pays 50% $1,500 lifetime maximum
Out-of-network coverage: Visit the Mercer Marketplace 365+ website for coverage details.		

*Preventive and diagnostic services apply to the annual maximum benefit.
**If you want to receive enhanced preventive services, you or your provider can contact Delta Dental and notify them of your health condition.

Use your dental benefits wisely

Here's how to make the most of your dental benefits:

- Choose a provider – Each time you need dental care, you have a choice of providers. Selecting a participating dentist in the Delta Dental of Iowa network will ensure you receive the highest benefits from your plan. To find a provider, go to Delta Dental of Iowa at deltadentalia.com.
- If your service will exceed $300, submit a request for a pretreatment estimate. You should always submit a request for a pretreatment estimate for procedures and services your dentist believes will exceed $300 (procedures such as crowns, inlays, bridges and periodontics). For more information about pretreatment estimates, call Delta Dental of Iowa at 800-544-0718 or visit the Delta Dental of Iowa website at deltadentalia.com.
- Check your claim status and other information on the Delta Dental of Iowa website at deltadentalia.com. You can review Explanation of Benefits (EOB) statements, check if claims have been paid and more.

Vision

Overview

Having an annual eye exam is one of the best ways to make sure you're keeping your eyes healthy. You can enroll in vision coverage to save money on eligible vision care expenses such as eye exams, glasses and contact lenses.

Learn about the vision plan available to you through United Healthcare. For complete cost and coverage details and to enroll, visit the Mercer Marketplace 365+ website.

2024 vision plan

- Standard Plan

Key features

- Eye exam covered every year; you pay only a small copay for each exam
- Coverage for prescription eyeglasses or contact lenses so you can choose the method of correction you prefer
- Extensive network of providers, including some retail chains, that have agreed to negotiated rates, which helps you save money

Find a network provider
You'll generally pay less when you use a provider in the UnitedHealthcare Vision Network. Visit myuhcvision.com for a list of providers.

If you enroll in vision coverage, you can print your ID card at United Healthcare's vision website at myuhcvision.com after you register.

Coverage details

	Standard Plan
In-network	
Exam	One exam every 12 months $10 copay
Prescription glasses	$25 copay
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular	Once every 12 months; included in prescription glasses
Lens options	The most popular lens options (standard scratch coating, polycarbonate lenses*) are covered in full with the $25 prescription glasses copay. Non-covered lens options (such as tint, anti-reflective coating, progressive, and more) are covered at participating providers for an additional cost (UHC provides a discount).
Frames	Once every 24 months • Retail allowance of $130

		• 30% savings at most participating in-network providers on any amount over the retail allowance
	Elective contact lenses (instead of glasses)	Once every 12 months • Covered up to $130 allowance • Contact lens exam (fitting and evaluation) covered in full with a copay not to exceed $60
	Necessary contact lenses	$25 copay
	Out-of-network: Visit the Mercer Marketplace 365+ website for coverage details.	

*Polycarbonate lenses are covered in full with the $25 material copay for dependents up to age 19.

Tax-Advantaged Accounts

Overview

You can save money on health care and dependent care expenses by paying for them with tax-advantaged accounts. For more details and to enroll, visit the Mercer Marketplace 365+ website.

2024 accounts

- Health Savings Account (HSA): Available only to employees who enroll in the $4,500, $3,200 or $1,850 Deductible Plans
- Flexible Spending Accounts (FSAs):
  - Health Care FSA: Available to employees who do not enroll in an HSA, or do not elect medical coverage through Transamerica
  - Combination FSA: Available to employees who are enrolled in an HSA
  - Dependent Care FSA: Available to all employees to pay for child and elder day care services so you can go to work

Key features

- Lower income taxes – Money goes into your HSA and/or FSA from your paycheck before taxes are deducted, which means you won't pay any taxes when you reimburse yourself for eligible expenses.
- Convenient payroll deductions – Contribute to your accounts easily and effortlessly.
- Helpful budgeting tool – Plan for upcoming expenses by setting aside money each paycheck.

Transamerica is the administrator for these accounts. If you newly enroll in an FSA or HSA, you will receive information directly from Transamerica regarding your debit card and account information. Note: You will only receive one card which you can use for all accounts.

How much could you save?
Here's an example. Let's say Tom decides to set aside $2,000 in an HSA or FSA for the year. Normally, on that money, he'd pay $480 in federal income tax, $100 in state income tax and $153 in FICA tax. So, by contributing that $2,000 to his HSA or FSA, he'll get a $733 tax savings for the year.

Without an HSA or FSA, Tom would pay …	Savings
24% in federal income tax……	$480
5% in state income tax……	$100
7.65% in Federal Insurance Contributions Act (FICA) tax……	$153
His total tax savings for the year with an HSA or FSA ……	$733

This hypothetical illustration is for educational purposes only. Dollar amounts or savings will vary depending on income, state and city tax rules and other factors. Please consult a tax, legal or financial advisor about your own personal situation.

Health Savings Account

With the $4,500, $3,200 and $1,850 Deductible Plans, you may be eligible to open and contribute money to a tax-advantaged Health Savings Account (HSA) — and receive Reward Dollars for participating in the wellness program and reaching certain point levels. Transamerica is the administrator for your HSA.

Are you eligible for an HSA?
In order to establish and contribute to an HSA, you:

- Must be enrolled in an HSA-eligible high-deductible health plan, like the $4,500, $3,200 or $1,850 Deductible Plans.
- Cannot simultaneously participate in the Health Care FSA (but participation in a Combination FSA is allowed).
- Cannot be enrolled in any other medical coverage, including a spouse's plan, Medicare or Tricare.
- Cannot be claimed as a dependent on someone else's tax return.

You should review IRS rules for making HSA contributions if you will turn age 65 during the year. For more information, see IRS Publication 969.

HSA features

<table>
<tr><td>Contribute money on a pre-tax basis.
Contribute to your HSA through pre-tax payroll deductions (up to annual limits)
Change your contribution without a qualifying change in status</td><td rowspan="2">Pay for care tax-free.*
Pay for eligible medical, prescription, dental and vision expenses for you and your family using your HSA debit card (provided sufficient funds are in your account). View a list of eligible expenses at irs.gov/publications.
Track your spending, check your balance, reimburse yourself and more at transamerica.com/portal.</td></tr>
<tr><td>Receive Reward Dollars for participating in the wellness program.
Up to $500 for Self Only coverage
Up to $800 if you cover a spouse and/or child(ren) on your medical plan</td></tr>
<tr><td colspan="2">Carry unused money over.
All the money in your HSA is yours to keep, year after year.
You can build up savings to pay for future health care expenses. You can even invest your money once it reaches a minimum balance, which gives you the potential for tax-advantaged earnings growth and a way to plan ahead for your medical costs in retirement.</td></tr>
</table>

Contribution limits

In 2024, the IRS limits on total contributions to your account (from both you and Transamerica) are:

- $4,150 for Self Only coverage
- $8,300 if you cover a spouse and/or child(ren) on your medical plan

These limits include contributions from all sources, including Reward Dollars deposited by the Company, before-tax payroll contributions and after-tax non-payroll contributions that you make directly to the account.

Add $1,000 to these limits if you're age 55 or older for "catch up" contributions.

Please note: In order to receive Company contributions to your HSA, you must elect an HSA when you enroll in 2024 benefits through Mercer Marketplace 365+.

Increase your tax savings with a Combination FSA
Consider contributing to an HSA and a Combination FSA for additional tax savings. The Combination FSA has an added advantage — in addition to eligible dental and vision expenses, you can also use the account to

reimburse yourself for medical and prescription expenses after meeting a specific IRS-defined portion** of the medical plan deductible.

*Money in an HSA can be withdrawn tax free as long as it is used to pay for qualified health-related expenses. If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn, plus a 20% penalty tax if you withdraw the money before age 65.

** The IRS-defined deductible for 2024 is $1,600 for Self Only and $3,200 for all other coverage tiers, regardless of whether you choose the $1,850, $3,200 or $4,500 deductible plan.

If you newly enroll in an HSA, you will receive a debit card and account information from Transamerica.

Flexible Spending Accounts

Using an FSA is like getting a discount on everyday health and/or dependent care expenses because you're paying with pre-tax money. There are separate FSAs for health care and dependent care. Learn more on the Mercer Marketplace 365+ website.

Health Care FSA

Available to employees who do not enroll in an HSA, or do not elect medical coverage through Transamerica

- Contribute through pre-tax payroll deductions to help cover eligible medical, prescription, vision and dental expenses. View a list of eligible expenses at irs.gov/publications/p502/index.html.
- Contribute up to $3,200 in 2024 through pre-tax payroll deductions.
- Choose your contribution amount during enrollment. You can only change your contribution amount during the year if you have a qualifying event.
- Pay your eligible expenses by using your FSA debit card, or log in to Transamerica to request reimbursement for payments you've made.
- Your entire annual contribution amount is available to you from the beginning of the plan year.
- Up to $640 of unused money may be carried over to the next year; amounts above $640 will be forfeited.
- You have 90 days after the end of the calendar year to submit receipts for expenses you incurred during the prior year. You cannot use your FSA debit card to pay expenses from the previous year; you must submit receipts to Transamerica via fax, mail, online or mobile app to request reimbursement.

Combination FSA

Available only to employees who enroll in an HSA-eligible high-deductible health plan

- Designed to work together with your Health Savings Account (HSA) for additional tax-saving opportunities.
- Works like a Health Care FSA, but has an added advantage — in addition to eligible dental and vision expenses, you can also use the account to reimburse yourself for medical and prescription expenses after meeting a specific IRS-defined portion* of the medical plan deductible. For a list of eligible expenses, refer to IRS Publication 502 at irs.gov/publications/p502/index.html.
- When you meet the IRS-required deductible, you must submit the Deductible Verification Form (available on the Mercer Marketplace 365+ website) to Mercer Marketplace 365+. This document serves as a one-time notification that the deductible was met. You may use funds in your HSA while meeting this deductible requirement.
- Contribute up to $3,200 in 2024 through pre-tax payroll deductions.
- Choose your contribution amount during enrollment. You can only change your contribution amount during the year if you have a qualifying event during the year.

- Pay for eligible expenses using your FSA debit card, or log in to transamerica.com/portal to request reimbursement for payments you've made.
- Your entire annual contribution amount is available to you from the beginning of the plan year.
- Up to $640 of unused money may be carried over to the next year; amounts above $640 will be forfeited.
- You will have 90 days after the end of the calendar year to submit receipts for expenses you incurred during the prior year. You cannot use your FSA debit card to pay expenses from the previous year; you must submit receipts to Transamerica via fax, mail, online or mobile app to request reimbursement.

* The IRS defined deductible for 2024 is $1,600 for Self Only and $3,200 for all other coverage levels, regardless of whether you choose the $1,850, $3,200, or $4,500 deductible plan.

Dependent Care FSA

Available to all employees

- Contribute up to $5,000 annually through pre-tax payroll deductions to use for day care expenses for your child(ren) (up to age 13) and dependent elders. For a list of eligible expenses, visit irs.gov/publications/p503/index.html.
- Log in to Transamerica to request reimbursement for payments you've made.
- Choose your contribution amount during enrollment. You can only change your contribution amount during the year if you have a qualifying life event.
- Unused money does not carry over at the end of each year — you must use it or you lose it.

If you newly enroll in an account for 2024, you will receive a debit card and account information from Transamerica. To receive reimbursement for charges incurred in 2024, you will need to submit receipts for reimbursement to Transamerica (via fax, mail, online or mobile app) within 90 days after the end of the calendar year.

Compare health accounts

	HSA	Combination FSA	Health Care FSA
Designed to work with	$4,500 Deductible Plan $3,200 Deductible Plan $1,850 Deductible Plan		$900 Deductible Plan If you waive medical coverage if you enroll in an HSA-eligible plan but do not enroll in an HSA*
Receive Reward Dollars for participating in the wellness program	Up to $500 for Self Only coverage; up to $800 if you cover a spouse and/or child(ren)	No	No
Change your contribution amount without a qualifying change in status	Yes	No	No
Access your entire annual contribution amount starting on your first day of coverage	No	Yes	Yes

Access only funds that have been deposited	Yes	No	No
"Use it or lose it" at year-end	No	Yes (Carry over up to $640)	Yes (Carry over up to $640)
Money is always yours to keep	Yes	No	No

*If you do not enroll in an HSA, you will not be eligible to receive Reward Dollars for participating in the wellness program.

Wellness

Overview

We want to help you live your best life. To do this, we partner with Health Solutions to provide you with a wellness platform designed to support many aspects of your health and wellbeing. From simple tips for being active and managing stress to health condition management, there are a variety of features on the platform to guide you in your health journey.

Reward Dollars

In addition to this valuable resource, we support your efforts through our Reward Dollars program. If you have a Health Savings Account, or HSA, through Transamerica, we'll contribute to your account when you earn enough points through the wellness platform.

You and your covered spouse (if applicable) can earn Reward Dollars within six weeks of reaching a point level. Employees can earn up to $500, and a covered spouse has the opportunity to earn an additional $300 in Reward Dollars. Employees covering themselves and child(ren) can earn up to $800 (only the employee is required to complete the activities).

You must be enrolled in one of the Company's high deductible health plans and elect a 2024 HSA to be eligible to earn Reward Dollars. Prior year elections do not carry over into the next year (although the money in your HSA will carry over). Even if you don't plan to contribute to an HSA, you must elect one to receive Reward Dollars.

If you have questions about the wellness program or Reward Dollars, contact Health Solutions at 888-362-5920 between 9 a.m. and 4 p.m. CT Monday through Friday, or by email at CustomerCare@hsi-rx.com.

Visit the Wellness Platform* after January 1 to review our 2024 wellness program and start earning rewards.

*Spouses: Visit Transamerica.MyHealthyWithHSI.com and register as a new user or log on using your existing username and password.

You have until November 30 each year to accumulate points and earn Reward Dollars.

Details for the 2024 wellness program will be available on January 1.

Consumer Tips

Overview

When it comes to purchasing products, we usually look at the price tag. Yet with all the money we spend on health care — from premiums to prescriptions to doctor's office visits — we don't always consider the price of these services. As health care prices continue to rise, your care ends up costing more. Here are ways you can help control your health spending.

- Use in-network providers. They've agreed to charge only up to negotiated rates and bill your insurance company directly, which saves you money and time. Also, check with your medical plan carrier to ensure that the services you and your dependents require are covered before you receive care.
- Keep up with preventive care. It's covered in full by all of our medical plans and can help detect and prevent potentially costly health issues early. You pay nothing for annual physicals, recommended immunizations, routine cancer screenings and more when you see in-network providers.
- Use pre-tax money to pay for eligible health expenses. Contributing to a Health Savings Account (HSA) and/or a Flexible Spending Account (FSA) is easy and saves you money on expenses you'd have to pay anyway.
- Shop smart for prescriptions. Using generic alternatives will almost always save you money — and they're just as effective as brand name prescriptions. It's also a good idea to call a few local pharmacies to compare prices before deciding where to fill a prescription. Remember, after you've filled the same 30-day prescription at a retail pharmacy three times, your ongoing maintenance prescriptions must be filled using the mail-order service or get your 90-day supply through CVS or Walgreens.
- Take advantage of the Transamerica wellness program. Our wellness program offers valuable resources to help you improve your health, which could prevent the need for costly care. Plus, if you are enrolled in one of the high deductible health plans and have an HSA with Transamerica, you'll earn Reward Dollars when you participate in the wellness program!
- Compare costs. Use the cost comparison tools available on your medical plan carrier website.
- Choose the right place to get care. Should you go to a doctor's office, urgent care facility or emergency room? Going to the most appropriate place for your needs will save you time and money.

VIRTUAL VISITS	DOCTOR'S OFFICE	URGENT CARE CLINIC	EMERGENCY ROOM
Use it to... Consult a doctor on minor health issues without having to visit a doctor's office.	**Use it to...** A condition that doesn't need immediate attention and can wait until the next day.	**Use it to...** A condition that needs immediate care but is not life- or limb-threatening.	**Use it to...** A life-threatening or potentially crippling condition that needs immediate care.
Examples: • Cold • Allergies • Flu	**Examples:** • Sore throat, fever • Routine exam, screening • Checkup, vaccination, prescription refill	**Examples:** • Broken bones, severe sprain or strain • Cut requiring stitches • Anxiety attack	**Examples:** • Sudden weakness, dizziness or loss of consciousness • Uncontrollable bleeding • Chest pain, difficulty breathing
Average price: $ Varies by provider	**Average price: $$** $0 (preventative) $139 (nonpreventative)	**Average price: $$$** $182	**Average price: $$$$** $645 (minor): $2,419 (moderate); $5,176 (severe)

Average costs are from healthcarebluebook.com. Contact your health insurance plan for specific costs.

Life & Accident Insurance

Overview

It's important to protect your family's financial security in case the unexpected happens. That's why Transamerica provides employees with Basic Life Insurance — at no cost to you.

You also have the option of buying:

- Supplemental Employee Life Insurance
- Dependent Life Insurance
- Universal Life Insurance
- Supplemental Accidental Death and Dismemberment (AD&D) Insurance

You pay the full cost of this supplemental coverage through easy payroll deductions.

You also have the protection of Company-paid Business Travel Accident Insurance.

Basic Life

Transamerica provides Basic Life Insurance to assist you and your family in the event of your death. These benefits are fully paid by the Company. Company-paid coverage is automatic; you do not need to enroll. Basic Life Insurance benefits are equal to your basic annual earnings up to $1 million (subject to any age reductions as specified in the group policy). The company-provided basic life insurance and any additional supplemental employee life insurance you purchase includes an accelerated death benefit. In the event you are diagnosed with a terminal illness with less than a year to live, you can draw on this insurance while still living.

Supplemental Employee Life Insurance

You can purchase additional life insurance for yourself. You pay the full cost of this coverage on an after-tax basis and must enroll at Mercer Marketplace 365+. Generally, you may elect coverage amounts of one, two, three or four times your basic annual earnings, up to an additional $1 million of coverage (subject to any age reductions as specified in the group policy).

Dependent Life Insurance

You may purchase Dependent Life Insurance[1] on an after-tax basis for:

- Your spouse/domestic partner[2] in $5,000 increments up to $250,000. First time enrollment is a guaranteed issue amount up to $50,000. If your spouse/domestic partner is also employed by Transamerica, you are not eligible to elect this benefit.
- Your child(ren) in the amounts of $5,000 or $10,000. As a reminder, dependent children are only eligible to age 26 and cannot be employed by Transamerica. If your spouse/domestic partner is also employed by Transamerica, only one of you may elect this benefit.

[1]You must purchase supplemental employee life insurance to be eligible to elect dependent life insurance and the amount of your dependent life insurance cannot exceed the value of your supplemental coverage.
[2]Coverage is only available until the end of the month following the date your spouse/domestic partner reaches age 70.

Evidence of Insurability

Evidence of insurability is not required when you are first eligible for benefits, such as when you are hired or become eligible for benefits during the year.

Evidence of insurability is required for the following situations:

1. An increase to your Supplemental Employee Life Insurance by more than one coverage level; and
2. An increase to spouse life greater than $5,000 or any increase to more than $50,000.

Universal Life Insurance

You also have the option to purchase universal life insurance for yourself, your spouse/domestic partner and children, offered through Transamerica Life Insurance Company.

Universal life insurance products are competitively priced policies with flexible premiums that combine protection with the ability to grow cash value. To help you provide protection for a secure financial future, these policies have a specified death benefit, plus the opportunity to tailor coverage to fit personal situations and family needs, including the potential for tax-deferred cash value accumulation.

This policy also includes a Chronic Condition Rider for you and your covered spouse that provides benefits if you are diagnosed with a chronic condition and unable to perform two of six activities of daily living and expected to be permanent. This added benefit can help you pay for unexpected expenses such as household or credit card bills, costs for an assisted living facility or even to help pay family caregivers.

This is a brief summary of TransElite® Universal Life Insurance underwritten by Transamerica Life Insurance Company (TLIC), Cedar Rapids, IA. TLIC is not an authorized insurer in New York. Policy form series CPGUL300 and CCGUL300. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

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Accidental Death & Dismemberment (AD&D) Insurance

You have the option to purchase AD&D insurance for just yourself or your whole family. AD&D insurance provides benefits for the loss of life, limb, sight, speech, hearing or for paralysis, as a result of a covered accident. You pay for AD&D coverage on a pre-tax basis. Coverage is available in increments of $25,000, up to $2 million (subject to any age reductions as specified in the group policy). If your spouse/domestic partner is also employed by Transamerica, your spouse can only be covered once (i.e., cannot be covered under your family plan and have an individual plan themselves).

Business Travel Accident Insurance

When traveling on behalf of the Company, be assured you are protected under a Company-paid Business Travel Accident Insurance policy if an accident occurs. This policy provides coverage for certain injuries or death resulting from an accident during business travel.

The Company provides coverage of $500,000 at no cost to you. Business travel accident insurance pays life and dismemberment benefits for losses occurring within 365 days of a covered travel accident.

Don’t forget to add or update your beneficiary!
Be sure you have provided beneficiary information for life insurance when you enroll. Once you’ve designated your beneficiaries, it’s a good idea to re-visit these elections as your personal circumstances

	change. You can designate a separate beneficiary for each life insurance policy — basic life insurance coverage, as well as any supplemental life or AD&D coverage you elect. Visit the Mercer Marketplace 365+ website or call the Mercer Marketplace 365+ dedicated Transamerica Benefits Center at 866-891-4274 to add or change a beneficiary at any time.

Disability Insurance

Overview

The loss of income due to illness or injury can cause serious financial hardship for your family. Disability insurance replaces a portion of your income to help you continue paying your bills and meeting your financial obligations during this difficult time.

Short-Term Disability (STD)

- Coverage is automatic and Company-paid; no need to enroll.
- Benefit begins after seven consecutive calendar days of disability.
- Replaces 100% of basic earnings for a period of time (based on years of service), then 60% for an additional period.
- Benefits end after 26 weeks.

Important note for Transamerica Agency Network employees: STD coverage only applies to Agency Coordinators, Managing Directors and Associate Directors.

Long-Term Disability (LTD)

- Coverage is automatic and Company-paid; no need to enroll.
- Benefit begins after you have been disabled for 26 weeks.
- Benefit replaces 50% of basic earnings up to $25,000/month.

Important note for Transamerica Agency Network employees: LTD coverage takes effect the first of the month following your first service anniversary with the Company.

Additional LTD

- Coverage is optional and employee-paid on an after-tax basis; you must enroll at the Mercer Marketplace 365+ website.
- Benefit replaces an additional 10% of basic earnings, up to a total of 60% of your salary (maximum of $25,000/month).

Other Benefits & Discounts

Overview

Transamerica also gives you access to a variety of additional programs that can help save you money and provide important assistance with everyday needs. You can learn more about these benefits by calling the Transamerica Benefits Center at 866-891-4274 or visiting the Mercer Marketplace 365+ website.

Legal Plan

The MetLife Legal Plan offers economical access to a nationwide network of 13,000 attorneys for legal services such as will preparation, estate planning and family law. Legal advice is a phone call away, and representatives will help you find an attorney in your area. Learn more about the many covered services available to you through the MetLife Legal Plan at legalplans.com.

When accessing the MetLife Legal Plan website, click "Let's Get Started" from the home page.

If you want to enroll in this benefit, you will do this directly on the Mercer Marketplace 365+ website. Premiums will be deducted from your paycheck.

Pet Insurance

Nationwide Pet Insurance provides coverage to help you cover the costs of veterinary care using any veterinarian worldwide. You will receive a discount of 5% or more on premiums through Mercer Marketplace 365+ and you can enroll any time of year. Learn more at my.petinsurance.com.

If you are interested in pet insurance, you will be able to elect this directly from the Mercer Marketplace 365+ website and you will then be automatically redirected to Nationwide's site to complete enrollment and set up premium payments.

Identity Theft Protection

Services from Allstate Identity Protection monitor your identity, detect fraud and restore your identity in the event of theft, giving you peace of mind around your personal financial data. You'll have access to certified privacy advocates who act on your behalf to resolve identity theft issues.

Learn more at myaip.com/mercermarketpp.

If you want to enroll in this benefit, you will do this directly on the Mercer Marketplace 365+ website. Premiums will be deducted from your paycheck.

Discounts

You have access at no cost to exclusive prices, discounts and offers from hundreds of local and national merchants through the PerkSpot Online Discount Mall at transamerica.perkspot.com, which is on the Mercer Marketplace 365+ website. There's no enrollment required and you can save up to 40% through offers that interest you, including health clubs, movie theaters, restaurants, retailers and cellphone providers.

Additional Support for You and Your Family

	Transamerica provides a variety of additional benefits to help you and your family with everyday challenges and to prepare for your future. You don't need to enroll in these benefits. Lifestyle Benefits • Adoption Assistance • Bright Horizons Back-Up Child and Elder Care • Bright Horizons College Coach • Bright Horizons Enhanced Family Supports • Employee Assistance Program • Paid Time Off • Paid Volunteer Time • Parental Leave • Tuition Reimbursement Retirement Benefits • Transamerica 401(k) Retirement Savings Plan • Transamerica Pension Plan Details about these Transamerica benefits, including eligibility, are available on ePortal at https://transamerica.service-now.com/hrportal or by calling People Solutions at 866-558-5560, Option 2.

New Hires

Welcome to Transamerica!
Transamerica provides a comprehensive suite of benefits. You have a choice of medical, dental and vision plans, plus a variety of other plans and voluntary benefits.

As a new employee of Transamerica, you must enroll for health benefits within the 30-day deadline provided to you by Mercer Marketplace. Enrollment in Transamerica's benefits are optional. While the Affordable Care Act individual mandate penalty was eliminated, certain state-level individual mandates do exist. As a result, you may still want to enroll in health coverage depending upon where you reside to avoid a penalty.

What You Need to Do

1. Learn about all your 2024 health benefits options by reviewing this online decision guide.

   For details on benefits that are automatically offered to you as a Transamerica employee, like the employee assistance program, paid time off and the Transamerica 401(k) Retirement Savings Plan, visit ePortal at https://transamerica.service-now.com/hrportal, or call People Solutions at 866-558-5560, Option 2.

2. Enroll in your benefits prior to the 30-day deadline provided to you by Mercer Marketplace. You will receive an email to your work email address from Mercer Marketplace, which will include your deadline and instructions on how to enroll in benefits on the Mercer Marketplace website.
   - If you're a Transamerica employee, your coverage will be effective on the first of the month immediately following your date of hire.
   - If you're a Transamerica Agency Network employee, your coverage will be effective on the first of the month following your 55th day of employment.

   If you do not enroll within the 30-day deadline, you will only have Company-provided benefits, as applicable.

   You cannot make a new election until the next Annual Benefits Enrollment period (for 2025 benefits) unless you have a qualifying change in status, such as marriage or the birth of a child during the year. For a complete list of qualifying events, see the Making Benefit Changes section on page 44 of this guide.

3. If you have any questions on your benefits, contact the Mercer Marketplace 365+ dedicated Transamerica Benefits Center at 866-891-4274. Benefits counselors are available from 6 a.m. to 8 p.m. CT Monday through Friday.

4. If you are covering a dependent, you will need to submit dependent verification documentation to Mercer Marketplace within 31 days of the date you enroll your dependent or your dependent's benefits will not be activated. Submit verification using one of the methods below.
   - Upload to the Mercer Marketplace website
   - By mail: Mail copies of documentation to Mercer Marketplace, PO Box 10398, Des Moines, IA 50306-0398

   It may take up to 10 business days to process your dependent verification after documentation has been received.

5. Watch your mail for ID cards, debit cards and more information — Depending on the benefits you have chosen, you will receive an ID card for:
    - Medical (from Wellmark Blue Cross Blue Shield, United Healthcare or Kaiser)
    - Prescription Drugs (from Express Scripts)

    If you enroll in dental coverage, Delta Dental will mail you an ID card. You can also print your ID card on the Delta Dental of Iowa website at deltadentalia.com after you register.

    If you enroll in vision coverage, you can print your ID card on the United Healthcare website at myuhcvision.com after you register.

    If you enroll in a Health Savings Account (HSA) or a Flexible Spending Account (FSA), you will receive a card and account information from Transamerica. You will only receive one debit card that you will use for any of the accounts you elected.

How to Enroll

Take Action Within Your 30 Day Deadline

How to access the Mercer Marketplace 365+ website
You can enroll in benefits through the Mercer Marketplace 365+ website.

Enter benefits.transamerica.com in your browser window.
- If you <u>are connected</u> to the network, it won't be necessary to enter additional credentials.
- If you're <u>not connected</u> to the network, you'll need to enter your network username, password and domain. Most employees will enter "US" as the domain (Corporate Center will use "DS").

Please note: If you're part of the Transamerica Agency Network, you'll be required to enter your credentials regardless of whether you are connected to the network or not, enter the same ID and password you use for ePortal and Integrity Ed, and enter "US" as the domain.

During your benefits enrollment, you'll use Mercer Marketplace 365+, our online benefits platform, to enroll in:
- Medical
- Supplemental Health Insurance
- Savings and Spending Accounts
- Dental
- Vision
- Life
- Disability
- Voluntary Benefits

Enrolling Is Easy

Once logged in, follow the on-screen prompts to enroll into your benefits. As you go through the Mercer Marketplace 365+ site, you will see the coverage details and costs for each plan clearly displayed in your

shopping cart. When you check out, you'll have a chance to review your elections and see your total cost. Save a summary of your elections to keep for your records.

If you prefer to enroll by phone, you can also contact the Mercer Marketplace 365+ dedicated Transamerica Benefits Center at 866-891-4274.

If you have questions, benefit counselors are available to advise and assist — from 6 a.m. to 8 p.m. CT Monday through Friday. These hours give you access to support on the phone and through live online chat.

Benefits counselors can help answer any questions you may have or direct you to the appropriate resource. They can help you understand what benefits you're eligible for, provide general information about your benefit options, answer questions about specific plans and guide you through the enrollment process. If you need to change your elections, you may do so within your new hire deadline provided by Mercer Marketplace.

Note: If you've enrolled dependents, you'll need to submit verification documentation within 31 days of the date you enroll your dependent on Mercer Marketplace 365+. Adding a dependent to your profile does not add them to your benefits; you must elect benefits separately. If you do not submit dependent verification timely, your dependent will be removed from your benefits.

Decision Support

Resources to Help You Choose

With so many benefit choices, you have important decisions to make. You will have support every step of the way, with access to education and resources that help you understand your options and the enrollment process.

Mercer Marketplace 365+ enrollment website — Visit the Mercer Marketplace 365+ website to find educational information and decision-support tools to help you select the benefits that are right for you. These tools allow you to:

- Model different cost scenarios;
- Compare plans side-by-side;
- Get personalized "Best Match" plan suggestions; and
- Learn about the advantages of health savings and flexible spending accounts.

2024 benefits program presentations – These recorded presentations, available on Transamerica Learn, can be watched at your convenience, from work or home. If you are connected to the network, it won't be necessary to enter additional credentials. If you are not connected to the network or part of the Transamerica Agency Network, you'll need to enter your network username, password and domain.

- Click here to get started with any of the following courses. We know your time is valuable, so most presentations are less than 5 minutes in length.
- Medical
- Wellmark Narrow Network Plan (Iowa Only)
- Dental and Vision
- Life and Disability
- Voluntary Benefits
- Spending and Saving Accounts
- Reward Dollars

2024 Premium Rates

As you review your options, take an active role in managing your costs by selecting the right amount of coverage for your needs — remember, you'll pay more from your paycheck for plans with lower deductibles and higher cost-sharing when you need care, but if you don't expect to need a lot of care, higher deductible plans could save you money overall.

You can view your 2024 premium rates for medical, dental, vision, life insurance and long-term disability coverage online at mytabenefits.com.

Enrollment Checklist

Use this checklist to prepare.

- Learn about your benefit options by reviewing the online Benefits Decision Guide.
- Think about your coverage needs, including how much health care — and what type of care — you anticipate needing for yourself and your family.

- Think about how you prefer to handle costs. For instance, would you rather pay more from your paycheck for a medical plan that covers more of your costs when you need care or pay as little as possible from your paycheck — even if that means bigger bills when you need care?
- Consider if you have enough protection to provide sufficient income for your loved ones in the event of a disability, dismemberment or death.
- Verify your dependent's eligibility and submit required documentation within 31 days from the date you add your dependent to your coverage.
- Enroll in an FSA and/or HSA to help you save money — these accounts allow you to pay for eligible expenses with pre-tax money. — If you elect an HSA for 2024, you are eligible to receive Reward Dollars for participating in the wellness program between January 1 and November 30, 2024.
- Add your beneficiaries during the enrollment process.
- Complete your benefits enrollment.
- Save your confirmation statement.

TIP: Think about the whole cost.
When choosing a medical plan, it's important to think about the whole cost of coverage — the amount you'll spend out of your paycheck, as well as out of your pocket (deductibles and coinsurance).

Top 4 Questions

1. What happens if I don't enroll within 30 days of my first day of employment?
If you do not enroll within 30 days of your first day of employment, you will only have Company-provided benefits, as applicable.

After you make your initial benefit elections, you will only be able to change or add benefits if you have a qualifying change in status, such as a marriage or the birth of a child in the middle of the year. Go to the *Making Benefit Changes* section to see a more complete list of the events that would qualify you to change your benefit elections mid-year.

2. How are the medical plans different?
The key difference between the plans is how much you pay from your paycheck and how much you pay toward the cost of health care you receive throughout the year. Consider how you prefer to handle costs. For instance, would you rather pay extra every pay period for a medical plan that covers more of your costs when you need care, or pay as little as possible from your paycheck — even if that means bigger bills at the time you receive services? The other consideration is that the three high deductible health plans allow you to contribute to an HSA, but the $900 Deductible Plan does not.

3. What's the difference between the Health Care Flexible Spending Account (FSA) and the Health Savings Account (HSA)?
The way the Health Care FSA and the HSA work is largely the same — you contribute to your account through automatic, pre-tax payroll deductions, then use the money to pay for eligible health care expenses. However, there are some important differences. For example, all the money in an HSA rolls over year after year and is always yours to keep, whereas you can only carry over $640 in a Health Care Flexible Spending Account. With an HSA, you must have the funds available in your account to pay for an expense; an FSA allows you to reimburse yourself up to the total amount you choose to contribute for the year — even if the money has not yet been contributed to your account. It's also important to note that you cannot contribute to both an HSA and Health Care FSA at the same time; however, you can contribute to both an HSA and a Combination FSA.

	4. I have questions about my benefits. Whom do I contact? Benefits counselors are available by phone through Mercer Marketplace's dedicated Transamerica Benefits Center at 866-891-4274 or via secure online chat on the Mercer Marketplace 365+ website, Monday through Friday between 6 a.m. and 8 p.m. CT. After your benefits enrollment ends, benefits counselors can assist you with making coverage changes if you have a qualifying event during the year, help you locate providers and specialists and answer questions about how your benefits work.

Eligibility

Overview

In general, you are eligible for health and welfare benefits if you are a regularly scheduled employee working 30 or more hours per week. If you are working less than 30 hours per week you are not eligible for health and welfare benefits, however you may be eligible for medical benefits if you are considered a full-time employee in accordance with the eligibility requirements of the Affordable Care Act.

Dependent Eligibility

When you enroll in benefits, you can cover yourself and eligible members of your family.

Eligible dependents include your:

- Spouse[1] (legally married, including a common law spouse as determined under applicable state law)
- Domestic partner (subject to receipt and approval of the Affidavit of Domestic Partnership)
- Child(ren) up to age 26: biological child(ren), adopted child(ren) (including child(ren) placed for adoption), stepchild(ren) or child(ren) for whom you have legal guardianship
- Disabled dependent[2] child(ren) who are older than age 26 (must be covered under the Plan before age 26 and qualify as your financial dependent)

[1]Any reference to "spouse" is inclusive of an eligible domestic partner, and any reference to "child(ren)" includes those of an eligible domestic partner.

[2]If the child meets the criteria for a disabled child, but you did not apply for coverage within 30 days of the onset of your child's disability because you were not employed with the Company at that time, or your child had coverage under another parent's medical plan, you must apply for coverage upon employment with the Company or within 30 days of your child's loss of coverage under the other parent's medical plan.

If you are adding a dependent, you must provide proof of the dependent's eligibility to Mercer Marketplace's dedicated Transamerica Benefits Center within 31 days of submitting your election. When you complete your enrollment, a notice may be sent to your Transamerica email address with directions for submitting dependent verification. We recommend that you refer to the Mercer Marketplace 365+ website after you enroll or contact Mercer Marketplace by phone for information on what is required. If you do not submit dependent verification timely, your dependent will be removed from coverage. You can send verification in one of the following ways:

- Upload to the Mercer Marketplace 365+ website

- By mail: Mail copies of documentation to Mercer Marketplace, PO Box 10398, Des Moines, IA 50306-0398

It may take up to 10 business days to process your dependent verification after documentation has been received.

Making Benefit Changes

After you make your initial benefits elections, you may not change or cancel your benefit elections during 2024 unless you experience a qualifying life event or qualify for special enrollment.

Qualifying life events include, but are not limited to:

- Marriage
- Divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Loss or addition of other group coverage
- Change in your spouse's work status (part-time to full-time or vice versa; taking or returning from an unpaid leave of absence)
- Change in your work status that affects your benefits
- Change in residence that affects your eligibility for coverage
- You or your covered dependent becomes eligible for Medicare

Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Provisions
Special enrollment events allow you and your eligible dependents to enroll for health coverage outside the Annual Benefits Enrollment period under certain circumstances.

What to do if you experience a life event
If you need to make changes to your 2024 benefit elections as a result of a qualifying life event, visit the Mercer Marketplace 365+ website or call a benefits counselor at the Transamerica Benefits Center at 866-891-4274. You may be asked to provide documentation to serve as proof of the life event. If so, you will be given instructions that explain what documentation is required. Changes must be made within 30 days* of your qualifying life event. All changes other than birth and adoption are effective on the first of the month following the date of the event.

*For loss of Medicaid or CHIP eligibility, changes must be made within 60 days. For court orders (QMSCO), changes must be made within 30 days.

Dependent verification
If you add a dependent to coverage as the result of a qualifying life event, you must provide proof of the dependent's eligibility to Mercer Marketplace's dedicated Transamerica Benefits Center, including the Dependent Verification Form, which you can find on the enrollment website under Resource Center. After you enroll, information on what documents are required will be available on the Mercer Marketplace website. Contact Mercer Marketplace prior to your deadline if you need information for dependent verification or if you need to extend your deadline. You will have 31 days from the date you enroll your dependent on Mercer Marketplace 365+ to provide the documentation. If you do not provide dependent verification timely, your dependent will be removed from coverage. You can send verification in one of the following ways:

- Upload to the Mercer Marketplace 365+ website
- By mail: Mail copies of documentation to Mercer Marketplace, PO Box 10398, Des Moines, IA 50306-0398

It may take up to 10 business days to process your dependent verification after documentation has been received.

The information in this online guide is published to provide a benefits summary in an easy-to-read manner. This is not a plan document. You cannot rely on any conflict or inconsistency between this guide and the underlying plans to give you rights not provided in the plans.

The terms and conditions of all employee benefit plans are governed by the respective plan documents and their respective insurance policies and contracts, which will control in the event of conflict or dispute. No employee has the authority to change any provisions of the plans or legally bind the Company.

Help

General benefit inquiries Transamerica Benefits Center 866-891-4274 6 a.m. to 8 p.m. CT Monday through Friday	Medical Wellmark Blue Cross Blue Shield wellmark.com 800-524-9242	Medical United Healthcare myuhc.com 877-561-2833
Medical Kaiser kp.org 877-580-6125	Benefit Advocacy TouchCare touchcare.com 866-486-8242	Prescription Drugs Express Scripts esrx.com 877-845-2761
Dental Delta Dental of Iowa deltadentalia.com 800-544-0718	Vision United Healthcare myuhcvision.com 800-638-3120	Health Savings Account (HSA) 877-248-0510 Transamerica transamerica.com/portal 833-571-0504
Flexible Spending Accounts (FSAs) Transamerica transamerica.com/portal 833-571-0504	Wellness Program Health Solutions wellness.transamerica.com 888-362-5920	Accident Insurance Transamerica Life Insurance Company transamericabenefits.com 888-763-7474
Hospital Indemnity Insurance Transamerica Life Insurance Company transamericabenefits.com 888-763-7474	Critical Illness Insurance Transamerica Life Insurance Company transamericabenefits.com 888-763-7474	Cancer Insurance Transamerica Life Insurance Company transamericabenefits.com 888-763-7474
Disability MetLife metlife.com/mybenefits 800-396-8689	Life Transamerica Benefits Center: 866-891-4274	Accidental Death & Dismemberment (AD&D) Cigna cigna.com/welcome/Mercer Claim Intake: 800-362-4462 Medical Underwriting: 800-732-1603
Legal Plan MetLife Hyatt Legal Plan legalplans.com 800-438-6388	Pet Insurance Nationwide Pet Insurance my.petinsurance.com 855-525-1458	Identity Theft Protection InfoArmor myprivacyarmor.com/marketplace365 800-789-2720
Discount Mall PerkSpot transamerica.perkspot.com 866-606-6057		

Glossary

- Coinsurance: How you and your medical plan share costs after you meet the plan's annual deductible. For example, your plan may cover 80% of charges for a covered hospitalization, leaving you responsible for the other 20%. This 20% is your coinsurance.

- Deductible: The amount you pay for health care services each year before your plan begins to pay benefits. For example, if your annual deductible is $3,200, your plan won't pay anything until you've paid that amount in out-of-pocket expenses first. The exception is in-network preventive care, which is fully covered, with no deductible.

- Dependent Care Flexible Spending Account (FSA): You may choose to enroll in this account to pay for eligible day care expenses for your child(ren) (up to age 13) and dependent elders with pre-tax dollars. You contribute to your FSA through automatic, pre-tax payroll deductions. The Dependent Care FSA has a "use it or lose it" rule, meaning that any money left in your account at year-end is forfeited. In addition, the Dependent Care FSA requires you to incur the expense first and then file a claim for reimbursement after services have been provided. For a full list of eligible expenses, refer to IRS Publication 503 at irs.gov/publications/p503/index.html.

- Health Care Flexible Spending Account (FSA): You may choose to enroll in this account to pay for eligible health care expenses — including deductibles and coinsurance for medical, dental and vision care — with pre-tax dollars. You contribute to your FSA through automatic, pre-tax payroll deductions. Up to $640 of unused money may be carried over to the next year; amounts above $640 will be forfeited. By law, you cannot participate in a Health Care FSA and a Health Savings Account (HSA) at the same time, but you can contribute to both an HSA and a Combination FSA. For a full list of eligible expenses, refer to IRS Publication 502 at irs.gov/publications/p502/index.html.

- Health Savings Account (HSA): A tax-advantaged savings account that is only available to participants in a qualified high deductible health plan, such as the $4,500, $3,200 and $1,850 Deductible Plans. You contribute to your HSA through pre-tax payroll contributions and can use the money to pay for eligible medical expenses — including deductibles and coinsurance for medical, dental and vision care. In addition, Transamerica will contribute money to your account in 2024 as a reward for participating in the wellness program – up to $500 for Self Only coverage and $800 if you cover a spouse and/or child(ren) on your medical plan. You must actively enroll in an HSA each year in order to receive employer contributions.

  In 2024, the total amount that you and Transamerica contribute to your HSA cannot exceed $4,150 for Self Only coverage or $8,300 if you cover a spouse and/or child(ren) on your medical plan. You can change your contribution amount during the year for any reason. To make a change to your HSA contributions, visit the Mercer Marketplace website. (Please note that while your medical plan premiums are also deducted from your paycheck, they are separate from your HSA/FSA contributions and are paid to the insurance carrier providing your coverage — only the amounts you specifically elect to contribute to an HSA or FSA go into those accounts.)

  All of the money in your HSA rolls over from year to year and is always yours to keep. For example, you may use the money in your HSA to pay for eligible health expenses in retirement. For a full list of eligible expenses, refer to IRS Publication 502 at irs.gov/publications/p502/index.html.

  In order to establish and contribute to an HSA, you:

  - Must be enrolled in an HSA-eligible high deductible health plan, like the $4,500, $3,200 or $1,850 Deductible Plans.

- Cannot simultaneously participate in the Health Care FSA (but participation in a Combination FSA is allowed).
- Cannot be enrolled in any other medical coverage, including a spouse's plan, Medicare or Tricare.
- Cannot be claimed as a dependent on someone else's tax return.

You should review IRS rules for making HSA contributions if you will turn age 65 during the year. For more information, see IRS Publication 969.

- Combination Flexible Spending Account (FSA): Available only to employees who enroll in an HSA, this FSA is designed to provide additional tax-saving opportunities. This type of spending account is a Limited Purpose Health Care plan that is converted to a general purpose Health Care FSA once you meet the IRS-required medical deductible of $1,600/Self Only and $3,200/Spouse and/or Child(ren). Initially, only dental and vision expenses are eligible for reimbursement in a Limited Purpose Health Care FSA; then, once you've met the required IRS medical deductible amount, you can also reimburse yourself for eligible medical expenses. When you meet the IRS-required medical deductible, you must submit the Deductible Verification Form (available on the Mercer Marketplace 365+ website) to Mercer Marketplace. This document serves as a one-time notification that the deductible was met. You may use funds in your HSA while you are in the process of meeting this deductible requirement.

- Out-of-pocket maximum: This limit protects you financially by capping the amount you'll pay in a plan year for covered health expenses. If you reach your medical plan's out-of-pocket maximum, your plan pays 100% of covered services for the rest of the year. Your deductible and coinsurance count toward your out-of-pocket maximum.

- Premiums: A fixed amount that is deducted from each of your paychecks to pay for coverage under a medical plan. Premiums can vary widely by the type of plan you choose and are paid to the insurance carriers who provide coverage. To see what the premiums are for each plan, visit the Mercer Marketplace 365+ website. Please note that while your HSA and FSA contributions are also deducted from your paycheck, they are separate from your premiums — only the amounts you specifically elect to contribute to an HSA or FSA go into those accounts.

- Preventive care: In-network preventive care is fully covered under all of Transamerica's medical plans, with no deductible. Preventive care includes routine care designed to prevent illness or disease, including annual physicals, recommended immunizations and routine cancer screenings. If the same tests are done to diagnose an illness or treat a known condition, they are not considered preventive care and your plan's normal charges will apply.

Appendix – Supplemental Health Insurance

Accident Insurance

AccidentAdvance

Limitations and Exclusion
We will not pay benefits for losses caused by or as a result of an insured person:

- Injuries that occur in the workplace or during the course of any employment for pay, benefit or profit;
- Driving any taxi for wage, compensation or profit;
- Mountaineering, parachuting or hang gliding;
- Voluntarily taking, administering, absorbing or inhaling poison, gas or fumes;
- Participating in any sport or sporting activity for wage, compensation, profit, or racing any type of vehicle in an organized event;
- Traveling in or descending from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip;
- War, or any act of war, whether declared or undeclared;
- Participating in any activity or event, including the operation of a vehicle, while intoxicated or under the influence according to the laws of the jurisdiction in which the accident occurred;
- Participating in a riot, civil commotion, civil disobedience or unlawful assembly;
- Committing, attempting to commit, or taking part in a felony or assault or engaging in an illegal occupation;
- Intentionally self-inflicting bodily injury or attempting suicide while sane or insane;
- Any loss incurred while on active duty status in the armed forces. If you notify us of such active duty, we will refund any premiums paid for any period for which no insurance is provided as a result of this exception.

Termination of Insurance
Subject to the Portability Option, insurance on the employee will end on the earliest of:

- The date of his or her death;
- The date he or she ceases to be eligible for insurance;
- The last date for which premium payment has been made to us, subject to the grace period;
- The date he or she terminates employment;
- The date the group master policy terminates;
- The date he or she sends us a written notice to cancel insurance.
- The insurance on a dependent will cease on the earliest of:
- The date of the employee's death;
- The date the employee's insurance terminates;
- The last date for which premium payment has been made to us, subject to the grace period;
- The date the dependent no longer meets the definition of dependent;
- The date the certificate is modified so as to exclude dependent insurance;

Extension of Benefits
Whenever termination of insurance under this section occurs due to termination of employment, such termination will be without prejudice to:

- Any hospital confinement which began while insurance was in force; or
- Any covered treatment or service for which benefits would be provided and which began while insurance was in force; provided, however that the insured person is and continues to be hospital confined or receiving treatment. Such Extension of Benefits will continue for up to the earlier of:
  - 30 days; or

– The date on which the insured person is no longer hospitalized or receiving treatment.

Portability Option
If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

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Critical Illness Insurance

CriticalEvents

Limitations and exclusions
We do not pay benefits for losses caused by, or as a result of, the insured person's:
- Participation or attempting to participate in an illegal activity.
- Intentionally causing self-inflicted injury.
- Committing or attempting to commit suicide, whether sane or insane.
- Involvement in any period of armed conflict.
- Under no condition will we pay any benefits for losses incurred prior to the effective date.

Portability option
If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us at our administrative office within 31 days after termination. We will bill the employee directly once we receive notification to continue this insurance.

Termination of insurance
Employee insurance will terminate on the earliest of:
- The date the group master policy terminates, subject to the portability option.
- The date an employee ceases to be eligible for insurance.
- The date of the employee's death.
- The premium due date on which we fail to receive the employee's premium.

Dependent insurance will terminate on the earliest of:
- The date the employee's insurance terminates.
- The premium due date on which we fail to receive the employee's premium.
- The date the dependent no longer meets the definition of dependent.
- The date the group master policy or certificate is modified to exclude dependent insurance.

We may end the insurance of any insured person who submits a fraudulent claim under the policy.
Termination of the employee's insurance will not affect any claim which begins before the date of termination.

Termination of the group master policy
The group may end the policy on any premium due date by submitting a 60-day advance written notice. A group policy will not continue if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the portability option.

Other insurance with us

An employee can only have one critical illness policy or certificate with us. If a person already has critical illness insurance with us, such person is not eligible to apply for this insurance.

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Hospital Indemnity Insurance

Hospital Select II

Limitations and exclusions
Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior confinement. Successive confinements separated by more than 30 days will be treated as a new and separate confinement.

No benefits under this contract will be payable as the result of the following:

- Suicide or attempted suicide, whether while sane or insane.
- Intentionally self-inflicted injury.
- Rest care or rehabilitative care and treatment.
- Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless Wellness Indemnity Benefit Rider is included).
- Any pregnancy of a dependent child including confinement rendered to her child after birth.
- Routine newborn care (unless Wellness Indemnity Benefit Rider is included).
- An insured person's abortion, except for medically necessary abortions performed to save the mother's life.
- Treatment of mental or emotional disorder (unless Inpatient Mental and Nervous Disorder Indemnity Benefit Rider is included).
- Treatment of alcoholism or drug addiction (unless Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider is included).
- Participation in a felony, riot or insurrection.
- Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician or taken according to the physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred).
- Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- Sex change, reversal of tubal ligation or reversal of vasectomy.
- Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician's services, unless required by law.
- Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
- Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip.
- Any loss incurred on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no benefits are provided as a result of this exception.)
- An accident or sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits may be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made.
- Involvement in any war or act of war, whether declared or undeclared.

Portability Option
If the employee loses eligibility for any reason other than nonpayment of premiums, insurance can be continued by paying premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

Termination of Insurance
The insurance terminates on the earliest of:
- The insured's death.
- The premium due date when we fail to receive a premium, subject to the grace period.
- The date the policy terminates.
- The date the insured ceases to be eligible for insurance.

Dependent insurance ends on the earliest of:
- The date the insured's insurance terminates for any of the reasons above.
- The date the dependent no longer meets the definition of a dependent.
- The premium due date when we fail to receive a premium, subject to the grace period.
- The date the policy is modified so as to exclude dependent insurance.
- The insurance company has the right to terminate the insurance of any insured who submits a fraudulent claim.
- Termination will not impact any claim which begins before the date of termination.

Off-the-Job Accidental Injury Indemnity Benefit Rider:
Does not cover injuries which are caused by an accident that occurs while in the course of any legal or illegal occupation, activity, or employment for pay, benefit or profit.

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Cancer Insurance

CancerSelect Plus

Limitations and exclusions
We provide benefits only for cancer as defined herein, which is positively diagnosed while insurance is in force. It does not provide benefits for any other illness or disease.

We may reduce or deny a claim or void insurance for loss incurred by an insured person:
- During the first 2 years from the effective date of such insurance for any misstatements in the application which would have materially affected our acceptance of the risk.
- At any time for fraudulent misstatements in the application.
- We will only pay for loss as a direct result of cancer. Proof of positive diagnosis must be submitted to us for each new claim. We will not pay for any other disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of cancer, except as specifically covered under the contract.
- If a covered hospital confinement is due to more than one covered condition, benefits will be payable as though the confinement or expense were due to one condition. If a hospital confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the part of the hospital confinement or expense due to the covered disease or condition.
- Under no condition will we pay any benefits for losses or medical expenses incurred prior to the effective date.

Pre-Existing Condition Limitation – No benefits are provided during the first 12 months for pre-existing conditions for which the insured person has been diagnosed, treated or for which the insured person has

incurred expense or has taken medication within 12 months prior to the effective date of such person's insurance. Pre-existing condition also includes a condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

Total Disability means the inability to perform all of the material and substantial duties of the employee's regular occupation. Total Disability will be considered to exist when under the regular care and attendance of a physician for the necessary treatment of cancer. After the first two years of Total Disability, the employee will continue to be considered Totally Disabled if unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. On or after age 65, Total Disability will mean that a physician has certified that the employee is unable to perform two or more Activities of Daily Living (continence, transferring, dressing, toileting, eating and bathing) without direct personal assistance as a result of cancer.

12-Month Benefit Period – The initial 12-Month Benefit Period is the 12-month period beginning on the date of positive diagnosis. Subsequent 12-Month Benefit Periods begin on the same month and day as the immediately preceding 12-Month Benefit Period; however, if the insured person incurs no covered loss during the 3 months after the end of any 12-Month Benefit Period, the next 12-Month Benefit Period will begin on the next date a covered loss is incurred. Benefit Periods are determined separately for each insured person.

First Occurrence Rider
Benefits are not payable:

- For cancer diagnosed prior to the Effective Date of this Rider;
- For any other illness or disease other than internal Cancer;
- For Skin Cancer or any Cancer excluded from insurance by name or specific description.

Intensive Care Rider
We will only pay one daily indemnity benefit per day. We will not pay any benefits for loss resulting from:

- Specifically excluded diseases or conditions in the Contract or in this Rider;
- An attempted suicide while sane or insane or an intentionally self-inflicted injury;
- Any act of war either declared or undeclared;
- Alcoholism or drug addiction;
- Mental or nervous disorders;
- An overdose of drugs, narcotics, hallucinogens, unless administered on the advice of a Physician;
- Intoxication, or being under the influence of any intoxicant or narcotic, unless administered on the advice of a Physician;
- Injury received while engaging in an illegal occupation or activity.

Termination of Insurance
Employee insurance will terminate on the earliest of:

- The date of the employee's death;
- The date on which the employee ceases to be eligible for insurance;
- The last date for which premium payment has been made to us;
- The last date on which employment terminates;
- The date the group master policy terminates; or

Dependent insurance will terminate on the earliest of:

- The date the employee's insurance terminates;
- The last date for which premium payment has been made to us;
- The date the dependent no longer meets the definition of dependent;
- The date the group master policy is modified so as to exclude dependent insurance; or

- We will have the right to terminate the insurance of any insured person who submits a fraudulent claim under the policy.

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the Portability Option.

Other Insurance with Us

An individual can only have one cancer policy or certificate with us. If a person already has cancer insurance with us, such person is not eligible to apply for this insurance.

U&L Limitations and Exclusions

Limitations and Exclusions

If an insured employee withdraws the cash value, tax consequences and/or surrender charges may apply. Fluctuations in interest rates or policy charges may require the payment of additional premiums. Individuals currently on disability or on premium waiver are not eligible for insurance.

During the first two years, the death benefit for suicide is limited to the return of premiums paid, less any loans, partial surrender amounts, and accelerated benefits paid, if any.

Accelerated Death Benefit for Living Benefit Rider

We will not pay rider benefits for care that is received or loss incurred as a result of:

- an intentionally self-inflicted injury or attempted suicide.
- war or any act of war, declared or undeclared, or service in the armed forces of any country.
- the insured's alcohol, drug or other chemical dependence, except if the drug dependency is for a drug prescribed by a physician in the course
- of treatment for an injury or sickness.
- the insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the insured's involvement in an illegal activity.

Extension of Benefits Rider

The rider will terminate on the earliest of:

- the date the contract terminates;
- the date the contract lapses, subject to the grace period;
- the date the policy owner requests termination;
- the date the policy owner dies;
- the date the entire death benefit has been paid under the Accelerated Death Benefit for Living Benefit Rider, or when the policy no longer
- satisfies the Eligibility for Benefits provision;
- the date the cumulative death benefit increases under this rider total 100% of the death benefit in force on the date the first monthly
- accelerated death benefit was paid under the Accelerated Death Benefit for Living Benefit Rider;

- the date the nonforfeiture option, if any, becomes effective; or
- the date a one-time lump sum payment under the Accelerated Death Benefit for Living Benefit Rider is paid.

Accelerated Death Benefit for Terminal Condition Rider
We will not pay for any conditions diagnosed prior to the effective date of the rider.

Waiver of Monthly Deductions for Layoff or Strike Rider
We will waive deductions for:

- up to three layoffs or strikes in one 12-month period;
- for up to six months in any one 12-month period.
- A 12-month period will be measured from the date the first month deduction is waived.
- If the portability option provision of the contract is exercised, if any, the policy owner will need to provide proof of being employed (other than
- self-employment) for the 6 months prior to the layoff or strike.
- This rider is not available for self-employed individuals.
- The rider will terminate on the earliest of:
- the date the contract terminates;
- the date the contract lapses, subject to the grace period;
- the date the policy owner requests termination;
- the date the policy owner dies;
- the anniversary date on or after the insured reaches age 60;
- the date the policy owners assigns the contract to another individual; or
- the date a nonforfeiture option, if any, becomes effective.

Child Term Insurance Rider
This rider is only available during the initial enrollment. This rider will terminate on the earliest of:

- the date the contract terminates, subject to the Conversion Options of this rider;
- the date the contract lapses, subject to the grace period;
- the date the policy owner requests termination;
- the anniversary date on or after the insured child is no longer eligible as a dependent child;
- the anniversary date on or after the last insured child has reached age 26; or
- the date a nonforfeiture option, if any, becomes effective.

Termination of Insurance
Insurance, including all riders, ends on the earliest of the following dates:

- the monthly contract date following the receipt of written request to terminate.
- the maturity date.
- the date the insured dies.
- the date the contract lapses or becomes fully paid-up life insurance, subject to the grace period.
- the date a nonforfeiture option becomes effective.

Portability Option
If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue insurance.

Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and the insurance of all remaining insureds will end, subject to the Portability Option.

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