



**Taylor Wiseman & Taylor**  
ENGINEERS | SURVEYORS | SCIENTISTS



# 2026

## OPEN ENROLLMENT GUIDE

# Welcome to Open Enrollment

**November 3 - November 17, 2025**

This year we will be holding an **ACTIVE** Open Enrollment. If you do not submit your 2026 benefit elections by Wednesday, November 17th, you will not have coverage effective January 1, 2026.

## 2026 Benefits Highlights

- There will be no changes to your benefit vendors or plan design offerings. Your new medical/prescription drug contributions can be found on page 12. There will be no contribution changes for vision and dental contributions have decreased slightly from last year.
- We are continuing the wellness program offering rewards to employees for healthy activities
- Enrollment will continue to be completed online via the Paylocity platform

For More information about your benefit plans, please refer to the BenePortal by visiting [www.twtbenefits.com](http://www.twtbenefits.com).

## Questions?

If you have questions about your benefits, please contact the Benefits MAC Team at **800.563.9929** (Monday through Friday, 8:30 am to 5:00 pm ET) or visit [www.connerstrong.com/memberadvocacy](http://www.connerstrong.com/memberadvocacy) and complete the fields to submit a request online.

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# Benefits MAC

## Conner Strong & Buckelew

Employee benefits can be complex making it difficult to fully understand your coverage options or how to use benefits properly. Benefits MAC allows you to speak to a specially trained Client Service Associate who can answer your questions and help you get the most out of your benefits.

### You Can Contact Benefits MAC for Assistance if You:

- Believe your claim was not paid properly
- Need clarification on information from the insurance company
- Have a question regarding a bill from a doctor, lab or hospital
- Are unclear on how your benefits work
- Need information about adding or deleting a dependent
- Need help to resolve a problem you've been working on

The Benefits MAC Team is available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

### How To Contact the Benefits MAC Team

**You may contact the Benefits MAC Team in any of the following ways:**

- Phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Web: **[www.connerstrong.com/memberadvocacy](http://www.connerstrong.com/memberadvocacy)** and complete the fields
- Email: **[cssteam@connerstrong.com](mailto:cssteam@connerstrong.com)**
- Fax: **856.685.2253**



# Medical & Prescription Drug Benefits

## Meritain



### Need Help Finding an In-Network Provider?

Register at [www.meritain.com](http://www.meritain.com) and click Register at the top right of the page. Once you register you'll be able to:

- Find a provider
- View claims history
- View your Explanation of Benefits
- View healthcare cost information

### Point of Service (POS)

|                                             | In-Network <u>ONLY</u>              |
|---------------------------------------------|-------------------------------------|
| Deductible                                  | \$1,250 Individual / \$2,500 Family |
| Coinsurance                                 | Plan pays 80%                       |
| Out-of-Pocket Maximum                       | \$3,500 Individual / \$7,000 Family |
| Preventive Care Services                    | Plan pays 100% - no deductible      |
| PCP Office Visit                            | \$20 copay                          |
| Specialist Office Visit                     | \$40 copay                          |
| Diagnostic Laboratory (Independent Lab)     | Plan pays 100%                      |
| Diagnostic Laboratory (Outpatient Facility) | Plan pays 80% after deductible      |
| Advanced Imaging (MRI, MRA, CT/PET Scans)   | Plan pays 80% after deductible      |
| Emergency Room                              | \$250 copay (waived if admitted)    |
| Urgent Care Center                          | \$50 copay                          |
| Inpatient Hospital                          | Plan pays 80% after deductible      |
| Outpatient Surgery                          | Plan pays 80% after deductible      |

### Prescription Drug Plan

| Retail (Up to a 30-day supply)     |             |
|------------------------------------|-------------|
| Generic                            | \$10 copay  |
| Preferred Brand                    | \$50 copay  |
| Non-Preferred Brand                | \$75 copay  |
| Mail Order (Up to a 90-day supply) |             |
| Generic                            | \$25 copay  |
| Preferred Brand                    | \$125 copay |
| Non-Preferred Brand                | \$188 copay |

# Wellness Program

For 2026, Taylor Wiseman & Taylor will continue the wellness program to help encourage employees to engage in healthy habits and maintain their overall health status.

## Do I Have to Participate?

Participation in the wellness program is optional, but we highly encourage everyone to participate. Those who do participate in the program will be eligible for an incentive. Employees who are also covering a spouse are eligible for an additional incentive if the spouse participates as well.

## What Are the Requirements?

During the upcoming year, the wellness program requirements include:

- Completion of an annual physical with your primary care doctor; and
- Conducting a biometric screening as part of that visit

An explanation of benefits must be provided as proof that you completed the activities. Meritain will mail you an explanation of benefits, or you can log on to [www.meritain.com](http://www.meritain.com) and obtain a copy.

Both of these services are 100% covered by the health plan. Employees are required to complete both of these tasks to be eligible for the incentive. Covered spouses are also required to complete both tasks to be eligible for the additional incentive.

## What are the Incentives?

For those who participate and complete the tasks, Taylor Wiseman & Taylor will reward you with a \$50 VISA gift card. If you and your covered spouse complete both activities, we will reward you with a \$100 VISA gift card.

## When Do I Have to Complete the Requirements?

You must provide proof to HR that both activities have been completed and have until **September 30, 2026**.



# Cancer Management Program

## CancerCARE

This program is available to those enrolled in the medical/prescription drug plan. The CancerCARE program is a free, fully integrated cancer solution that supports you from the first day of your diagnosis well into the stages of aftercare. CancerCARE coordinates care and benefits for patients with new or existing cancer diagnoses. The CancerCARE expert medical team advocates for the best possible care in your community or at a leading national Center of Excellence location.

### Participating in the CancerCARE Program Includes:

- Access to a team of cancer experts who help guide you through your care
- Confirmation that you are receiving the most effective treatment for your diagnosis
- Identification of commonly misstated and/or misdiagnosed cancers
- Access to national Centers of Excellence for complex surgeries, care, and second opinions
- Assistance in finding financial and community support

### How to Use the Program

If you or an enrolled family member receive a cancer diagnosis, call the CancerCARE triage team at 877.640.9610. By enrolling at the time of diagnosis, the CancerCARE team can make the most positive impact on outcomes and success in recovery, as there will be no missed opportunity for assistance in the early steps and planning phase of cancer treatment. When you connect with CancerCARE, you are taking a pivotal step on the road to wellness.

### How to Register

You can easily register at the time of diagnosis in any of the following ways:

- Phone: **877.640.9610**
- Web: **[www.cancercareprogram.com](http://www.cancercareprogram.com)**
- Email: **[cancermanagement@cancercareprogram.com](mailto:cancermanagement@cancercareprogram.com)**



# Vision Plan

## VSP

Eligible employees have the option of electing the VSP Vision Plan below. Please note, vision coverage is voluntary and is not included with medical coverage.

### Vision Plan

|                                                  | In-Network                       | Out-of-Network         |
|--------------------------------------------------|----------------------------------|------------------------|
| <b>Exam</b>                                      | \$20 copay                       | Reimbursed up to \$45  |
| <b>Frames</b>                                    | Covered up to \$130              | Reimbursed up to \$70  |
| <b>Lenses</b>                                    |                                  |                        |
| Single Vision Lenses                             | Covered 100%<br>after \$20 copay | Reimbursed up to \$30  |
| Bifocal Lenses                                   |                                  | Reimbursed up to \$50  |
| Trifocal Lenses                                  |                                  | Reimbursed up to \$65  |
| Lenticular Lenses                                |                                  | Reimbursed up to \$100 |
| <b>Contact Lenses</b><br>(in lieu of eyeglasses) | Covered up to \$130              | Reimbursed up to \$105 |
| <b>Frequency</b>                                 |                                  |                        |
| Vision Exam                                      | Once every 12 months             |                        |
| Lenses                                           | Once every 12 months             |                        |
| Frames                                           | Once every 24 months             |                        |

### VSP Online Resources

Be sure to register online at [www.vsp.com](http://www.vsp.com) to find a provider, check your claim status, print your member ID card, and review your benefit details.





# Dental Plan

## MetLife

Eligible employees have the option of enrolling in the Dental plan, administered by MetLife.

### MetLife PPO

|                                                                                                                  | In-Network                      | Out-of-Network                  |
|------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------|
| Calendar Year Deductible                                                                                         | \$50 Individual<br>\$150 Family | \$50 Individual<br>\$150 Family |
| Calendar Year Maximum (per patient)                                                                              | \$1,750                         |                                 |
| <b>Preventive &amp; Diagnostic Services</b><br>Bitewing X-rays, Full mouth X-Rays,<br>Cleaning, Oral exam        | 100%                            | 100%                            |
| <b>Basic Services</b><br>Fillings (one surface), General Anesthesia,<br>Simple Extractions, Sealants (per tooth) | 80%                             | 80%                             |
| <b>Major Services</b><br>Scaling & Root Planing (per quadrant),<br>Dentures, Single Crowns                       | 50%                             | 50%                             |
| <b>Orthodontia Benefits</b>                                                                                      | 50%                             | 50%                             |
| Orthodontia Lifetime Maximum (per patient)                                                                       | \$1,500                         |                                 |

To find a dental provider, please visit [www.metlife.com/dental](http://www.metlife.com/dental) and click “**Find a Participating Dentist.**” You can locate a dentist in your area by entering your zip code and selecting your network.

# Flexible Spending Accounts

## Flores

Taylor Wiseman & Taylor provides you with the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through the Flexible Spending Accounts (FSA). **The FSA plan year runs from January 1, 2026 to December 31, 2026.**

### Healthcare FSA

The Healthcare FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. The maximum you can contribute to the Healthcare FSA in 2026 is \$3,400.

#### *Eligible expenses include:*

- Doctor office copays
- Non-cosmetic dental procedures (crowns, dentures, orthodontics)
- Prescription contact lenses, glasses and sunglasses
- LASIK eye surgery

### Dependent Care FSA

The Dependent Care FSA is used to reimburse expenses related to the care of eligible dependents. The maximum that you can contribute to the Dependent Care FSA is \$7,500 if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is \$3,750.

#### *Eligible expenses include:*

- Au Pair
- After school programs
- Baby-sitting/dependent care to allow you to work or actively seek employment
- Day camps and preschool
- Adult/eldercare for adult dependents

### How Much Should I Contribute?

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period.

You are permitted to have a maximum of \$680 of unused Healthcare FSA funds carried over into the next plan year if not used in the current year. The run out period will be 90 days. Any amount in excess of \$680 remaining in your Healthcare FSA is forfeited.

If you do not use the money you contributed toward a Dependent Care FSA, it will not be refunded to you or carried forward to a future plan year. This is the use-it-or-lose-it rule.



# Commuter & Parking Benefit

You can reduce the cost of commuting to and from work by paying for commuter vehicle expenses, transit passes, and qualified parking expenses on a pre-tax basis.

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*Two separate “spending accounts” are available:*

- Commuter’s Spending Account:
- Parking Spending Account

Employees may establish these accounts to reimburse predictable expenses incurred for qualified out-of-pocket commuter, transit and parking expenses. Once they have determined their annual predictable expenses for the plan year, a portion of that amount may be paid for with pre-tax pay, withheld on a pre-tax basis from each paycheck, deposited to the spending account which has been elected.

## How Do Commuter Spending Accounts Work?

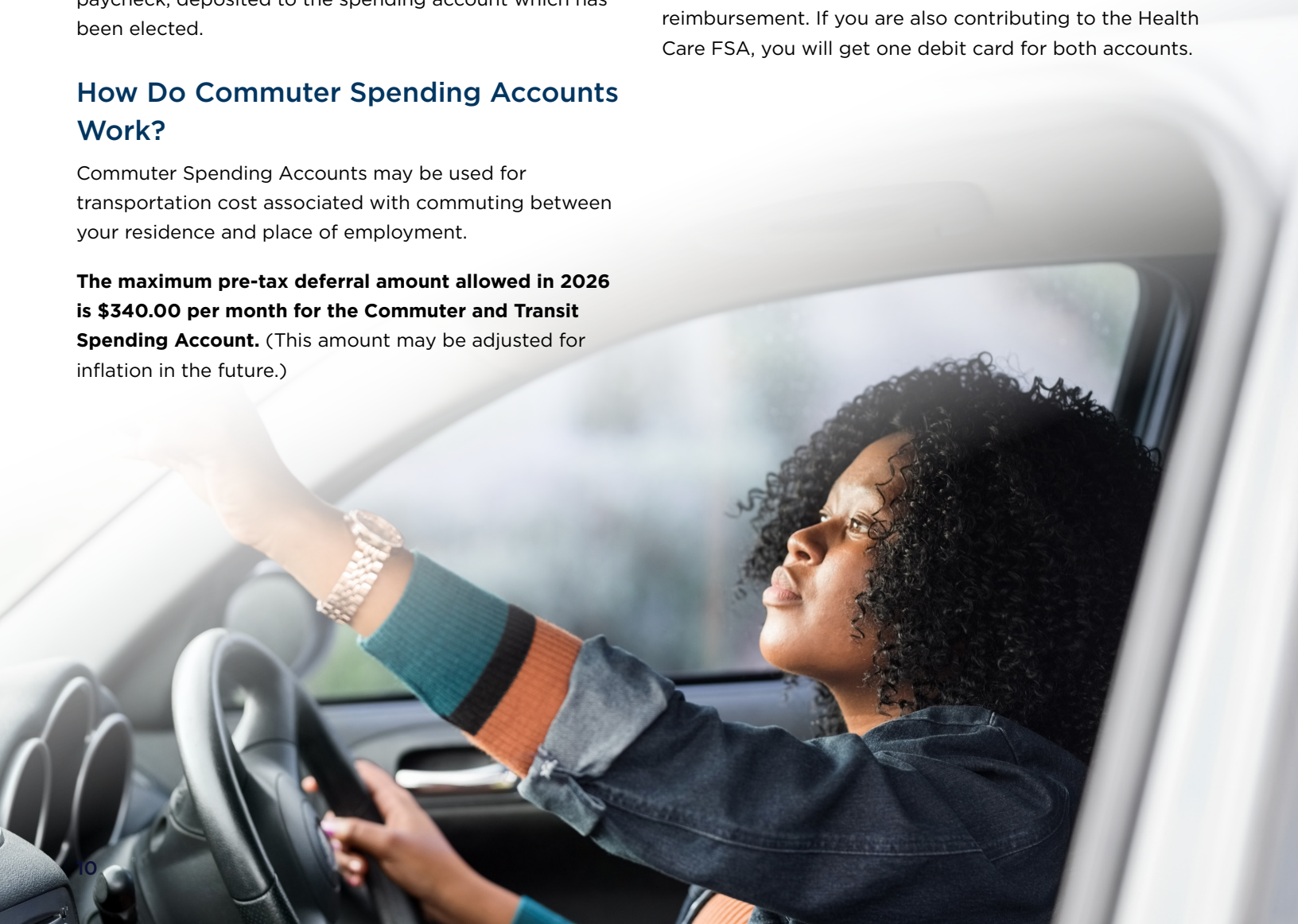
Commuter Spending Accounts may be used for transportation cost associated with commuting between your residence and place of employment.

**The maximum pre-tax deferral amount allowed in 2026 is \$340.00 per month for the Commuter and Transit Spending Account.** (This amount may be adjusted for inflation in the future.)

## How Do Parking Spending Accounts Work?

Expenses that may be included are parking expenses which means parking lots on or near your place of employment or on or near a location from which they commute to work by mass transit, commuter highway vehicle, or by carpool. Parking near your personal residence is not eligible for reimbursement. **The maximum pre-tax deferral amount allowed in 2026 is \$340.00 per month for the Parking Spending Account.** (This amount may be adjusted for inflation in the future.)

Employees can use the debit cards provided or complete a claim form and submit it along with their paid bills to Flores. Once the claim is received, it will be processed for reimbursement. If you are also contributing to the Health Care FSA, you will get one debit card for both accounts.



# Life & Disability

## Prudential

We will continue our partnership with Prudential for our life and disability plans. If you or your spouse elect over the guaranteed issues amount, you or your spouse will be required to go through the medical underwriting process.

### Life Insurance

All active, full-time employees regularly working at least 30 hours each week are automatically enrolled in the Basic Life and Accidental Death and Dismemberment (AD&D) plan. Taylor Wiseman & Taylor pays 100% of the Basic Life and AD&D premium.

Benefit Amount: 200% of annual salary up to a maximum of \$100,000

- **Age Reduction:**
  - 65% at age 65
  - 40% at age 70
  - 20% at age 75

### Supplemental Life Insurance

You also have the option of purchasing additional life insurance, as outlined below:

- **Employee:** \$10,000 increments up to a maximum amount of \$500,000
- **Spouse\*:** \$5,000 increments up to a maximum amount of \$250,000
- **Child\*:**
  - Age 14 days to 6 months: \$250
  - Age 6 months through age 19: \$5,000 (up to age 26 if a full time student)

#### *The Guaranteed Issue Amounts:*

- Employee: \$100,000
- Spouse: \$25,000
- Child: All Amounts

\* You must purchase Supplemental Life Insurance for yourself to be eligible to purchase Supplemental Life Insurance for your spouse and/or child(ren). Spouse amount may be limited to 50% of the employee amount dependent on the state regulations and will deduct in the same manner as the employee amount, upon the spouse's attainment of the reducing ages.

### Short-Term Disability (STD)

All active, full-time employees regularly working at least 30 hours each week are eligible to receive STD coverage. Taylor Wiseman & Taylor pays 100% of the premium.

- **Benefit Amount:** 66.67% to \$1,500
- **Elimination Period:** 7 days accident or sickness
- **Maximum Duration:** 25 weeks

### Long-Term Disability (LTD)

All active, full-time employees regularly working at least 30 hours each week are eligible to receive LTD coverage after one year following their date of hire. Taylor Wiseman & Taylor pays 100% of the premium.

- **Benefit Waiting Period:** 180 days
- **Monthly Benefit:** Equal to 60% of covered monthly earnings up to a maximum of \$9,000
- **Maximum Duration:** Age 65 or Social Security Retirement Age

**Please Note:** If you did not enroll in Supplemental Life Insurance when it was first offered to you, then you will be considered a late enrollee, and be required to submit evidence of insurability, for any amount.





# Voluntary Benefits

## Prudential

Your income is an important part of your life, so you'll want to make sure it's protected in case you're ever unable to work due to an accident or hospitalization. With the following voluntary benefit options, you can prepare for the unexpected and have a plan in place to help cover your expenses if needed.

### Accident Insurance

The Accident Insurance plan helps with out-of-pocket expenses that are incurred as a result of an accident.

#### *Benefit Highlights:*

- Paid in addition to medical and disability benefits.
- Benefits paid, based on a schedule, for injuries such as burns, fractures and lacerations.
- You could also receive dollars for events and treatments such as ambulance, emergency room, intensive care, physical therapy, crutches, blood, travel and more.

### Hospital Indemnity Insurance

Hospital Indemnity payments directly to members when they have a covered inpatient hospital stay.

It's no secret that a hospital stay can be extremely expensive. The Hospital Indemnity insurance plan, administered by Prudential, can help offset the costs incurred from a hospital stay. Hospital indemnity coverage protects you from the financial strain of a hospital stay. Payouts are most often used to cover things like health insurance deductibles, copays, household bills and out-of-pocket costs.

The plans covers inpatient hospital, intensive care unit (ICU) and chronic condition admissions and stays spouses/domestic partners and dependent children.

# Additional Resources

## SmartConnect

SmartConnect powered by SmartMatch is an exclusive free program designed to help Medicare eligible employees, and your family members explore health insurance options with confidence. SmartConnect simplifies the process of comparing Medicare and your employer health insurance plans, empowering you to make informed decisions without the frustration of navigating complex options alone.

Through SmartConnect You Will Gain Access To:

- Education on Medicare coverage, including Parts A, B, C, D, and Medicare Supplement plans
- Access to licensed agents to help guide you through your decision-making process
- Ability to explore plan options from national insurance carriers
- Customized strategies based on your health needs
- Access ongoing assistance for policy reviews and carrier related questions

To begin exploring Medicare options, visit [www.smartmatch.com/connect/taylorwiseman](http://www.smartmatch.com/connect/taylorwiseman) or call **855-248-1648**.

## Keep It Simple Surgery (KISx Card)

Taylor Wiseman and Taylor will continue to offer the KISx Card provided by Valenz Health. The KISx Card benefit provides employees and their dependents enrolled in the medical plan access to the nation's largest surgical and direct contacting network – AT NO COST TO YOU.

With the KISx Card employees and their families will pay **\$0 out of pocket** when choosing a KISx Card provider for common procedures such as orthopedic surgery, general surgery, MRIs, CT/PET scans and more! There are over 400 eligible procedures and facilities available in all 50 states.

For more information, visit [www.getkisx.com](http://www.getkisx.com) or call **877-438-5479**.

## HUSK Marketplace

HUSK members can access exclusive savings and flexible membership options to a variety of gyms and fitness center facilities. HUSK members also have access to

- Virtual nutrition counseling with a Registered Dietitian
- Virtual mental health assistance from a licensed therapist
- Discounts on home equipment and wearable technology

## Get Started Today!

To learn more, visit [marketplace.huskwellness.com](http://marketplace.huskwellness.com), call **800.294.1500**, or email [customerservices@huskwellness.com](mailto:customerservices@huskwellness.com). When registering for an account use code **P15178** for the eligibility ID.



# Weekly Employee Contributions

| Tier                     | Meritain POS Plan |
|--------------------------|-------------------|
| <b>SINGLE</b>            | \$35.00           |
| <b>2 ADULTS</b>          | \$87.80           |
| <b>PARENT/CHILD(REN)</b> | \$68.90           |
| <b>FAMILY</b>            | \$120.50          |

| Tier                     | VSP Vision Plan |
|--------------------------|-----------------|
| <b>SINGLE</b>            | \$1.39          |
| <b>2 ADULTS</b>          | \$2.23          |
| <b>PARENT/CHILD(REN)</b> | \$2.28          |
| <b>FAMILY</b>            | \$3.67          |

| Tier                     | MetLife Dental Plan |
|--------------------------|---------------------|
| <b>SINGLE</b>            | \$6.77              |
| <b>2 ADULTS</b>          | \$13.51             |
| <b>PARENT/CHILD(REN)</b> | \$18.56             |
| <b>FAMILY</b>            | \$25.31             |



# Carrier Contacts



| Benefits             | Carrier                  | Phone Number       | Website                                                                                           |
|----------------------|--------------------------|--------------------|---------------------------------------------------------------------------------------------------|
| Medical/Prescription | Meritain                 | 800-925-2272       | <a href="http://www.meritain.com">www.meritain.com</a>                                            |
| Dental               | MetLife                  | 1-800-275-4638     | <a href="http://www.metlife.com/dental">www.metlife.com/dental</a>                                |
| Vision               | VSP                      | 800-877-7195       | <a href="http://www.vsp.com">www.vsp.com</a>                                                      |
| Life                 | Prudential               | Life: 800-542-0542 | <a href="http://www.prudential.com">www.prudential.com</a>                                        |
| Disability           | Prudential               | 800-842-1718       | <a href="http://www.prudential.com">www.prudential.com</a>                                        |
| Voluntary Accident   | Prudential               | 844-455-1002       | <a href="http://www.prudential.com">www.prudential.com</a>                                        |
| Hospital Indemnity   | Prudential               | 844-455-1002       | <a href="http://www.prudential.com">www.prudential.com</a>                                        |
| Benefits MAC         | Conner Strong & Buckelew | 800-563-9929       | <a href="http://www.connerstrong.com/memberadvocacy">www.connerstrong.com/<br/>memberadvocacy</a> |

# Legal Notices

## Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program).

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

**Loss of eligibility for Medicaid or a State Children's Health Insurance Program.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

**New dependent by marriage, birth, adoption, or placement for adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

**Eligibility for Medicaid or a State Children's Health Insurance Program.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, please speak with Human Resources

## Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, [or midwife], or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

## Women's Health and Cancer Rights Act

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid  
Website: <http://myalhipp.com/>  
Phone: 1-855-692-5447

ALASKA – Medicaid  
The AK Health Insurance Premium Payment Program  
Website: <http://myakhipp.com/>  
Phone: 1-866-251-4861  
Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid  
Website: <http://myarhipp.com/>  
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid  
Health Insurance Premium Payment (HIPP) Program Website:  
<http://dhcs.ca.gov/hipp>  
Phone: 916-445-8322  
Fax: 916-440-5676  
Email: [hipp@dhcs.ca.gov](mailto:hipp@dhcs.ca.gov)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)  
Health First Colorado Website: <https://www.healthfirstcolorado.com/>  
Health First Colorado Member Contact Center:  
1-800-221-3943/State Relay 711  
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>  
CHP+ Customer Service: 1-800-359-1991/State Relay 711  
Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>  
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid  
Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>  
Phone: 1-877-357-3268

GEORGIA – Medicaid  
GA HIPP Website: <https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp>  
Phone: 678-564-1162, Press 1  
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>  
Phone: 678-564-1162, Press 2

# Legal Notices

## INDIANA – Medicaid

Health Insurance Premium Payment Program

All other Medicaid

Website: <https://www.in.gov/medicaid/>  
<http://www.in.gov/fssa/dfr/>

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

## IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

Iowa Medicaid | Health & Human Services

Medicaid Phone: 1-800-338-8366

Hawki Website:

Hawki - Healthy and Well Kids in Iowa | Health & Human Services

Hawki Phone: 1-800-257-8563

HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services ([iowa.gov](http://iowa.gov))

HIPP Phone: 1-888-346-9562

## KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

## KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program

(KI-HIPP) Website:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: [KIHIPPPROGRAM@ky.gov](mailto:KIHIPPPROGRAM@ky.gov)

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

## LOUISIANA – Medicaid

Website: [www.medicaid.la.gov](http://www.medicaid.la.gov) or [www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)

Phone: 1-888-342-6207 (Medicaid hotline) or

1-855-618-5488 (LaHIPP)

## MAINE – Medicaid

Enrollment Website: [https://www.mymaineconnection.gov/benefits/s/?language=en\\_US](https://www.mymaineconnection.gov/benefits/s/?language=en_US)

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine relay 711

## MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: [masspremassistance@accenture.com](mailto:masspremassistance@accenture.com)

## MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

## MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

## MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: [HSHIPPProgram@mt.gov](mailto:HSHIPPProgram@mt.gov)

## NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

## NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

## NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: [DHHS.ThirdPartyLiabi@dhhs.nh.gov](mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov)

## NEW JERSEY – Medicaid and CHIP

Medicaid Website:

<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

## NEW YORK – Medicaid

Website: [https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)

Phone: 1-800-541-2831

## NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

## NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

## OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

## OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

## PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>

Phone: 1-800-692-7462

CHIP Website: Children's Health Insurance Program (CHIP) ([pa.gov](http://pa.gov))

CHIP Phone: 1-800-986-KIDS (5437)

## RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or

401-462-0311 (Direct Rite Share Line)

## SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

## SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

## TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

## UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website:

<https://medicaid.utah.gov/upp/>

Email: [upp@utah.gov](mailto:upp@utah.gov)

Phone: 1-888-222-2542

Adult Expansion Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

## VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-250-8427

## VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

## WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

## West Virginia – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/>

<http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

## WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

## WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin>

[medicaid/programs-and-eligibility/](https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/)

Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration

[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services

[www.cms.hhs.gov](http://www.cms.hhs.gov)

1-877-267-2323, Menu Option 4, Ext. 61565

# Legal Notices

## ELIGIBILITY

An eligible employee with respect to the programs described in this Guide is any individual who is designated as eligible to participate in and receive benefits under one or more of the component benefit programs described herein. The eligibility and participation requirements may vary depending on the particular component program. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program. Certain individuals related to you, such as a spouse or your dependents, may be eligible for coverage under certain component benefit programs. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Plan Document for the applicable component benefit programs.

## AVAILABILITY OF SUMMARY HEALTH INFORMATION

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: [www.twtbenefits.com](http://www.twtbenefits.com). A paper copy is also available, free of charge, by contacting Human Resources.

## PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

## Notice to Enrollees in a Self-Funded Nonfederal Governmental Group Health Plan For Plan Years Beginning On or After September 23, 2010

[This notice is appropriate in the case of a collectively bargained plan ratified on or after March 23, 2010.]

Group health plans sponsored by State and local governmental

employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Taylor Wiseman & Taylor has elected to exempt the medical plans from all of the following requirements:

- Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
- Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
- Certain requirements to provide benefits for breast reconstruction after a mastectomy.
- Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the 2025 plan year beginning January 1, 2025 and ending December 31, 2025. The election may be renewed for subsequent plan years.

[If the Plan provides protections similar to any of the exempted requirements, either voluntarily or in accordance with State law, those protections may be identified.]

This Guide is intended to provide you with the information you need to choose your 2025 benefits, including details about your benefits options and the actions you need to take during this [year's Annual] Enrollment period. It also outlines additional sources of information to help you make your enrollment choices. If you have questions about your 2025 benefits or the enrollment process, call Human Resources. The information presented in this Guide is not intended to be construed to create a contract between Taylor Wiseman & Taylor and any one of Taylor Wiseman & Taylor's employees or former employees. In the event that the content of this Guide or any oral representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document are controlling. Taylor Wiseman & Taylor reserves the right to amend, modify, suspend, replace or terminate any of its plans, policies or programs, in whole or in part, including any level or form of coverage by appropriate company action, without your consent or concurrence.

## Important Notice from Taylor Wiseman & Taylor About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Taylor Wiseman & Taylor and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and

Medicare's prescription drug coverage:

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

## When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Taylor Wiseman & Taylor coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Taylor Wiseman & Taylor coverage, be aware that you and your dependents may not be able to get this coverage back.

## When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Taylor Wiseman & Taylor and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Taylor Wiseman & Taylor changes. You also may request a copy of this notice at any time.

# Legal Notices

## For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

## For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

**Contact:** Human Resources

**Address:** 804 East Gate Drive, Suite 100, Mount Laurel, NJ 08054

## Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the “Notice”) describes the legal obligations of Taylor Wiseman & Taylor’s group health plan (the “Plan”) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan that relates to:

- Your past, present or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact your Human Resources representative.

## Effective Date

This Notice is effective July 1, 2025

## Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail to your address on file

## How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment.** We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

**For Payment.** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**For Health Care Operations.** We may use and disclose your protected health information for other Plan operations. These

uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stoploss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. If the Plan uses or discloses protected health information for underwriting purposes, including determining eligibility for benefits or premium, the Plan will not use or disclose protected health information that is genetic information for such purposes, as prohibited by the Genetic Information Nondiscrimination Act of 2008 (GINA) and any regulations thereunder.

**To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

**As Required by Law.** We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

**To Plan Sponsors.** For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

**Special Situations.** In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**Organ and Tissue Donation.** If you are an organ donor, we may release your protected health information to organizations that

# Legal Notices

handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority. **Workers' Compensation.** We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths; to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

**Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

**Coroners, Medical Examiners and Funeral Directors.** We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**Research.** We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

**Required Disclosures.** The following is a description of disclosures of your protected health information we are required to make.

**Government Audits.** We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

**Disclosures to You.** When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

**Other Disclosures of Your Medical Information Require Your Authorization Written**

**Authorization:** Your medical information will not be used or disclosed for any purpose not mentioned above in the "How We May Use and Disclose Your Protected Health Information" section except as permitted by law or as authorized by you. This includes disclosures to personal representatives and spouses and other family members as described below. In the event that the Plan needs to use or disclose medical information about you for a reason other than what is listed in this notice or required by law, we will request your permission to use your medical information and the medical information will only be used as specified in your authorization. You may complete an Authorization form if you want the Plan to disclose medical information about you to someone else.

Any authorization you provide will be limited to the specific information identified by you and you will be required to specify the intended use or disclosure and name then person or organization that is permitted to use or receive the information specified in the authorization form. You have the right to revoke a previous authorization. Requests to revoke an authorization must be in writing. The Plan will honor your request of revocation for the prospective period of time after the Plan has received your request. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

In addition, the Plan will not sell your medical information or use it for marketing purposes (that are not considered as part of treatment or healthcare operations) without a signed authorization from you. Also, if applicably, the Plan will not disclose psychotherapy notes without a signed authorization from you.

**Personal Representatives.** We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

**Spouses and Other Family Members.** With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

**Your Rights You have the following rights with respect to your protected health information:**

**Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information maintained in any form (paper or electronic) that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to Human Resources. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Human Resources.

# Legal Notices

**Right to Amend.** If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to Human Resources. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

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

To request this list or accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to Human Resources. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

**Right to be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information. You will receive a notification to your last known address within 60 days of the discovery. The notification will include:

- specific information about the breach including a brief description of what happened
- a description of the types of unsecured medical information involved in the breach
- any steps you should take to protect yourself from potential harm resulting from the breach
- a brief description of the investigation the Plan is performing to mitigate the harm to you and protect you from future breaches
- a contact information where you may direct additional questions or get more information about the breach.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Human Resources.

**Complaints** If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

## General Notice of COBRA Continuation Coverage Rights Introduction

You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

## What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

# Legal Notices

## When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

## How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

## Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only

available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## Are there other coverage options besides COBRA Continuation Coverage?

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

## Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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

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

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

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

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

## If you have questions

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

## Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You

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

## Plan contact information

Human Resources  
804 East Gate Drive, Suite 100, Mount Laurel, NJ 08054

# Marketplace Notice

**PART A: General Information**

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

**Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%<sup>11</sup> of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.<sup>2</sup>

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31,

2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

**What about Alternatives to Marketplace Health Insurance Coverage?**

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

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

**How Can I Get More Information?**

For more information about your coverage offered through your employment, please check your health plan’s summary plan description or contact

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

**PART B: Information About Health Coverage Offered by Your Employer**

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

|                                                                                   |                                                       |                                                |
|-----------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------|
| 3. Employee Name<br>Taylor Wiseman & Taylor                                       | 4. Employer Identification Number (EIN)<br>22-1892933 |                                                |
| 5. Employer Address<br>804 East Gate Drive, Suite 100                             | 6. Employer phone number<br>856-235-7200              |                                                |
| 7. City<br>Mount Laurel                                                           | 8. State<br>NJ                                        | 9. Zip Code<br>08054                           |
| 10. Who can we contact about employee health coverage at this job?<br>Joe Scimone | 11. Phone number<br>856-437-8081                      | 12. Email address<br>scimone@taylorwiseman.com |



Taylor Wiseman & Taylor reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about your Guide, contact Human Resources.