M&M INDUSTRIES

Employee Benefits Guide

January 1, 2024 - December 31, 2024

What's Inside

Summary Plan Description

Please note this guide is designed to provide an overview of the coverages available. Your employer reserves the right to amend or change benefit offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations. If any discrepancy exists between this guide and the official documents, the official documents will prevail. If you would like a printed copy of the materials, please contact your employer, or you can access SPD's, plan documents, and other pertinent benefit information at www.benefitfirst.com via the Resource Center (refer to enrollment instructions on page 12).

Please contact Human Resources if you have any questions regarding your benefits plan.

Enrollment Changes

Changes to your enrollment may be made annually during open enrollment each year. Changes outside of the open enrollment period may be made for qualifying events such as marriage/divorce, birth/adoption, death, change in job status of yourself or your spouse, and or change in Medicaid/CHIP eligibility.

All changes must be made within 30 days (with the exception of Medicaid/CHIP which gives you up to 60 days) of your qualifying event. You must notify Human Resources immediately when you experience a qualifying event.

Section 125 Plan Premium Conversion

Section 125 Premium Conversion Plan lets you exclude your Medical, Dental and Vision premiums from your taxable income, meaning your premiums will come out of your income pre-tax. This lowers your taxable income. By default, your premiums will be deducted pre-tax, increasing your take-home pay anywhere from a couple hundred dollars to a thousand or more annually.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Annual Notices section for more details.

Benefit Contacts

Benefit	Carrier	Group Number	Phone Number	Website/Email
Medical Benefits	BlueCross BlueShield of TN	124553	1-800-565-9140	www.bcbst.com
Pharmacy Benefit Manager	VeracityRx / ProCare	MMINDUST	888-388-8228	www.veracity.procarerx.com
Flexible Spending Account (FSA)	HRPro	MMI	1-800-989-8776	www.hrpro.com
Health Savings Account (HSA)	Health Equity	00424	1-866-855-4067	www.healthequity.com
Dental Benefits	BlueCross BlueShield of TN	124553	1-800-565-9140	www.bcbst.com
Vision Benefits	BlueCross BlueShield of TN	124553	1-800-565-9140	www.bcbst.com
Basic and Voluntary Life and AD&D	Mutual of Omaha	G000BJCQ	1-800-228-7104	www.mutualofomaha.com
Disability Products	Mutual of Omaha	G000BJCQ	1-800-228-7104	www.mutualofomaha.com
Worksite Products	Aflac (Sharon Sessoms - local representative)	AGC0000931028	1-800-433-3036 423-645-2071	www.aflac.com OR sharon_sessoms@us.aflac.com
Employee Assistance Program	Mutual of Omaha	G000BJCQ	1-800-316-2796	www.mutualofomaha.com/eap
M&M Human Resources	Stephanie Buscemi	N/A	423-821-3302	sbuscemi@mmcontainer.com

Medical Benefits

M&M Industries' medical benefits are provided through **BlueCross BlueShield of Tennessee** ("BCBST").

M&M Industries offers plan options in the BCBST S and P Networks for employees located in TN. Employees outside of the state of TN will be enrolled in Network P. In these networks, you have the flexibility to go to any provider that you choose*; however, anytime you select an in-network physician or facility, you will see significant discounts and savings.

If you select an out-of-network physician or facility, you will be subject to higher deductibles and out-of-pocket maximums. You are also responsible for the difference between billed charges and the maximum allowable charge. It definitely works to your advantage to go in network whenever possible.

To find an in-network provider near you, go to www.bcbst.com and click on "Find Care." Please be sure to consult either the online directory or the BCBST customer service department to confirm that your provider participates in the network.

Options 1, 3 & 5 - Network S - For TN Employees Only
Options 2, 4 & 6 - Network P - For All Employees

Medical Benefits**	Options 1 and 2 PPO/Flex In-Network	Options 3 and 4 HDHP/HSA Plan In-Network	Options 5 and 6 PPO/Copay Plan In-Network
Deductible: Individual / Family	$2,600 / $5,200	$3,200 / $6,400	$2,000 / $4,000
Out-of-Pocket Maximum: Individual / Family	$2,600 / $5,200	$3,200 / $6,400	$4,000 / $8,000
Preventive Care			
Preventive Care Visits	100%*		
Office Visits			
Primary Care Provider	0% After Deductible	0% After Deductible	$30 Copay
Specialist	0% After Deductible	0% After Deductible	$50 Copay
Physical, Occupational, Speech, Audiology and Cognitive Therapy	0% After Deductible	0% After Deductible	20% After Deductible
Outpatient and Group Therapy	0% After Deductible	0% After Deductible	20% After Deductible
Urgent & Emergency Care			
Urgent Care	0% After Deductible	0% After Deductible	20% After Deductible
Emergency Care (Includes urgent care centers at a hospital. Copay waived for inpatient hospital admissions)	0% After Deductible	0% After Deductible	20% After Deductible
Most Other Services	0% After Deductible	0% After Deductible	20% After Deductible

*Network S: East Ridge Hospital and Parkridge Hospital are excluded from the network.
**Review plan documents for out-of-network benefits, prior authorization requirements, limits on the number of visits per year and service restrictions.

Pharmacy Benefits

All pharmacy goes through **VeracityRx**. VeracityRx handles all claims and customer service functions including specialty and international pharmacy fulfillment.

Pharmacy	Options 1 and 2	Options 3 and 4	Options 5 and 6
	$200 Brand Only Deductible	Preventive Drugs	$200 Brand Only Deductible
Generic	$15 Copay	$5 Copay	$15 Copay
Preferred	$40 Copay	$25 Copay	$40 Copay
Non-Preferred	$60 Copay	$50 Copay	$60 Copay
Other Details		**Non-Preventive Rx** 0% After Deductible	

Registration Information

Visit https://veracity.procarerx.com to register. Use your online account to:

- Access and/or restrict profile viewing by other family members
- Review prescription claims history or individual prescriptions
- Look up a drug to identify formulary status and preferred alternatives
- Locate pharmacies within a zip code, state, city or county

Customer Service

With 24/7 access available, you can contact Customer Service anytime: **1-888-388-8228**.

Pharmacy Benefit Provider

VeracityRx

Phone: 888-388-8228
Portal: https://veracity.procarerx.com

When to call:

- To locate a pharmacy
- To ask a benefit question
- To get information on prior authorizations
- To get help when you are at the pharmacy and a drug is denied

Be sure to use **select pharmacies*** (including Walmart and Sam's Club) for **greater savings**!

**Non-select pharmacies include: CVS, Target, Rite-Aid and Walgreens. These pharmacies generally have much higher prices.*

90-Day Prescriptions

MAINTENANCE DRUGS
At Retail: All Pharmacies

Specialty Medications and International Mail

HIGH-COST DRUGS
Contact VeracityRx Specialty Pharmacy Services at www.veracity-rx.com for assistance.

Specialty & International Drugs

Below is a list of the most common Specialty and International Drugs. If you take one of these drugs or something similar, you must contact **VeracityRx** about enrolling in the Specialty Program. The International Program is optional. A Veracity team member will contact you about the Specialty program to explain the process and discuss your case. You will be required to furnish financial information to see if you qualify for assistance. If approved, you will have little to no copay for your medication. You may also obtain medications from Canada through the International Drug Program. Personal importation medications received through this program are $0 cost to you. If you choose not to participate in the International Drug Program, there is no penalty; however your drug will be more costly.

Commonly Prescribed Specialty Medications	
Drug	Drug
Actemra	Kuvan
Acthar	Lenvima
Adempas	Mekinist
Afinitor	Olumiant
Amjevita	Opsumit
Aubagio	Orgovyx
Cabometyx	Otezla
Cosentyx	Promacta
Dupixent	Rebif
Enbrel	Rydapt
Envarsus XR	Stelara
Epidiolex	Strensiq
Firazyr	Tafinlar
Gilenya	Taltz
Haegarda	Tobi Podhaler
Ilaris	Tremfya
Imbruvica	Tyvaso
Ingrezza	Vumerity
Jynarque	Zelboraf
Kesimpta	Zenpep

Commonly Prescribed Personal Importation Medications		
Drug	Drug	Drug
Anoro Ellipta	Invokamet	Silenor
Apidra	Isentress	Skyrizi
Apidra Solostar	Janumet	Spiriva Respimat
Arnuity Ellipta	Janumet XR	Symbicort
Atripla	Januvia	Tagrisso
Basaglar Kwikpen	Jardiance	Tivicay
Biktarvy	Juluca	Toujeo Solostar
Breo Ellipta	Levemir Flextouch	Tradjenta
Cimzia	Omnaris	Trelegy Ellipta
Combivent Respimat	Orencia	Trintellix
Dulera	Ozempic	Trulicity
Eliquis	Prezcobix	Victoza
Entresto	Pulmozyne	Xarelto
Farxiga	Qvar	Xeljanz
Fiasp	Rexulti	
Flovent HFA	Rinvoq	

Dental Benefits

Your dental benefits at M&M Industries are provided by **BCBST**. This dental plan is a PPO (similar to your medical plan), in that you may visit any provider that you choose, however, you will most likely see increased benefit levels if you go to a provider in network.

To find a provider in the network, visit www.bcbst.com and click on “Find Care.”

Dental Benefits	In-Network
Deductible: (Aggregate) Individual / Family	$50 / $150
Calendar Year Maximum	$1,500
Benefits Paid by the Plan	
Preventive - Includes exams, cleanings (2 per year), sealants, x-rays	100%
Basic - Fillings, periodontic services, minor oral surgery	80%
Major - Root Canals, periodontic surgery, crowns, dentures, bridges, anesthesia	50%
Orthodontia Coinsurance / Lifetime Maximum (Child to age 18)	50% / $1,500

Vision Benefits

Your vision plan is provided by **BCBST**. When using in-network providers, this PPO plan covers most exams, eyeglass and medically necessary contacts in full. Discounts are available for upgrades on covered frames and lenses, as well. BCBST has also partnered with several refractive eye surgery centers to offer discounts to its members. To find an in-network provider or surgery center, call customer service or go to www.bcbst.com and click on “Find Care.”

Should you choose to see an out-of-network provider, BCBST will reimburse you up to a specified amount. Please see the plan document for the out-of-network reimbursement schedule.

Vision Benefits	In-Network	
	Frequency	Details
Vision Exam	Every 12 months	$10 Copay
Prescription Glasses		$25 Copay
Frames	Every 24 months	Up to $120; 20% off balance over $120
Lenses	Every 12 months	
Contact Lenses (instead of glasses)	Every 12 months	Up to $120 copay
Conventional		Up to $120
Disposable		Up to $120
Medically Necessary		$0

Health Savings Account

HealthEquity

If you are enrolled in the High Deductible Health Plan, you are eligible to participate in a Health Savings Account (HSA) through **Health Equity**.

2024 Annual Maximum Contributions to your HSA

Employee:	**$4,150**
Family:	**$8,300**
Catch-Up Contribution for those 55+:	**$1,000**

An HSA is established to pay for future qualified medical, dental and vision expenses that are incurred by you or your IRS-eligible dependents enrolled in the plan, allowing you to set aside money pre-tax.

Your contributions to the HSA will be payroll deducted and the funds deposited into a HSA account when payroll processes. When a qualified expense is incurred, you use your Health Savings Account debit card or request reimbursement for the expense. Unused account dollars are yours to keep, even if you retire or leave the company.

Please note: If you can't claim a child as a dependent on your tax returns, then you may not spend HSA dollars on services provided to that child.

What Does the HSA Cover?

You can use your HSA to pay for thousands of HSA-eligible items, such as:

- Medical services (copays, coinsurance, fees and expenses charged by health care providers)
- Dental treatment (including fillings, extractions, braces and x-rays)
- Eye examinations, glasses, contact lenses, surgery
- Prescription medicines
- Certain over-the-counter medication and supplies

For a complete list of IRS qualified healthcare expenses, scan the QR code on the right with your mobile phone's camera or visit www.irs.gov/publications/p502.

Scan Me!

Flexible Spending Account

M&M Industries offers employees the option to defer money on a pre-tax basis for use on approved medical and dependent care expenses. This is NOT insurance. This is simply a way for you to save on your medical (FSA) or day-care expenses (DCA) by setting money aside from your gross income, pre-tax for expenses that you anticipate for the plan year. You are eligible to participate in FSA the same day you are eligible to participate in the medical plan.

Medical FSA: With the Medical FSA, the total dollar amount set aside for the plan year is eligible for withdrawal from the account on day one of your first payroll deduction towards the account. The maximum medical FSA annual contribution amount is $3,050*. If you are a new hire and enroll in the plan outside of the open enrollment period, your rates will be prorated for the annual amount you select.

Dependent Care Account (DCA): You may elect to set money aside to use for your approved childcare services, provided at a day-care facility, in your home, or in someone else's residence through a DCA. Certain requirements must be satisfied for the services to be approved for reimbursement. The maximum DCA annual contribution amount is $5,000 per family (if you are head of household or married and file a joint tax return) or $2,500 (if you are married and file a separate tax return).

Note: You can only deduct what is in your account for Dependent Care. By setting aside money pre-tax into either a FSA or DCA, you save on taxes and take home more spendable income!

Please contact customer service or Human Resources for a list of eligible medical and dependent care expenses.

**At time of publication, 2024 limits have not yet been released.*

HSA vs. FSA

HSAs and FSAs are two of the most common tax-free benefit plans. You can save money with either, but they have many differences. Here is a brief outline:

	HSA	FSA
Owner	Employee-owned	Employer-owned
Eligibility	Must be enrolled in HDHP	Anyone is eligible, although you can't be enrolled in an HSA and a Medical FSA
Carryover	All funds you can carry over from year to year	Unused funds do not carry over from year to year
Portability	The HSA is portable, so the funds in the account stay with you wherever you go	FSAs are employer-owned accounts, so the funds are forfeited if you leave M&M
Investment Options	You can invest in HSA funds	You can't invest FSA funds
Substantiation	It's not required, but you'll want to keep all documentation in case you're ever the subject of an IRS audit	The IRS required substantiation for some FSA expenses to show the eligibility of the expense
Availability of Funds	Only the funds that have been contributed are available	All funds are available on the first day

Basic and Voluntary Life

Basic Life/AD&D Insurance

At M&M Industries, Basic Life/Accidental Death and Dismemberment (AD&D) Insurance is a provided benefit at no cost to you through **Mutual of Omaha**.

Basic Life/AD&D	
Coverage Amount	1x annual salary up to $200,000
Age Reduction	65

**Benefit will terminate upon retirement.*

Voluntary Life and AD&D Insurance

You have the option to purchase Voluntary Term Life and AD&D through **Mutual of Omaha**. AD&D Insurance pays an additional percentage of the amount of your life insurance benefit. You may purchase:

Voluntary Life/AD&D			
	Employee	**Spouse**	**Child(ren)**
Coverage Amount	Up to $500,000 not to exceed 5x annual salary	$250,000 or 100% of employee election	$10,000
Guaranteed Issue Amount	$150,000	$50,000	N / A
Age Reduction	Beginning at age 70		N / A

By electing at least one increment as a new hire, you can increase by one increment at future open enrollments without health questions!

Disability Products

Voluntary Short-Term Disability Insurance

Short-Term Disability (STD) Insurance can help support you and your family should you become temporarily disabled. This coverage is provided by **Mutual of Omaha** and is paid entirely by you.

Voluntary Long-Term Disability Insurance

Long-Term Disability (LTD) Insurance can protect your income in case of a long-term injury or illness. This coverage is provided through **Mutual of Omaha** and paid entirely by you.

Disability Details	Voluntary Short-Term Disability	Voluntary Long-Term Disability
Income Replacement	60% of weekly earnings	60% of monthly earnings
Maximum Benefit	$1,600/week	$7,000/month
Accident Elimination Period	begins on the 15th day	180 days
Illness Elimination Period	begins on the 15th day	
Benefit Duration	Up to 26 weeks	Social Security Normal Retirement Age

Worksite Products

You have the option to enroll in payroll deduction recovery policies through **Aflac**.

- **Accident Insurance** - Accident insurance is designed to help you meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. You'll receive lump sum benefits for over 50 types of injury or treatments that might result from an accident directly, and it's up to you how you use the funds. The accident plan is guaranteed issue, so no health questions are ever required. *Accident Insurance also features a Wellness Benefit. See details in the Resource Center when enrolling through* Benefit*first*™.
- **Critical Illness Insurance** - Critical Illness insurance is designed to help you offset the financial impact of a catastrophic illness with a lump sum benefit if anyone covered by the policy is diagnosed with a covered critical illness. You can use this benefit more than once - if you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. *Critical Illness Insurance also features a Wellness Benefit. See details in the Resource Center when enrolling through* Benefit*first*™.
- **Hospital Indemnity Insurance** - Helps with the expenses that health insurance doesn't cover so you can worry less about covering your everyday needs. *See details in the Resource Center when enrolling through* Benefit*first*™.

Employees interested in payroll deduction for Accident, Critical Illness and Hospital Indemnity policies will enroll through Benefit*first*™, where more policy information is posted in the Resource Center.

Available on the App Store

GET IT ON Google Play

Download the MyAflac® mobile app

Scan here for a short video that shows how MyAflac makes our claims process easy.

Employee Assistance Program

Mutual of Omaha's employee assistance program services include counseling for marital/family, depression, addiction, stress/anger, life transitions or any issue for short-term counseling for you or an immediate household family member. The employee assistance program can help you get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker M&M Industries counts on to get the job done.

- In-person help with short-term issues; up to 3 sessions per household, per year
- Unlimited telephonic support - Legal service, financial service, work/life service
- Discount on in-person consultations with network lawyers
- Financial consultations and referrals
- Work/life services for assistance with child care, finding movers, kennels and pet care, vacation planning, and more.
- Toll-free phone and web access 24/7
- All contact is completely confidential

Get Unlimited FREE help at:

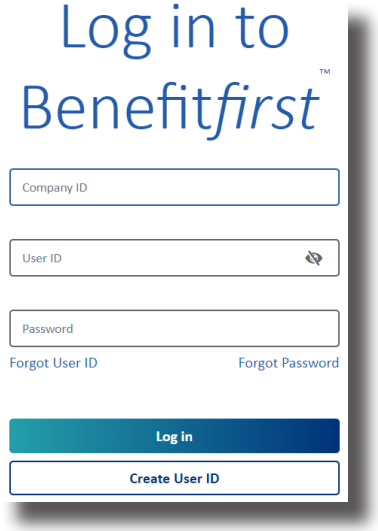
www.mutualofomaha.com/eap

Or Call 1(800) 316 - 2796

How to Enroll

You may enroll from home or work -- with 24-hour access. You may enroll online or at www.benefitfirst.com or by downloading the Benefit*first*™ app from the Apple App Store or Google Play.

Enroll in 5 Easy Steps



1. Login at www.benefitfirst.com or mobile app.
2. After selecting *Create User ID*:
   - Use company ID: **961**
   - Enter your first name and last name as it appears on your paycheck.
   - Enter your date of birth in the following format: mm/dd/yyyy.
   - Enter the last five digits of your Social Security Number.
3. Create a unique User ID.
4. Select *SUBMIT*.
5. Create your Password with the same information above.
6. Once at your homepage, choose *ENROLL NOW!*
   - If you are a new hire, choose *ENROLL IN OR DECLINE BENEFITS AS A NEWLY ELIGIBLE EMPLOYEE*.
   - If you are an existing employee going through annual enrollment or wanting to make a family status change, choose the appropriate transaction and click *CONTINUE*.
   - Check your personal information for accuracy and click *NEXT.*
   - Add any eligible dependents to the dependent screen and click *NEXT.*
7. Starting with the medical screen, complete your selections. Choose the level of coverage, the plan desired and the dependents to be added.
8. When you get to the last enrollment screen, you will be asked to review your elections and certify them by re-entering your password.
9. The final step is to click the SUBMIT button. That's it...the entire process can take as little as 4 minutes to complete!

Reminders for New Hires:

- Your enrollment must be completed within the first 31 days of employment.
- Your benefits and insurance cost will be effective the 1st date of employment - missed insurance deductions in the 31 day enrollment period will need to be paid in full - contact HR is you need to establish a re-payment plan.

Need an explanation of insurance terms or help deciding between your benefit options? Visit the ***Decision Support Center*** *on the Benefit*first *homepage.*

No hablo ingles?
Por favor llame para inscribirse.

M&M INDUSTRIES, INC. - TENNESSEE

INSURANCE RATES AS OF JANUARY 1, 2024

BLUECROSS MEDICAL PPO PLAN (OPTION 1 AND 2)			
PRESCRIPTION COPAYS: $15 / $40 / $60; $200 BRAND NAME DEDUCTIBLE $2,600 INDIVIDUAL / $5,200 FAMILY DEDUCTIBLE (RX DEDUCTIBLE NOT INCLUDED)			
PPO/FLEX NETWORK S (Option 1)			
	2023 COST PER WEEK	**2024 COST PER WEEK**	**YOU PAY % OF POLICY**
EE (Employee Only)	$23.00	$25.00	15.4%
ES (Employee + Spouse)	$54.00	$57.00	16.9%
EC (Employee + Children)	$48.00	$50.00	17.0%
FAM (Employee, Spouse & Children)	$79.00	$83.00	17.0%

PPO/FLEX NETWORK P (Option 2)			
	2023 COST PER WEEK	**2024 COST PER WEEK**	**YOU PAY % OF POLICY**
EE (Employee Only)	$25.00	$27.00	15.3%
ES (Employee + Spouse)	$58.00	$62.00	16.9%
EC (Employee + Children)	$52.00	$54.00	16.9%
FAM (Employee, Spouse & Children)	$85.00	$91.00	17.1%

BLUECROSS MEDICAL HDHP/HSA PLAN (OPTION 3 AND 4)			
PREVENTIVE COPAYS: $5 / $25 / $50; ALL OTHERS TO DEDUCTIBLE $3,200 INDIVIDUAL / $6,400 FAMILY DEDUCTIBLE			
HDHP/HSA NETWORK S (Option 3)			
	2023 COST PER WEEK	**2024 COST PER WEEK**	**YOU PAY % OF POLICY**
EE (Employee Only)	$18.00	$18.00	12.0%
ES (Employee + Spouse)	$49.00	$42.00	13.5%
EC (Employee + Children)	$43.00	$37.00	13.7%
FAM (Employee, Spouse & Children)	$71.00	$61.00	13.5%

HDHP/HSA NETWORK P (Option 4)			
	2023 COST PER WEEK	**2024 COST PER WEEK**	**YOU PAY % OF POLICY**
EE (Employee Only)	$19.00	$20.00	12.1%
ES (Employee + Spouse)	$53.00	$46.00	13.5%
EC (Employee + Children)	$46.00	$40.00	13.4%
FAM (Employee, Spouse & Children)	$78.00	$67.00	13.5%

BLUECROSS MEDICAL PPO PLAN (OPTION 5 AND 6)			
PRESCRIPTION COPAYS: $15 / $40 / $60; $200 BRAND NAME DEDUCTIBLE $2,000 INDIVIDUAL / $4,000 FAMILY DEDUCTIBLE (RX DEDUCTIBLE NOT INCLUDED)			
PPO/COPAY NETWORK S (Option 5)			
	2023 COST PER WEEK	**2024 COST PER WEEK**	**YOU PAY % OF POLICY**
EE (Employee Only)	N/A	$27.00	16.4%
ES (Employee + Spouse)	N/A	$61.00	17.9%
EC (Employee + Children)	N/A	$54.00	18.1%
FAM (Employee, Spouse & Children)	N/A	$89.00	18.0%

PPO/COPAY NETWORK P (Option 6)			
	2023 COST PER WEEK	**2024 COST PER WEEK**	**YOU PAY % OF POLICY**
EE (Employee Only)	N/A	$30.00	16.7%
ES (Employee + Spouse)	N/A	$67.00	18.0%
EC (Employee + Children)	N/A	$58.00	17.9%
FAM (Employee, Spouse & Children)	N/A	$97.00	18.0%

BLUECROSS DENTAL			
	2023 COST PER WEEK	**2024 COST PER WEEK**	**YOU PAY % OF POLICY**
EE (Employee Only)	$3.85	$4.00	55%
ES (Employee + Spouse)	$8.40	$9.00	57%
EC (Employee + Children)	$8.35	$9.00	57%
FAM (Employee, Spouse & Children)	$14.00	$15.00	57%

BLUECROSS VISION			
	2023 COST PER WEEK	**2024 COST PER WEEK**	**YOU PAY % OF POLICY**
EE (Employee Only)	$0.70	$0.70	72%
ES (Employee + Spouse)	$1.40	$1.40	72%
EC (Employee + Children)	$1.45	$1.45	71%
FAM (Employee, Spouse & Children)	$2.25	$2.25	70%

M&M INDUSTRIES, INC. - NON-TENNESSEE
INSURANCE RATES AS OF JANUARY 1, 2024

BLUECROSS MEDICAL PPO PLAN (OPTION 2)			
PRESCRIPTION COPAYS: $15 / $40 / $60; $200 BRAND NAME DEDUCTIBLE $2,600 INDIVIDUAL / $5,200 FAMILY DEDUCTIBLE (RX DEDUCTIBLE NOT INCLUDED)			
PPO/FLEX NETWORK P (Option 2)			
	2023 COST PER WEEK	2024 COST PER WEEK	YOU PAY % OF POLICY
EE (Employee Only)	$25.00	$27.00	15.3%
ES (Employee + Spouse)	$58.00	$62.00	16.9%
EC (Employee + Children)	$52.00	$54.00	16.9%
FAM (Employee, Spouse & Children)	$85.00	$91.00	17.1%

BLUECROSS MEDICAL HDHP/HSA PLAN (OPTION 4)			
PREVENTIVE COPAYS: $5 / $25 / $50; ALL OTHERS TO DEDUCTIBLE $3,200 INDIVIDUAL / $6,400 FAMILY DEDUCTIBLE			
HDHP/HSA NETWORK P (Option 4)			
	2023 COST PER WEEK	2024 COST PER WEEK	YOU PAY % OF POLICY
EE (Employee Only)	$19.00	$20.00	12.1%
ES (Employee + Spouse)	$53.00	$46.00	13.5%
EC (Employee + Children)	$46.00	$40.00	13.4%
FAM (Employee, Spouse & Children)	$78.00	$67.00	13.5%

BLUECROSS MEDICAL PPO PLAN (OPTION 6)			
PRESCRIPTION COPAYS: $15 / $40 / $60; $200 BRAND NAME DEDUCTIBLE $2,000 INDIVIDUAL / $4,000 FAMILY DEDUCTIBLE (RX DEDUCTIBLE NOT INCLUDED)			
PPO/COPAY NETWORK P (Option 6)			
	2023 COST PER WEEK	2024 COST PER WEEK	YOU PAY % OF POLICY
EE (Employee Only)	N/A	$30.00	16.7%
ES (Employee + Spouse)	N/A	$67.00	18.0%
EC (Employee + Children)	N/A	$58.00	17.9%
FAM (Employee, Spouse & Children)	N/A	$97.00	18.0%

BLUECROSS DENTAL			
	2023 COST PER WEEK	2024 COST PER WEEK	YOU PAY % OF POLICY
EE (Employee Only)	$3.85	$4.00	55%
ES (Employee + Spouse)	$8.40	$9.00	57%
EC (Employee + Children)	$8.35	$9.00	57%
FAM (Employee, Spouse & Children)	$14.00	$15.00	57%

BLUECROSS VISION			
	2023 COST PER WEEK	2024 COST PER WEEK	YOU PAY % OF POLICY
EE (Employee Only)	$0.70	$0.70	72%
ES (Employee + Spouse)	$1.40	$1.40	72%
EC (Employee + Children)	$1.45	$1.45	71%
FAM (Employee, Spouse & Children)	$2.25	$2.25	70%

Annual Notices

SUMMARY OF BENEFIT COVERAGE The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is provided by your Medical carrier. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual open enrollment period, upon plan renewal and upon request at no charge to you.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA** (3272).

To see if any other states have added a premium assistance program since **July 31, 2023**, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
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
1-877-267-2323, Menu Option 4, Ext. 61565

Alabama	855-692-5447
Alaska	866-251-4861
Arkansas	855-692-7447
California	916-445-8322
Colorado	800-221-3943
Florida	877-357-3268
Georgia	678-564-1162
Indiana	877-438-4479
Iowa	888-346-9562
Kansas	800-792-4884
Kentucky	855-459-6328
Louisiana	855-618-5488
Maine	800-442-6003
Massachusetts	800-862-4840
Minnesota	800-657-3739
Missouri	573-751-2005
Montana	800-694-3084
Nebraska	855-632-7633
Nevada	800-992-0900
New Hampshire	603-271-5218
New Jersey	800-701-0710
New York	800-541-2831
North Carolina	919-855-4100
North Dakota	844-854-4825
Oklahoma	888-365-3742
Oregon	800-699-9075
Pennsylvania	800-692-7462
Rhode Island	855-697-4347
South Carolina	888-549-0820
South Dakota	888-828-0059
Texas	800-440-0493
Utah	877-543-7669
Vermont	800-250-8427
Virginia	800-432-5924
Washington	800-562-3022
West Virginia	855-699-8447
Wisconsin	800-362-3002
Wyoming	800-251-1269

For a listing of State websites, visit: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

For states not listed:
877-543-7669
www.insurekidsnow.gov

OMB Control Number 1210-0137
Expires 1/31/2026

NOTICE OF PATIENT PROTECTIONS

Your medical plan may require the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. Until you make this designation, the medical plan may designate one for you. For information on how to select a PCP, and for a list of the participating providers, contact your carrier.

If you must select a PCP for your child(ren), you may designate a pediatrician as such.

You do not need prior authorization from your carrier or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your carrier.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Introduction. The Consolidated Appropriations Act of 2021 was enacted on December 27, 2020, and contains many provisions to help protect consumers from surprise bills, including the No Surprises Act under title I and Transparency under title II.

Your Rights and Protections Against Surprise Medical Bills. When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted

to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

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

You are protected from balance billing for:

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

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

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

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

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).

Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

HIPAA– PRIVACY ACT LEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract providers.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

SECTION 111 OF JANUARY 1, 2009 Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including Social Security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine if the Employer plan or Medicare/Medicaid/SCHIP is primary for those employees covered under a government plan and an employer sponsored plan.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

MICHELLE'S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC), this law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38. The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the USERRA. See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides employees with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain

their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans' Preference.

HIPAA SPECIAL ENROLLMENT

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

Loss of Other Coverage If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

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

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

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage. For More Information or Assistance To request special enrollment or obtain more information, please contact:

Stephanie Buscemi, HRIS Manager

316 Corporate Place, Chattanooga, TN, 37419

(423) 821-3302

sbuscemi@mmcontainer.com

Note: If you or your dependents enroll during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the "Health Information Technology for Economic and Clinical Health (HITECH) Act." The HITECH Act supports the concept of meaningful use (MU) of electronic health records (EHR), an effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

RESCISSIONS The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

PREVENTIVE CARE Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

HIPAA PRIVACY NOTICE The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law.*** We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, the right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Individual Rights You may obtain a copy of your health claims records

and other health information from us typically within a 30 day period from your request. We may charge a reasonable, cost-based fee. You may ask us to correct your health/claims records if you think they are incorrect. We reserve the right to say "no" to your request, but will give you an explanation in writing within a 60 day period. Requesting a specific way to contact you for confidential reasons is permitted (home or office phone for example), specifically if you would be in danger from a certain form of communication.

If you would like us not to use or share certain health information for treatment, payment or our operations, you are permitted to do so. However, we are not required to agree to your request if it would affect your care. At your request, we will provide you with a list of the times we have shared your health information up to six years prior to your request date, who we shared it with, and why. This list will include all disclosures excluding treatment, payment, and health care operations, as well as other certain disclosures (such as any you ask us to make). We provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You can ask for a paper copy of this notice at any time, which we will promptly provide, even if you have agreed to receive the notice electronically. If you have given someone medical power of attorney or if you have a legal guardian, that person can exercise your rights and make choices about your health information. We will make sure they have this authority and can act in your interests before we take any action.

If you feel that we have violated your rights, you may contact us using the information on the back page, or file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We can assure no retaliation from us against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. You have the right and choice to tell us to share information with your family, close friends, or others involved in payment for your care, and in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest and when needed to lessen a serious and imminent threat to health or safety. We never share your information for marketing purposes of sale of your information without your expressed written consent.

Our Uses and Disclosures We typically use or share your information in several different ways. We help manage the healthcare treatment you receive by sharing information with professionals who are treating you. We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage (this does not apply to long term care plans). Our organization can use and disclose your health information as we pay for your health services, as well as disclose your health information to your health plan sponsor for plan administration.

Other Uses and Disclosures Typically in the matter of public health and safety issues, we can use and share your information. For instance, preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, as well as preventing or reducing a serious threat to anyone's health or safety, and health research.

We may need to share your information if state or federal law requires it, including the Department of Health and Human Services if it wishes to see that we're complying with federal privacy law. Other organizations and professionals we may share your information with are organ procurement organizations, coroners, medical examiners, and funeral directors. We can share your information in special instances such as for worker's compensation claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share information about you in response to a court or administrative order, or in response to a subpoena.

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

"We, Our, and Us" is defined as the insurance carrier for fully insured plans or the plan administrator or third party administrator for self insured plans.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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."

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; 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 the appropriate party/parties.

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

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

For more information visit https://www.medicare.gov/medicare-and-you, or https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes. To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Stephanie Buscemi, HRIS Manager

316 Corporate Place, Chattanooga, TN, 37419

(423) 821-3302

sbuscemi@mmcontainer.com

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Important Notice from Our Company About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Our Company has determined that the prescription drug coverage offered by the medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current employee coverage will not be affected. You can keep this coverage if you elect part D and the Medical Carrier plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Our Company's 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 Our Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every

month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date	01/2024
Name of Entity	M&M Industries
Contact	Stephanie Buscemi, HRIS Manager
Address	316 Corporate Place Chattanooga, TN 37419
Phone	(423) 821-3302
Email	sbuscemi@mmcontainer.com

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information
With the key parts of the health care law that took effect in 2014, there is a new way to buy health insurance: **the Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by M&M Industries, Inc..

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The Open Enrollment period for 2023 plans is November 1st 2022 through January 15th 2023;
The Open Enrollment period for 2024 plans is November 1st 2023 through January 15th 2024.
Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you may not be eligible for a tax credit through the Marketplace depending on the below factors and your household income. You may want to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the 2023 year, more than 8.39% of your household income for the 2024 year, or if the coverage your employer provides does not meet the "minimum value"* standard set by the Affordable Care Act, you may be eligible for a tax credit. Beginning in 2021 with the American Rescue Plan Act (ARPA), and extended for tax years 2023-2026 by the Inflation Reduction Act of 2022, the

federal poverty ceiling is no longer capped at 100%-400%, and the applicable percentage of household income to qualify for a tax credit through the marketplace has been lowered to 8.5 %.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, you may lose the employer contribution (if any) to the employer-offered coverage. Additionally, the employer contribution, as well as your employee contribution to employer-offered coverage, are often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your employer.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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. Residents of the following states must use the state-run health exchange, and more information about the state-specific sites can be found at https://www.healthcare.gov/marketplace-in-your-state/

CA, CO, CT, DC, ID, KY, MA, MD, ME, MN, NJ, NM, NV, NY, PA, RI, VT, WA

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.

1. Employer Name: M&M Industries, Inc.
2. Employer Identification Number (EIN): 62-1260875
3. Employer Address: 316 Corporate Place
4. Employer phone number: (423) 821-3302
5. City: Chattanooga
6. State: TN
7. ZIP code: 37419
8. Who can we contact about employee health coverage at this job: Stephanie Buscemi
9. Phone number for contact: (423) 821-3302
10. Email address: sbuscemi@mmcontainer.com

Here is some basic information about health coverage offered by this employer:

• As your employer, we offer a health plan to: Eligible Employees.

Eligible employees are: Regular full-time employees who work an average of 30 or more hours per week.

• With respect to dependents: We do offer coverage to all eligible dependents.

Eligible dependents are: Legal spouse and dependent children of eligible employee.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.*Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. if you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

M & M Industries, Inc. 401(k) Profit Sharing Plan

Withdrawal/Distribution Procedures

For your benefit, M & M Industries, Inc. is streamlining its process related to withdrawals, distributions and loans on the retirement Plan. This new process will improve turnaround times and accuracy on your requests. This process will be for:

Hardship Distribution Withdrawals
In-Service Distribution Withdrawals
Post-Severance Distribution Withdrawals
Retirement Distribution Withdrawals

To initiate any of the above Withdrawals, please call or email:

ERISA Services, Inc.
Michelle Sisk
P.O. Box 24628
Knoxville, TN 37933
msisk@erisaservices.com

(865) 218-3109 Direct Line
(865) 218-5706 Direct Fax
(865) 966-1225 Main Line

If Michelle Sisk is on the other line, please leave a message with **your:**

Name
Company you work for
Type of distribution you are requesting
Contact Information – Phone, email, and mailing address

You will need to leave a phone number where we can reach you, an email address, or a mailing address where we can send your paperwork.

Upon signing and completing the paperwork provided by ERISA Services, you must return it to ERISA Services by email, fax or mail. It is prudent to keep a copy of what you completed. You can expect your withdrawal, distribution or loan to be sent to you within 10 business days of being processed.

John Hancock

How to get the most from your retirement plan *benefit*

Steps you can take now—to be prepared later

Welcome to John Hancock

Your employer is partnering with John Hancock to offer a retirement plan benefit that gives you a tax-advantaged way to save for your future. Register your account and enroll now, if you haven't done so already!

Let's get started!

Your retirement plan is one of the most important sources of income you'll have when you retire. To help you get started, you'll need to answer two important questions: "How much can I put away each payday?" and "How should I invest?". Let's take them one by one.

The benefits of participating

- Convenient automatic payroll deductions
- Pretax contributions
- Compound earnings that can really add up
- Tax-deferred savings
- And more

Need help with enrollment? Call us at **855-JHENROLL (543-6765)**.

Register

Register your account to help keep it secure. Go to **myplan.johnhancock.com** or download John Hancock's retirement app. Either way, you'll find a convenient, safe way to access your retirement account.

Download John Hancock's retirement app

Anroid

iOS

Enter your information, including:

Your contract number

112739

Then follow these steps:

1 Create a username and password,
2 Choose your challenge questions and answers, and
3 Confirm your information, and you're all set!

If you're joining for the first time, after you register, click "**Enroll now**"

You'll need your enrollment access number

165189

Save for tomorrow, today

You can contribute as much of your salary as you want each payday—up to plan or IRS limits. The more you contribute to your account, the greater the impact of compounding (when your earnings are reinvested and generate their own earnings) and the more you're likely to save over the long term.

There's a cost to waiting. Consider that the earlier you start saving, the more time your money has the potential to grow.

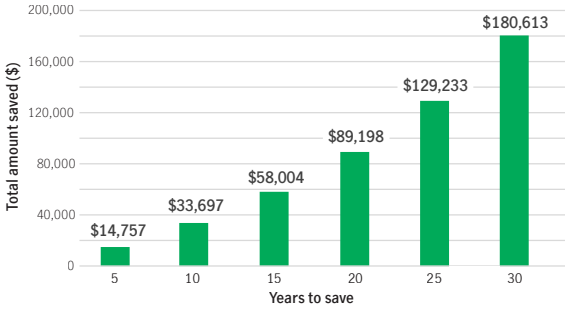
Tip

Even a 1% increase in your contribution amount can make a big difference. Use the online retirement planner at **myplan.johnhancock.com** or the mobile app to see how changing your current contribution amount can make a big difference. You can change your contribution rate at any time.*

Example

Let's say your take-home pay is usually $500 per week. If you want to save $50, your take-home pay should be $450. But, if you save on a pretax basis, your take-home pay would be $460, which is only $40 less. You'll contribute $2,600 per year and lower your annual income taxes by $525.

Here's how that $50 could add up over time:



This hypothetical example assumes $0 savings, a 5% annual rate of return, and contributions of $50 per week/$217 per month. It assumes no withdrawals and does not take into account investment fees. There is no guarantee that the results shown will be achieved, and the assumptions provided may not be reflective of your situation.

Ways to *invest*

Your retirement plan offers a wide range of investments that match your retirement goals and risk tolerance. And you can choose the option that works best for the level of involvement you want to have.

Level of involvement

High / Medium / Low

Do it yourself by selecting and managing your investments.
Choose a mix of investments from the plan's options (build your own portfolio).

Determine which type of investor you are, such as conservative or aggressive.
Choose a professionally managed portfolio targeted to your risk tolerance (target-risk portfolio).*

Have investment professionals do it for you.
Choose a professionally managed portfolio targeted closest to your expected retirement date (target-date fund).*

Choosing investments within different asset classes (such as cash, bonds, and stocks) is called **diversification**. Dividing your money among those groups is called **asset allocation**. Using both approaches when selecting your investments can help you find the right balance of risk and reward to fit your situation.

Every investment comes with a mixture of risk and return

Past performance is no guarantee of future results.

* Check your plan's investment lineup to see which options are available.

Neither asset allocation nor diversification guarantees a profit or protects against a loss. An asset allocation investment option may not be appropriate for all participants, particularly those interested in directing their own investments.

There is no guarantee that any investment strategy will achieve its objectives.

Your retirement at your fingertips

Go to **myplan.johnhancock.com** or John Hancock's retirement app to review, manage, and personalize your plan for retirement whenever it's convenient for you.

Questions about your account?

Details about your plan's features, investment options, contribution limits, calculators, and more can be found online or on the retirement app—or call us anytime at **800-395-1113**.

Not yet ready to *make* a choice?

Your money will be invested in the plan's "default" investment option. You can return at any time to update or change your investments. Whatever you choose, be sure to review your investments periodically and make adjustments as needed.

Tip

Take the Risk Quiz to find out which type of investor you are. Go to **jhriskquiz.com** or scan the QR code.

Your quiz results may change over time. We encourage you to take the risk quiz each year to ensure that your risk profile accurately matches your risk tolerance.

Access hands-on tools and educational resources to help you get financially fit

Track

View your account details at a glance, including balance, rate of return, and investments, making it easy to monitor progress toward your retirement goal.

Analyze

Take a closer look at your cash flow, spending habits, and debts to help manage your budget.

Combine

Consider combining your retirement accounts from past employers to see your total retirement savings in one place. Contact us at **800-555-5165** for more information.†

† Available for plans using John Hancock's Consolidation Services; rollovers are subject to the provisions of a company's plan. As other options are available, participants are encouraged to review these options to determine if combining their retirement accounts is suitable for them.

The content of this document is for general information only and is believed to be accurate and reliable as of the posting date, but may be subject to change. It is not intended to provide investment, tax, plan design, or legal advice (unless otherwise indicated). Please consult your own independent advisor as to any investment, tax, or legal statements made herein.

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NOT FDIC INSURED. MAY LOSE VALUE. NOT BANK GUARANTEED.

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Enrollment form instructions

Fill out the attached form, sign it, and return to your plan administrator.

Important—after completing this form, you'll still need to register on our website to manage your account and select investments.

Investment option(s)

By signing this form, you agree that all contributions will be invested 100% in the plan's default investment option (DIO) selected by your plan trustee(s), until you select another investment option(s) online at **myplan.johnhancock.com** or by calling **800-395-1113**. During your enrollment, you may also call your personal enrollment specialist at **855-543-6765**.

If your plan's DIO changes, you'll remain invested in the fund(s) listed on the form. If your plan's DIO is a target-date suite, you'll be invested based on the target date that's closest to the year you reach age 67. If you don't provide a date of birth, your contributions will be invested in the most conservative target-date fund.

Consider consolidating your retirement accounts†

If you have other retirement accounts, such as a 401(k) account with a former employer or an IRA, you may be able to move them into your new retirement account with John Hancock.

To learn more about this option, if consolidating your accounts is right for you, simply indicate that you'd like to discuss your options on the enrollment form or call us at **1-877-525-7655.**

Speak with a financial representative to determine if combining your retirement accounts is suitable for you, as other options are available.

† Available for plans using John Hancock's consolidation services; rollovers are subject to the provisions of your company's plan.

John Hancock Life Insurance Company (U.S.A) (John Hancock USA) and John Hancock Life Insurance Company of New York (John Hancock New York) are collectively referred to as "John Hancock."

John Hancock
200 Berkeley Street
Boston, MA 02116

My *enrollment* form

Need help enrolling?
Contact your personal enrollment specialist at 855-543-6765.

Complete, sign, and return to your plan administrator
Contract name **M & M INDUSTRIES, INC.**
Contract number **112739**

My personal information

Last name

First name, Initial

Social Security number

Date of birth (mmm/dd/yyyy)

My contributions per paycheck

☐ **Pretax only** (☐ YES! Increase my pretax contribution **1 % annually**) **OR** ☐ **Roth only**

☐ 6% ☐ 8% ☐ 10% ☐ 12% ☐ 15%

Other: To choose a different amount/percentage or split pretax and Roth, fill out below:

Pretax: % Roth: %

My investments

To review and select investment options, go online at **myplan.johnhancock.com** or call us at 800-395-1113. Until another investment option is selected, 100% of contributions will be invested in the plan's Default Investment Option (DIO) (listed below). If your plan's DIO is a target-date suite, you'll be invested based on the target date that's closest to the year you reach age 67. If you don't provide your date of birth, your contributions will be invested in the most conservative portfolio within the target date suite.

Fund name	Code	%
John Hancock Multi-Index Preservation Portfolio	RC	100

What's next? Connect your accounts

☐ **YES!** I want to learn more to see if combining retirement accounts is right for me. Preferred method of contact:

☐ **Call:** Best time (circle) A.M./P.M.

☐ **OR** Email:

Signature

I have read, understood, and agreed with the information, terms, and conditions regarding my enrollment, contributions, and investments provided on this form, including the instructions to this form. I agree that 100% of my contributions will be invested in the plan's DIO until I select another investment option(s).

Signature of Participant: _____ Date: _____

John Hancock

Opt-out form

Complete, sign, and return to your plan administrator.

Need help enrolling?
Contact your personal enrollment specialist at **855-543-6765.**

Contract name:
Contract number:

My personal information

Last name

First name, Initial

Social Security number

Date of birth (mm/dd/yyyy)

My contributions

Saving for retirement is important.

However, if you decide not to contribute to your retirement at this time, select the option below, sign, and deliver to your plan administrator. When you're ready to contribute, visit **johnhancock.com/myplan** to enroll.

For more details on eligibility periods or any restrictions that your plan may have, refer to your summary plan document or speak to your plan administrator.

☐ I elect **not** to contribute to my retirement plan at this time.

Signature of participant: _____ Date: _____