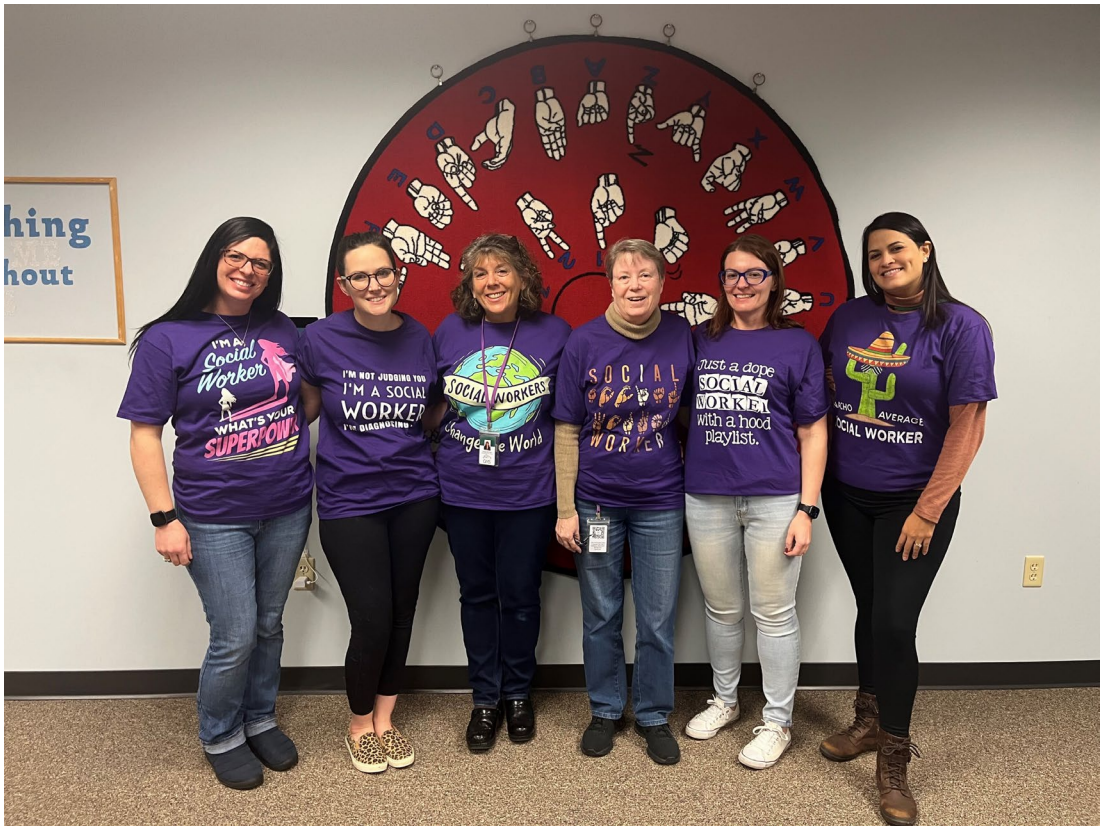

GMS

Supporting Independence

Careers. Community. Connections.

Group Main Stream

July 1, 2023 – June 30, 2024
Employee Benefit Guide

An overview of the wide array of benefits provided by Group Main Stream to help you enjoy increased well-being and financial security.

Prepared by Cross Insurance for Group Main Stream

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Benefits for July 1, 2023 – June 30, 2024

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This Guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

Welcome

Benefits for July 1, 2023 – June 30, 2024

Welcome

OUR EMPLOYEES ARE OUR MOST VALUABLE ASSET.

That's why Group Main Stream strives to provide you and your family with a comprehensive benefits package. We want you to pick the best benefits for you and your family. We've put together this Benefit Guide for open enrollment and for new employees hired during the year.

Open enrollment is an important time - it is a short period each year when you can make changes to your benefits. The IRS allows employees to select certain benefits through pre-tax salary reductions, which lowers taxes and saves money. Because of these tax savings, after your initial benefits selection at time you're hired, the IRS allows you to make changes only during an open enrollment period, unless you experience a qualified status change. Since this is your one opportunity to enroll in or make changes to your benefits this year, please carefully consider your anticipated needs for the upcoming plan year. Elections you make during open enrollment will be **effective on July 1, 2023.**

This Guide outlines the different benefits Group Main Stream offers, so you can identify which offerings are best for you and your family. The Guide also provides definitions for important terms, contact information for each of the carriers, as well as some important annual notices you should be aware of.

This Benefit Guide includes summary descriptions of Group Main Stream's benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This Guide and plan summaries do not constitute a contract of employment and benefits described in this Guide may be changed by the employer.

Welcome (continued)

Benefits for July 1, 2023 – June 30, 2024

Contacts

If you have questions or need further information, please do not hesitate to contact Group Main Stream Human Resources Representative or our dedicated broker representatives at Cross Benefit Solutions.

Name: Matt Giesecke
Phone: 207-523-5175
Email: mgiesecke@gmsme.org

Your contact for daily claims and benefits questions:

Adriana Killam, Senior Account Service Representative
116 Community Drive, Suite 2
Augusta, ME 04330
Phone: 207-523-2405
Fax: 207-623-7810
Adriana.Killam@crossagency.com

In Adriana's absence, please contact:

Kristi Sanfasin, Account Manager
2367 Congress Street
Portland, ME 04102
Phone: 207-523-2436
Fax: 207-828-8907
Kristi.Sanfasin@crossagency.com

OR

Jessika Williams, Account Executive
116 Community Drive, Suite 2
Augusta, ME 04330
Phone: 207-523-2406
Fax: 207-623-7810
Jessika.Williams@crossagency.com

Eligibility and Enrollment

Benefits for July 1, 2023 – June 30, 2024

Eligibility & Enrollment

Who Is Eligible?

All eligible employees may elect to enroll in the benefit program during our annual open enrollment period, or when you first become eligible. The minimum required hours you must work to be eligible, as well as the waiting periods before you can enroll yourself and eligible family members are different for different types of coverage:

Coverage	Minimum Weekly Hours	Waiting Period	Eligible Family
Medical	30	1st of the month following 60 days	Employee, Domestic Partner/Spouse and Children
Dental and Vision	35	1st of the month following 60 days	Employee, Domestic Partner/Spouse and Children
Life/AD&D – Basic	35	1st of the month following 60 days	Employee
Life/AD&D – Voluntary	35	1st of the month following 60 days	Employee, Domestic Partner/Spouse and Children
STD and LTD Disability	35	1st of the month following 60 days	Employee
EAP	1	Date of hire	Employee and Household Members
Accident & Critical Illness	35	1st of the month following 60 days	Employee, Spouse, and Children

How to Enroll During Open Enrollment

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When to Enroll

The benefits you choose during Open Enrollment will become **effective on July 1, 2023.** For newly hired or newly eligible employees, coverage will begin using the waiting period schedule above.

How to Make Changes

Unless you experience a life-changing Qualifying Event, you cannot make changes to your benefits until the next Open Enrollment Period. Qualifying events include things like: (1) marriage, divorce or legal separation; (2) birth or adoption of a child; (3) death of spouse, child or other qualified dependent; (4) residence change in certain instances; (5) change in child's dependent status; or (6) change in employment status or a change in coverage under another employer-sponsored plan.

If you have a Qualifying Event, in most cases changes must be made within 30 days of the event, or you will need to wait until the next Open Enrollment.

Medical

Benefits for July 1, 2023 – June 30, 2024

Medical

Key Terms to Remember

Annual Deductible

The amount you have to pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

Annual Out-of-Pocket Maximum

This is the total amount you can pay out-of-pocket each calendar year before the plan pays 100% of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible*, copays and coinsurance.

*Except for Grandfathered medical plans

Plan Types

Preferred Provider Organization (PPO) – A network of doctors, hospitals and other health care providers. You generally receive higher benefits when you go to a network health care provider.
Point of Service (POS) – A network of doctors, hospitals and other health care providers that usually requires you to select a Primary Care Physician (PCP) who coordinates your health care.
High Deductible Health Plan (HDHP) – A plan that has higher annual deductibles in exchange for lower premiums. The ME PPO HSA Best Buy Indemnity 3000 and ME PPO Best Buy HSA Indemnity 5000 are HDHPs and you can set up a Health Savings Account (HSA) to accompany these plans.

Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share (a percentage) of the allowed amount charged for a service and is generally billed to you after the health insurance company reconciles the bill with the provider.

Medical (continued)

Benefits for July 1, 2023 – June 30, 2024

Medical

Preventive Care

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and to incorporate healthy habits into your lifestyle. Some examples include; getting regular physical examinations, mammograms and immunizations. Through the plans offered by Group Main Stream, all covered individuals and family members are **eligible to receive routine wellness services like these at no cost; all copays, coinsurance and deductibles are waived.**

"An ounce of prevention is worth a pound of cure"

Which Preventive Care Services Are Covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act compliant plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered for 2023:

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence
- Depression Screening
- Blood Pressure Screening

Medical

Benefits for July 1, 2023 – June 30, 2024

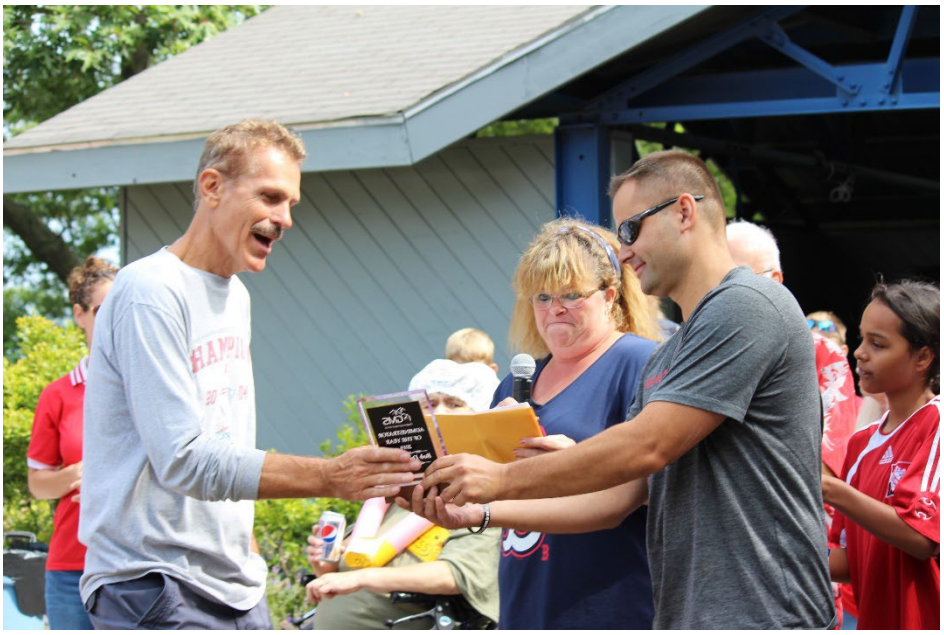
Medical

Defined Contributions

- Amount of money that Group Main Stream provides for employees to purchase benefits
- Issues in the form of a “credit” to employees
- Employers financed “credits” are non-taxable, as part of Code Section 125, if “credits” are applied to the purchase of non-taxable benefits such as health, dental or vision insurance

	Weekly Amount	Annual Amount
Medical Benefit Dollars	$132.69	$6,900
Ancillary Benefit Dollars*	$28.85	$1,500

*Only available for Employees working 35+ hours per week.



Medical (continued)

Benefits for July 1, 2023 – June 30, 2024

Medical

Who Is Eligible and When?

Benefits are available to employees working 30 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Group Main Stream offers ME PPO $1,500 and ME PPO $2,500 from Harvard Pilgrim.

Summary of Coverage

Plan Features	Harvard Pilgrim ME PPO 1500		Harvard Pilgrim ME PPO 2500	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible (Ind/Family)	$1,500 / $3,000	$3,000 / $6,000	$2,500 / $5,000	$5,000 / $10,000
Out-of-Pocket Maximum (Ind/Family)	$4,500 / $9,000	$9,000 / $18,000	$5,500 / $11,000	$11,000 / $22,000
Coinsurance Percentage	You pay 20%	You pay 40%	You pay 20%	You pay 40%
PCP Office Visits				
-Preventive Care	$0, no Deductible	40% after Deductible	$0, no Deductible	40% after Deductible
-Sick Care	$30 Copay	40% after Deductible	$30 Copay	40% after Deductible
Specialist Office Visits	$50 Copay	40% after Deductible	$50 Copay	40% after Deductible
Labs/Diagnostic & Imaging Services	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Emergency Room Care	20% after Deductible		20% after Deductible	
Urgent Care	Convenience Care $30; Urgent Care & Hospital Urgent Care Center: $50 Copay	40% after Deductible	Convenience Care $30; Urgent Care & Hospital Urgent Care Center: $50 Copay	40% after Deductible
Inpatient Hospital Care	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Chiropractic Care	$30 Copay	40% after Deductible	$30 Copay	40% after Deductible
Physical, Speech and Occupational Therapy	$30 Copay	40% after Deductible	$30 Copay	40% after Deductible
Prescription Drugs (Rx)*				
1 - Generic Drugs	Tier 1: $10		Tier 1: $10	
2 - Preferred Brand	Tier 2: $20		Tier 2: $20	
3 - Non-Preferred Brand	Tier 3: $35		Tier 3: $35	
4 – Preferred Specialty	Tier 4: $70		Tier 4: $70	
5 – Non-Preferred Specialty	Tier 5: 30% up to $300		Tier 5: 30% up to $300	

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Refer to your Medical plan documentation for more information.

Medical (continued)

Benefits for July 1, 2023 – June 30, 2024

Medical

Who Is Eligible and When?

Benefits are available to employees working 30 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Group Main Stream offers a ME POS $1,500 from Harvard Pilgrim.

Summary of Coverage

Plan Features	Harvard Pilgrim ME POS 1500	
	IN-NETWORK	OUT-OF-NETWORK
Deductible (Ind/Family)	$1,500 / $3,000	$3,000 / $6,000
Out-of-Pocket Maximum (Ind/Family)	$4,500 / $9,000	$9,000 / $18,000
Coinsurance Percentage	You pay 20%	You pay 40%
PCP Office Visits* -Preventive Care -Sick Care	 $0 Copay, no Deductible $30 Copay	 40% after Deductible 40% after Deductible
Specialist Office Visits	$50 Copay	40% after Deductible
Labs/Diagnostic & Imaging Services	20% after Deductible	40% after Deductible
Emergency Room Care	20% after Deductible	
Urgent Care	Convenience Care $30; Urgent Care & Hospital Urgent Care Center: $50 Copay	40% after Deductible
Inpatient Hospital Care	20% after Deductible	40% after Deductible
Chiropractic Care	$30 Copay	40% after Deductible
Physical, Speech and Occupational Therapy	$30 Copay	40% after Deductible
Prescription Drugs (Rx)** 1 - Generic Drugs 2 - Preferred Brand 3 - Non-Preferred Brand 4 – Preferred Specialty 5 – Non-Preferred Specialty	 Tier 1: $10 Tier 2: $20 Tier 3: $35 Tier 4: $70 Tier 5: 30% up to $300	

*This plan requires you to designate a Primary Care Physician (PCP). If you do not elect one, a PCP will be selected for you.
**Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery
pharmacy. Specialty Drugs are limited to a 30-day supply.

Refer to your Medical plan documentation for more information.

Medical (continued)

Benefits for July 1, 2023 – June 30, 2024

Medical

Who Is Eligible and When?

Benefits are available to employees working 30 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment section** are eligible.

Benefits You Receive

Group Main Stream offers ME PPO Best Buy HSA Indemnity $3,000 and PPO Best Buy HSA Indemnity $5,000 from Harvard Pilgrim.

Summary of Coverage

Plan Features	Harvard Pilgrim ME PPO Best Buy HSA Indemnity 3000		Harvard Pilgrim ME PPO Best Buy HSA Indemnity 5000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible (Ind/Family)	$3,000 / $6,000	$3,000 / $6,000	$5,000 / $10,000	$5,000 / $10,000
Out-of-Pocket Maximum (Ind/Family)	$3,000 / $6,000	$6,000 / $12,000	$5,000 / $10,000	$10,000 / $20,000
Coinsurance Percentage	You pay 0%	You pay 20%	You pay 0%	You pay 20%
PCP Office Visits				
-Preventive Care	$0 Copay, no Ded	20% after Deductible	$0 Copay, no Ded	20% after Deductible
-Sick Care	0% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Specialist Office Visits	0% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Labs/Diagnostic & Imaging Services	0% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Emergency Room Care	0% after Deductible		0% after Deductible	
Urgent Care	0% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Inpatient Hospital Care	0% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Chiropractic Care	0% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Physical, Speech and Occupational Therapy	0% after Deductible	20% after Deductible	0% after Deductible	20% after Deductible
Prescription Drugs (Rx)				
1 - Generic Drugs	Tier 1: 0% after Ded		Tier 1: 0% after Ded	
2 - Preferred Brand	Tier 2: 0% after Ded		Tier 2: 0% after Ded	
3 - Non-Preferred Brand	Tier 3: 0% after Ded		Tier 3: 0% after Ded	
4 – Preferred Specialty	Tier 4: 0% after Ded		Tier 4: 0% after Ded	
5 – Non-Preferred Specialty	Tier 5: 0% after Ded		Tier 5: 0% after Ded	
Preventive Rx	Not Subject to the Deductible		Not Subject to the Deductible	

*Benefits shown are for a 30-day supply. Coverage for up to a 90-day supply is available for certain drugs through the home delivery pharmacy. Specialty Drugs are limited to a 30-day supply.

Refer to your Medical plan documentation for more information.

Health Savings Account (HSA)

Benefits for July 1, 2023 – June 30, 2024

Who Is Eligible and When?

When you are enrolled on the Qualified High Deductible medical plans, Group Main Stream offers you a Health Savings Account (HSA) through Paylocity. With an HSA, employees can save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany High Deductible Health Plans (HDHPs).

How Do I Benefit from an HSA?

The main purpose of this account is to offset the cost of a qualifying HDHP and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement.

This is a "portable" account. You own your HSA! It's included in your employee benefits package, but after you set up your account, it's yours to keep, even if you change jobs or retire.

Why is it a Good Idea to Have an HSA?

HSAs benefit everyone who is eligible to have this account – single individuals, families, and soon-to-be retirees. You save money on taxes in three ways:

- **Tax-free deposits** – The money you contribute to your HSA isn't taxed (up to the IRS annual limit).
- **Tax-free earnings** – Your interest and any investment earnings grow tax-free.
- **Tax-free withdrawals** – The money used toward eligible health care expenses isn't taxed – now or in the future.

Setting aside pre-tax dollars into your HSA means you pay fewer taxes and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket. For example, if you are in the 30 percent tax bracket, you can save $30 on every $100 spent on eligible health care expenses.

HSA funds roll over from year to year and accumulate in your account. There is no "use-it-or-lose-it" rule with HSAs, and you decide how and when to use your HSA funds, which can be used for eligible expenses you have now, in the future, or during retirement. And when you have a certain balance in your HSA, investment opportunities are available.

What Expenses are Covered Under an HSA and How Much Can I Contribute?

Once your HSA is established you can contribute to your account up to a total of $3,850 if you have individual coverage and $7,750 if you have family coverage in 2023. Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum. You can then use your HSA dollars tax-free to pay for eligible health care expenses. You save money on expenses you're already paying for, such as doctors' office visits, prescription drugs, and much more. Best of all, you decide how and when to use your HSA dollars.

Refer to your HSA documentation for more information.

Voluntary Dental

Benefits for July 1, 2023 – June 30, 2024

Dental

Who is Eligible and When?

Benefits are available for purchase to employees working 35 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment** are eligible.

Benefits You Receive

Group Main Stream offers a core dental PPO plan you can purchase from Anthem.

Summary of Coverage

Anthem Core PPO Dental	In-Network
Calendar Year Deductible (Per Person/Family) (Applies ONLY to Basic and Major Restorative Services)	$50 / $150
A - Diagnostic and Preventive Services	100%
B - Basic Restorative Services	70%
C - Major Restorative Services	50%
Calendar Year Maximum	$1,000

A - Preventive Services	B - Basic Restorative Services	C- Major Restorative Services
Oral Exams 1 per 6-month period Second opinion consultation Cleanings 1 per 6-month period X-rays: • Bitewing (1 per calendar year) • Occlusal (2 per calendar year) • Periapical (4 per calendar year) • Full mouth survey (1 per 60 months) • Extraoral (2 per 12 months) Fluoride (1 per calendar year) to age 15 Sealants to permanent molars (1 per 36 months) to age 15 Space maintainers to age 15 Harmful habit appliance to age 15	Emergency exams (1 per 6 months) Periodontal maintenance Fillings Stainless steel crowns Simple & complex oral surgery General anesthesia/IV sedation Periodontics including scaling and root planning (1 per quad per 24 months) Periodontal surgical procedures (1 per quad per 36 months) Simple & complex endodontics	Crowns (1 per tooth per 60 months) Inlays, onlays, cast post and core, core buildup (1 per tooth per 60 months) Implants (1 per tooth per 60 months) Bridges – initial placement; replacement after 60 months Complete or partial dentures – initial placement; replacement after 60 months Repairs – partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture

Refer to your Dental plan documentation for more information.

Voluntary Dental

Benefits for July 1, 2023 – June 30, 2024

Dental

Who is Eligible and When?

Benefits are available for purchase to employees working 35 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment** are eligible.

Benefits You Receive

Group Main Stream offers an enhanced dental PPO plan you can purchase from Anthem.

Summary of Coverage

Anthem Enhanced PPO Dental	In-Network
Calendar Year Deductible (Per Person/Family) (Applies ONLY to Basic and Major Restorative Services)	$50 / $150
A - Diagnostic and Preventive Services	100%
B - Basic Restorative Services	90%
C - Major Restorative Services	60%
Calendar Year Maximum	$1,500
D - Orthodontic Services	50%
Lifetime Maximum for Orthodontic Services	$1,000

A - Preventive Services	B - Basic Restorative Services	C- Major Restorative Services	D - Orthodontic Services
Oral Exams 1 per 6-month period Second opinion consultation Cleanings 1 per 6-month period X-rays: • Bitewing (1 per calendar year) • Occlusal (2 per calendar year) • Periapical (4 per calendar year) • Full mouth survey (1 per 60 months) • Extraoral (2 per 12 months) Fluoride (1 per calendar year) to age 15 Sealants to permanent molars (1 per 36 months) to age 15 Space maintainers to age 15 Harmful habit appliance to age 15	Emergency exams (1 per 6 months) Periodontal maintenance Fillings Stainless steel crowns Simple & complex oral surgery General anesthesia/IV sedation Periodontics including scaling and root planning (1 per quad per 24 months) Periodontal surgical procedures (1 per quad per 36 months) Simple & complex endodontics	Crowns (1 per tooth per 60 months) Inlays, onlays, cast post and core, core buildup (1 per tooth per 60 months) Implants (1 per tooth per 60 months) Bridges – initial placement; replacement after 60 months Complete or partial dentures – initial placement; replacement after 60 months Repairs – partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture	Child Orthodontics covered up to age 19

Refer to your Dental plan documentation for more information.

Voluntary Vision

Benefits for July 1, 2023 – June 30, 2024

Vision

Who is Eligible and When?

Benefits are available for purchase to employees working 35 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment** are eligible.

Benefits You Receive

Group Main Stream offers the Voluntary vision you can purchase from Anthem.

Summary of Coverage and Employee Payroll Deduction

Plan Features	Anthem Voluntary Vision	
	Blue Vision Network	
	In-Network	**Out-of-Network**
	Your Cost	**Plan Pays Up To**
Vision Exam – every 12 months	$10 Copay	$42
Frames– every 24 months	$200 Allowance, 20% Off Balance	$45
Lenses– Standard - every 12 months		
Single	$25 Copay	$40
Bifocal	$25 Copay	$60
Trifocal	$25 Copay	$80
Lenticular	$25 Copay	No Coverage
Lens Options		
Standard Progressive	$0 Copay	No Coverage
Contact Lens Fit and Follow-up – Standard Lenses	$55 Copay	No Coverage
Contact Lens Fit and Follow-up – Premium Lenses	$55 Copay	No Coverage
Contacts– every 12 months		
Elective	$200 Allowance, 15% off Balance	$105
Medically Necessary	$25 Copay	$210
Laser Vision Correction	15% off regular price and 5% off promotional price. You only receive these discounts from contracted clinics.	No Coverage

Refer to your Vision plan documentation for more information.

Basic Life Insurance

Benefits for July 1, 2023 – June 30, 2024

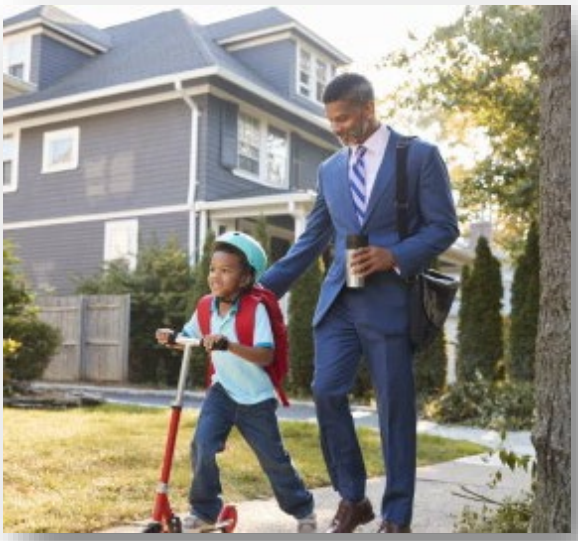
Life

Who is Eligible and When?

Benefits are available to employees working 35 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility.

Benefits You Receive

At no cost to you, Group Main Stream offers you employer-sponsored Group Life and Accidental Death and Dismemberment (AD&D) insurance from Anthem. As long as you are eligible, you are automatically enrolled and can receive coverage of $10,000 without having to answer any questions about your health. This is referred to as the Guarantee Issue amount. The AD&D insurance amount is also $10,000. This insurance can help provide for your family if something happens to you. You must choose a beneficiary or beneficiaries - the person(s) or entity you name who will receive the proceeds from your life or AD&D insurance in the event of your death or injury.



Benefits are summarized below.

Summary of Coverage

Plan Features	Basic Life – Anthem
Employee Benefit Amount	$10,000
AD&D Benefit Amount	$10,000
Guarantee Issue Amount	$10,000
The following shows how much benefits are reduced at certain ages – coverage is available if you are still employed at Group Main Stream	
Age Reduction	**Benefits Available**
Age 65	65%
Age 70	50%

Refer to your Life and AD&D plan documentation for more information.

Voluntary Life Insurance

Benefits for July 1, 2023 – June 30, 2024

Life

Who is Eligible and When?

Benefits are available for purchase to employees working 35 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility. Family members listed in **Eligibility and Enrollment** are eligible.

Benefits You Receive

Group Main Stream offers you employer-sponsored Group Life and Accidental Death and Dismemberment (AD&D) insurance from Anthem. As long as you are eligible, you can purchase coverage in $25,000 increments not to exceed $300,000. The AD&D insurance amount is the same as the Life amount. This insurance can help provide for your family if something happens to you. You must choose a beneficiary or beneficiaries - the person(s) or entity you name who will receive the proceeds from your Life or AD&D insurance in the event of your death or injury.

Coverage can also be purchased for family members. Benefits are summarized below.

Summary of Coverage

Employee - Plan Features	Voluntary Life – Anthem
Employee Life Benefit Amount	Lesser of 5x Salary or $300,000 in $25,000 Increments
AD&D Benefit Amount	Same as Life
Guarantee Issue Amount	$150,000
The following shows the percentage of benefits available to you as you reach certain ages – coverage is available if you are still employed at Group Main Stream	
Age	**Benefits Available**
Age 75	65%
Age 80	45%
Spouse - Plan Features	**Voluntary Life – Anthem**
Spouse Life Benefit Amount	100% of the Employee Insured Amount up to $100,000 in $5,000 Increments
AD&D Benefit Amount	Same as Life
Guarantee Issue Amount	$30,000
Age Reduction	By 35% When Reaches Age 75 and additional 20% at age 80
Child(ren) - Plan Features	**Voluntary Life – Anthem**
Child(ren) Benefit Amount (age 15 days to 26 years)	100% of Employee Insured Amount up to $10,000 in $2,000 Increments

Refer to your Life and AD&D plan documentation for more information.

Voluntary Short-Term Disability

Benefits for July 1, 2023 – June 30, 2024

Disability

Who is Eligible and When?

Benefits are available for purchase to employees working 35 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility.

Benefits You Receive

Group Main Stream offers you the opportunity to purchase Short-Term Disability insurance from Anthem. If you become disabled from a non-work-related injury or illness, disability income benefits will provide a partial replacement of lost income.

Summary of Coverage

Plan Features	Short-Term Disability – Anthem	
Benefits Begin **Accident** **Sickness**	8th Day 8th Day	
Weekly Benefit	Benefit Amount	60% of Your Weekly Earnings
	Maximum	$1,200 Per Week
Benefits Duration	Up to 26 Weeks	
Pre-Existing Condition Limitation	No benefits are available for an injury or sickness for which you received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day you become insured. No benefits will be provided for any disability caused by, attributable to, or resulting from a pre-existing condition which begins in the first 12 months after you are continuously insured under the Policy.	

Refer to your STD plan documentation for more information.

Voluntary Long-Term Disability Insurance

Benefits for July 1, 2023 – June 30, 2024

Disability

Who is Eligible and When?

Benefits are available for purchase to employees working 35 or more hours per week. New employees are eligible for benefits on the first day of the month following 60 days from the date of hire/eligibility.

Benefits You Receive

Group Main Stream offers you the opportunity to purchase Long-Term Disability insurance from Anthem. If you become disabled from a non-work-related injury or illness, disability income benefits will provide a partial replacement of lost income.

Summary of Coverage

Plan Features	Long-Term Disability – Anthem	
Benefits Begin **Accident** **Sickness**	The later of 180 days or the date your Short-Term Disability coverage ends	
Monthly Benefit	Benefit Amount	50% of Your Monthly Earnings
	Maximum	$6,000 Per Month
Benefits Duration **Mental Health or Substance Abuse** **Your Own Occupation** **Other Occupations for which Reasonably Suited**	Up to 24 months Up to 24 months Your Social Security Normal Retirement Age (SSNRA)	
Pre-Existing Condition Limitation	No benefits are available for an injury or sickness for which you received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day you become insured. No benefits will be provided for any disability caused by, attributable to, or resulting from a pre-existing condition which begins in the first 12 months after you are continuously insured under the Policy.	

Refer to your LTD plan documentation for more information.

Employee Assistance Program (EAP)

Benefits for July 1, 2023 – June 30, 2024

EAP

Who is Eligible and When?

Benefits are available to all employees and their household members. New employees and household members are eligible for benefits on their date of hire.

Benefits You Receive

The EAP is a completely confidential program that can help you or family members in your household deal with life challenges. You are entitled to up to 4 counseling and/or referral sessions with a licensed mental health professional at no cost to you. Members can address a wide variety of concerns including marital, family issues, workplace stress, anxiety, depression, substance abuse, grief, and many other matters. EAP also provides resources on health, legal, personal growth, balanced life, and other topics. There are health and mental health screenings, articles, and videos related to many issues including parenting, resolving conflicts, and templates for legal forms such as wills and living wills.

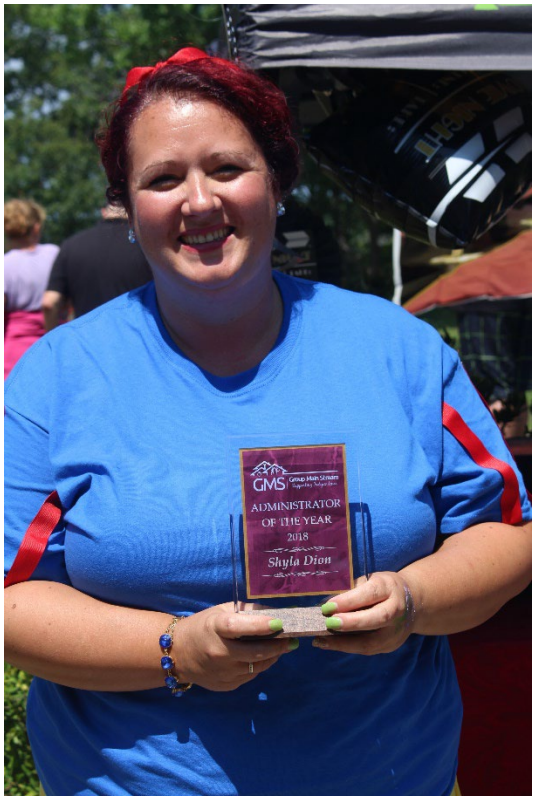
Employee Payroll Deduction

There is no cost to you for EAP.

Contact

www.workforceeap.com
Scroll down and client on the **Employee Assistance Program** tab
Click on **Work/Life Services** on the left
Click on Current client log in here
First time users will need to Register.
Enter the requested information and choose your own Username and password.
Company Code is: ahc-gms

1-800-769-9819



Refer to your EAP plan documentation for more information.

ID & Cyber Theft

Benefits for July 1, 2023 – June 30, 2024

Identity & Cyber Theft

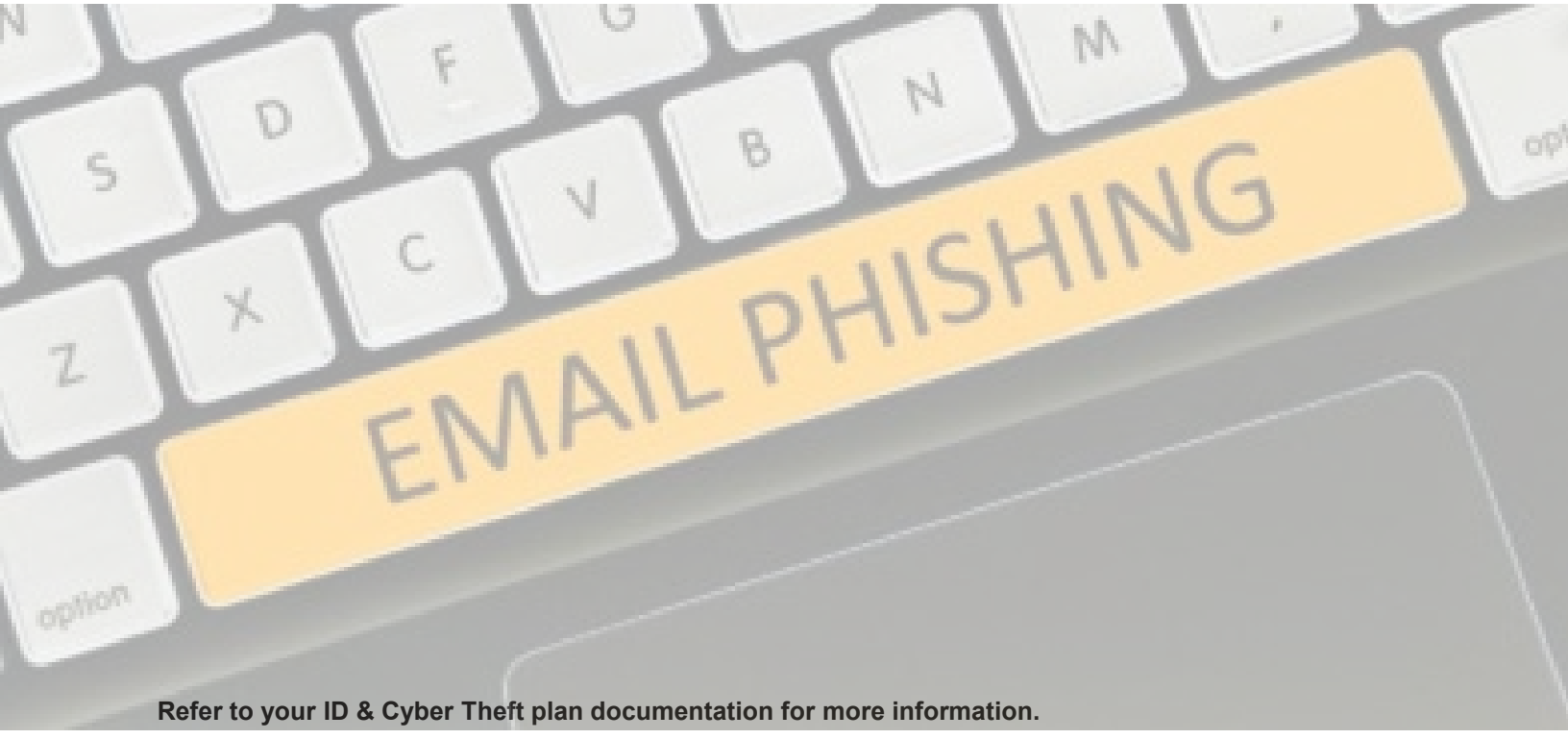
Identity theft is the fastest growing crime in the US and is the top consumer complaint for the past 12 years. This crime can be financially devastating and extremely time-consuming to remedy.

Group Main Stream offers Identity Protection Pro Plus from Allstate to benefits-eligible employees. Allstate's identity protection service will monitor any signs of criminal activity, including but not limited to: data breaches, ATM overlays, malware and viruses, medical ID theft, tax related theft, social security ID theft, new account monitoring, and credit monitoring.

In the event your identity is compromised, a dedicated U.S. based restoration agent will work diligently to resolve your issue. Allstate will reimburse you up to $1 million to replace stolen funds like 401k, HSA funds, or fraudulent tax returns.

Individual
$9.95 per month
Family
$17.95 per month

Call (800) 799-2720 or visit www.allstateidentityprotection.com to enroll in a plan tailored to you and your family's needs.



Refer to your ID & Cyber Theft plan documentation for more information.

Pet Insurance

Benefits for July 1, 2023 – June 30, 2024

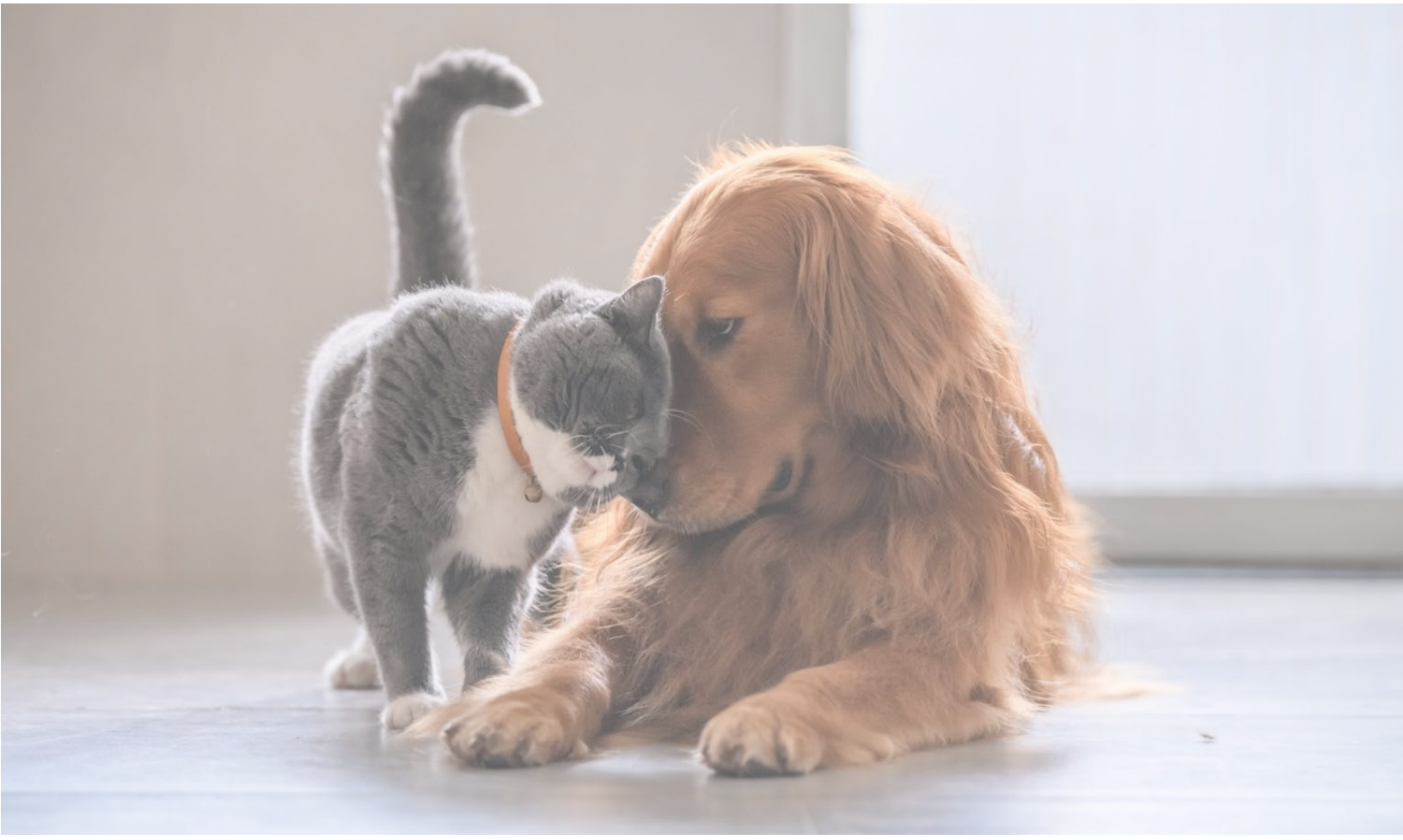
Pet

You can purchase health care coverage for your pets from **Nationwide.** The My Pet Protection Pet insurance plan gives you protection at an affordable price, including:

- 50%, 70% or 90% back on vet bills depending on level of coverage;
- Exclusivity - unavailable to the general public;
- One set price, regardless of the pet's age;
- Use any vet anywhere; and
- A wellness plan option that includes spay/neuter, dental cleaning, exams, vaccinations, and more.
- Submit claims online
- Electronic claim payments
- 24/7 access to veterinary professionals for any pet health concern
- Discounts on pet products and services

https://benefits.petinsurance.com/gmsme

Refer to your Pet insurance plan documentation for more information.



401(k)

Benefits for July 1, 2023 – June 30, 2024

401(k)

Who is Eligible and When?

A 401(k) plan encourages you to accumulate savings for retirement through convenient pretax or Roth (after-tax) payroll deductions along with generous company contributions. As a full-time employee you are eligible to participate in the 401(k) plan when you have completed 1 year of service. The 401(k) plan offers a wide array of investment funds from which to choose, including stock, bonds and blended (target date) funds.

Plan Description

You are allowed to allocate a portion of your pay (from 1% to 100%) into the plan, up to maximum amounts set by the IRS. Those who are 50 years of age or older are also eligible to make "catch-up" contributions.

Group Main Stream will match the first 3% of your contributions at 100% and 50% of the next 2% of your contributions. All of your contributions are immediately 100% vested. See the Employer Match below:

Employer Match						
Your Contribution	**1%**	**2%**	**3%**	**4%**	**5%**	**6%**
Employer Match	**1%**	**2%**	**3%**	**3.5%**	**4%**	**4%**

Refer to your 401(k) plan documentation for more information.

Time Off

Benefits for July 1, 2023 – June 30, 2024

Time Off

Earned Benefit Time (EBT)

GMS recognized the importance of time off from work to relax, spend time with family, and enjoy leisure activities. GMS provides paid EBT to all employees for these purposes and employees are encouraged to take vacation during the year. Additionally, EBT must be used for days off due to sickness or other personal time. Full-time employees will accrue EBT according to the following schedule:

Service	Monthly Accrual
Date of Hire – 12 months	**7 hours**
2 – 3 years	**9 hours**
4 – 7 years	**11 hours**
8 – 10 years	**14 hours**
11 – 14 years	**18 hours**
More than 15 years	**20 hours**

Earned Paid Leave (EPL)

The Maine "Earned Paid Leave Law" became effective January 1, 2021. This law requires employers with more than 10 employees in the usual course of business to offer all Full-Time, Part-Time and Per Diem employees who have been employed for 120 calendar days to Earned Paid Leave (EPL) time based on the employee's base pay rate.

Earned Paid Leave can be used for vacation, sick, personal time, or for any reason and can be accrued for up to 40 hours per year, based on the employee's date of hire. One (1) hour is earned for every 40 hours worked regardless of how long it takes an employee to work 40 hours – "earn as you work."

For more information about time off, please refer to the Employee Handbook.

Time Off

Benefits for July 1, 2023 – June 30, 2024

Holidays

Group Main Stream observes the following paid holidays each year for all full-time employees:

- **New Year's Day**
- **Memorial Day**
- **Independence Day**
- **Labor Day**
- **Thanksgiving Day**
- **Christmas Day**

Full-Time Administrative employees also receive the following paid holidays each year:

- **Martin Luther King Jr Day**
- **Presidents Day**
- **Juneteenth**
- **Indigenous People's Day**
- **Veterans Day**
- **Day After Thanksgiving Day**

Floating Holiday(s)

In addition to regular holidays and EBT, Group Main Stream allows **Full-Time Program employees 6** Floating Holidays each calendar year. With approval Floating Holidays can only be taken on or after the actual holiday. Floating Holidays must be scheduled and approved in advance. You cannot carry over unused Floating Holidays to the next year beyond January 31st.

For more information about time off, please refer to the Employee Handbook.

Additional Voluntary Benefit Offerings

Benefits for July 1, 2023 – June 30, 2024

Who is Eligible

Voluntary Benefits are a cost-effective way to help employees offset out-of-pocket medical expenses and provide financial stability. As an employee of Group Main Stream, you have the opportunity to apply for personal programs and insurance products. These benefits can enhance your current benefits portfolio and can be customized to fit your individual needs. These programs and insurance products have advantages including:

- Any benefits are paid directly to you;
- You can take the coverage with you if you change jobs or retire; and
- Any premiums are payroll deducted.

The following insurance plans are offered:

Accident Insurance

- Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.
- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. In this case you would be billed directly.
- Includes a wellness benefit each year where each family member who is enrolled in the coverage can also receive $50 for getting covered screening tests.

Critical Illness Insurance

- If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want. The money can help you pay out-of-pocket medical expenses, like co-pays and deductible.
- You can use the coverage more than once – Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness except skin cancer. The reoccurrence benefit pays 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.
- If you apply during your initial enrollment, you can get coverage without a health exam or medical questions
- Coverage is portable meaning you can choose to take the coverage with you if you leave or retire and you would be billed at home.
- Includes a wellness benefit each year where each family member who is enrolled in the coverage can also receive $50 for getting covered screening tests.

Refer to your plan documentation for more information.

Legal Notices

GMS
Supporting Independence
Careers. Community. Connections.

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman'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:

1. All stages of reconstruction of the breast on which mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan. If you would like more information on WHCRA benefits, please contact your health plan administrator at 207-523-5175**.**

HIPAA Notice of Privacy Practices

The Plan's HIPAA Notice of Privacy Practices is available upon request. To obtain a copy of the Plan's HIPAA Notice of Privacy Practices, please contact the HR Department. For more information on the Plan's privacy policies or your rights under HIPAA, contact Matt Giesecke at 207-523-5175**.**

HIPAA Special Enrollment Rights

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Group Main Stream's health plan under "special enrollment provisions" briefly described below.

- Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Group Main Stream's health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after your or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under Group Main Stream's health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in Group Main Stream's health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the Plan Administrator at 207-523-5175 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan descriptions or insurance contract.

Legal Notices (continued)

Important Notice From Group Main Stream 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 Group Main Stream 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. Group Main Stream has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current coverage through Group Main Stream may be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop Group Main Stream's medical plan with prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back at a later date.

Legal Notices (continued)

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 Group Main Stream 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 percent 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 percent 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 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of 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**. You can call 24 hours a day, 7 days a week.

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: July 1, 2023
Contact: Matt Giesecke
Name of Entity/Sender: Group Main Stream
Address: PO Box 1280, Westbrook, ME 04098
Phone Number: 207-523-5175

Legal Notices (continued)

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)**.

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 January 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Legal Notices (continued)

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – 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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331 or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Legal Notices (continued)

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

This Guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

Legal Notices (continued)

To see if any other states have added a premium assistance program since January 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

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. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance, or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other healthcare 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 healthcare 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

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 can 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 states have enacted balance billing protections for patients receiving emergency services. For example, New Hampshire, Maine, Massachusetts and Vermont all have laws protecting patients from balance billings. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

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.

Legal Notices (continued)

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.

State law prohibitions against balance billing may also apply. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

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 deductible 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 (also known as "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 your insurance carrier by calling the number on your insurance card. You may also contact the state insurance regulator or the No Surprises helpdesk at 1-800-985-3059.

Visit *https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act* for more information about your rights under federal law.

Newborns' and Mothers' Health Protection Act of 1996

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). In any case, plans and issuers 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).

Patient Protection Notice

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you. For children, you may designate a pediatrician as the primary care provider.

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

Legal Notices (continued)

Massachusetts Minimum Creditable Coverage Requirement

For employees who reside in Massachusetts, Minimum Creditable Coverage (MCC) is the minimum level of benefits that you need to have to be considered insured and avoid tax penalties in Massachusetts. These benefits include:

- Coverage for a comprehensive set of services (e.g. doctor visits, hospital admissions, day surgery, emergency services, mental health and substance abuse, and prescription drug coverage).
- Doctor visits for preventive care, without a deductible.
- A cap on annual deductibles of $2,850 for an individual and $5,700 for a family.
- For plans with up-front deductibles or coinsurance on core services, an annual maximum on out-of-pocket spending of no more than the annual limit set by the IRS for high deductible health plans. In 2023, out-of-pocket costs are limited to $9,100 for an individual plan and $18,200 for a family plan.
- No caps on total benefits for a particular illness or for a single year.
- No policy that covers only a fixed dollar amount per day or stay in the hospital, with the patient responsible for all other charges.
- For policies that have a separate annual prescription drug deductible, it cannot exceed $350 for an individual or $700 for a family.

The Harvard Pilgrim ME PPO $1,500, ME POS $1,500, and ME PPO $2,500 plans offered by Group Main Stream **do meet** the Massachusetts Minimum Creditable Coverage requirements. The Harvard Pilgrim ME PPO Best Buy HSA Indemnity $3,000, and ME PPO Best Buy HSA Indemnity $5,000 plans offered by Group Main Stream **do not meet** the Massachusetts Minimum Creditable Coverage requirements. Please contact Matt Giesecke at 207-523-5175 with any questions.

Legal Notices (continued)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2022 and ends December 15, 2022 for coverage starting as early as January 1, 2023.

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 will not be eligible for a tax credit through the Marketplace and may wish 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. For Plan Years beginning in 2023, 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 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.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is 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 Matt Giesecke at 207-523-5175.

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

[1]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.

Legal Notices (continued)

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. Employer name Group Main Stream		4. Employer Identification Number (EIN) 01-371245
5. Employer address PO Box 1280, 15 Saunders Way, Ste 500-G		6. Employer phone number 207-523-5170
7. City Westbrook	8. State ME	9. ZIP code 04098
10. Who can we contact about employee health coverage at this job? Matt Giesecke		
11. Phone number (if different from above) 207-523-5175	12. Email address mgiesecke@gmsme.org	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

Working 30 or more hours per week

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Employee, Domestic Partner/Spouse and Children until age 26

☐ We do not offer coverage.

☑ If checked, 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.

Legal Notices (continued)

Continuation Coverage Rights Under COBRA

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 [*choose and enter appropriate information:* must pay *or* aren't required to 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.

Legal Notices (continued)

Continuation Coverage Rights Under COBRA (continued)

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;
- 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:

Matt Giesecke
Group Main Stream
PO Box 1280
Westbrook, ME 04098
207-523-5175

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.

Legal Notices (continued)

Continuation Coverage Rights Under COBRA (continued)

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.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Legal Notices (continued)

Continuation Coverage Rights Under COBRA (continued)

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**. (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.

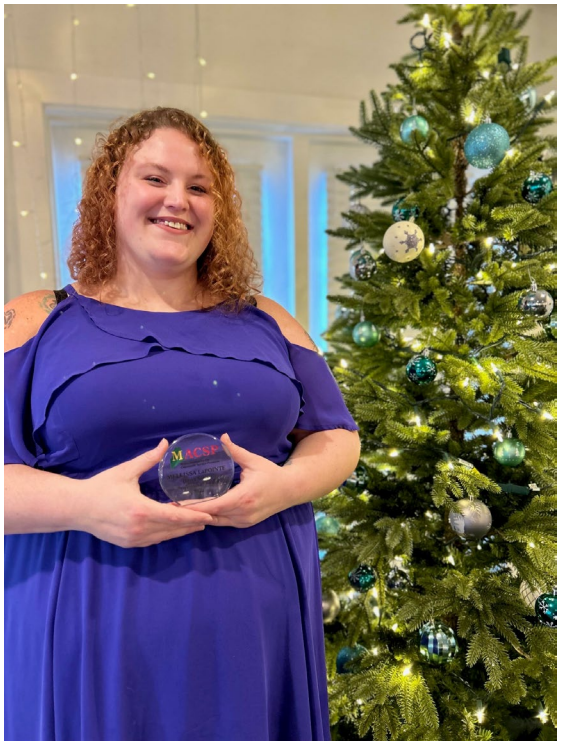
Plan contact information

Matt Giesecke
Group Main Stream
PO Box 1280
Westbrook, ME 04098
207-523-5175

Contacts

Contacts

Plan Type	Carrier Name	Website	Phone Number
Medical	Harvard Pilgrim	www.harvardpilgrim.com	(888) 333-4742
Voluntary Dental	Anthem	www.anthem.com	(844) 729-1565
Voluntary Vision	Anthem	www.anthem.com	(866) 723-0515
Life and AD&D	Anthem	www.anthem.com	(800) 232-0113
Voluntary Short-Term Disability	Anthem	www.anthem.com	(800) 232-0113
Voluntary Long-Term Disability	Anthem	www.anthem.com	(800) 232-0113
Employees Assistance Program	Work Force	www.workforceeap.com	(800) 769-9819
ID & Cyber Theft	Allstate	www.allstateidentityprotection.com	(800) 799-2720
Pet Insurance	Nationwide	www.Benefits.petinsurance.com/gmsme	(800) 540-2016
Accident & Critical Illness	Anthem	www.anthem.com	(888) 828-2432



This Guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

Benefits Brought to You by:

GMS

Supporting Independence
Careers. Community. Connections.

Benefits Brokered by:

CROSS INSURANCE