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EMPLOYEE BENEFITS GUIDE

For the coverage period effective January 1 through December 31, 2025

Welcome!

As an employee of EMM Loans, enjoying your work and making valuable contributions to business is equally vital. The health, satisfaction, and security of you and your family are important to your well-being and ultimately, to achieving the goals of our organization.

For the 2025 plan year, EMM Loans has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our employees healthy and secure. We understand that your situation is unique. That is why EMM Loans offers a robust benefits package with many possible choices - one that can be shaped and molded by you to fit your needs.

This guide summarizes all benefits offered at EMM Loans. This document will help you learn about your benefit options and how you can enroll. We encourage you to take the time to educate yourself and choose the best coverage for you and your family.

Wellness Program

- Preventive Care Services are covered 100% under the EMM Loans medical plans.
- EMM Loans offers the opportunity for wellness savings in 2026 if you and your enrolled spouse/partner (if applicable) complete your annual physical and routine bloodwork! Both the employee and spouse/partner must comply to be eligible for savings.
- New hires who start employment in 2025 may be eligible for the wellness savings if your annual physical and routine bloodwork is completed within 60 days of your date of hire. Please reach out to HR for more information.

Coordination of Benefits

Annually, members are required to complete Coordination of Benefits (COB) for Meritain. This requirement is commonly referred to as "Other Insurance Coverage". Completing this process ensures that your claims will be paid. If you do not complete COB, your claims may be denied. To help effectively manage your future claims, please share any additional healthcare coverage you or your dependents may have. Other healthcare coverage could include medical, dental, vision, or Medicare.

You have the option to submit online through the member portal, which is the quickest and easiest way, or you can send to Meritain another way. The form can be found on the BenePortal www.emmloansbenefits.com.

- **Online through your member portal:**
 - Visit www.meritain.com and log in
 - Navigating to Benefits and Coverage in the menu bar, then select Coordination of Benefits
- **Mail, fax, or email:**
 - Mail completed forms to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085
 - Fax to **1-716-541-6672**
 - Take a picture of the form with your mobile device and email it to forms.direct@meritain.com

Questions?

If you have questions about your benefits, please contact the Benefits Member Advocacy Center (Benefits MAC) at **800.563.9929** (Monday through Friday, 8:30 am to 5:00 pm ET) or go to www.connerstrong.com/memberadvocacy and complete the fields.

How to Elect Your Coverage

When Coverage Begins and Ends

Benefit coverage begins on the 1st of the month following 30 days of full-time (30+ hours per week) employment.

Your coverage under the benefit plans will end if you no longer meet the eligibility requirements, your contributions are discontinued, or the Group Insurance Policy is terminated.

Online Enrollment Instructions

When you are ready to enroll in or make changes to your benefits, you **MUST** enroll through our online enrollment system, ADP at <https://workforcenow.adp.com>

Before you begin, make sure you have your **Social Security Number**. If you are updating coverage for your dependent(s), or enrolling dependent(s) in coverage for the first time, be sure to have their date of birth and Social Security Number.

If you do not remember your ADP username, please contact Human Resources or call ADP directly at **855.547.8508**.

New hires must make their elections in ADP within 30 days of their date of hire.



Qualifying Life Events

Choose your benefit plans and coverage levels carefully.

Mid-Year changes to your benefit elections are allowed only for certain qualifying life events, such as:

- Loss of coverage or acquisition of new coverage from another source
- Change in Employee's legal marital status (marriage or divorce)
- Change in the number of eligible dependents (i.e. birth, death, court order)
- Dependent now satisfies or ceases to satisfy dependent eligibility requirements
- Change in employment status that affects benefit eligibility
- Significant changes in coverage under the plan of the spouse's or dependent's employer

You must notify Human Resources and provide documentation (e.g., birth certificates, marriage certificates, court orders and decrees, etc.) as proof of your qualifying life event in order to make any changes. **You must notify HR within 30 days of the event.**

Who Can Enroll?

Benefit-Eligibility is defined as:

- Full-time employees hired to work 30 or more hours per week.

Note: Employees who are currently ineligible for health benefits may become eligible for medical coverage in the future under the Affordable Care Act requirements. Human Resources tracks hours worked and notifies any employee that becomes eligible for coverage.



Eligible Dependents Include:

- A legal spouse or domestic partner and children up to the age of 26. Children include, natural children, stepchildren, foster children, adopted children, and children placed for adoption.
 - * Coverage for dependent children enrolled in the medical/prescription drug plan and the vision plan will terminate at the end of the month in which they turn 26.
 - * Dental benefits will terminate at the end of the year in which your child(ren) turn 26.
- Your children over age 26 if mentally or physically incapable of caring for themselves. Your dependent must be reliant upon your support. Additional documentation may be needed.

When enrolling a dependent, you will be required to attest that they meet the EMM Loans eligibility rules. You must provide supporting documentation such as a marriage certificate, birth certificate, etc. Coverage is not effective until valid documentation is submitted. Documentation can be sent to Human Resources via email to HR@emmlloans.com.

You will be required to certify that the information you are providing is true and accurate to the best of your knowledge, and that intentional falsification or significant omissions will be grounds for discipline including, but not limited to:

- Termination of medical plan coverage and requirement of reimbursement of claims paid
- Loss of employment

Medical Benefits:

Meritain - Aetna Choice POS II Network

	MED 1 EPO HSA PLAN	MED 2 EPO PLAN	MED 3 PPO PLAN	
BENEFIT	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual/Family	\$2,000/\$4,000*	\$1,500/\$3,000	\$500/\$1,000	\$1,500/\$3,000
Out-of-Pocket Maximum Individual/Family	\$4,000/\$6,750**	\$4,000/\$8,000	\$3,000/\$6,000	\$6,000/\$12,000
Preventive Care Services	Plan pays 100% no deductible	Plan pays 100% no deductible	Plan pays 100% no deductible	Plan pays 60% after deductible
Primary Care Physician (PCP) Required?	No	No	No	
PCP Office Visit	Plan pays 90% after deductible	\$20 copay	\$20 copay	Plan pays 60% after deductible
Specialist Office Visit	Plan pays 90% after deductible	\$40 copay	\$40 copay	Plan pays 60% after deductible
Diagnostic Laboratory (Lab/X-Ray) Office Based Hospital Based	Plan pays 90% after deductible Plan pays 70% after deductible	\$20 (PCP) / \$40 (Specialist) - no deductible Plan pays 70% after deductible	Plan pays 100% after deductible	Plan pays 60% after deductible
Advanced Imaging (MRI/CT-Scan) Freestanding Hospital Based	Plan pays 100% after deductible Plan pays 70% after deductible	\$20 (PCP) / \$40 (Specialist) - no deductible Plan pays 70% after deductible	Plan pays 100% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 70% after deductible	\$100 copay; Plan pays 70% after deductible	Plan pays 100% after deductible	
Inpatient Hospital	Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 100% after deductible	Plan pays 60% after deductible
Urgent Care Center	Plan pays 90% after deductible	\$40 copay	\$40 copay	Plan pays 60% after deductible
Outpatient Surgery Ambulatory Surgical Center Hospital Setting	Plan pays 70% after deductible Plan pays 70% after deductible	Plan pays 70% after deductible \$100 copay; Plan pays 70% after deductible	Plan pays 100% after deductible	Plan pays 60% after deductible
Teladoc	\$56 copay per consult	\$0 copay	\$0 copay	
Vision Care Maximum Benefit Per Year (exam, refractions, lenses, frames, contacts)	\$100	\$100	\$100	\$100

* The entire family deductible must be satisfied if you cover any dependent child(ren) or spouse before the plan begins to pay.

** The entire family out-of-pocket maximum must be met (by any combination of one or more family members) before the plan will pay 100% for covered services.

FIND A PROVIDER

- Visit www.aetna.com/docfind.
- Enter your ZIP code, city, county or state.
- Enter in **Aetna Choice POS II (Open Access)** under "Select a Plan". Or you can select **Aetna Choice POS II (Open Access)** from the list of plans.
- Next you can either click on one of the categories under "Find what you need by category", or you can use the search box, and choose your provider from the list of providers displayed.

Prescription Drug Plan:

Express Scripts

The prescription drug plan is administered by Express Scripts. When you enroll in one of the medical plans you are automatically enrolled in the corresponding prescription drug plan. Your medical plan ID card will include information related to your prescription drug plan (one ID card for Medical/Rx).

EPO HSA PLAN		EPO PLAN	PPO PLAN
RETAIL (UP TO A 30-DAY SUPPLY)			
Generic	Plan pays 70% after deductible	\$15 copay	\$15 copay
Preferred Brand	Plan pays 70% after deductible	\$35 copay	\$35 copay
Non-Preferred Brand	Plan pays 70% after deductible	\$70 copay	\$70 copay
Specialty	Plan pays 70% after deductible	Plan pays 80% no deductible	Plan pays 80% no deductible
MAIL ORDER (UP TO A 90-DAY SUPPLY)			
Generic	Plan pays 70% after deductible	\$30 copay	\$30 copay
Preferred Brand	Plan pays 70% after deductible	\$70 copay	\$70 copay
Non-Preferred Brand	Plan pays 70% after deductible	\$140 copay	\$140 copay

Express Scripts Pharmacy

Express Scripts has a network of nearly 60,000 independent and chain pharmacies nationwide. When you visit a participating pharmacy, you will receive up to a 30-day supply after paying the applicable cost share (or a 90-day supply of maintenance medications through the Smart90 Program). Remember to take your Medical/Rx ID card with you.

Sign up online at www.express-scripts.com/rx or download the Express Scripts mobile app. You can easily manage your prescriptions, make payments, request refills, and check the status of your order all through your member portal.

Need assistance getting started?

Call **800.669.3612** and speak with a representative today!

Specialty Medications

Specialty drugs are medications that require special handling, administration, or monitoring. These are generally administered by injection. Your provider will be able to indicate if the medication you are being prescribed is considered a specialty medication. Specialty medications must be filled by the Express Scripts specialty pharmacy, Accredo.

Visit www.accredo.com and click “Find a Medication” to get started.

Please note, that if you take a specialty medication, you are not automatically enrolled with Accredo Specialty Pharmacy.

PRICE ASSURE

Express Scripts has partnered with GoodRx to help you and your family manage prescription costs. With the Price Assure program, your prescription prices are automatically discounted. Just show your Medical/Rx ID card at a participating GoodRx pharmacy, and if GoodRx offers the lowest price, that’s all you pay!

- Discounts apply to generic medications that are covered by the plan, excluding specialty generics.
- Out-of-pocket costs count toward your medical/prescription drug deductible and out-of-pocket maximum.

Visit www.goodrx.com to find a GoodRx participating pharmacy close to you.

Telemedicine:

Teladoc

If you are enrolled in a EMM Loans medical/prescription drug plan, you and your dependents have access to a telemedicine benefit through Teladoc.

Teladoc provides you with 24/7 access to U.S. board-certified doctors. It allows you to talk to a doctor who can diagnose, recommend treatment, and prescribe medication when appropriate.

You may access Teladoc in one of three ways:

- Call **1.800.TELADOC (835.2362)**
- Download the free Teladoc mobile phone app
- Visit **www.teladoc.com**

How Much Does Teladoc Cost?

- Med 1 (EPO HSA): \$56 per consult (applied to the deductible)
- Med 2 (EPO): \$0 per consult
- Med 3 (PPO): \$0 per consult

Tip: Save time and register your account so that when you need to access this benefit, you are already set up!



Talk to a Doctor Anytime

With Teladoc, plan members can conveniently consult with board-certified physicians through phone or video consults. A wide range of common non-emergency conditions may be treated, including:

- Allergies or allergic reactions
- Cold and flu
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever
- Headaches
- Insect bites
- Pink eye
- Rashes and other skin irritations
- Respiratory problems
- Sore throat
- Urinary tract infections
- Vomiting

Dental Plan:

Delta Dental

To locate a network provider, visit www.deltadental.com and select the appropriate network for your plan.

BENEFIT	PPO/PREMIER PLAN	DMO PLAN*	
	IN AND OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Network	PPO & Premier	DeltaCare USA	
Calendar Year Deductible Individual/Family	\$50/\$150	None	N/A
Calendar Year Maximum (per patient)	\$1,500	None	N/A
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year) Fluoride Treatment (once in a calendar year, children to age 19)	Plan pays 100% (deductible does not apply)	Fee Schedule	N/A
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	Plan pays 80% after deductible	Fee Schedule	N/A
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	Plan pays 50% after deductible	Fee Schedule	N/A
Orthodontia Benefits (up to age 19)	50%	Fee Schedule	N/A
Orthodontia Lifetime Maximum (per patient)	\$1,000	Fee Schedule	N/A

Please Note: A fee schedule applies to the DMO plan. Please visit BenePortal to view the fee schedule.

* Only available to employees in PA, NY, NJ, and FL

Additional Plan Features

Please note, these features apply to the PPO Plan only.

Carryover Max Benefit

Allows members to carry over part of their unused standard annual maximum in one year to increase benefits for the following year and beyond.

Special Needs Benefit

Members with a qualifying special healthcare need are eligible to receive up to four dental cleanings, additional examinations and/or consultations, and treatment delivery modifications.

Learn more by visiting the EMM Loans BenePortal.



Vision Plan:

VSP

VISION PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Exam	\$20 copay	Up to \$45 reimbursement
Frames	\$130 allowance 20% off balance over \$130	Up to \$70 reimbursement
Lenses		
Single Vision Lenses	\$20 copay	Up to \$30 reimbursement
Bifocal Lenses	\$20 copay	Up to \$50 reimbursement
Trifocal Lenses	\$20 copay	Up to \$65 reimbursement
Lenticular Lenses	\$20 copay	Up to \$100 reimbursement
Contact Lenses (in lieu of eyeglasses)	\$130 allowance Up to \$60 copay for fitting exam	Up to \$105 reimbursement
Frequency		
Vision Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	

TruHearing

Employees enrolled in the VSP vision plan have access to a hearing aid program through TruHearing. TruHearing makes hearing aids more affordable by offering exclusive savings. You can save up to 60% on a pair of hearing aids! Plus, your dependents and extended family members are also eligible for these savings. Please visit www.emmloansbenefits.com for more detailed information.

How to Find a Doctor

Click the tab **Find a Doctor** on www.vsp.com. View a map and use the drop-pin functionality to find the right VSP network practice location for you. You can also filter by business hours or appointment availability. Look for the orange **Premier Program** banner to find a VSP network eye doctor that will help you maximize your savings. The VSP Vision Care app offers navigation and a personalized dashboard, so you can get the benefit information you need, exactly when you need it.

Eyeconic

Eyeconic seamlessly connects your eyewear, your insurance coverage, and the VSP doctor network. Plus, you get the convenience of online shopping along with the personal touch from a VSP doctor.

1. Create an account at www.vsp.com. Review your vision benefit and access your eligibility and coverage information, including how to apply your benefits at Eyeconic.
2. Find superior eye care near you. The decision is yours—choose a conveniently located VSP doctor or any out-of-network provider. Visit www.vsp.com or call **800.877.7195** to find the best provider for you.
3. Check out Eyeconic and browse the frame brands you love. You can connect to your VSP benefits, upload your prescription at checkout, and order your glasses following your WellVision Exam.



Scan the QR code below to download the VSP Vision Care App.

Employee Payroll Contributions

MEDICAL/PRESCRIPTION DRUG PLAN CONTRIBUTIONS

COVERAGE TIER	MED 1: EPO HSA			MED 2: EPO			MED 3: PPO		
	EE COST/ MONTH	EE COST/ 24 PAY	EE COST/ 52 PAY	EE COST/ MONTH	EE COST/ 24 PAY	EE COST/ 52 PAY	EE COST/ MONTH	EE COST/ 24 PAY	EE COST/ 52 PAY
Employee Only	\$348.08	\$174.04	\$80.33	\$575.70	\$287.85	\$132.85	\$895.45	\$447.72	\$206.64
Employee + Spouse	\$656.95	\$328.48	\$151.60	\$1,031.89	\$515.95	\$238.13	\$1,593.40	\$796.70	\$367.71
Employee + Child(ren)	\$526.27	\$263.13	\$121.45	\$833.60	\$416.80	\$192.37	\$1,306.35	\$653.17	\$301.47
Family	\$886.86	\$443.43	\$204.66	\$1,393.32	\$696.66	\$321.53	\$2,189.04	\$1,094.52	\$505.16

EMM Loans offers a voluntary wellness program for all employees and spouses enrolled in the medical plans.

Action Items: *Get an annual physical AND routine bloodwork!*

- In order to earn credit, enrolled employees **AND** spouses (if applicable) must complete **both** action items.

REMEMBER: Preventive care is covered 100% under the EMM Loans medical plans.

WELLNESS PARTICIPANTS: MEDICAL/PRESCRIPTION DRUG PLAN CONTRIBUTIONS

COVERAGE TIER	MED 1: EPO HSA			MED 2: EPO			MED 3: PPO		
	EE COST/ MONTH	EE COST/ 24 PAY	EE COST/ 52 PAY	EE COST/ MONTH	EE COST/ 24 PAY	EE COST/ 52 PAY	EE COST/ MONTH	EE COST/ 24 PAY	EE COST/ 52 PAY
Employee Only	\$252.36	\$126.18	\$58.24	\$451.53	\$225.77	\$104.20	\$746.21	\$373.10	\$172.20
Employee + Spouse	\$443.44	\$221.72	\$102.33	\$784.24	\$392.12	\$180.98	\$1,318.68	\$659.34	\$304.31
Employee + Child(ren)	\$355.23	\$177.62	\$81.98	\$633.54	\$316.77	\$146.20	\$1,062.79	\$531.40	\$245.26
Family	\$598.63	\$299.32	\$138.15	\$1,058.92	\$529.46	\$244.37	\$1,780.91	\$890.46	\$410.98

New hires who start employment in 2025 may be eligible for the wellness savings if they complete their annual physical and routine bloodwork within 60 days of their start date. Please reach out to HR for more information.

Employee Payroll Contributions

DENTAL PLAN CONTRIBUTIONS

COVERAGE TIER	DELTA DENTAL PPO PREMIER			DELTA DENTAL DMO (PA/NJ/NY ONLY)		
	EE COST/MONTH	EE COST/24 PAY	EE COST/52 PAY	EE COST/MONTH	EE COST/24 PAY	EE COST/52 PAY
Employee Only	\$30.86	\$15.43	\$7.12	\$13.82	\$6.91	\$3.19
Employee + Spouse	\$55.09	\$27.55	\$12.71	\$24.26	\$12.13	\$5.60
Employee + Child(ren)	\$55.09	\$27.55	\$12.71	\$24.34	\$12.17	\$5.62
Family	\$95.10	\$47.55	\$21.95	\$36.00	\$18.00	\$8.31

VISION PLAN CONTRIBUTIONS

COVERAGE TIER	VSP VISION		
	EE COST/MONTH	EE COST/24 PAY	EE COST/52 PAY
Employee Only	\$6.04	\$3.02	\$1.39
Employee + Spouse	\$9.66	\$4.83	\$2.23
Employee + Child(ren)	\$9.86	\$4.93	\$2.28
Family	\$15.90	\$7.95	\$3.67



Behavioral Health:

Meritain



With these resources, you will have the support you need to prioritize your mental well-being. Please visit EMM Loans Beneportal at www.emmloansbenefits.com to view a list of providers and their contact information to get started.

Behavioral Health Resources

Meritain

Members enrolled in an EMM Loans medical/prescription drug plan can access mental well-being services from anywhere.

Take care of your mental health with convenient telehealth appointments and virtual mental well-being programs. Whether you are seeking counseling, medication, or support for mental health concerns, you can connect with providers in Meritain's network from the comfort of your home or wherever it is convenient for you. Providers are available to treat both adolescents* and adults for depression, anxiety, eating disorders, and more.

Please note: Coverage for telehealth services may vary depending on your plan and state in which you reside. Be sure to review your plan details on your member portal or call the number on the back of your ID card to confirm eligibility before scheduling services.

General Mental Well-Being (Depression, Anxiety, and Other Concerns):

- Brightline* (available in select states)
- Alma Health*
- Rula*
- Telemynd*
- Talkspace*
- Meru Health
- Brightside Health
- CVS MinuteClinic

Serious Mental Health Conditions:

- Charlie Health* (available in select states)

Chronic Medical and Mental Health Conditions:

- AbleTo

Eating Disorders:

- Equip Health*

*Available to dependents under age 18

Health Savings Account

Clarity

The HSA is only available to employees who elect the Med 1 EPO HSA Plan option and are otherwise eligible according to HSA eligibility rules. HSAs are known for their triple tax advantage — contributions are made pre-tax, growth is tax-free and withdrawals used for qualified health-care expenses are also untaxed.

HSA Highlights

An HSA is portable, meaning that if you leave your employer, you can take your HSA funds with you. There is no “use it or lose it” provision with an HSA. If you don’t use the money in your account by the end of the year, it just stays there and collects interest on a tax-deferred basis.

HSA Eligibility

You may contribute to an HSA if you:

- Are covered under an HSA Qualified High Deductible Health Plan (HDHP)
- Do not have disqualifying coverage such as other “first dollar” medical coverage etc.
- Are not entitled to (eligible and enrolled) Medicare
- Cannot be claimed as a dependent on someone else’s tax return

HSA Eligible Expenses Include:

- Medical and prescription drug deductibles, coinsurance, and copayments
- Dental deductibles, coinsurance, and copayments
- Orthodontia or other dental care
- Eye exams, contact lenses, and glasses

HSA Contributions

The maximum amount that can be contributed to an HSA in a tax year is established by the IRS and is dependent on whether you have single or family coverage. For 2025, the contribution limits are: **\$4,300** for individual coverage and **\$8,550** for family coverage. The annual catch-up contribution for individuals age 55 and older is \$1,000.

Getting Started is Easy!

If you enroll in the Med 1 EPO HSA Plan for 2025 and wish to participate in the HSA, you need to make your election via the ADP enrollment site. If you are turning 65 or older, please see www.medicare.gov for restrictions on HSA accounts.

*Scan the QR code to view a list of eligible healthcare expenses. Be sure to select **Clarity HSA** from the drop-down menu under **Solution!***



For more information on eligible expenses, please visit
www.irs.gov/publications/p502

Flexible Spending Accounts:

Clarity

Healthcare FSA

The Healthcare FSA is used to reimburse out-of-pocket healthcare expenses incurred by you and your dependents. The maximum you can contribute to the Healthcare FSA is **\$3,300**. You may carry over **\$660** of unused funds to the next plan year.

Eligible Expenses Include:

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

Dependent Care FSA

The Dependent Care FSA is used to reimburse expenses related to the care of eligible dependents. The maximum that you can contribute to the Dependent Care FSA is **\$5,000** if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is **\$2,500**.

Eligible Expenses Include:

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

Limited Purpose FSA

For those enrolled in Med 1 EPO HSA Plan, you may participate in a Limited Purpose FSA. The maximum you can contribute to the Limited Purpose FSA is **\$3,300**. Eligible expenses under the Limited Purpose FSA include dental and vision expenses only. You may carry over **\$660** of unused funds to the next plan year.

How Much Should I Contribute?

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period. If you do not use the money you contributed, it will not be refunded to you or carried forward to a future plan year. This is the use-it-or-lose-it rule.

*Scan the QR code below to view a list of eligible healthcare expenses. Be sure to select **Clarity FSA** or **Dependent Care FSA** from the drop-down menu under Solution!*



REMINDER: You cannot participate in both the Health Savings Account (HSA) and Healthcare Flexible Spending Account (FSA).

Commuter Benefits:

Clarity

Commuter Contributions

For the 2025 plan year you may contribute:

- **TRANSIT:** up to **\$325** per month for transportation (mass transit, train, subway, bus fares, ferry rides). Transit requires payment with the EMM Loans FSA debit card only.
- **PARKING:** up to **\$325** per month for parking expenses incurred at or near your work location or near a location from which you commute using mass transit.

At the end of the plan year, any balances in either account will remain in your account and be available for your use in the next plan year, unless your employment with EMM Loans is terminated.

Carryover & Eligible Expenses

There is no annual “use-it-or-lose-it” rule for Commuter Benefits. While unused amounts cannot be cashed out, they can be carried over to provide transit benefits in subsequent years.



Life and AD&D Insurance:

Guardian

Basic Life and AD&D Insurance

All active, full-time employees working at least 30 hours per week are eligible for the Basic life and AD&D plan. **EMM Loans pays 100% of the Basic life and AD&D premium.**

BASIC TERM LIFE AND AD&D PLAN	
Benefit Amount	\$25,000

Supplemental Life and AD&D Insurance - Employee

All active, full-time employees working at least 30 hours per week are eligible to purchase Supplemental Life and Accidental Death and Dismemberment (AD&D) insurance. Employees are responsible for 100% of the premium amount.

NOTE: Employees may increase current election amount by \$50,000 annually until your total coverage amount equals guaranteed issue amount of \$200,000, if under the age of 65.

SUPPLEMENTAL EMPLOYEE TERM LIFE AND AD&D	
Benefit Increments	\$10,000
Maximum Amount	\$500,000
Guaranteed Issue	
Employees under age 65	\$200,000
Employees age 65-69	\$50,000
Employees over age 70	\$10,000

Please note: Benefits reduce by 35% at age 65, and by 50% at age 70.

Supplemental Life and AD&D Insurance - Spouse

If you purchase Supplemental Life Insurance for yourself, you may purchase Supplemental Life and AD&D Insurance for your spouse as outlined below. You are responsible for 100% of the premium amount.

SUPPLEMENTAL SPOUSAL TERM LIFE AND AD&D	
Benefit Increments	\$5,000
Maximum Amount	\$250,000
Guaranteed Issue	
Spouses under age 65	\$25,000
Spouses age 65-69	\$10,000
Spouses over age 70	\$0

Please note: Benefits reduce by 35% at age 65, and by 50% at age 70.

Supplemental Life and AD&D Insurance - Child(ren)

You have the option of purchasing life insurance for your dependent child(ren), at your own expense.

SUPPLEMENTAL CHILD(REN) TERM LIFE AND AD&D	
Benefit Election	
Up to 14 days of age	\$1,000
14 days to 26 years	\$5,000 or \$10,000
Maximum Amount	
Up to 14 days of age	\$1,000
14 days to 26 years	\$10,000

Evidence of Insurability (EOI)

If you are newly participating in coverage, EOI is required if:

- You did not enroll when you initially became eligible for coverage
- You wish to elect additional coverage above the guaranteed issue amount
- Your spouse and/or dependent child(ren) elect any amount of additional coverage (even below guaranteed issue)

Disability Insurance:

Guardian



Disability Insurance

Long-Term Disability (LTD) Plan - Non-Contributory

All active, full-time employees regularly working at least 30 hours per week are eligible for the long-term disability (LTD) plan. **This plan is available to employees at no cost - EMM Loans pays 100% of the LTD premium.**

LONG-TERM DISABILITY (LTD) NON-CONTRIBUTORY PLAN	
Benefits Percent	50%
Benefit Maximum	\$1,300 per month
Duration	To SSNRA
Elimination Period	180 days

Disability Insurance

Long-Term Disability (LTD) Plan - Voluntary Buy-Up

All active, full-time employees regularly working at least 30 hours per week are eligible for the voluntary long-term disability (LTD) buy-up plan. **Employees pay 100% of the cost for this plan.**

LONG-TERM DISABILITY (LTD) VOLUNTARY BUY-UP PLAN	
Benefits Percent	60%
Maximum Benefit	\$5,000 per month
Duration	To SSNRA
Elimination Period	180 days

Disability Insurance

Short-Term Disability (STD) Plan - Voluntary

All active, full-time employees regularly working at least 30 hours per week (excluding those working in New Jersey or California) are eligible for the voluntary short-term disability (STD) plan. **Employees pay 100% of the cost for this plan.**

SHORT-TERM DISABILITY (STD) VOLUNTARY PLAN	
Benefits Percent	60%
Maximum Benefit	\$1,000 per week
Duration	26 weeks
Elimination Period	Accident: 0 days Sickness: 7 days

Evidence of Insurability (EOI) is required for LTD and STD if you did not enroll in coverage when you initially became eligible.

For more details on these plans, please refer to BenePortal.

Voluntary Benefits:

Guardian

Please Note: These benefits are voluntary and employees are responsible for **100%** of the premium.

Accident Insurance

If you and your family are active, chances are, you're no stranger to a hospital emergency room. Even with medical insurance, a fall while riding your bicycle or your child's sprained ankle at soccer practice can cost you a bundle in out-of-pocket expenses.

Financial Support to Help You Get Back on Your Feet

- No matter what kind of medical coverage you have, you may have out-of-pocket costs that could really set you back financially.
- Guardian pays you cash benefits on covered injuries, treatments and services.
- Payments go directly to you and can help pay for other expenses, like traveling to the hospital, childcare and lost income from missed work.
- The "Child Organized Sport" benefit pays you an extra 25% cash benefit for each accident when the dependent child is injured while playing an organized sport.

An Example of How Accident Insurance Works

While Sue was hiking in a local park, she fell and tore cartilage in her knee. She went to the hospital emergency room for treatment and stayed overnight. The doctor gave her a brace and scheduled her for a follow up visit. See how Accident Insurance offset Sue's Expenses:

Ambulance	\$200	Knee Brace	\$100
Hospital Admission	\$1,000	X-Ray	\$40
Emergency Room Visit	\$200	Knee Cartilage Tear	\$500
Hospital Confinement (1 Day)	\$250	6 Follow-Up Visits	\$300
MRI	\$200		

TOTAL CASH BENEFIT PAID FOR COVERED SERVICES: \$2,790

Critical Illness Insurance

Health care costs are on the rise. Even with medical insurance, you're often still responsible for both medical and non-medical expenses related to your recovery from a serious illness. The cost you pay for copays and deductibles, as well as other expenses could set you back financially.

Help Protect Your Savings

- The plan pays you cash benefits based on each eligible diagnoses such as heart attack, stroke or cancer.
- Pays a benefit for up to 33 covered illnesses, as well as offers a benefit for a reoccurring condition.
- The cash benefits are paid directly to you, so you decide how to use them.

Wellness Benefit

If you or a covered dependent complete an annual routine wellness screening or procedure such as a colonoscopy, mammogram, cholesterol testing etc., you will receive a benefit payment once a year. Please review the plan documents found on BenePortal for a full list of wellness screenings and procedures.

Employees and dependents that did not enroll when initially eligible but want to enroll during open enrollment or who wish to increase their coverage must complete the health questionnaire found on Beneportal:

- If you answered NO to all questions, then coverage may be issued
- If you answered YES to any questions, you do not qualify for enrolling in this plan or increasing your current coverage
- Forms must be signed and submitted to Guardian via email at CRU@glic.com

Additional Benefits

401(k)

Employees are auto-enrolled in the 401(k) plan at 4% following 60 days of employment. Employees do have the option of opting out.

EMM Loans has a “Contributory Plan” where the company will contribute 0.25% for every 1% that an eligible full-time employee contributes to their respective 401(k) account, to a maximum of 1% for the first 4% of employee contributions. For example, if an employee makes \$50,000 per year and contributes the maximum of 4% to their 401(k), they will receive the employer match of \$500.

More information related to the SPD, vesting requirements, available funds, and enrollment are available from the Human Resources Department.

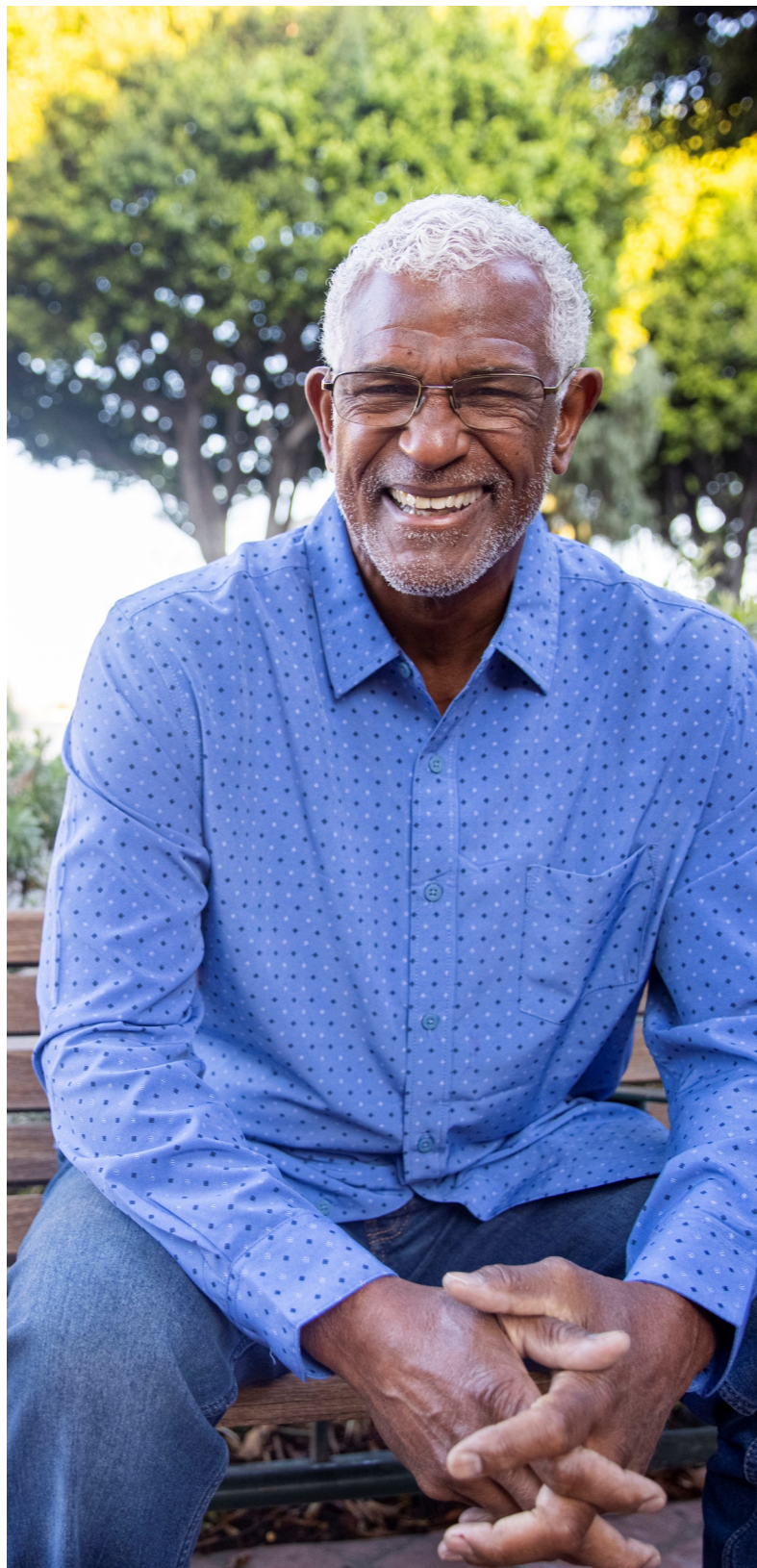
Pet Insurance

Pets Best Health Insurance offers a flexible, customizable insurance plan for a wide range of breeds with up to 90% reimbursement to cover accidents and illness with no annual limits and routine care included. Additional benefits and convenient options include:

- Direct-to-vet pay or direct deposit reimbursement
- Pre-authorization of claims
- Online and mobile app claim submission
- 24/7 vet helpline

Premiums are based on your pet’s specific information. Discounted premiums are available through LifeMart in ADP. Visit LifeMart in ADP for more information, to obtain a quote, and to enroll.

If elected, this benefit program is not processed via payroll deduction and you will be billed directory by Pets Best.



Wellness Resources:

Conner Strong & Buckelew



HealthyLearn

This resource covers over a thousand health and wellness topics in a simple, straightforward manner. The HealthyLearn On-Demand Library features all the health information you need to be well and stay well. Learn more at:

www.healthylearn.com/connerstrong

HUSK Marketplace

Achieving optimal health and wellness doesn't have to be complicated or expensive. Access exclusive best-in-class pricing with some of the biggest brands in fitness, nutrition, and wellness with HUSK Marketplace.

You can learn more about HUSK by visiting:

<https://marketplace.huskwellness.com/connerstrong>

Benefit Perks Discount Program

Benefit Perks is a discount and rewards program provided by Conner Strong & Buckelew that is available to all employees at no additional cost. The program allows consumers to receive discounts and cash back for hand-selected shopping online at major retailers.

Use the Benefit Perks website to browse through categories such as Automotive, Beauty, Computer & Electronics, Gifts & Flowers, Health & Wellness, and much more! Consumers can also, print coupons to present at local retailers and merchants for in-person savings, including movie theatres and other services.

Start saving today by registering online at:

<https://connerstrong.corestream.com>

Please note: You do not have to be enrolled in benefits to take advantage of these programs!

Benefit Resources:

Conner Strong & Buckelew

Benefits Member Advocacy Center

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits MAC can help guide the way!

The Benefits Member Advocacy Center ("Benefits MAC"), provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider of your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Guide you through the enrollment process or how you can add or delete coverage for a dependent
- Discover all that your benefit plans have to offer!

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

You may contact Member Advocacy in any of the following ways:

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am, to 5:00 pm (Eastern Time)
- Via web: **www.connerstrong.com/memberadvocacy**
- Via e-mail: **cssteam@connerstrong.com**
- Via fax: **856.685.2253**



BenePortal

BenePortal is a valuable online resource that houses all of our benefit program information. It's your One-Stop-Shop for:

- All benefits-related information and downloads, including benefit summaries and detailed plan documents
- Quick links to carrier websites
- Enrollment forms and wellness forms
- And much more!

You and your family can access
BenePortal anytime at
www.emmloansbenefits.com

Carrier Contacts

BENEFIT PLAN	CARRIER NAME/CONTACT	PHONE NUMBER	WEBSITE/EMAIL
Medical	Meritain	800.925.2272	www.meritain.com
Prescription Drug	Express Scripts	800-669-3612	www.express-scripts.com
Dental	Delta Dental	PPO: 800-452-9310 DHMO: 800-422-4234	www.deltadental.com
Telemedicine	Teladoc	800-835-2362	www.teladoc.com
Mental/Behavioral Health Resources	Array	800-442-8938	https://arraybc.com
Vision	VSP	800-877-7195	www.vsp.com
Flexible Spending Accounts	Clarity Benefit Solutions	888-423-6359	www.claritybenefitsolutions.com
Life & Disability and Voluntary Benefits	Guardian	888-600-1600	www.guardiananytime.com
Assistance With Claims	Benefits Member Advocacy Center ("Benefits MAC")	800-563-9929	www.connerstrong.com/memberadvocacy
Assistance With Medicare	Karen Carella/The Assurance Group	856-533-0213	kacarella@assuregrp.com
HR Questions/Enrollment Changes	Amy Mallon	800-793-9633 x 117	amallon@emmloans.com



Legal Notices

Eligibility

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

Notice Regarding Special Enrollment

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

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of coverage for Medicaid or a State Children's Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP).

New dependent by marriage, birth, adoption, or placement for adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Human Resources

Newborns' and Mothers' Health Protection Act

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

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

Women's Health and Cancer Rights Act

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

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

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

Availability of Summary Health Information

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

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

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

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 July 31, 2024. Contact your State for more information on eligibility –

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

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

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ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIP (855-692-7447)

CALIFORNIA – MEDICAID

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 (CHIP+)

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

FLORIDA – Medicaid

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid Website: <https://www.in.gov/medicaid/>
<http://www.in.gov/fss/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <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

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPPI.PROGRAM@ky.gov
KCHIP Website: <https://kynect.ky.gov>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: www.mymaineconnection.gob/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: 800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840 TTY: 711
Email: masspreassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 1-573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-495-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

Legal Notices

PENNSYLVANIA – Medicaid and CHIP

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

Phone: 1-800-692-7462

CHIP Website: <https://www.pa.gov/en/agencies/dhs/resources/chip.html>

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

RHODE ISLAND – Medicaid and CHIP

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

Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

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

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

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

Phone: 1-888-828-0059

TEXAS – Medicaid

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

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

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

Email: upp@utah.gov

Phone: 1-888-222-2542

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

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

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

VERMONT – Medicaid

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

Phone: 1-800-562-3022

VIRGINIA – Medicaid and CHIP

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

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

Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <http://mywvhipp.com/> and <https://dhhr.wv.gov/bms/>

Medicaid Phone: 304-558-1700

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

WISCONSIN – Medicaid and CHIP

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

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

Notice Regarding Wellness Program

EMM Loans offers a voluntary wellness program for all employees and spouses enrolled in a medical plan with EMM Loans. Employees and spouses who choose to participate must both receive their annual physicals and routine bloodwork. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Employees and covered spouses (if applicable) who participate in the wellness program will contribute less towards their medical/prescription drug premiums compared to those who choose not to participate.

If you are unable to participate in the wellness program, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation to an alternative standard by contacting Amy Mallon at 856-581-2017.

The results of your biometric screening and bloodwork provide you with information to help you understand your current health and potential risks. You are also encouraged to share your results or concerns with your own doctor.

Legal Notices

Important Notice From EMM Loans 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 EMM LOANS 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. EMM LOANS has determined that the prescription drug coverage offered by the [Insert Name of 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 EMM LOANS coverage will not be affected. If you elect Part D coverage, the plan will coordinate with Part D.

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

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

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

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

Contact Human Resources for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through EMM LOANS 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.

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:	September 2024
Name of Entity/Sender:	EMM Loans
Contact-Position/Office:	Amy Mallon, VP of Human Resources
Address:	1950 Route 70 East, 3rd Floor Cherry Hill, NJ 08003
Phone Number:	800-793-9633 x 117

Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 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 in October 2013 for coverage starting as early as January 1, 2014.

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. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% 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 the insurance carrier's customer service number located on your ID card. 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. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to <https://www.healthcare.gov/marketplace/individual/>.

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.

Important Notice

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

3. Employer Name Emm Loans LLC		4. Employer Identification Number (EIN) 54-2070914	
5. Employer Address 1950 Route 70 East, 3rd Floor		6. Employer phone number 856-581-2017	
7. City Cherry Hill	8. State New Jersey	9. Zip Code 08003	
10. Who can we contact about employee health coverage at this job? Amy Mallon, VP Human Resources			
11. Phone number (if different from above)		12. Email address HR@emmloans.com	

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.



This benefit summary provides selected highlights of the employee benefits program at EMM Loans. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at EMM Loans. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. EMM Loans reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.