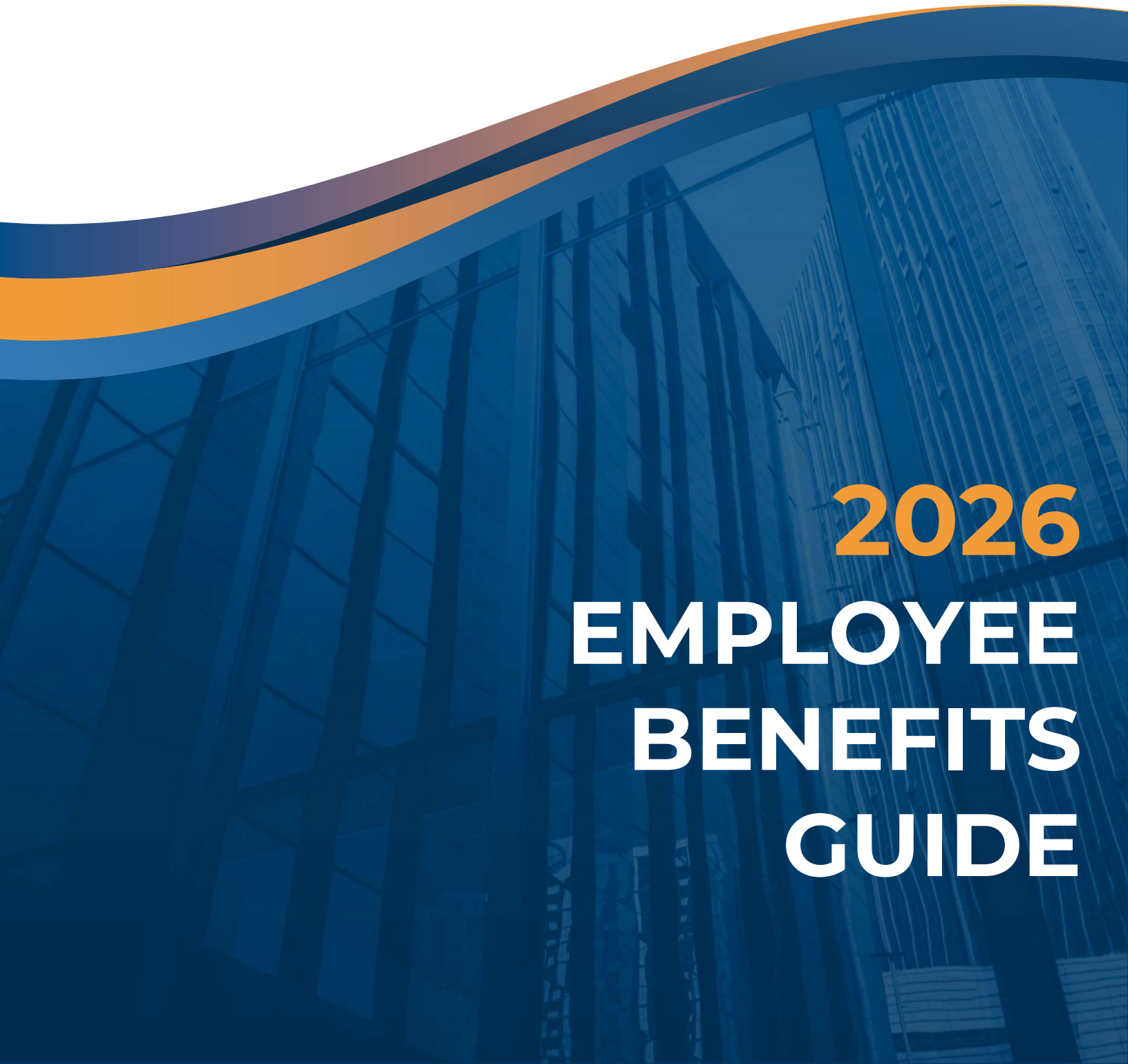
LIBERTY



2026 EMPLOYEE BENEFITS GUIDE

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Welcome to your **2026 Benefits Guide**

Whether you are new to The Liberty Company (*Welcome!*) or a current employee (*Thank you for your service!*), information you need for enrollment is available in this guide and on **the microsite**.

Here you will find a wide spectrum of plans and benefits for you and your family. Use this guide to learn what is available and how to enroll in your benefits*. You may also visit Liberty's Employee Benefits Workvivo Space before you enroll and check back throughout the year for benefits related information and updates.

Take time to review, ask questions and make decisions that give you the best coverage to fit you and your family's needs. More details on a topic or benefit can also be found in Workvivo or Paycom, or email **benefits@libertycompany.com**

Have questions?
We are here to help!

Email: benefits@libertycompany.com

Phone: 818-914-3986

**The information included in this guide is intended as an overview only. It is not a complete description, nor is it a substitute for the applicable plan documents, Summary Plan Descriptions or insurance contracts. In all cases, the official plan documents govern and are the final authority on the terms of the benefit plans. The company reserves the right to modify, amend or terminate the benefit plans at any time and for any reason. Receiving this document or participating in company benefits is not a guarantee of future or continued employment or benefits.*

Eligibility

The Liberty Company's benefits are available to you if you're actively working 30 hours or more per week and designated as a full-time employee.

The waiting period for coverage is the first day of the month following your date of hire in a benefits-eligible position for new hires, or reclassification as a full-time employee in a benefits-eligible position.

As a new employee, you must enroll in benefits within 30 days of your date of hire. If you do not actively elect benefits during this window, your next opportunity is the following open enrollment period. You will automatically be enrolled in employer-paid benefits. Be sure to add your beneficiaries accordingly. You may also change your benefits within 30 days of a document-supported qualifying life event.

An open enrollment window is provided each year so employees can review and change their coverage(s) for the following year's benefits plan, running from January 1st through December 31, 2026. To take advantage of The Liberty Company's benefits in 2026, you must enroll by the applicable deadline. Remember, you need to take action to make sure you have the coverage that is right for you.

Eligible Dependents

- Your spouse. The term "spouse" means the individual lawfully married to you.
- Your domestic partner. Domestic partners must be 18 years of age or older and unmarried; not related by blood in any manner that would prohibit legal marriage; have assumed mutual obligations for the welfare and support of each other; share a common residence and live together as a couple in the same household; and each other's sole domestic partner.
- Your qualified child(ren) under the age of 26. This can be your biological son or daughter, stepson or stepdaughter, a legally adopted individual, or an individual who is lawfully placed with you for legal adoption.
- Your unmarried child(ren) who is disabled, living with you, dependent on you for support and unable to support themselves due to a mental or physical disability. Documentation required.

Documentation Requirements for Dependents

If you enroll your spouse, domestic partner, and/or eligible dependent child(ren), you may be required to provide documentation to The Liberty Company's HR Department to confirm their eligibility for coverage.

Acceptable Forms of Documentation include but are not limited to:

- Marriage license for spouse.
- Domestic partner attestation.
- Birth certificate for children.
- First page of your most recent tax return, listing eligible dependents (for spouse and/or children).
- Court-ordered guardianship papers, adoption papers, or placement letter.
- Divorce decree to show parent/child relationship when names don't match or to identify responsibility for providing health coverage.

Enroll Online

To enroll, go to **Paycom**. Then follow these easy steps.

1. Go to the Notifications Center (bell icon), tap the current year's Benefits Enrollment, review the instructions, then tap "Start Enrollment."
2. Ensure you review your information as well as tap "Edit" to make any changes or "Next" to continue.
3. Choose to enroll in or decline a plan by checking the appropriate option. If necessary, choose which dependent(s) to add. When finished, tap "Enroll." Continue for each benefit plan.
4. When finished, review your enrollment and tap "Finalize." Then, tap "Sign and Submit" in the pop-up window. Your enrollment is complete! *Don't forget to save a copy of your enrollment confirmation for your records.*

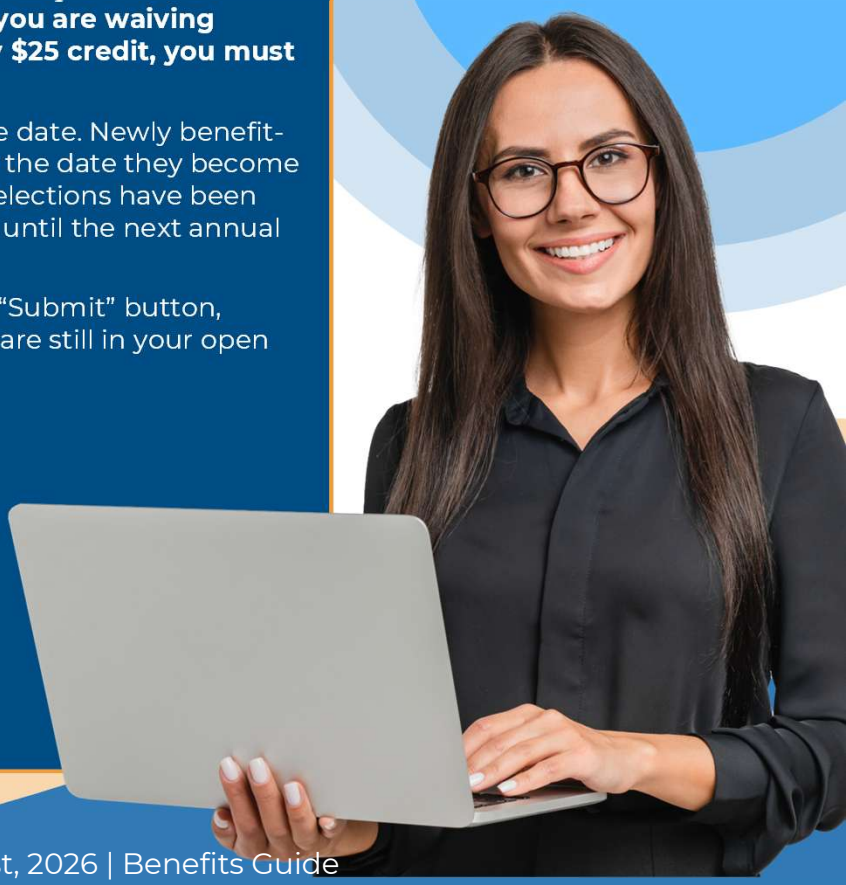
You will be required to either elect or waive each benefit.

Enrollment is Easy...and Just a Click Away

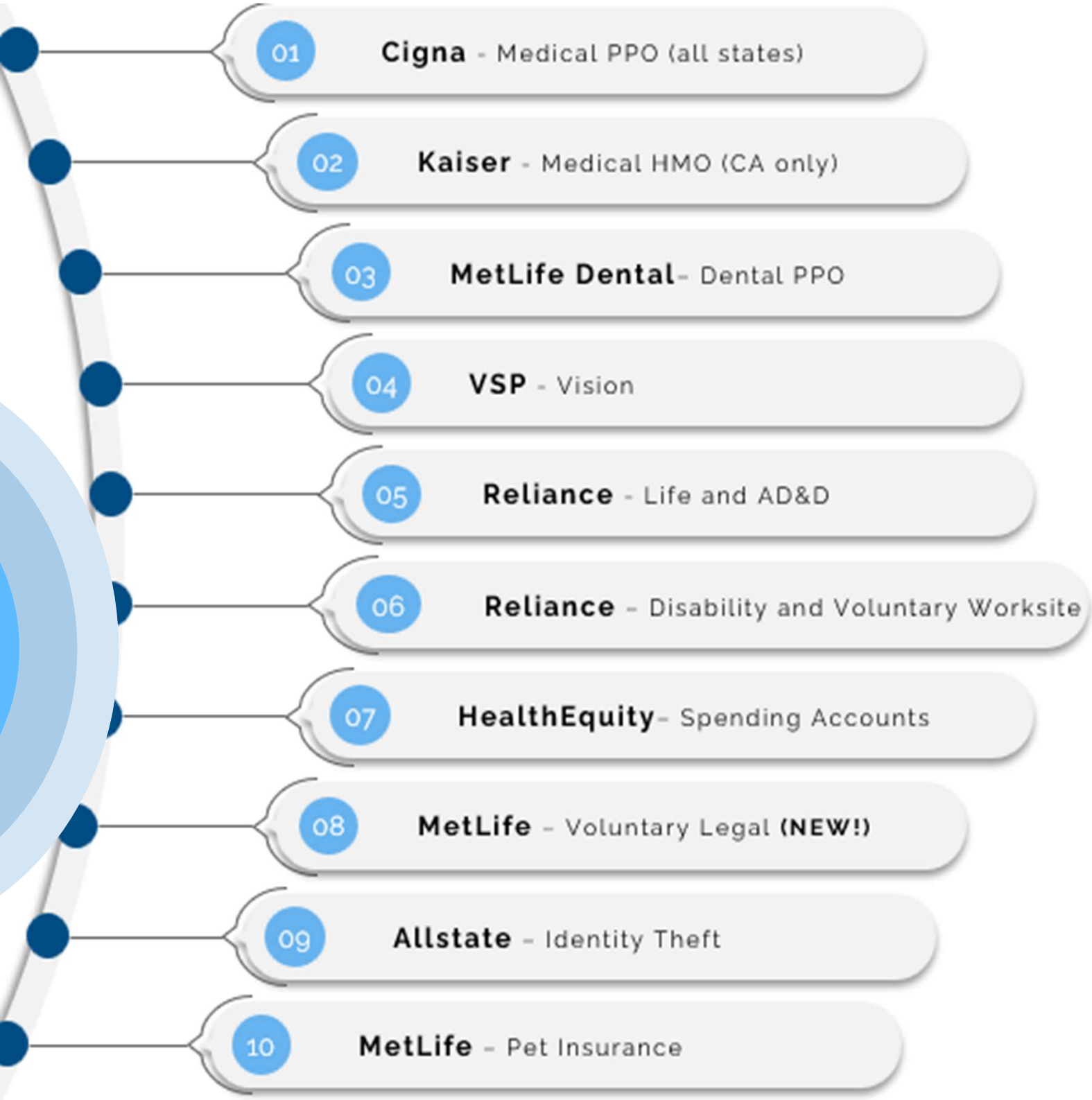
- Once you are ready to enroll, you will need:
  - Your Paycom username and password.
  - Social security numbers and dates of birth for yourself and any covered dependents.
  - Beneficiary information, such as names, date of births, addresses and social security numbers.

Below are a few reminders and helpful hints to help you through the process:

- All benefit-eligible employees need to enroll to receive benefits in 2026.
- Don't want benefits? You still need to log in and assign beneficiaries when prompted as well as decline coverages. **If you are waiving medical but want to receive the semi-monthly $25 credit, you must opt into the credit.**
- New hires must enroll within 30 days of their hire date. Newly benefit-eligible employees must enroll within 30 days of the date they become benefit eligible. Keep in mind that once benefit elections have been finalized, changes to selections cannot be made until the next annual enrollment period.
- Your selections are complete once you click the "Submit" button, however you may edit your selections while you are still in your open enrollment window.



Benefits Snapshot



Premium Payment

You and The Liberty Company contribute to the cost of your benefits. If enrolled in health benefits that require an employee contribution as well as FSAs and HSAs, your share is deducted from your paycheck on a pre-tax basis (if eligible); the money is taken out of your pay before the following taxes have been deducted:

- Federal income taxes
- State income taxes
- Social Security taxes

This means your current taxable income is lower and you pay less in taxes.

Your contributions for all other benefits where you purchase coverage, such as optional life insurance, spousal/domestic partner and/or child life insurance, accident, critical illness, ID Theft, and Legal Services are all post-tax.

The value of any Domestic Partner coverage is deducted from your paycheck on an after-tax basis per IRS rules.

Benefits	Who pays the Cost	Pre-Tax or Post-Tax
Medical and Prescription Drug Coverage	Shared	Pre-tax
Dental Coverage	Shared	Pre-tax
Vision Coverage	Shared	Pre-tax
Life Insurance—Basic	Company	No cost to employee
Life Insurance—AD&D	Company	No cost to employee
Life Insurance—Optional	You	Post-tax
Life Insurance—Optional AD&D	You	Post-tax
Spouse Life & AD&D Insurance—Optional	You	Post-tax
Child Life & AD&D Insurance—Optional	You	Post-tax
Flexible Spending Accounts— (Heath and Dependent Care)	You	Pre-tax
Health Spending Account (HSA)	Shared	Pre-tax
Short-term Disability (STD)	Company	No cost to employee
Long-term Disability (LTD)	Company	No cost to employee
Employee Assistance Program (EAP)	Company	No cost to employee
Accident Insurance	You	Post-tax
Critical Illness Insurance	You	Post-tax
Identity Theft	You	Post-tax
Pet Insurance	You	**Direct bill**
Legal Services (NEW!)	You	Post-tax
Retirement - 401(k)	Shared*	Pre-tax

**Shared based on eligibility for employer contribution is met.*

Health Care Premiums

Premiums for Coverage

The Liberty Company provides medical, dental, and vision care benefits on a cost-sharing basis. Liberty will pay for a portion of the plan premiums. To access these benefits, you pay the remainder of the premium. The premium is deducted before taxes (if eligible) from your pay on a semi-monthly basis.

- The amount you pay is determined by whether you want to include just yourself, your entire family, or some combination in between.
- All employees have the option of selecting a medical plan from Cigna. There are three options: Cigna Core PPO, Cigna Buy-Up PPO, and Cigna HDHP. For those who reside in California, there are two additional options with Kaiser Permanente: HMO (High) and HMO (Low).. The premiums for each of these plans vary, as do the benefits covered. You should consider both the premium amount and the amount of benefits coverage under each plan before making your selection.
- You are free to choose any other health care coverage you wish and decline any coverage you do not need. For instance, you can select medical coverage but decline dental and vision. Or select dental, but no medical or vision. Any combination is acceptable.
- If you waive the medical coverage because you are enrolled in medical elsewhere, The Liberty Company provides a $25 semi-monthly medical opt out payment to your paycheck.

Full-Time Employees — 2026 Semi-Monthly Deductions (per paycheck)

Coverage	Cigna Core PPO	Cigna Buy-Up PPO	Cigna HDHP	Kaiser HMO $15 (High) CA Only	Kaiser HMO $750 (Low) CA Only	Waive Medical	MetLife Dental	VSP Vision
Employee Only	$59.04	$84.16	$0.00	$44.26	$0.00	$25 credit	$1.94	$0.45
EE + Spouse/ Domestic Partner	$383.77	$436.45	$109.95	$309.79	$200.92		$13.85	$2.08
EE + Child(ren)	$324.73	$372.39	$76.98	$265.53	$166.56		$17.57	$2.16
EE + Family	$649.45	$724.70	$258.28	$486.81	$338.35		$32.66	$4.60



Medical Plans & Pharmacy

You have options when it comes to your medical and pharmacy benefits, each with different levels of coverage. When you visit providers within the **Cigna PPO, Cigna HDHP**, or **Kaiser Permanente HMO** network, your cost is less. When seeking care outside of the network, you will pay an increased portion of the costs.

Understanding Your Options:

Cigna PPO (Core & Buy-Up)

PPO stands for Preferred Provider Organization. A PPO plan allows you to seek care in and outside of the Cigna OAP provider network. You do not need a referral and are not required to select a Primary Care Provider (PCP). You or your covered dependents will pay less out of your pocket by obtaining care in the Cigna provider network. You have access to the telehealth provider MDLive, so you can access care when, where, and how you need it.

Cigna High Deductible Health Plan (HDHP)

In a High Deductible Health Plan, you have access to seek in and outside of the Cigna OAP provider network, just like the PPO plans. Under a HDHP, you will need to first satisfy your deductible. Then you will pay a percentage of the cost of covered services through coinsurance until your out-of-pocket maximum is reached, after which the plan will pay 100% of the cost of covered services by in-network providers for the remainder of the plan year. For out-of-network claims you will be responsible for the costs over the allowed Cigna charges and balance billed by the provider or facility. You have access to the same Telehealth providers as the PPO.

The Cigna HDHP plan can be paired with an HSA account. An HSA is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses, including dental and vision. By saving money into your account, you reduce your taxable income. HSAs are the only benefit account to provide a triple tax benefit, which means that you can make tax-free contributions, you can earn interest tax-free, and funds that are withdrawn for qualified expenses are also tax-free.

- Contributions are tax-free*
- Account growth is tax-free*
- Qualified withdrawals are tax-free

If you choose to enroll in the HDHP plan, the Liberty Company will contribute to your HealthEquity HSA bank account to invest in your health and to offset your expenses. As an employee only, the contribution will be up to $500 and up to $1,000 if you are enrolled as employee with 1 or more dependents.

**HSA contributions and earnings are not subject to federal taxes and not subject to state taxes in most states. A few states do not allow pretax treatment of contributions or earnings. Please consult your personal tax advisor or contact your plan administrator for information about your state.*

Kaiser Permanente HMO (Low and High)

HMO stands for Health Maintenance Organization. Kaiser's integrated care delivery system offers care and coverage together in one package, under one roof. The HMO requires you to choose a Kaiser Primary Care Physician (PCP) to direct your care including referrals to in-network specialists, when necessary.

You will pay a copayment (copay) or coinsurance for most services. There is no out-of-network care, unless it is an emergency. If you are traveling outside the Kaiser California network, they offer extended emergency room care through the Cigna Network. Telehealth visits are available to ensure you and your covered dependents have many convenient ways to access care.

MEDICAL PLANS

	Cigna Base PPO		Cigna Buy-Up PPO		Cigna HDHP		Kaiser HMO $15	Kaiser HMO $750 Deductibl
General Plan Information	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**
Health Savings Account								
Employer HSA Contribution	Not Applicable		Not Applicable		Up to: $500/Individual; $1,000/Family (Employee + one or more)		Not Applicable	Not Applicable
Deductible								
Individual Deductible (ded)	$750	$2,000	$250	$750	$3,000 $3,400 Individual in a Family	$6,000	$0	$750
Family Deductible (ded)	$2,250*	$6,000*	$750*	$2,250*	$6,000*	$12,000*	$0	$1,500
Out-of-Pocket Maximum								
Individual	$3,000	$10,000	$2,500	$5,000	$4,000	$10,000	$1,500	$3,000
Family	$6,000	$20,000	$5,000	$10,000	$8,000	$20,000	$3,000	$6,000
Coinsurance & Copays								
Coinsurance	20%	50%	20%	50%	20%	50%	N/A	20%
Primary Care	$30 copay	50% after ded	$20 copay	40% after ded	$30 copay after ded	50% after ded	$15 copay	$30 copay
Specialist	$30 copay	50% after ded	$20 copay	40% after ded	$30 copay after ded	50% after ded	$15 copay	$40 copay
Telehealth Visit	$30 copay	N/A	$20 copay	N/A	$30 copay after ded	N/A	100%, no copay	100%, no copay
Preventative Care Services	100%, no copay	50% after ded	100%, no copay	40% after ded	100%, no copay	50% after ded	100%, no copay	100%, no copay
Urgent Care & Emergency								
Urgent Care	$35 copay	50% after ded	$25 copay	40% after ded	20% after ded	50% after ded	$15 copay	$30 copay
Emergency Room	$100 copay, waived if admitted		$100 copay, waived if admitted		$100 copay, waived if admitted; after ded		$200 copay	20% after ded
Hospital Services								
Inpatient	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	$250/admission	20% after ded
Outpatient	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	$15/procedure	20% after ded
Other Services								
Mental Health/Substance Abuse								
Inpatient	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	$250/admission	20% after ded
Outpatient	$30 copay	50% after ded	$20 copay	40% after ded	$30 copay after ded	50% after ded	$15 copay	$30 copay
Durable Medical Equipment	20% after ded	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded	20% coinsurance	20% coinsurance
Chiropractic Care	$30 copay, 20 visits	Not Covered	$20 copay, 20 visits	Not Covered	20% after ded, 20 visits	Not Covered	$15 Copay, 20 visits	$15 Copay, 20 visits

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	Cigna Base PPO		Cigna Buy-Up PPO		Cigna HDHP		Kaiser HMO $15	Kaiser HMO $750 Deductible
General Plan Information	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Prescription Drugs								
Retail	30 days		30 days		30 days		30 days	30 days
Generic	$15 copay	Not Covered	$15 copay	Not Covered	$15 copay after ded	Not Covered	$10	$15
Preferred Brand	$30 copay		$30 copay		$30 copay after ded		$30	$35
Non-Preferred Brand	$60 copay		$60 copay		$60 copay after ded		$30	$35
Specialty	20%, $250 max		20%, $250 max		20%, $250 max after ded		20%, $250 max	20%, $250 max
Mail Order	90 days		90 days		90 days		100 days	100 days
Generic	$45 copay	Not Covered	$45 copay	Not Covered	$45 copay after ded	Not Covered	$20	$30
Preferred Brand	$90 copay		$90 copay		$90 copay after ded		$60	$70
Non-Preferred Brand	$180 copay		$180 copay		$180 copay after ded		$60	$70
Specialty	N/A		N/A		N/A		N/A	N/A

Comparing the Options

While you review your medical plan options, you should understand how they work. Start with these terms:

- Coinsurance: A set percentage you pay of the cost of the care you receive, for example 20%.
- Copay: A set dollar amount you pay when you receive health care, for example $35 when you see a specialist.
- Deductible: A set amount you must pay out of your pocket before the plan starts paying part of the cost unless a copay applies.
- Out-of-pocket maximum: The most you will pay in a calendar year for provider visits, prescriptions, etc., for covered expenses and includes your deductible, copays, and coinsurance. This "safety net" provides peace of mind for those who have a serious condition or illness.

** Family members are responsible to only meet their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.*

***Member Choice Cigna Go Now: This network of pharmacies includes major retail chains of Walgreens and CVS, in addition to other grocery, retailer, and independent pharmacies. You will be aligned with either the Walgreens OR CVS network based on your existing pharmacy relationship. Where no relationship exists, you will be aligned with the CVS network. There is the option to select the Walgreens network by going to myCigna.com or calling the phone number on the back of your ID Card.*

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Medical Plans & Pharmacy

You will get the best cost savings by going to a provider listed in the Health Plan Provider Directory.

To locate an in-network provider:

- **Cigna**: log on to www.cigna.com , select "OAP" and click "Find a Doctor"
- **Kaiser**: log on to www.kp.org and click "Doctors & Locations"

Wellness/Preventive Benefits

Treatment for most wellness and preventive care services are covered at 100% with no cost to you from in-network providers. Using these benefits is an excellent way to take care of your health!

To receive 100% coverage, your provider will need to code preventive services as wellness and preventive care.

If non-routine or non-preventive care is added at the time of treatment, such as additional tests, procedures or lab work, then the cost may be subject to copays, deductibles and coinsurance.

If you have any questions about how your claims for preventive care are managed, contact:

- **Cigna**: 888-806-5094 or visit www.mycigna.com
- **Kaiser**: 800-464-4000 or visit www.kp.org.

Prescription Drug Coverage

Prescription drug coverage for you and your covered dependents is included with either the Cigna or Kaiser Medical plan. When you or a covered family member need a prescription filled, you may use your medical ID card at the retail pharmacy that participates in the pharmacy network. You pay a share of the cost of your prescription in the form of a copay or coinsurance. The amount you pay depends on whether you receive a generic, preferred brand, non-preferred brand name or specialty drug and which pharmacy you choose. Formularies are subject to change during the plan year.

If you have any questions about prescription drug benefits, contact:

- **Cigna**: 888-806-5094 or visit www.mycigna.com
- **Kaiser**: 800-464-4000 or visit www.kp.org.

Please note that ID cards are not issued. You can download a digital copy and/or print a paper copy by logging in to your Cigna or Kaiser account online or through the app.

Download the MyCigna® App

Cigna

Available on the App Store

GET IT ON Google Play

Download the Kaiser Permanente App

Available on the App Store

GET IT ON Google Play

Dental

The dental care plan is administered through **MetLife**. While you can visit any licensed dentist, your cost is lower when you visit a dentist in the MetLife network. MetLife pays based on the 90th percentile of the Usual and Customary Rate to out-of-network dental providers, so you could receive a balance bill for any service provided by an out-of-network provider including preventive care. See the chart below for the differences in coverage and benefit levels. Download the MetLife US mobile app to have your ID card and plan details at your fingertips!

Please note that ID cards are not issued. You can download a digital copy by logging in to your MetLife account or the MetLife US mobile app, or the provider will look you up with your social security number.

If you or your dependents, are covered by another dental plan in addition to The Liberty Company's Dental Plan, you should advise your dental office so that benefits can be coordinated between the plans. For more information, see the Dental Plan summary plan description (SPD).

For additional information or to obtain a list of providers in the network, visit www.metlife.com/mybenefits or call 800-GET-MET8.

MetLife Dental		
	PPO In-Network	Out-of-Network*
Preventative	0% deductible waived	0% deductible waived
Deductible		
Individual/Family	$25/$75	
Basic	You pay 20% after ded.	You pay 20% after ded.
Major	You pay 40% after ded.	You pay 50% after ded.
Annual Maximum	$5,000 per person	
Orthodontia		
Adults and Dependents (Under Age 26)	50%	50%
Orthodontia Lifetime Maximum	$1,000 per person	

Value Added Benefits

- **Teledentistry options**- connect with a dentist from your smartphone, tablet, or computer
- **International Dental Travel Assistance** – 24/7 help in multiple languages, access to providers in 200 countries
- **MetLife SpotLite on Oral Health** – a recognition awarded to dentists who focus on preventative oral care and improved oral health outcomes. Look for this badge when selecting a dentist!

GET IT ON Google Play

Available on the App Store

Vision

The vision care plan is administered by **Vision Service Plan (VSP).** It is designed to encourage you to maintain your vision through regular exams and to help with expenses for prescription glasses and contact lenses. With this plan, you may use in- or out-of-network providers, but the level of benefit is higher when you receive care from a network provider.

A listing of network providers can be found at www.vsp.com or by calling 800-877-7195. **Please note that ID cards are not issued.** You can download a digital copy by logging in to your VSP Vision account, or the provider will look you up with your social security number.

For more information, including plan limitations, exclusions, and discounted services; please refer to the Vision Care Summary Plan Description (SPD) by visiting the Liberty Employee Benefits space on Workvivo.

VSP Benefit Coverage	In-Network	Out-of-Network
Exams		
Frequency	Every Calendar Year	
Exam Copay	$10	up to $45
Frames		
Frequency	Every Other Calendar Year	
Allowance	$180 frame allowance	up to $70
Discount on amount over allowance	20% savings	N/A
Frame Copay	$25	$25
Lenses*		
Frequency	Every Calendar Year	
Allowance	Included in prescription glasses	
Single Vision	Included	up to $30
Bifocal/Trifocal	Lined Bifocal/Trifocal Included	up to $50/up to $65
Progressives (Standard or Premium)	Standard: $0, Premium: $95-$105 copay, Custom: $150-$175 copay	No Coverage
Contact Lenses*		
Frequency	Every Calendar Year	
Copayment	up to $60	N/A
Examination Fee	Fitting & Evaluation Included in copay	N/A
Elective Contact Lens Allowance – Disposable and Conventional	up to $180	up to $105 Elective for Professional Fees & Materials

**VSP will cover either eyeglasses OR contact lenses each year, but not both*

Value Added Benefits

- Retina Screening – up to $39 with exam, $0 for diabetics
- Prescription sunglasses – Extra $20 coverage on featured frame brands, plus 20% savings.
- Laser Eye Surgery – 15% off regular price, 5% off promotional price
- Use Vision Rescue for 15-20% off eye care products including contact lens solutions, eye drops, vitamins, and more.
- VSP Simple Values hosts a wide variety of discount offers and services.

Savings and Spending Accounts

HealthEquity®

The Health Savings Account (HSA) and Flexible Spending Accounts (FSA) are administered by **HealthEquity** and subject to non-discrimination testing. These accounts help you save money on out-of-pocket expenses that you and your dependents incur during the calendar year. They help reduce your taxable income while also paying for eligible expenses for yourself and your dependents.

It's important to keep a record of the expenses you pay with your HSA or FSA in case you are asked to prove to the IRS that an expense was eligible for reimbursement from your account. Examples of records you should keep include receipts, Explanation of Benefits (EOB), medical diagnosis/physician diagnosis letters, and prescriptions.

NOTE: You may only participate in the HSA bank account if you are enrolled in the Cigna HDHP plan and meet eligibility requirements. **You can only participate in a LPFSA if you have the HSA**.

Flexible Spending Accounts (FSA) – Healthcare and Dependent Care

Flexible Spending Accounts (FSA) allow you to set aside pre-tax money in an account to pay for certain expenses for yourself and your dependents. Contributions to your FSA will be taken out of your paycheck pre-tax, so you save money by lowering your taxable income. Simply present your FSA debit card for the purchase of eligible services and goods.

Visit the HealthEquity Education page to learn how to maximize these benefits!

*Visit **irs.gov** for definition of eligib tax dependent as well as a view full list of eligible expenses under Section 125.*

Savings and Spending Accounts

HealthEquity®

Guidelines and Eligible Expenses*

Healthcare FSA	Dependent Care FSA	NEW! Limited Purpose FSA
$3,400 annual maximum. Your entire election is available immediately regardless of actual payroll deduction amounts. Carry over up to $680 for the following calendar year. Expenses can be for you or anyone you claim as a dependent on your Federal tax return** Expenses must be incurred by December 31st and submitted for reimbursement by March 31st of the following year	$7,500 annual maximum. Can only be reimbursed up to what has been deducted from payroll (pay as you go). There is no carryover allowance. Dependents include children under age 13 or dependents that are physically or mentally unable to care for themselves and who have lived with you for more than half a year. Expenses must be incurred by December 31st and submitted for reimbursement by March 31st of the following year	$3,400 annual maximum. Your entire election is available immediately regardless of actual payroll deduction amounts. Carry over up to $680 for the following calendar year. Expenses can be for you or anyone you claim as a dependent on your Federal tax return** Expenses must be incurred by December 31st and submitted for reimbursement by March 31st of the following year **Can be used with an HSA**
Eligible health care, vision, and dental expenses include but are not limited to: • Medical plan office visit copays, deductibles and coinsurance. • Dental care – cleanings, fillings, exams, orthodontia. • Eye care – eyeglasses, contact lenses, LASIK.	Used for dependent day care expenses while you (and your spouse) work, look for work. or attend school full- time. • Expenses for a day care center, summer day camp, or preschool for children under 13 years of age. • Expenses for an unlicensed day care center that cares for six or fewer children. • Expenses at an adult day care facility (but not expenses for overnight, nursing home facilities).	Eligible vision and dental expenses include but are not limited to: • Dental care – cleanings, fillings, exams, orthodontia. • Eye care – eyeglasses, contact lenses, LASIK.

To view a comprehensive list of eligible expenses, visit the HealthEquity QME site.

*This is only an example of eligible expenses.

*Visit **irs.gov** for definition of eligible tax dependent as well as a view a full list of eligible expenses under Section 125.*

Using Your Flexible Spending Account

How it Works

- Estimate your expenses and make an annual deduction election for the account(s) that applies to you. Unused FSA funds may be forfeited at the end of each plan year, so budget carefully.
- Your annual election is calculated on a per pay period basis; it is deducted from your paycheck. Payroll deductions begin the effective date of your election and continue through the end of the calendar year.
- A Health Equity debit card will be issued to all participants. When you incur eligible expenses throughout the year, present your debit card for payment.
- Eligible expenses are only reimbursable if they occur on or after the date of benefit eligibility.

Filing Claims and the Reimbursement Process

- It's important to keep a record of the expenses you pay with your FSA. The IRS requires documentation for many expenses to confirm they are eligible under the plan.
    - Keep all receipts. Use your debit card at the time of service or submit your receipts with a completed reimbursement claim form. Some debit card transactions may still require a receipt.
- You can download the HealthEquity Mobile App to view your dashboard and manage claims.
- For more information on FSAs, including available balance, savings calculator, expense planning worksheets, reimbursement claim forms, and IRS publications, visit healthequity.com or call their customer service line at **866-346-5800.**



GET IT ON Google Play

Available on the App Store

Health Savings Account (HSA)

The HSA is a savings account used to pay for qualified medical, dental, and vision expenses by using your HealthEquity HSA debit card or to reimburse yourself at any time for qualified expenses paid out-of-pocket.

Maximum contributions are set by the IRS. For 2026, the total (employer + employee) maximum contribution is $4,400 for single coverage, or $8,750 for family coverage (per household). An annual catch-up amount of $1,000 is available for employees ages 55-65.

The Liberty Company will contribute up to $500 into your HSA Account for an employee-only plan or up to $1,000 for a family plan including at least one dependent. This contribution is prorated based upon your enrollment date. This will be paid incrementally each pay period.

It's important to keep a record of the expenses you pay with your HSA in case you are asked to prove that an expense was eligible for reimbursement from your account. Examples of records you should keep include receipts, Explanation of Benefits (EOB), medical diagnosis/physician diagnosis letters, and prescriptions.

There is no time limit to reimburse yourself and the funds must be available in the account to use them. Be sure to check your balance before making a payment or swiping your card at a provider's office. Any unused funds rollover and all funds are yours to keep!

HSA Plan Advantages

- ✓ Medical plan **paired with a** tax-exempt health care savings account
- ✓ **Employer sponsored & funded**
- ✓ **Employee funded** – you decide how much
- ✓ **Employee-owned & portable**
- ✓ No "use-it-or-lose-it" rule – **funds roll over annually**
- ✓ Increase the contribution amount at any time
- ✓ Ability to invest
- ✓ **Triple tax favored**
  1. Funds go into HSA pre-tax
  2. Funds grow tax free*
  3. Withdraw funds for health care tax free

YOU benefit from flexibility, tax savings & retirement savings!

The Liberty Company is investing in your health and will deposit up to **$500/single** -or- up to **$1,000/family** into a bank account YOU own

(amounts paid incrementally each pay period)

- ✓ IRS sets **maximum contributions** annually
  - **2026: $4,400/Individual | $8,750/Family**
  - "Catch-up" contributions for age 55-65: $1,000
- ✓ **In addition to Liberty's contribution, you can contribute any amount up to:**

Under 55:	Between 55-65:
• $3,900/single	• $4,900/single
• $7,750/family	• $8,750/family

**HSA contributions and earnings are not subject to federal taxes and not subject to state taxes in most states. A few states do not allow pretax treatment of contributions or earnings. Please consult your personal tax advisor for information about your state.*



Health Savings Account (HSA)

To be eligible for a Health Savings Account (the banking component), you must meet the following requirements set by the IRS:

- You must be enrolled in an IRS-qualified High Deductible Health Plan (HDHP) by the first of the month. (The Cigna HDHP plan satisfies this requirement)
    - If your health plan effective date is after the first of the month, your HSA will be established on the first of the following month
- You may not be covered by any other health plan, including Medicare (A, B, C, or D), TRICARE, or a health FSA provided through Liberty or your spouse's employer (if your spouse's health plan is another HDHP and/or you are participating in a LPFSA, it's okay).
- You cannot be claimed as a dependent on someone else's tax return

If at any point you change medical plans and are no longer enrolled in the Cigna HDHP Plan, or lose eligibility, you cannot continue to contribute or receive contributions to your HSA. However, you may still use any funds in your HSA to pay for qualified medical expenses.

If you currently have an HSA Account with another vendor, you can choose to transfer the money to your HealthEquity account. We will not be sending contributions to other vendors. Please contact your account administrator and HealthEquity for additional details.

The HSA is administered by HealthEquity. You can connect to HealthEquity at healthequity.com or call their customer service line at 866-346-5800.

In accordance with the USA Patriot Act, you may be asked to provide HealthEquity with identification documentation to verify and establish your HSA.

Remember your money is saved pre-tax, grows tax-free and is withdrawn tax-free*. You own your HSA. Your account carries over from year to year and goes with you if you take a job with another employer.



Life and AD&D

Life and Accidental Death and Dismemberment (AD&D) coverage is administered by Reliance Standard. This coverage can help you prepare for the unexpected. The chart below provides a summary of the coverage.

Basic Life and AD&D Coverage	• No cost - just elect your beneficiaries for this benefit. • Full-time employees - flat $50,000 policy. • Term life insurance policy. • At ages 70 and 75, there are life insurance amount reductions • Provides coverage in case of an accidental death or dismemberment. • Benefits are payable in the event of loss of life, limb, sight, speech or hearing.
Employee Optional Life and AD&D Coverage	• Coverage must be elected in increments of $10,000 • Maximum coverage - up to 5 times your annual earnings (maximum $750,000). • Request to add coverage subject to completion and approval of Evidence of Insurability form if election was not made when first eligible for coverage. • Term life insurance policy • At ages 70 and 75, there are life insurance amount reductions • You do not need to elect the Life Benefit to enroll in AD&D coverage; coverage amounts do not need to match. • Provides coverage in case of an accidental death or dismemberment • Benefits are payable in the event of loss of life, limb, sight, and speech or hearing.
Spouse/ Domestic Partner Optional Life and AD&D Coverage	• Available if you, our employee, enroll in the Optional Life and/or AD&D Coverage • Choose from a minimum of $5,000 to a maximum of $500,000 in $5,000 increments, not to exceed 100% of employee amount • Request to add coverage subject to completion and approval of Evidence of Insurability form if election was not made when first eligible for coverage. • Term life insurance policy. • At ages 70 and 75, there are life insurance amount reductions • The employee must enroll in optional AD&D coverage to enroll a spouse/domestic partner in AD&D coverage. For the AD&D benefit, the amount does not need to match your optional life coverage election. • Provides coverage in case of an accidental death or dismemberment. • Benefits are payable in the event of loss of life, limb, sight, and speech or hearing.
Child Optional Life and AD&D Coverage	• Available if you, our employee, enroll in the Optional Life and/or AD&D Coverage • Coverage amount options of $2,000 to $10,000, in increments of $2,000 per eligible child. • Term life insurance policy. • Eligible until the child's 26th birthday. • The employee must enroll in optional AD&D coverage to enroll child(ren) in AD&D coverage. For the AD&D benefit, the amount does not need to match your optional life coverage election. • Provides coverage in case of an accidental death or dismemberment. • Benefits are payable in the event of loss of life, limb, sight, and speech or hearing.

Designate Your Beneficiary

When you enroll online for benefits, look for the prompts to designate a beneficiary for your Liberty Company-provided life insurance coverage and/or your optional life insurance plans. If a beneficiary is not designated, benefits will be paid according to the carrier policy. It is not necessary to add a beneficiary for your spousal life or child life insurance coverage since you are automatically the beneficiary for any spouse or dependent coverage you elect.

Evidence of Insurability

You may be asked to provide Evidence of Insurability (EOI) or proof of good health if:

- You do not enroll for coverage when first eligible and choose to enroll later.
- You want to increase your coverage after your initial enrollment outside of the allowable increase amounts.
- **OPEN ENROLLMENT FEATURE**: Eligible employees can increase their election incrementally up to $50,000, and Spouse up to $10,000, up to the Guarantee Issue amounts without having to submit an EOI.
- EOI Link

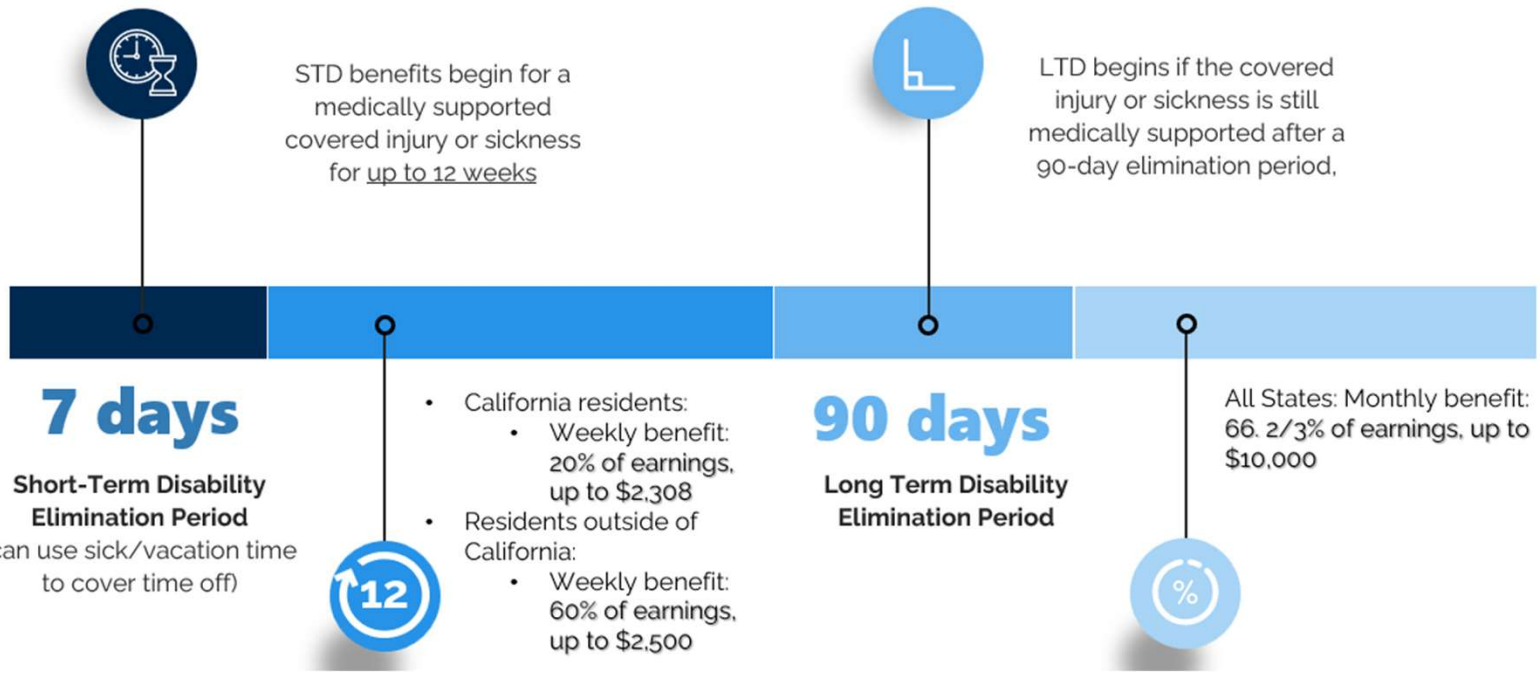
Disability

The disability benefits are administered by **Reliance Standard**, and consist of a Short-term Disability (STD) Plan and Long-term Disability (LTD) Plan. The plans work together to replace a portion of your income when you are on an approved absence from work for your own serious health condition.

Plan	Benefit Amounts and Guidelines
Short-term Disability (STD)	• STD has a 7-day elimination period and pays up to 12 weeks of benefits. Pre-existing conditions limitations may apply. • Contact Reliance Standard to file your STD claim at 877-202-0055 or go to www.matrixabsence.com. • For Non-California Employees, replaces 66.67% of your pre-disability pay ($2,500 per week maximum). • For California Employees, replaces 20% of your pre-disability pay ($2,308 per week maximum).
Long-term Disability (LTD)	• Provides coverage after a 90-day elimination period. • Contact Reliance to update your LTD claim at 877-202-0055. • Replaces 66.67% of your pre-disability pay ($10,000 monthly maximum). Pre-existing conditions limitations may apply.

NOTE: *If you become disabled during the first 12 months of coverage due to a pre-existing condition, the disability plans may not pay benefits.*

Your effective date of coverage is the first day of the month following your date of hire or re-classification as a full-time employee. For more detailed information, please see the summary plan descriptions available on Workvivo.



Voluntary Benefits

Voluntary benefits provide an additional layer of financial protection for you and your family. These benefits will help cover any extra out-of-pocket expenses if you suffer a qualifying accident or an unexpected, serious illness.

Accident Insurance

Reliance Standard's Accident Insurance pays a fixed lump sum cash benefit directly to you in the event of a non-work-related accident. This additional cash support can be used to help pay any out-of-pocket expenses related to the injury. Payments are made tax free, to be used at your discretion.

Accident Insurance Wellness Benefit

$50 per insured person per year for completing routine wellness screenings.

The tables below highlight some of the key benefits covered under this plan and give an example of how this plan would pay out for a broken ankle.

Some Covered Benefits	Benefit Amount
Hospital Admission	$900
Daily Hospital Confinement (up to 365 days)	$230
Daily ICU Confinement (up to 30 days)	$300
Burns	Up to $15,040
Ambulance (ground/air)	$200/$1,000
Emergency Treatment	$203

Accident Insurance Plan	Semi-Monthly Deduction
Employee Only	$1.95
Employee + Spouse	$3.30
Employee + Child(ren)	$3.81
Employee + Family	$5.19

Example: Broken Ankle	Benefit Amount
Emergency Room	$203
Broken Ankle, Closed Reduction (no surgery)	$180
Crutches	$300
Physical Therapy (6 sessions)	$228
Physician Follow-Up (per visit)	$100
Total Dollars Payable to Team Member	**$1,011***

**This is an example only*

Critical Illness Insurance

There can be a lot of expenses incurred with a critical illness and a major medical plan may not cover them all. Critical Illness with Cancer coverage with **Reliance Standard** pays cash directly to you upon a diagnosis.

You have the option to select the tiered coverage amount of your choice. Employees can elect up to $20,000 of coverage in increments of $5K. Spouse/ Domestic Partner can elect $5,000 or $10,000, not to exceed 50% of the employee's amount. Child(ren) coverage is automatically included at 50% of the employee's benefit amount, maximum of $10,000. An employee must elect coverage for themselves to have coverage on dependents.

- No age-based reduction in benefits.
- No waiting period.
- No pre-existing condition limitation.
- Recurring benefit payouts included.

Critical Illness Wellness Benefit

$100 per insured person per year for completing routine wellness screenings.

Age	Semi-Monthly Premiums, Non-Tobacco* $10,000	
	Employee	Spouse
< 29	$0.50	$0.50
30-34	$1.00	$1.00
35-39	$1.25	$1.25
40-44	$1.60	$1.60
45-49	$2.25	$2.25
50-54	$3.05	$3.05
55-59	$4.15	$4.15
60-64	$5.45	$5.45
65-69	$8.05	$8.05

Below is an example of how the Critical Illness plan works:

Donna's life was turned upside down when she suffered a heart attack, which was followed by a stroke only a month later. Not only did she miss work, but so did her husband to help her during her recovery. Their income took a hit and bills piled up. Donna had enrolled in Reliance Standard's Critical Illness plan with a $20,000 benefit amount per diagnosis. She received a total benefit payment of $40,000 in her family's greatest time of need.



Example Amount Paid to Donna**	
Heart Attack	$20,000
Stroke	$20,000
Total Direct Benefit Payment to Donna	$40,000

**Premiums determined by coverage amount, age and tobacco use.. See plan information for additional premiums.*
***This is an example only*

Identity Theft

Allstate helps provide you peace of mind with comprehensive identity theft plus cyber security protection. If a potential threat is detected, you are notified via email, text, phone or mobile app alerts. Should you become a victim of identity theft, Allstate provides a dedicated restoration specialist to help restore your identity. The plan coverage details are outlined below:

ID Theft Coverage	Semi-Monthly Deduction
Employee Only	$3.75
EE + Family	$6.75

With the Allstate Pro+ Cyber coverage, some of the included services are:

Family Protection

- Protection for the whole family when enrolled in the family coverage tier.
  - Senior family coverage (parents, grandparents, and in-laws age 65+)**
  - Elder fraud protection & fraud center.
  - Scam support.

Privacy & Data Monitoring

- Allstate Digital Footprint℠
  - Personalized online account discovery.
  - Privacy insights & management tools.
  - Data breach notifications.

Credit

- Tri-bureau credit monitoring.
- Credit lock (adults & minors).
- Credit report disputes.

Cyber Protection

- Personal computer security
  - Antivirus protection.
  - Safe browsing and phishing protection.
  - Web filtering.
  - Data breach notifications.
- Mobile Device Security
  - Mobile device and app security for 5 mobile & desktop devices.
- Password manager

Identity & Financial Monitoring

- Rapid alerts.
- Allstate Security Pro® emerging threats and scam alerts.
- Financial transaction monitoring.
- Dark web monitoring for personal data and passwords.

Restoration

- U.S.-based, 24/7 customer care
- Full-service remediation support
- Remediation for pre-existing conditions
- Fraud resolution tracker
- Unemployment Fraud Center
- Tap-to-call from mobile app

GET IT ON Google Play

Available on the App Store

Visit www.myaip.com or call 800.789.2720 for more information!

Pet Insurance



Should your pet ever get sick or have a serious accident, **MetLife's** comprehensive pet insurance plans are always here for you. MetLife strives to make the best pet insurance plans available to dogs, cats, avian & exotic pets of all ages, providing them access to the best medical coverage and veterinary care options. Now, giving your loved ones the best pet insurance coverage is as easy as growing old together!

The pet insurance is now direct-bill to the employee rather than payroll deduction.
Changes to policies can be made during renewal and are subject to underwriting approval.

- ✓ **Get cash back on eligible vet bills**: Choose your reimbursement level up to 90%
- ✓ **Preferred pricing exclusively for employees**
- ✓ **Use any vet, anywhere:** No networks, no pre-approvals

Coverage includes:

- Accidents
- Hereditary and congenital conditions
- Cancer
- Rx therapeutic diets
- Dental diseases
- Illnesses
- Holistic treatments
- And more*

Quote and Enroll at:

www.metlife.com/getpetquote (be sure to select Liberty as your employer) or **Call (877-649-7351)**

MetLife Legal Plan

The plan covers over 100 legal matters, including:

- **Estate Planning**: Create wills, living wills, powers of attorney, and trusts online or with an attorney.
- **Family & Personal Matters**: Name changes, adoption, elder care, and sending kids to college.
- **Home & Real Estate**: Buying, selling, renting, and security deposit disputes.
- **Financial Issues**: Student loan help, identity theft resolution, and contacting creditors.
- **Civil Lawsuits & Traffic Violations**: Legal representation and advice (excluding DUI).

Get more information:
Visit **members.legalplans.com**, or call 1-800-821-6400 to learn more.

Making Changes During the Year

Once enrolled, you can make mid-year changes to your benefits during the plan year **only within 30 days of a change in life status (qualified life event).**

Note: The mid-year changes you are eligible to make depend on the type of life-status change you have experienced. If you miss this 30-day deadline, you will not be able to enroll yourself or your dependents until the next annual enrollment window.

Qualified life events include:

- You marry or divorce.
- You or your spouse give birth or adopt a child.
- Your spouse has a change in employment status, causing gain or loss of coverage for you or your dependents.
- You lose your current coverage under a different plan.
- Your spouse or a dependent dies.
- Your dependent child is no longer eligible or is newly eligible.

Qualified life event changes will be effective on the first of the month following the date of notification of the qualified life event, except for the birth or adoption of a child, which will be effective on the date of the event.

Your dependent is eligible for the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP). Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

To make a change to your benefits following a qualified life event, contact Liberty's Employee Benefits at benefits@libertycompany.com within 30 days of the date of the event to begin the process.



Employee Assistance Program (EAP)

The Liberty Company offers an EAP through **Reliance Standard** for you and your dependents at no cost. The EAP provides confidential services and access to local counselors and resource specialists to help you deal with a variety of issues, The Dedicated Member Portal and Mobile App also has online requests and chat options, and the option to explore thousands of articles, webinars, podcasts and tools covering total well-being.

Help Available 24/7

Call: 855-RSL-HELP

(855-755-4357)

Text: (858)-224-2094

Email: rsli@acieap.com

Chat Online: mylifeexpert.com

24-Hour Travel Assistance

On Call International provided through Reliance Standard



In the U.S., toll free
(800) 456-3893



Worldwide, collect
(603) 328-1966

Employee Health and Productivity

Behavioral Health Sessions
Up to 5 sessions to help manage stress, anxiety and depression, resolve conflict, improve relationships, overcome substance abuse and address any personal issues.

Grief Counseling Sessions
Available with up to 3 telephonic grief counseling sessions for assessment and referral. All sessions are conducted by licensed mental health clinicians.

Travel Assistance
A comprehensive range of services and information before and during your trip that is more than 100 miles from home or in a foreign country, including medical assistance, safety and security.

Legal Consultations
To help with a variety of personal legal matters including estate planning, wills, real estate, bankruptcy, divorce and child custody. Includes one 30-minute in-office or telephonic consultation with a local attorney and 25% discount for continued services.

Financial Consultations
Includes telephonic financial consultation and an optional 30-day financial coaching benefit with a 90-day action plan.

Medical Advocacy
Access to a Medical Advocate who can answer questions regarding specific treatment options, secure appointments with specialists, and help answer questions related to insurance matters.

Employee Personal Assistant
To provide information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, pet care., home services, repairs, travel, entertainment, dining, personal services, and more

Life Coaching
To help reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

ID Theft Prevention and Recovery
Complimentary phone consultation with a Fraud Resolution Specialist regarding reducing your risk of ID theft and/or tools to independently resolve your issue if you have been the victim of ID Theft.

Retirement Savings

401(k) Plan

The Liberty Company's 401(k) plan is administrated by **Voya**. Both traditional (pre-tax) and Roth (post-tax) accounts are available. You may choose in invest in one or both.

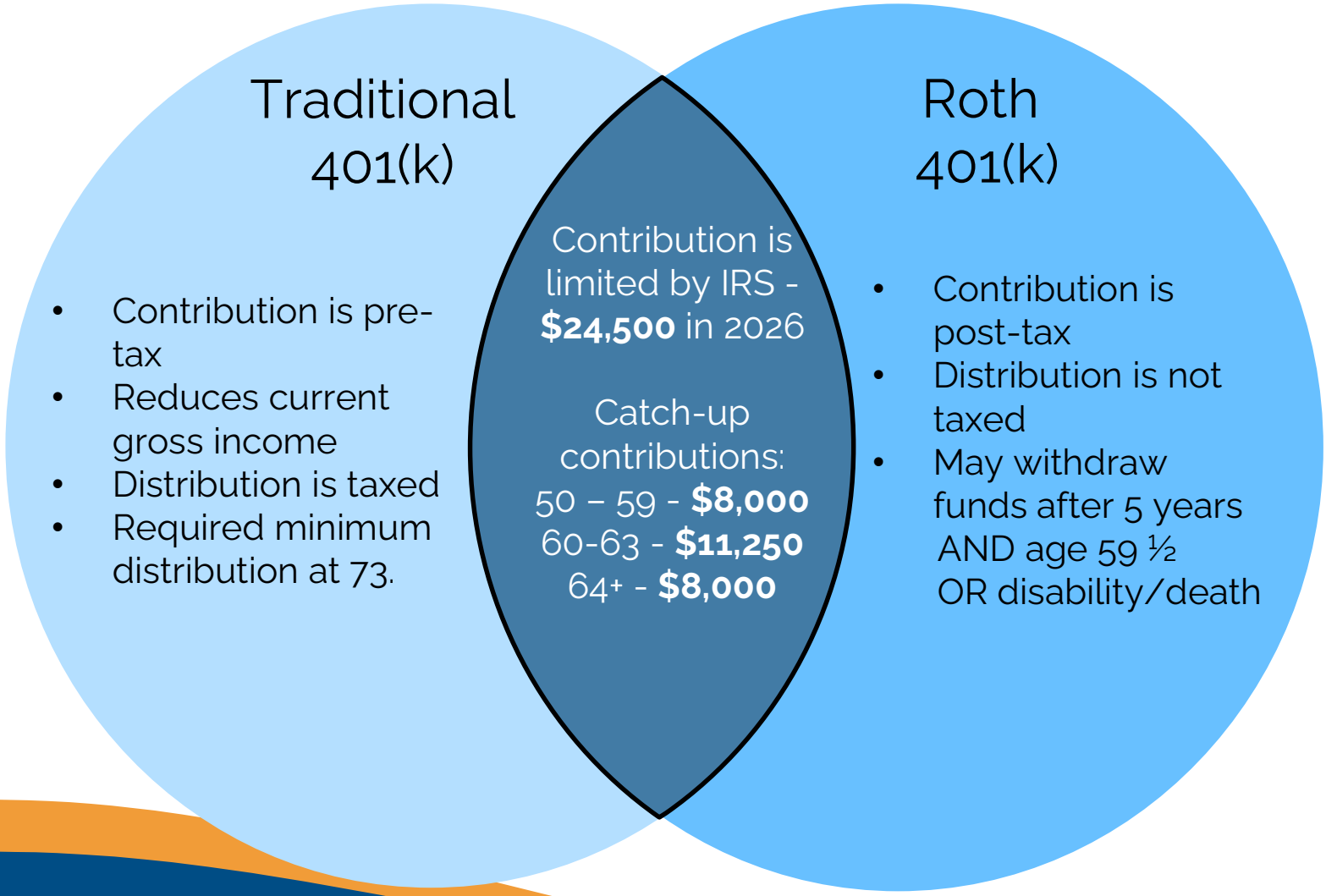
Regular full time eligible employees 21 years of age or older may participate in the plan as of date of hire. All other eligible employees may participate upon completion of 1,000 hours in a consecutive 12-month period.

Long-term part-time employees will be eligible to participate in the 401(k) plan if they have completed at least 500 hours of service in each of two consecutive 12-month periods and have attained age 21 by the end of the second 12-month period.

Liberty offers a company match from your hire date for eligible employees. The company will match the first 3% of the employee contributions, limited to a maximum matching amount of $3,000 per year. You are 100% vested in the company contributions after 4 years.

You may rollover money from a prior employer's tax-qualified plan into The Liberty Company 401(k) Plan.

Please refer to the 401(k) Plan Notice for additional information.



Retirement Savings

401(k) Plan

Ready to enroll? Follow the instructions below:

Ready to set yourself up for retirement? Enroll here.



Click:
myretirementbenefit.voya.com/t/Rb4z

Plan Number: 864151

Plan verification number: 86415199

Scan:

Need help enrolling? Call us at 888-311-9487
weekdays from 8 a.m. to 9 p.m., ET

Educational Benefit

Liberty Company Insurance Brokers has partnered with **Franklin University** to provide tuition discounts on associate, bachelor's and master's degree and certificate programs. The following discounts are available:

- 10% tuition discounts on all Undergraduate programs
- 20% tuition discount on all Graduate programs and Graduate Certificates
- 10% tuition discount on all Doctoral programs
- Free Textbooks for all Liberty associates

Franklin University offers a variety of programs through the Ross College of Business, College of Arts, Sciences & Technology, College of Health & Public Administration and the International Institute for Innovative Instructions. Earn your degree 100% online at a nonprofit, accredited university that has been dedicated to educating working adults for more than 115 years.

To learn more, go to franklin.edu/lcib

To apply, go to franklin.edu/apply-lcib

To verify employment, go to franklin.edu/verification

Questions? Contact: Partnership Accounts
E: partners@franklin.edu PH: 614-947-6840



FRANKLIN UNIVERSITY
Makes It Possible

Important Information

Imputed Income for Domestic Partner Coverage

If you enroll a domestic partner or your partner's child(ren) under your medical, dental or vision plan, and that individual does not meet the IRS definition of a qualified tax dependent, the IRS considers the fair market value of the additional coverage as "imputed income." Unlike health coverage for other family members, the value of the additional coverage is a taxable benefit. This means that the imputed income increases your taxable gross income for purposes of federal income and FICA taxes (Social Security and Medicare). Federal and FICA taxes on imputed income are withheld from each paycheck. Imputed income is separate from, and in addition to, your other benefit deductions.

The amount of your imputed income depends on:

- The plan option(s) in which you are enrolled.
- The level of coverage you elect.

Imputed income is reported on your annual W-2 form.



Contact Information

Liberty Benefits Team:
benefits@libertycompany.com

Provider	Group Number	Contact	Description	Registration
Dental Plan				
MetLife Dental	5780575	(800)-GET-MET8 www.metlife.com/dental	Dental claims, EOB, Provider ID Card	Member ID: Your SSN
Disability - Short & Long Term				
Reliance Standard	STD: 169859 LTD: 134251	(877) 202-0055 www.matrixabsence.com	Disability claims and covered benefits	
Employee Assistance Program (EAP)				
Reliance Standard/ACI Specialty Benefits	N/A	(855) 755-4357 www.mylifeexpert.com	Counseling services, behavioral health, legal advice, and substance abuse issues	Company Code: RSLI859
FSA - Flexible Spending Account (*Health and Dependent Day Care*)				
HealthEquity	N/A	(866)346-5800 https://learn.healthequity.com/the-liberty-company	Flexible spending claims and covered benefits	Member ID: Your SSN
HSA - Health Savings Account				
HealthEquity	N/A	(866)346-5800 https://learn.healthequity.com/the-liberty-company	Savings account balance and covered benefits	Member ID: Your SSN
Identify Theft Protection				
Allstate	9004	(800) 789-2720 www.myaip.com	Helps provide peace of mind with comprehensive identity theft protection	
Life Insurance (*Employer Paid and Optional*)				
Reliance Standard	Basic Life & AD&D, Optional Life: 166243 Optional AD&D: 210443	(877) 202-0055 www.reliancestandard.com	Life claims and covered benefits	
Medical Plans (*PPO, HDHP, HMO*)				
Cigna	634574	(888) 806-5094 www.mycigna.com	Medical claims, EOB, Provider Network, Temporary ID Card	
Kaiser (California Only)	Northern California: 722029 Southern California: 340983	(800) 464-4000 www.kp.org	Medical claims, EOB, Provider Network, Temporary ID Card	
Legal Benefit				
MetLife	TBA	(800)-821-6400 members.legalplans.com	Plan assists you with legal matters such as divorce or estate planning	
Pet Insurance				
MetLife	TBA	(877) 649-7351 www.metlife.com/mybenefits	Plan offsets the overall cost of your pet's medical bills	
Retirement Savings Plans: 401(k)				
Empower	506679-01	(800) 338-4015 https://participant.empower-retirement.com/	Online enrollment, retirement plan dashboard, and customer service assistance	Choose the "*I do not have a PIN*" option when registering
Vision				
VSP	30108173	(800) 877-7195 www.vsp.com	Vision claims and covered benefits	
Voluntary Accident Insurance & Critical Illness Insurance				
Reliance Standard	Accident: 8740467 Critical Illness: 874849	(877) 202-0055 www.matrixabsence.com	Cover any extra out-of-pocket expenses if you suffer an unexpected, serious illness or qualifying accident	

LIBWELL



Anthony Dippolito
Chief Wellness Officer
760-994-6739

At The Liberty Company, we know our strength comes from the well-being of every team member. That's why we prioritize all aspects of health through our core values and supportive culture. When we're at our best, we serve our clients better and work stronger together.

LibWell is our wellness program, accessible through Workvivo, offering resources to help you stay healthy and balanced. Enjoy expert speakers, guided meditations, wellness challenges, workbooks, newsletters, and more - all designed to keep you motivated as you pursue your goals!

LibWell isn't just for our team - it's also a valuable wellness solution we can offer to clients. By providing customized programs, access to top practitioners, and measurable results, LibWell helps organizations improve employee well-being, boost performance, and reduce healthcare costs. This strategic approach to wellness supports healthier workplaces and stronger business outcomes. If you're interested in offering LibWell's wellness solutions to your clients or want to learn more about how it can support their needs, please reach out to Anthony.

RESOURCES

LibWell in Workvivo

LibWell for Clients

- Dream Circles
- Meditation
- Organizational Behavior
- Leadership training
- Exercise Challenge
- Visualization
- Breathwork

Legal Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 Human Resources at 818-925-2236.

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.

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PART B: General 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 **The Liberty Company Insurance Brokers**	4. Employer Identification Number (EIN) **27-0063026**	
5. Employer Address **5955 De Soto Ave Suite 250**	6. Employer phone number **818-914-3986**	
7. City **Woodland Hills**	8. State **CA**	9. Zip code **91367**
10. Who can we contact about employee health coverage at this job? **Human Resources**		
11. Phone number (if different from above) **N/A**	12. Email address benefits@libertycompany.com	

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:

  Regular full-time employees who regularly work more than 30 hours per week. Temporary full-time employees scheduled to work more than 30 hours per week, and variable hour employees who have worked more than 30 hours per week over their one-year measurement period.

With respect to dependents:

- ☑ We do offer coverage. Eligible dependents are:
  - **Spouse, same-sex or opposite sex domestic partner (see Benefits Guide for specifics)**
  - **Dependent children under the age 26 provided that the child is not offered group insurance through their own employer**
  - **Dependent child with a physical or mental disability as defined by the Social Security Administration**
- ☐ 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.

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Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☑ **Yes** (Continue) (mm/dd/yyyy) (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

☐ **No** (**STOP** and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☑ **Yes** (Go to question 15) ☐ **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan $ 0

b. How often? ☐ Weekly ☐ Every 2 Weeks ☑ Twice a Month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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16. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months? $ _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan $_____

b. How often? ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Quarterly ☐ Yearly

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HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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).

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

To request enrollment or obtain more information, contact Liberty's Employee Benefits team.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Liberty's Employee Benefits team.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

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 caesarian 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 insurance issuer for prescribing a length of stay not in excess of 48 hours or (96 hours as applicable).

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Liberty Company's medical plans provide and administer mental health and substance abuse benefits as required by the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").

MHPAEA generally sets forth a parity requirement, which prohibits health plans and health insurance issuers from (a) applying any financial requirement or treatment limitation to mental health/substance use disorder benefits in any benefits classification that is more restrictive than the financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification, and (b) imposing separate financial requirements or treatment limitations that are applicable only with respect to mental health/substance use disorder benefits.

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For more information about The Liberty Company's group medical plans and their compliance under the MHPAEA, please refer to the Summary Plan Description (SPD) or the Summary of Benefits and Coverage (SBC).

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PATIENT PROTECTIONS NOTICE

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

Kaiser's group health plan (HMO) generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser via telephone at 800.464.4000.

For children, you may designate a pediatrician as the primary care provider.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).
- **For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.**

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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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 period1 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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.



The information included in this guide is intended as an overview only. It is not a complete description, nor is it a substitute for the applicable plan documents, Summary Plan Descriptions (SPDs) or insurance contracts. In all cases, the official plan documents govern and are the final authority on the terms of the benefit plans. The company reserves the right to modify, amend or terminate the benefit plans at any time and for any reason. Receiving this document or participating in company benefits is not a guarantee of future or continued employment or benefits.

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