Benefits Enrollment Guide

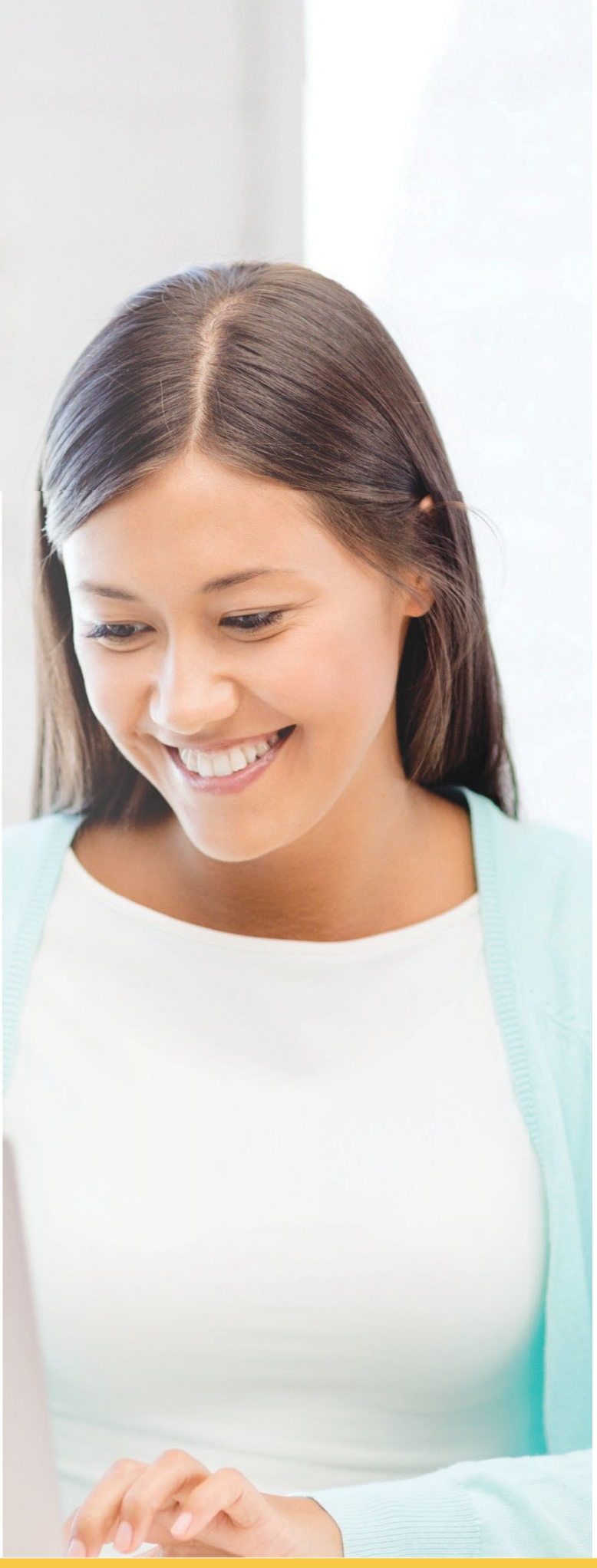
J M SMITH
CORPORATION

Wellness for Life!

Plan Year | 2024

Table of Contents

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.



When to Enroll

New Employee:

You must enroll online (see page 7 for instructions) by the deadline provided by your HR Department.

Open Enrollment for 2024:

You must finalize your enrollment on-line (see page 7 for instructions) no later than November 17, 2023. If you need help with your enrollment, please see your local Human Resource Department and they will work with you.

Refer to **www.jmsmithbenefits.com** for more information and forms.

Introduction

An important goal of J M Smith Corporation's strategic plan is to ensure that employees' needs are met and that job satisfaction remains high. One way to achieve this goal is to offer employees a benefit package that is highly competitive.

How to Use This Guide

This document has been designed to provide you with information about each plan in the J M Smith Corporation's benefit program and to guide you through the choices you have in each benefit area. We understand that you can always use a little help in navigating your way through these benefit decisions. So, throughout this guide you will find helpful hints that will answer your questions, emphasize important points, or guide you to additional information. Look for these icons:

Note!	Special points to consider as you are using the J M Smith Corporation's benefits
Q&A	Frequently asked questions and answers that will help you understand how each benefit works
Right for you?	Tips to help you decide which benefit options are right for you and your family
Website	Reminder that more information can be found on J M Smith's benefit website.

Note!

Make sure to attend the informational meetings about your benefit program. If you have questions after reviewing this guide, the meetings will provide you with additional information.

Making Your Choices

At J M Smith Corporation, you have the flexibility to choose from many benefit and coverage options so you can create a benefit package that meets your individual needs. It is important that you take time to review this guide and make your choices by the November 17, 2023 enrollment deadline or by the deadline provided by HR.

You will use an on-line enrollment system to make your benefit elections during the year. There are detailed instructions on how to use this system on page 6-7 of this booklet.

Benefit Website

J M Smith Corporation has devised a website to aid you and your dependents with questions and access to forms. The internet address for this site is **www.jmsmithbenefits.com**.

This site gives you access 24 hours a day to information about your benefits, from work or from home. It also makes it easy for you to obtain frequently used forms so you can keep your payroll and benefits information up to date.

Take a minute to explore **www.jmsmithbenefits.com** and see how it can make it easier for you to manage your benefits.

Throughout this booklet, you will find Healthy Notes which will provide helpful hints on your benefit plans as well as guidelines for a healthier lifestyle for you and your family.

Eligibility

If you are an active, full-time employee working at least 30 hours per week and classified as benefit eligible, you are eligible to enroll in the J M Smith Corporation's benefit program. Benefits will be effective 1st of the month following hire date or if hired on the first, benefits will be effective that day. If you enroll, you may cover eligible dependents, including:

- Your legal spouse;
- Your dependent child(ren) until the date on which he or she turns age 26;
- Your Stepchildren as long as natural parents remains married to employee and also resides in the employee's household;
- Natural and legally adopted children, children placed with you for adoption, or any other children for whom you or your spouse is named legal guardian, according to a letter of guardianship;
- Mentally or physically handicapped children dependent on you for support regardless of age; and
- Biological or legally adopted children for whom the plan is obligated under a Qualified Medical Child Support Order (QMCSO) to provide medical coverage.

Changing Your Benefits

The benefits you elect during the enrollment period become effective January 1, 2024 (or when you have completed your new hire waiting period) and will remain in effect through December 31, 2024. During the year, you can make changes only if you have a qualifying event which means a change in one of the following:

- Legal marital status: Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.
- Number of dependents: Events that change your number of dependents, including birth, adoption, placement for adoption or death of a dependent
- Employment status: A termination or commencement of employment by you, your spouse or your dependent
- Work schedule: A reduction or increase in hours of employment by you, your spouse or your dependent, including a switch between part-time and full-time, or commencement or return from an unpaid leave of absence.
- Eligibility of a dependent: An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to an attainment of age or any similar circumstance as provided in the health plan under which the employee receives coverage.
- Any other event determined to be a qualified change in status by the Plan Administrator

If you have a qualifying event, contact your Human Resources representative. Any benefit changes must be made within 31 days of the event and must be consistent with the qualifying event.

Q& A

What is COBRA?

COBRA is a federal law that allows employees and dependents of a company to continue health, dental and prescription drug coverage for a set amount of time.

Q& A

How long can coverage be continued under COBRA?

Regular termination up to 18 months; Disability termination up to 29 months (only if approved Social Security Disability); Death and Divorce termination up to 36-months

Registering on the Benefit Connector Enrollment Site

Step 1

Log on to: **https://jmsmith.benefitconnector.com**

Step 2

If you have never accessed the site, you must register.

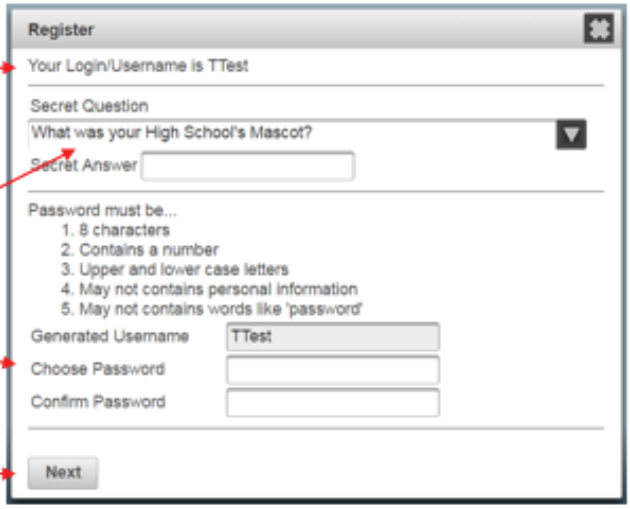
- From the log in screen, click '**register**' to begin registration process.

Step 3

- Enter the **Registration Information** - Last Name, Date of Birth, Last 4-Digits of SS#.
- Click 'Next' to continue.

Step 4

- Make note of your **Login/Username**
- Select and answer a **Secret Question**
- Create and verify a **Password**. Password strength is displayed as password is developed.
- Click 'Next' to continue.



Be sure to remember your Login/Username and Password for future access to Benefit Connector. If you forget your Password, it can be reset by following the instructions for **'Forgot Login/Password'** in the log in box.

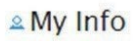
Online Enrollment Instructions

Your employer will provide you with the specific site address for the enrollment site. To access the site, go to:
https://jmsmith.benefitconnector.com

Usern a m e and Password are required to enter the enrollment site. If you are a first- t i m e user, you must go through the registration process. Click on '**Register**' and follow the simple registration instructions.

A default Username will be assigned. You will create your Password.

During an Open Enrollment period click **Start Enrollment** to begin the enrollment process. Depending on case settings you may or may not be asked to verify both employee and dependent information. Dependents who are currently listed in the system can be updated and verified at this point. Important: You'll be given the opportunity to add dependents during the actual enrollment process.



Your demographic information will be displayed in the **My Info** tab, some of which can be edited. If there is incorrect information in fields that you are not allowed to edit, please contact your HR Dept and provide them with the correct information. Suggestion: Depending on case settings you may or may not be asked to verify your employee information during the enrollment process. Complete your enrollment first. If you were not asked to verity your information during the enrollment process, you can view/update your information once you've completed enrollment.

Dependents who are currently listed in the system will be displayed in the **My Family** tab. Where allowed you can update and correct dependent information. Suggestion: Depending on case settings you may or may not be asked to verify your dependent information during the enrollment process. Complete your enrollment first. If you were not asked to verity your dependent information during the enrollment process, you can view/update your dependents once you've completed enrollment.

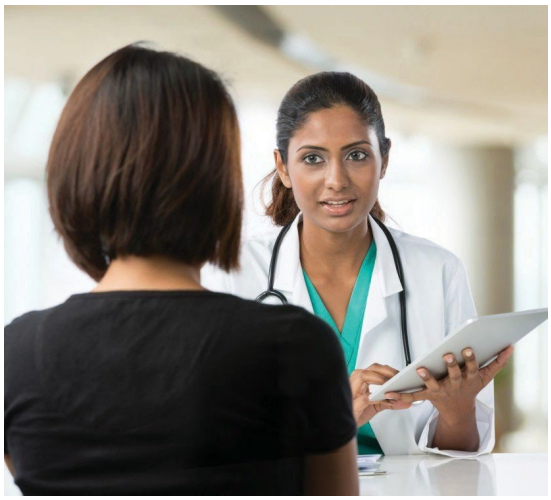
Select **My Current Benefits** to view a summary of the benefits you are currently enrolled in.

Selects **Documents** to view and print any Forms or Documents that have been posted by your employer

Selects **Settings** to change your Password or your Registration information.

Click for additional help information.

Medical Coverage



J M Smith Corporation offers multiple medical plans from which to choose. Keep in mind that all of the options encourage you to seek care through our Preferred Provider Organizations (PPO). If you choose our PPO network for your treatment, then you will receive a higher level of benefit. Your PPO acts as a contract between you and your healthcare providers. The PPO network and your plan benefits will ensure you get the best possible price. You may choose to utilize providers outside the network. However, you have no "contract" protection and may receive a lower level of benefit.

Plan Choice

Plan A (deductible)

Plan A (deductible) offers the highest level of out-of-pocket expense protection.

This plan pays 70% of charges with participating providers after you reach your deductible, with a maximum out of pocket amount. The majority of all medical benefits are covered this way under this plan.

Plan B (copay)

Plan B (copay) offers copayments for physician visits. All other benefits are subject to the deductible and coinsurance. This plan has a higher deductible and out-of-pocket maximum than Plan A.

Plan C (Palmetto Proactive)

Members must avail themselves of the services provided by Palmetto Proactive.

Outside charges are paid at 70% with participating providers after you reach your deductible with a maximum out of pocket amount.

Right for you?

Plan A (deductible) might be right for you if…

you know you are going to receive medical treatment outside of occasional illness.

Right for you?

Plan B (copay) might be right for you if...

you do not expect major health care problems and would like the copay option.

Deductible is the initial payment that you must pay before you receive your benefits. Your plan has a deductible for certain services and will be owed before the insurance will pay their portion of the coinsurance.

Coinsurance is the split between the health plan and you. For example, your plan may have an 70% / 30% split (in network). This means the health plan will pay 70% of your medical bill (once your deductible is met) and you are responsible for 30% up to an out-of-pocket maximum.

Benefit	Medical Benefits – Plan A	
	In-Network	Out-of-Network
Deductible – Individual Policy	$1,500 per Calendar Year	$2,500 per Calendar Year
Deductible – Family Policy	$3,000 per Calendar Year	$5,000 per Calendar Year
Coinsurance (after satisfying the deductible)	70% (Insurance pays 70%, you pay 30%)	50% (Insurance pays 50%, you pay 50%)
Out-of-Pocket Maximum – Individual Policy	$2,850 per Calendar Year in addition to Deductible	$4,950 per Calendar Year in addition to Deductible
Out-of-Pocket Maximum – Family Policy	$5,700 per Calendar Year in addition to Deductible	$9,900 per Calendar Year in addition to Deductible
Lifetime Maximum (per person)	No Lifetime Max	
Physician Office Visits Primary Care Physicians (PCP), Pediatrician, OB/Gyn, Internist (includes lab, x-ray and ancillary charges billed by the physician)	70% after deductible	50% after deductible
Specialist Office Visit Includes lab, x-ray and ancillary charges billed by the physician	70% after deductible	50% after deductible
Prescription Drugs	Patient responsible for 40% of the prescription cost except for generic drugs. Patient pays $4 for multisource generics. Patient pays $10 for single source generics. Not subject to a Deductible.	Not covered
Prescription Drugs Out-of-Pocket Maximum Applies to in and out of network pharmacy cost. Retail and home delivery copays apply to the Pharmacy Out-of-Pocket.	$3,500 Individual $7,000 Family	Not Covered
Preventive Care for Employees and Covered Spouses	See page 17	Not covered
Preventive Care for covered children Immunizations, Routine Physicals	100% of covered expenses	Not covered
Allergy Testing	70% after deductible	50% after deductible
Allergy Serum and Injections	70% after deductible	50% after deductible
Routine Physician Maternity Services Routine Prenatal, Delivery and Postnatal Care	70% after deductible	50% after deductible
Urgent Care	70% after deductible	50% after deductible
Emergency Room Copay is waived in case of injury, life threatening illness, or if admitted as inpatient	$200 copay then 70% after deductible	$200 copay then 70% after deductible
Ambulance Services	70% after deductible	70% after deductible
Inpatient Services Physician, Maternity, Nursery Room, Surgical, Anesthesia, Lab and X-ray Charges/Interpretation	70% after deductible	50% after deductible
Inpatient Hospital Services Per admission copayment is waived when a PPO hospital is used or admission occurs directly from Emergency Room	70% after deductible	$500 per admission copayment then 50% after deductible
Semi-Private Room Rate	Reimbursement Amount: If the hospital only has private room facilities, then private room charge will be considered as the semi-private.	
	70% Semi– Private Room Rate	50% Semi-Private Room Rate
Intensive Care Unit	70% Reimbursement Amount	50% Reimbursement Amount

Vision Coverage – Routine vision exams are covered as a preventive service under the medical plan. Benefits for routine exams are paid at !00% for all covered plan participants.

Benefit	Medical Benefits – Plan A	
	In-Network	Out-of-Network
Mental Disorders: Inpatient	70% after deductible	$500 copay, then 50% after deductible
Mental Disorders: Outpatient	70% after deductible	50% after deductible
Substance Abuse: Inpatient	70% after deductible	$500 copay, then 50% after deductible
Substance Abuse: Outpatient	70% after deductible	50% after deductible
Outpatient Services Hospital, Physician, Surgical, Anesthesia, Lab and X-ray Charges/interpretation	70% after deductible	50% after deductible
Outpatient Therapy Physical, Speech and Occupational	70% after deductible	50% after deductible
Outpatient Therapy Renal Dialysis, Chemotherapy and Radiation	70% after deductible	50% after deductible
Durable Medical Equipment	70% after deductible	50% after deductible
Home Health Care	70% after deductible with a 60 visit maximum per year	50% after deductible with a 60 visit maximum per year
Skilled Nursing Facility	70% after deductible with a 120 day maximum per calendar year	50% after deductible with a 120 day maximum per calendar year
Outpatient Private Duty Nursing	70% after deductible	50% after deductible
Hospice Care	70% after deductible	50% after deductible
Transplant Services Lung, Pancreas, Liver, Heart, Cornea, Kidney, Bone Marrow, Heart/Lung	70% after deductible	50% after deductible
Infertility Services	Not covered	Not covered
LASIK Eye Surgery	50% after deductible with a maximum of $1,000 per eye and $2,000 lifetime maximum	Not covered
TMJ	70% after deductible	50% after deductible
Accident Benefit	Pays 100% of the first $500 then subject to 70% of the remaining amount (not subject to the deductible); Charges must be incurred within 90 days of such accident	Pays 100% of the first $250 then subject to 50% of the remaining amount (not subject to the deductible); Charges must be incurred within 90 days of such accident
Chiropractic Services / Acupuncture Services	Subject to the deductible then a maximum payment of $15 per visit; $1,000 maximum per calendar year	Subject to the in-network deductible then a maximum payment of $15 per visit; $1,000 maximum per calendar year

The Medical Plan comparison chart explains the benefit levels available in each of the plans offered. You are responsible for knowing the benefits available in your medical plan, including deductibles, copayments, prior authorization requirements and benefit exclusions.

A summary plan description which contains complete details of the plan provisions is available on-line under the medical section.

Visit our benefit website at www.jmsmithbenefits.com.

Refer to www.jmsmithbenefits.com for administrative questions and participating providers. This site will also provide you with a link to www.southcarolinablues.com for claims inquiries.

Benefit	Medical Benefits – Plan B	
	In-Network	Out-of-Network
Deductible – Individual Policy	$1,700 per Calendar Year	$3,050 per Calendar Year
Deductible – Family Policy	$3,400 per Calendar Year	$6,100 per Calendar Year
Coinsurance (after satisfying the deductible)	70% (Insurance pays 70%, you pay 30%)	50% (Insurance pays 50%, you pay 50%)
Out-of-Pocket Maximum – Individual Policy	$3,250 per Calendar Year in addition to Deductible	$5,500 per Calendar Year in addition to Deductible
Out-of-Pocket Maximum – Family Policy	$6,500 per Calendar Year in addition to Deductible	$11,000 per Calendar Year in addition to Deductible
Lifetime Maximum (per person)	No Lifetime Max	
Physician Office Visits Primary Care Physicians (PCP), Pediatrician, OB/Gyn, Internist (includes lab, x-ray and ancillary charges billed by the physician)	Subject to $45 copayment per visit then paid at 100% of covered expenses	50% after deductible
Specialist Office Visit Includes lab, x-ray and ancillary charges billed by the physician	Subject to $55 copayment per visit then paid at 100% of covered expenses	50% after deductible
Prescription Drugs	Patient responsible for 40% of the prescription cost except for generic drugs. Patient pays $4 for multisource generics. Patient pays $10 for single source generics. Not subject to a Deductible.	Not covered
Prescription Drugs Out-of-Pocket Maximum Applies to in and out of network pharmacy cost. Retail and home delivery copays apply to the Pharmacy Out-of-Pocket.	$2,900 Individual $5,800 Family	Not Covered
Preventive Care for Employees and Covered Spouses	See page 17	Not covered
Preventive Care for covered children Immunizations, Routine Physicals	100% of covered expenses	Not covered
Allergy Testing and **Allergy Serum and Injections**	$55 copayment for Specialists	50% after deductible
Routine Physician Maternity Services Routine Prenatal, Delivery and Postnatal Care	70% after deductible	50% after deductible
Urgent Care	Subject to $45 copayment per visit then paid at 100% of covered expenses	50% after deductible
Emergency Room Copay is waived in case of injury, life threatening illness, or if admitted as inpatient	$200 copay then 70% after deductible	$200 copay then 70% after deductible
Ambulance Services	70% after deductible	70% after deductible
Inpatient Services Physician, Maternity, Nursery Room, Surgical, Anesthesia, Lab and X-ray Charges/Interpretation	70% after deductible	50% after deductible
Inpatient Hospital Services Per admission copayment is waived when a PPO hospital is used or admission occurs directly from Emergency Room	70% after deductible	$500 per admission copayment then 50% after deductible
Semi-Private Room Rate	Reimbursement Amount: If the hospital only has private room facilities then private room charge will be considered as the semi-private.	
	70% Semi– Private Room Rate	50% Semi-Private Room Rate
Intensive Care Unit	70% Reimbursement Amount	50% Reimbursement Amount

Vision Coverage – Routine vision exams are covered as a preventive service under the medical plan. Benefits for routine exams are paid at !00% for all covered plan participants.

Benefit	Medical Benefits – Plan B	
	In-Network	Out-of-Network
Mental Disorders: Inpatient	70% after deductible	$500 copay, then 50% after deductible
Mental Disorders: Outpatient	70% after deductible	50% after deductible
Substance Abuse: Inpatient	70% after deductible	$500 copay, then 50% after deductible
Substance Abuse: Outpatient	70% after deductible	50% after deductible
Outpatient Services Hospital, Physician, Surgical, Anesthesia, Lab and X-ray Charges/interpretation	70% after deductible	50% after deductible
Outpatient Therapy Physical, Speech and Occupational	70% after deductible	50% after deductible
Outpatient Therapy Renal Dialysis, Chemotherapy and Radiation	70% after deductible	50% after deductible
Durable Medical Equipment	70% after deductible	50% after deductible
Home Health Care	70% after deductible with a 60 visit maximum per year	50% after deductible with a 60 visit maximum per year
Skilled Nursing Facility	70% after deductible with a 120 day maximum per calendar year	50% after deductible with a 120 day maximum per calendar year
Outpatient Private Duty Nursing	70% after deductible	50% after deductible
Hospice Care	70% after deductible	50% after deductible
Transplant Services Lung, Pancreas, Liver, Heart, Cornea, Kidney, Bone Marrow, Heart/Lung	70% after deductible	50% after deductible
Infertility Services	Not covered	Not covered
LASIK Eye Surgery	50% after deductible with a maximum of $1,000 per eye and $2,000 lifetime maximum	Not covered
TMJ	70% after deductible	50% after deductible
Accident Benefit	Pays 100% of the first $500 then subject to 70% of the remaining amount (not subject to the deductible); Charges must be incurred within 90 days of such accident	Pays 100% of the first $250 then subject to 50% of the remaining amount (not subject to the deductible); Charges must be incurred within 90 days of such accident
Chiropractic Services / Acupuncture Services	Subject to the deductible then a maximum payment of $15 per visit; $1,000 maximum per calendar year	Subject to the in-network deductible then a maximum payment of $15 per visit; $1,000 maximum per calendar year

Q& A

What benefits are provided if I use a non-participating provider?

If you use a non- participating provider, then you may have to pay your bill in full for the services you receive and request reimbursement later by completing a claim form.

Visit our benefit website at www.jmsmithbenefits.com.

Refer to www.jmsmithbenefits.com for administrative questions and participating providers. This site will also provide you with a link to www.southcarolinablues.com for claims inquiries.

Benefit	Medical Benefits – Plan C	
	In-Network	Out-of-Network
Deductible – Individual Policy	$1,000	$2,500
Deductible – Family Policy	$2,000	$5,000
Coinsurance (after satisfying the deductible)	70% (Insurance pays 70%, you pay 30%)	50% (Insurance pays 50%, you pay 50%)
Out-of-Pocket Maximum – Individual Policy	$3,250 per Calendar Year in addition to Deductible	$4,950 per Calendar Year in addition to Deductible
Out-of-Pocket Maximum – Family Policy	$6,500 per Calendar Year in addition to Deductible	$9,900 per Calendar Year in addition to Deductible
Lifetime Maximum (per person)	No Lifetime Max	
Physician Office Visits Primary Care Physicians (PCP), Pediatrician, OB-Gyn, Internist (includes lab, x-ray and ancillary charges billed by the physician)	Palmetto Proactive physician—No charge Non-Palmetto Proactive physician—50% after deductible	Non- Palmetto Proactive physician—10% after deductible
Specialist Office Visit Includes lab, x-ray and ancillary charges billed by the physician	70% after deductible	50% after deductible
Prescription Drugs	Patient responsible for 40% of the prescription cost except for generic drugs. Patient pays $4 for multisource generics. Patient pays $10 for single source generics. Not subject to a Deductible.	Not covered
Prescription Drugs Out-of-Pocket Maximum Applies to in and out of network pharmacy cost. Retail and home delivery copays apply to the Pharmacy Out-of-Pocket.	$3,600 Individual $7,200 Family	Not Covered
Preventive Care for Employees and Covered Spouses	See page 17	Not covered
Preventive Care for covered children Immunizations, Routine Physicals	100% of covered expenses	Not covered
Allergy Testing and **Allergy Serum and Injections**	70% after deductible	50% after deductible
Routine Physician Maternity Services Routine Prenatal, Delivery and Postnatal Care	70% after deductible	50% after deductible
Urgent Care	70% after deductible	50% after deductible
Emergency Room Copay is waived in case of injury, life threatening illness, or if admitted as inpatient	$200 copay then 70% after deductible	$200 copay then 70% after deductible
Ambulance Services	70% after deductible	70% after deductible
Inpatient Services Physician, Maternity, Nursery Room, Surgical, Anesthesia, Lab and X-ray Charges/Interpretation	70% after deductible	50% after deductible
Inpatient Hospital Services Per admission copayment is waived when a PPO hospital is used or admission occurs directly from Emergency Room	70% after deductible	$500 per admission copayment then 50% after deductible
Semi-Private Room Rate	Reimbursement Amount: If the hospital only has private room facilities then private room charge will be considered as the semi-private.	
	70% Semi– Private Room Rate	50% Semi-Private Room Rate
Intensive Care Unit	70% Reimbursement Amount	50% Reimbursement Amount

Vision Coverage – Routine vision exams are covered as a preventive service under the medical plan. Benefits for routine exams are paid at !00% for all covered plan participants.

Benefit	Medical Benefits – Plan C	
	In-Network	Out-of-Network
Mental Disorders: Inpatient	70% after deductible	$500 copay, then 50% after deductible
Mental Disorders: Outpatient	70% after deductible	50% after deductible
Substance Abuse: Inpatient	70% after deductible	$500 copay, then 50% after deductible
Substance Abuse: Outpatient	70% after deductible	50% after deductible
Outpatient Services Hospital, Physician, Surgical, Anesthesia, Lab and X-ray Charges/interpretation	70% after deductible	50% after deductible
Outpatient Therapy Physical, Speech and Occupational	70% after deductible	50% after deductible
Outpatient Therapy Renal Dialysis, Chemotherapy and Radiation	70% after deductible	50% after deductible
Durable Medical Equipment	70% after deductible	50% after deductible
Home Health Care	70% after deductible with a 60 visit maximum per year	50% after deductible with a 60 visit maximum per year
Skilled Nursing Facility	70% after deductible with a 120 day maximum per calendar year	50% after deductible with a 120 day maximum per calendar year
Outpatient Private Duty Nursing	70% after deductible	50% after deductible
Hospice Care	70% after deductible	50% after deductible
Transplant Services Lung, Pancreas, Liver, Heart, Cornea, Kidney, Bone Marrow, Heart/Lung	70% after deductible	50% after deductible
Infertility Services	Not covered	Not covered
LASIK Eye Surgery	50% after deductible with a maximum of $1,000 per eye and $2,000 lifetime maximum	Not covered
TMJ	70% after deductible	50% after deductible
Accident Benefit	Pays 100% of the first $500 then subject to 70% of the remaining amount (not subject to the deductible); Charges must be incurred within 90 days of such accident	Pays 100% of the first $250 then subject to 50% of the remaining amount (not subject to the deductible); Charges must be incurred within 90 days of such accident
Chiropractic Services / Acupuncture Services	Subject to the deductible then a maximum payment of $15 per visit; $1,000 maximum per calendar year	Subject to the in-network deductible then a maximum payment of $15 per visit; $1,000 maximum per calendar year

Note!

You will have 3 identification cards for your medical, dental and pharmacy benefits. Please keep your card with you at all times. Additional cards can be requested from **www.southcarolinablues.com**, **www.maxorplus.com** and **www.deltadentalsc.com**.

Refer to **www.jmsmithbenefits.com** for administrative questions and participating providers. This site will also provide you with a link to **www.southcarolinablues.com** for claims inquiries.

Prescription Drug Coverage – MaxorPlus

When you elect medical coverage, you are automatically covered under the prescription drug plan. This coverage allows you to fill your prescriptions at participating retail pharmacies.

Participating Pharmacy	Preferred Pharmacy Network	Performance 90 Network
Maximum Supply Allowed	30 Days	90 Days
Multi-source Generic Copay	$4	
Single-Source Generic Copay	$10	
Brand Copay	40% of cost	40% of cost

There are multiple categories of drugs under the plan. The differences between these categories are described below:

- A generic drug is one that meets the same standards as name brand drugs for safety, purity, strength and effectiveness. Generic drugs are less expensive than name brand drugs.
- A multisource generic drug is a generic drug with multiple manufacturers.
- A single source generic drug is a generic drug with exclusive manufacturing rights.
- A single source drug is a name brand drug (patent protected) with no generic available.
- A multisource drug is a name brand drug (patent expired) with a generic available.

Under this plan, you have the opportunity to lower the amount you pay by choosing a generic whenever possible. Be sure to discuss this option with your physician when he or she writes your prescription.

If you request a brand name drug when a generic is available, you will be responsible for paying the difference in price between the brand name and the generic drug added to the generic copayment.

Note!

Drug card coinsurance and some over-the-counter supplies, with a prescription from you physician, can be included as qualified expenses under the FSA account (see page 26).

Only prescriptions obtained from participating pharmacies are covered by your prescription plan.

Prescription Medications Not Covered

Over-the-counter medications; fertility medications; vitamins except prenatals; anti-obesity; ostomy supplies; smoking deterrents; non-insulin syringes; cosmetic drugs; diagnostics; diabetic supplies; medical supplies and apparatus; experimental and investigational drugs; medications administered while admitted to a medical facility; medications covered by worker's compensation or similar government program.

MaxorPlus

MaxorPlus is a national pharmacy benefit management (PBM) company founded with the goals of managing prescription benefit costs while providing better customer service than anyone in the industry.

If you have any questions or just want to know if your local pharmacy is participating, please call MaxorPlus Customer Service at (800) 687-0707. You may also visit their website at **https:// maxorplus.com**.

Life Management

At J M Smith Corporation, we strive to be a "healthy company." The health and wellness of all J M Smith Corporation employees and their families is important to us. Our comprehensive medical coverage and wellness programs help employees and their families achieve personal health success.

If you have diabetes, hypertension, hyperlipidemia, or CAD, you and/or covered spouse/child(ren) are eligible to enter a voluntary education and improvement program. If you are "compliant" with the program you receive medications at a discount -

Generics - Free
Brand - You pay 20%, Plan pays 80%

How to be compliant*: You must set up monthly appointment with the Healthcare Professional at your location (regional employees: with the Healthcare Professional that has been assigned to you). It is YOUR responsibility to initiate these monthly appointments. If you do not comply with your monthly appointments, you will NOT receive free or discounted medications. You and your Healthcare Professional will set goals once you initiate your first appointment.

*Compliancy is tracked once a quarter. For example: If you do NOT make your MONTHLY appointments for January, February and March (all three months, not one, not two) - you will NOT receive your FREE medications for April, May, June.

Together, we can accomplish these goals by learning about healthy lifestyles choices, taking advantage of annual physicals, wellness checkups, and working to control the costs associated with our medical insurance program.

It is important that you understand from the start, J M Smith Corporation will not have access to your medical records. You will maintain strict privacy between you and your healthcare professional and health coach.

If it is unreasonably difficult for you to participate in any of our wellness programs, please see HR, and we will work with you to find an alternate.

Generic drugs have a long history of safety and effectiveness. Generic manufacturers must demonstrate that the generic drug has the same medical effect as its name brand equivalent by measuring the rate and extent of drug absorption.

Because generic drug companies do not have to spend millions of dollars on research and advertising, they can sell the generics for a lot less. These manufacturers compete against each other which keeps the prices affordable year after year.

Wellness

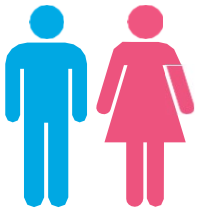
Wellness For Life

J M Smith Corporation wants to encourage employees and their covered spouses to take care of their health. Your health is of great value to J M Smith. All preventive care is covered under our plan 100%, including an annual physical, if rendered by a PPO provider.

See below for Preventive Care Services that are covered 100% by J M Smith Corporation in addition to your annual physical.

PSA (Prostate): Certain people are more at risk for prostate cancer, including African Americans and those who have a family history of the disease. A prostate exam is recommended once a man is at age 55. Major risk factors for prostate cancer include age, race, and family history.

Annual Physical Colonoscopy: Adhering to colon cancer screening guidelines is one of the best ways to prevent colon cancer. In general, your risk of developing colon cancer increases as you age. If this is your only risk factor, you are considered "average risk." Other factors in your personal and family medical history may increase your risk. The simplest way for average-risk individuals to prevent colon cancer is to receive colon cancer screening starting at age 50 and continuing through age 75.



Mammograms: The American Cancer Society and the Mayo Clinic advise women to begin having annual mammograms at age 50. Women in their 20s and 30s are advised to have a clinical breast exam about every three years. Women 50 and older also should have an annual clinical breast exam. If your mother had breast cancer, it is recommended that you get a mammogram in your 30s.

Pap Tests: Women should get screened for cervical cancer about 3 years after they start having vaginal sex, according to the American Cancer Society. They should also get a screening no later than 21 years old.

All covered spouses are required to have an annual screening also. Should they opt not to have their screenings, there will be a $50 surcharge.

There are some tests performed in a physician's office that do not qualify under the JMSC preventive measure coverage of 100%. There is coverage for these tests, however they may be subject to the deductible and coinsurance. Such tests include but are not limited to: X-Rays, EKGs, and anything resulting in a diagnostic procedure.

*A physician's recommendation of an alternate schedule is acceptable (in writing). The Plan will cover the service each year if the individual so chooses.

Visit our benefit website at www.jmsmithbenefits.com for additional information.

Health Item	Target Group	US Preventative Task Force recommendation	Options
Annual Preventative Health Review and Exam	All	Annually	**Required: MUST be done in your birth month**
Breast Cancer screening	Women aged 50 to 74 years. Women who place a higher value on the potential bene fit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.	Mammogram every 2 years. (Other groups recommend annual screening)	**Required if due**
Colon Cancer Screening	Adults aged 50 to 75 years – or if recommended by doctor to begin testing between 45-50	Colonoscopy every 10 years, Cologuard OR FIT or FIT-dna stool test every 1-3 years	**Required if due**
Cervical Cancer Screening	Women aged 21 to 29 years	Pap smear every 3 years with cervical cytology alone in women aged 21 to 29	**Required if due**
	Women age 30 -65	Pap every 3 years with cervical cytology alone OR Pap with HPV testing every 5 years	
Prostate Cancer Screening	Men aged 55 to 69 years	The decision to undergo periodic prostate-specific antigen (PSA)–based screening for prostate cancer should be an individual one. Before deciding whether to be screened, men should have an opportunity to discuss the potential bene-fits and harms of screening with their clinician and to incorporate their values and preferences in the decision.	**Option**

Surcharges

Note – JMSC will charge employees a surcharge in order to encourage good health practices. The surcharge(s) are broken down as follows:

- Tobacco Use (Employees Only)
  - ♦ Employees who enroll in a medical plan will complete an annual online verification
  - ♦ "No Tobacco" means no use of cigarettes, chewing tobacco and all types of smokeless tobacco.
  - ♦ $50 per month charge for tobacco use
- Preventative Care (Employees and Spouses Only)
  - ♦ $50 per month charge if you and your covered spouse do not complete your annual preventive care.
  - ♦ Only "one" $50 surcharge will apply. That is, if the employee completes the preventive measures and the covered spouses DOES NOT, there will be a $50 surcharge. If the employee and covered spouse do not complete the preventive measures, there will be a $50 surcharge (not $100).
  - ♦ NOTE - Preventative care is covered 100% by JMSC.
    - » PSA exam (Prostate) – Men
    - » Pap Test – Women
    - » Mammogram – Women
    - » Colonoscopy
    - » Annual Physical
    - » Hearing exam (optional)

Anyone hired in 2024 before July 1, 2024 must be tobacco free and complete preventative care in 2024 in order to meet requirements. Those hired after July 1, 2024 will have until the following term to comply, i.e. - they have the remainder of 2024 and all of 2024 before the surcharge applies.

- Spousal Surcharge
  - ♦ Enrolling a Spouse with other medical coverage
  - ♦ $125.00 per month charge if your spouse is working for an Employer that **offers** a medical benefit plan and they are **eligible** to enroll for such benefits, but choose not to enroll for **any** reason. Employees who enroll a spouse will receive an affidavit from the Corp Benefits coordinator for completion.

Dental Benefits

Premium Dental Plan

There are dental benefit coverages available at J M Smith Corporation. Please review the following information regarding the covered procedures in each dental category so you will have an understanding of your benefits.

Premium Dental Plan	
Annual Deductible	$50 per person
Annual Maximum (Preventive care does NOT accumulate towards the annual maximum)	
Non-orthodontic care	$2,000 (per calendar year)
Orthodontic care	$2,000 (lifetime maximum)
SERVICES	
Preventive Services • Oral exams (2 exams per 12 months) Waiting Period for Benefits to begin: None • Cleanings (2 exams per 12 months) • Bitewing x-rays (2 every 12 months) • Full set of x-rays (every 36 months) • Space maintainers for dependent children under the age of 16 • Fluoride treatments for dependent children under the age of 18 (2 each calendar year) • Sealants for dependent children under the age of 18 once per tooth in any 36 months	Plan pays 100% of the allowable charges; You pay 0%
Basic Services • Fillings, other then gold • Extractions • Periodontics • Oral Surgery • Anesthesia • Laboratory tests	Plan pays 80% of the allowable charges; You pay 20% (Subject to the deductible if not already met) Waiting Period for Benefits to begin: Late Entrants Only - The 1st 6 months of the covered person's coverage
Major Services • Crowns • Dentures • Bridgework • Repairs to crowns, bridges and dentures • Dental Implants	Plan pays 50% of the allowable charges; You pay 50% (Subject to the deductible if not already met) Waiting Period for Benefits to begin: Late Entrants Only - The 1st 12 months of the covered person's coverage
Orthodontic Services • Benefit is available for adults and children	Plan pays 50% of the allowable charges; You pay 50% Waiting Period for Benefits to begin: Late Entrants Only - The 1st 24 months of the covered person's coverage

Brush your teeth thoroughly twice per day. If possible, brush immediately after a meal. This can prevent plaque buildup on your teeth. Discuss with your dentist about the use of water picks and electric toothbrushes and what is the best approach for you.

Daily flossing is the best way to prevent gum disease. Floss gets rid of the buildup of plaque between your teeth and under the gum line.

Regular brushing and flossing regimens will go a long way toward the health of your teeth and gums.

Note!

Dental deductibles and coinsurance can be included as qualified expenses under the Health Care Spending Account (see page 26).

Dental Benefits

Basic Dental Plan

There are dental benefit coverages available at J M Smith Corporation. Please review the following information regarding the covered procedures in each dental category so you will have an understanding of your benefits.

Basic Dental Plan	
Annual Deductible	$50 per person
Annual Maximum	$1,000 (per calendar year)
SERVICES	
Preventive Services • Oral exams (2 exams per 12 months) Waiting Period for Benefits to begin: None • Cleanings (2 exams per 12 months) • Bitewing x-rays (2 every 12 months) • Full set of x-rays (every 36 months) • Space maintainers for dependent children under the age of 16 • Fluoride treatments for dependent children under the age of 18 (2 each calendar year) • Sealants for dependent children under the age of 18 once per tooth in any 36 months	Plan pays 100% of the allowable charges; You pay 0%
Basic Services • Fillings, other then gold • Extractions • Periodontics • Oral Surgery • Anesthesia • Laboratory tests	Plan pays 80% of the allowable charges; You pay 20% (Subject to the deductible if not already met) Waiting Period for Benefits to begin: Late Entrants Only - The 1st 6 months of the covered person's coverage
Major Services • Crowns • Dentures • Bridgework • Repairs to crowns, bridges and dentures • Dental Implants	Plan pays 50% of the allowable charges; You pay 50% (Subject to the deductible if not already met) Waiting Period for Benefits to begin: Late Entrants Only - The 1st 12 months of the covered person's coverage

Q & A

I have medical and dental insurance. Which one will cover the extraction of wisdom teeth?

If the teeth are fully impacted, then the extraction will be covered under the medical plan subject to the deductible.

If partially impacted, then it will be covered under the dental plan under the Basic Services.

Q & A

What happens if I have a claim at the end of year and don't submit it by December 31?

You will have time after the end of the year to file claims for eligible expenses that you incurred during this year. We recommend submitting claims by March 31 of the following year. Claims must be filed within one year from the date of service.

Vision Benefits

Vision Plan – New for 2024

There is standalone vision benefit coverage available at J M Smith Corporation. Please review the following information regarding the coverage under each vision l category so you will understand your benefits.

Vision VSP Plan	
Vision Plan Available for Equitable using the VSP Network. You can search for a provider by going to the following website: https://equitable.com/employee-benefits/vision-insurance/	
Eye Examination	• Covered in Full after $10 copay
SERVICES	
Prescription Eyeglasses **Frames** **Lenses** **Lens Enhancement** **Elective Contact Lenses** **Necessary Contact Lenses**	• $25 copay • $200 allowance for a wide selection of frames; 20% savings on amounts over $200 • Covered in Full • Standard Progressive - $55 copay • Premium Progressive - $95-105 copay • Custom Progressive - $150-$175 copay • $200 allowance for contacts; up to a $60 copay for Contact Lens Exam (In Lieu of glasses) • $25 copay, then covered in full only when Medically Necessary

• **Benefit Frequency***
  • **Eye Exam**
  • **Frames**
  • **Lenses**
	• Every 12 months
	• Every 12 months
	• Every 12 months
	
	*Frequency is calculated from last day of service/last date of purchase

Life and AD&D Insurance Coverage

J M Smith Corporation's Life and Accidental Death & Dismemberment insurance provides important financial protection for you and your survivors through Equitable. Basic Life insurance is $25,000 for you, $5,000 for your spouse and your children, if covered under the medical plan.

You may purchase supplemental insurance on your own life up to plan maximums. If you purchase supplemental life coverage, you may also purchase supplemental coverage for your spouse and your dependents up to plan maximum.

Summary of Life/AD&D Insurance Benefits			
Coverage Type	**Amount**	**Cost per Pay Period**	**Other Notes**
Basic Employee Life and AD&D Insurance	$25,000	Paid by J M Smith Corporation	Reduction of benefits begins at age 65
Basic Dependent Life Insurance	$5,000 for Spouse $5,000 per Child	Paid by J M Smith Corporation	Must be covered under the medical plan.
Supplemental Employee Life Insurance	Increments of $25,000 up to the lesser of 3 times your salary* or $375,000	Based on age rate per amount selected	Evidence of Insurability is required when employees increase their own coverage by more than $25,000 during annual open enrollment. Online Evidence of Insurability (EOI) application is available at the benefits enrollment site. New employees may elect any available amount up to the plan maximum without providing EOI.
Supplemental Spouse Life Insurance	Increments of $12,500 up to the lesser of $50,000 or 50% of supplemental employee life insurance	Based on age rate per amount selected	Evidence of Insurability is required if an employee increases spouse life by more than $12,500 during annual open enrollment. Online Evidence of Insurability (EOI) application is available at the benefits enrollment site. New employees may elect any available amount up to the plan maximum without providing EOI.
Supplemental Child Life Insurance	Choice of $2,500, $5,000, $7,500 or $10,000	Refer to Rate Sheet	Employee must elect supplemental employee life insurance to be eligible to purchase supplemental child life insurance.

Naming a Beneficiary

- You will be required to choose a beneficiary for this benefit at the benefits enrollment website. A beneficiary is an individual or entity that would receive the death benefit if the participant passes away. You may elect a primary beneficiary and contingent beneficiary if you choose. If you are married with children, you may consider your spouse as your primary beneficiary and your children (share and share alike) as your contingent. You will need your beneficiary's social security number, date of birth, and address to properly complete the beneficiary information. If you do not list a beneficiary, the life insurance will automatically go to your estate. This means these funds can be held up until the probate court decides how to handle your estate.

Right for you?

Supplemental Life insurance may be right for you if… you need more life insurance coverage because you have children or you have financial obligations such as a mortgage.

Right for you?

Dependent Life insurance may be right for you if… your spouse and/or child(ren) do not have other life insurance.

NOTE: Late enrollees in Supplemental Employee and Spouse Life Insurance must complete an online EOI application at the benefits enrollment website regardless of elected amount. The level of Supplemental life coverage will not change until the earlier of January 1, 2024, or the first of the month following approval of the new or increased amount.

Q& A

What is "guarantee issue amount"?

The "guarantee issue amount" of your life insurance is the amount of coverage that you are guaranteed without having to answer medical questions on an Evidence of Insurability form.

Disability Coverage

Voluntary Long-Term Disability

Long Term Disability insurance is provided through Equitable and is useful in the event that you are totally disabled and are unable to work for an extended period of time. Under the LTD policy, you may receive income protection if your absence (due to a disabling illness or injury) extends for longer than 60 days. The cost of this insurance is entirely the responsibility of the employee. J M Smith Corporation has negotiated a group rate but is not contributing to the cost.

- Benefits begin after you have been disabled for 60 consecutive days, provided that your disability meets the definition under the plan.
- To qualify for the first 24 months of disability, you must be unable to perform the duties of your own occupation. After 24 months, you must be unable to perform the duties of any occupation.
- Benefits are paid monthly until you are no longer eligible for benefits under your plan or to your SSNRA (Social Security Normal Retirement Age)
- Benefits equal 60% of your salary at the time of your disability with a maximum benefit of $15,000 per month.
- Because you pay 100% of the cost of the coverage with post tax dollars, benefits received under the plan are not subject to federal income taxes.

For more information on this long-term disability plan, please review the summary plan description available on **www.jmsmithbenefits.com**.

Note!

If you do not enroll for the LTD plan within 31 days of your eligibility date, then you will be required to complete an online Evidence of Insurability form. Evidence of Insurability (EOI) is available online at the benefits enrollment website. The insurance company has the right to deny coverage.

Note!

LTD costs are a function of your salary. At open enrollment each year, your plan cost may increase with prior salary changes.

For employees in commissioned sales positions, your base salary includes your basic annual earnings plus commissions averaged over the prior 24 months.

Disability Coverage

Short Term Disability*

J M Smith Corporation recognizes that on occasion, it may be necessary for an employee to be away from work to address his/her medical needs. Short term disability is a discretionary benefit provided by J M Smith to all regular full-time employees (exempt, non-exempt and hourly) who have completed two calendar months of service. After 1 year (anniversary date) of employment, an employee is eligible to receive 60% of the base pay for up to sixty (60) consecutive days. After 5 years of employment, an employee will receive 100% of the base pay for up to 60 days.

Note: Sixty (60) consecutive calendar days of short-term disability presently constitutes an exclusion period for optional long-term disability (LTD).

Short Term Disability Use Guidelines

1. Short term disability is only payable for the employee's illness or non-work-related injury. If state law or municipal ordinance mandates a different sick leave plan and is applicable to the employee, the J M Smith plan is preempted.

2. Each instance of illness or non-work-related injury during a Calendar Year (January to December) is a discrete occurrence for short term disability purposes; however, it is not considered a discrete occurrence if the short-term disability begins in one year and extends into the next year.

3. The first five (5) work days of EACH illness or non-work-related injury are not payable as short term disability with the exceptions noted in number 4 and number 5 below. The employee will take the first two (2) days as Sick Pay; if no Sick Pay is available then accured PTO will be used.

4. Short term disability is payable from Day 1 when the employee is hospitalized due to sickness or a non-work-related injury. Short term disability is payable from Day 1 for same day surgery or same day procedure. If recuperation time is needed following surgery, short term disability continues.

5. If an employee has a chronic medical condition which requires a medical procedure other than self-administered medication, short term disability is payable from Day 1. Examples include, but are not necessarily limited to: dialysis treatments, chemotherapy or radiation treatments for cancer, etc. Outpatient wellness medical procedures, such as a colonoscopy, are eligible for short term disability.

6. Short term disability is generally payable beginning on the 6th consecutive workday of the illness or non-work-related injury.

7. A return-to-work note from a medical practitioner is required for any employee who misses three (3) consecutive work days for illness or injury. A medical practitioner is a physician, doctor of osteopathy, physician's assistant, or nurse practitioner. Failure to provide this documentation can result in the employee taking PTO, time off without pay or the short-term disability being recovered retroactively, and the time missed converted to an unexcused absence.

8. Short term disability days are not hours worked and are not included in overtime calculations for non-exempt and hourly employees.

9. Short term disability days are either a stand-alone benefit or may coordinate with FMLA.

10. An employee who receives short term disability and is out of work for ten (10) or more consecutive days will be required to work seven (7) consecutive work days upon returning to work before they will be eligible to begin a new 60-day benefit cycle. If the employee does not work seven (7) consecutive work days and is away from work again for the same medical reason, the sixty (60) days will not restart and the short term disability benefit will pick up where the employee left off.

*Employees hired before 2024 will be grandfathered into the previous STD policy that pays 100%.

See also: Paid Time Off ("PTO"), Family Medical Leave ("FMLA"), AND Smith Drug's Operations Attendance Policies The PTO, Sick Days and Short-Term Disability policies are subject to, and will be applied in accordance with, all applicable state and federal laws.

Long Term Care

Long Term Care is the assistance received when someone needs help with two or more Activities of Daily Living – such as dressing, bathing, going to the bathroom, eating, and moving about – or when someone suffers a severe cognitive impairment. This could be provided in the home, in an assisted living or residential care facility, or in a skilled nursing facility such as a nursing home.

Most people don't think about long term care until it affects someone close to them and there are 10 million people who need long term care today. Roughly 40% of the Americans receiving Long Term Care are under age 65. In addition, most of us don't realize the cost of Long-Term Care. The national average for long term care is close to $81,000 per year.

J M Smith is proud to provide you with a base level of benefits to help you meet the needs that Long Term Care can create. J M Smith is providing a benefit amount of $1,000 per month payable for up to 3 years through Unum. In addition, J M Smith has designed a plan that will allow you to purchase additional coverage to enhance the benefits provided to you through Trustmark. If employee's previous purchased under the buy-up options from Unum, they will be able to continue that plan or choose to enroll under the new Trustmark Universal Life with Long Term Care coverage.

We will continue the basic employer paid Unum policy. Additional coverage will now come with the Trustmark Whole Life/Long Term Care plan.

Flexible Spending Accounts

The J M Smith Corporation's benefit program offers you the opportunity to take advantage of tax savings from two flexible spending accounts. These plans are administered by McGriff. You are eligible to enroll and make changes during open enrollment with an effective date of January 1st, or when you have completed your new hire waiting period.

You can deposit pre-tax dollars in your:

- Health Care Spending Account; and/or
- Dependent Care Spending Account.

Health Care Spending Account

You can deposit up to $3,050 per year in your Health Care Spending Account. Spouses may separately elect $3,050 with their employer. Spouses may elect $3,050, even if both work for the same employer; however, you cannot submit the same expenses for reimbursement. You can use the tax-free money in your account to reimburse yourself for:

- Eligible expenses not paid by your medical and dental coverage, and
- Out-of-pocket expenses, such as deductibles and copayments.

Eligible Expenses

- Deductibles and copayments not paid by other medical and dental insurance
- Hearing aids and batteries
- Smoking cessation aides

Ineligible Expenses

- Health care and dental care premiums that have been purchased with pre- tax dollars
- Automobile insurance premiums
- Custodial care in an institution
- Elective cosmetic surgery, such as liposuction, hair transplants, electrolysis and face- lifts
- Health club dues, YMCA dues, steam baths, etc.

REMINDER: FSA funds can be used to pay for medicines or drugs only if:

1. The medicine or drug requires a prescription, or
2. Is available without a prescription (an over-the- counter medicine or drug) and the individual obtains a prescription, or
3. Is insulin

Note!

The annual limit that you may contribute to your Health Care Spending Account is $3,050.

Right for you?

The Health Care Spending Account may be right for you if…

you and your eligible dependents typically have predictable out- of-pocket medical or dental expenses during the year.

Q& A

What happens if I have a claim at the end of year and don't submit it by December 31?

You will have time after the end of the year to file claims for eligible expenses that you incurred during this year. The deadline for submitting claims is March 31 of the following year. There are no rollover options available.

Dependent Care Spending Account

You can deposit up to $5,000 a year for individual or married couple filing jointly (or $2,500 if you and your spouse file separate income tax returns) in your Dependent Care Spending Account. This account lets you set aside pre-tax dollars to pay dependent care expenses that are necessary in order for you (and your spouse, if you're married) to work or attend school full-time. You can find examples of eligible and ineligible expenses in the list below.

Eligible Expenses:

- Home or day care for dependent children under age 13
- Payments made to a licensed nursery day care or day care center for preschool children
- Home or day care for dependents of any age who are mentally or physically disabled and are unable to care for themselves

Ineligible Expenses:

- Expenses for days you are not working, including sick leave or vacation days
- Child care services provided by another of your dependent children
- Care for dependents who have an annual income of $1,000 or more
- Expenses you already claimed as deductions or credits on a federal or state income tax return

IRS Requirements for the Dependent Care Spending Account:

Dependent care expenses will qualify for reimbursement if you meet these IRS requirements:

- If you're married, both you and your spouse must be working. Spouses who don't work must be full-time students or incapable of caring for themselves.
- If you're married, the total annual amount you deposit can't be more than the lower of your income or your spouse's income.
- If you're single, your dependent day care expenses must be necessary for you to work. You may change your dependent care contribution during the plan year only if you have a change in family status.

How the Accounts Work

Once you set up your account(s), you can use them to reimburse yourself during the year for any eligible expenses that you need to pay. Here's how:

- First, you estimate how much you'll need to cover your expenses.
- Then, the amount you choose is deducted from each paycheck. If you decide to set aside $650 for the entire calendar year, then you'll have to have $27.08 deducted from each paycheck.
- When you have an eligible expense, submit a claim and an itemized receipt to the claims administrator.
- Eligible expenses will be processed on a regular schedule. Keep in mind that you can have your reimbursements deposited directly into your bank account.
- You'll have a three-month grace period following the end of the year to submit claims for expenses incurred the prior year.
- If you have not spent all the amounts in your Health Flexible Spending Account or Dependent Care Flexible Spending Account by the end of the Plan Year, you may continue to incur claims for expenses during the "Grace Period." The "Grace Period" extends 2 1/2 months after the end of the Plan Year, during which time you can continue to incur claims and use up all amounts remaining in your Health Flexible Spending Account or Dependent Care Flexible Spending Account.

Use It, Don't Lose It!

If you do not file for reimbursement by March 31st, the money you set aside in your account(s) will not transfer to the next year's account(s). Due to IRS rules, you must forfeit any funds in your spending account(s) that you haven't used by the end of the year. It is very important for you to estimate your non-covered eligible health and dependent care expenses carefully so you don't forfeit your contributions.

Note!

If you decide to use the Dependent Care Spending Account, you cannot use the Federal Tax Credit for the same purpose. Consult your tax professional for advice on the most tax-efficient method for you.

Right for you?

The Dependent Care Spending Account may be right for you if…

you have day care expenses for an eligible dependent while you are at work.

Q & A

What happens if I have a claim at the end of year and don't submit it by December 31?

You will have time after the end of the year to file claims for eligible expenses that you incurred during this year. The deadline for submitting claims is March 31 of the following year.

Voluntary Benefits

Periodically, you may have the opportunity to purchase other benefits through payroll deduction. This employee-paid coverage is offered to you at group rates. If you purchase these policies, you can pay your premiums through convenient payroll deductions. J M Smith Corporation makes available the following voluntary benefits offered by Trustmark and Allstate insurance companies.

Universal Life Policy with Long-Term Care – Trustmark

This life policy also includes Long Term Care coverage that can be purchased for yourself, Spouse, Children and Grandchildren. Death benefits remain the same as you get older. Universal LifeEvents provides a higher death benefit during your working years, when you needs and responsibilities are at their highest. This policy also includes a long-term care (LTC) benefit that can help pay for these services at any age. Policy is totally portable when you retire or change jobs at the same cost.

Critical HealthEvents Insurance – Trustmark

Critical illness like heart attached and strokes can create a huge and unexpected financial burden on families. This policy pays lump sum benefits directly to you and in addition to all other coverage. This policy is totally portable when you retire or change jobs and will remain at the same cost. This plan also includes a wellness benefit payable each year.

Cancer Insurance – Allstate

Cancer policies pay benefits directly to you and in addition to all other coverage. Most families experience a huge financial loss when confronted with the out of pocket cost associated with the high cost of medical and non-medical expenses associated with the cure and treatment of Cancer. These benefits are indemnity benefits based on a predefined schedules as outlined in your policy. Coverage is available for spouse and children. Policy is totally portable when you retire or changed jobs at the same cost. This plan also includes a wellness benefit payable each year.

Accident Insurance – Allstate

This policy covers you 24 hours a day seven days a week and pays benefits directly to you in addition to all other coverage. Coverage is available for spouse and children. Policy is totally portable when you retire or change jobs at same cost. This plan also includes an Outpatient Physician's benefit of $50 per visit, maximum 2 visits/years, 4 visits if dependents are covered.

Dropping my Voluntary Benefits during the year

Universal Life coverage may be dropped at any time during the year. However, Cancer and Accident coverage may only be dropped during open enrollment or when you have a qualifying event that would allow you to change your medical or dental insurance.

Refer to www.jmsmithbenefits.com for more information and forms.

2024 Benefits Rate Sheet

All benefit elections will be made using the online enrollment system through www.jmsmithbenefits.com. If you have questions about the online enrollment process, please contact your local human resources staff or the J M Smith corporate benefits office.

Medical Coverage (contributions are monthly) *Surcharge(s) may be applicable.			
Plan A & B	**Employee Cost**	**Employer Cost**	**Total Premium**
Employee Only	$80	$673.55	$753.55
Employee & Spouse	$365	$1,116.26	$1,481.26
Employee & Child(ren)	$245	$980.77	$1,225.77
Employee & Family	$530	$1,416.30	$1,946.30

Medical Coverage (contributions are monthly) *Surcharge(s) may be applicable.			
Plan C	**Employee Cost**	**Employer Cost**	**Total Premium**
Employee Only	$50	$703.55	$753.55
Employee & Spouse	$300	$1,181.26	$1,481.26
Employee & Child(ren)	$200	$1,025.77	$1,225.77
Employee & Family	$450	$1,496.30	$1,946.30

Medical Coverage (contributions are monthly) *Surcharge(s) may be applicable.			
Warehouse	**Employee Cost**	**Employer Cost**	**Total Premium**
Employee Only	$25	$715.55	$735.55
Employee & Spouse	$255	$1,226.26	$1,481.26
Employee & Child(ren)	$125	$1,100.77	$1,225.77
Employee & Family	$325	$1,621.30	$1,946.30

Dental Coverage (contributions are monthly)		
	Premium Plan	**Basic Plan**
Employee Only	$40.61	$32.50
Employee & Family	$94.76	$75.80

Vision Coverage (contributions are monthly)	
	VSP Plan
Employee Only	$10.78
Employee & Spouse	$21.56
Employee & Child(ren)	$23.07
Employee & Family	$36.88

Long Term Disability Insurance

Long Term Disability benefits = 60% of covered income up to a maximum monthly benefit of $15,000

WORKSHEET TO HELP DETERMINE YOUR COST OF LTD COVERAGE

Multiply your hourly rate by 40 =	$_____ (This is your weekly salary)
Multiply by 52 =	$_____ (This is your annual salary)
Divide by 12 =	$_____ (This is your monthly salary)
Multiply by $0.00661 (rate) =	$_____ (This is your monthly cost)
Divide by 2 =	$_____ (This is your cost per pay period)

Important Notices

The following are required notices as established by the Patient Protection and Affordable Care Act. They may or may not apply to you. Please read them in their entirety. If you have questions, please contact your plan administrator.

Lifetime Limit Notice – The lifetime limit on the dollar value of benefits under all J M Smith Corporation Health Plans no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Pam Watson (866) 270-2316.

Children's Health Insurance Reauthorization Act – allows employees and dependents who are eligible for healthcare coverage under the group plan, but are not enrolled, will be permitted to enroll in the plan if they lose eligibility for Medicaid or CHIP coverage or become eligible for a premium assistance subsidy under Medicaid or CHIP. Individuals must request coverage under the plan within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Women's Health & 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 medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Plan A (Individual: 70% coinsurance and $1,500 deductible; Family: 70% coinsurance and $3,000 deductible)
Plan 2: Plan B (Individual: 70% coinsurance and $1,700 deductible; Family: 70% coinsurance and $3,400 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 864.582.1216 x1644 or kfleming@smithdrug.com.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms 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	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2024)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
J M Smith Corporation is committed to the privacy of your health information. The administrators of the J M Smith Corporation Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Kim Fleming - Vice President, Human Resources at 864.582.1216 x1644 or kfleming@smithdrug.com.

HIPAA Special Enrollment Rights

J M Smith Corporation Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the J M Smith Corporation Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

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 employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

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.

Eligibility for Premium Assistance Under 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 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 to obtain more information about the plan's special enrollment provisions, contact Kim Fleming - Vice President, Human Resources at 864.582.1216 x1644 or kfleming@smithdrug.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Important Notice from J M Smith Corporation

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 J M Smith Corporation 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. J M Smith Corporation has determined that the prescription drug coverage offered by the medical 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 J M Smith Corporation coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current J M Smith Corporation coverage, be aware that you and your dependents will 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 J M Smith Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through J M Smith Corporation 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:	**January 1, 2024**
Name of Entity/Sender:	**J M Smith Corporation**
Contact—Position/Office:	**Kim Fleming - Vice President, Human Resources**
Office Address:	**101 West Saint John St. Suite 305,** **Spartanburg, South Carolina – 29306,** **United States**
Phone Number:	**864.582.1216 x1644**

None of this information should be interpreted as a guarantee of employment. J M Smith Corporation reserves the right to amend,
modify, suspend or terminate any benefit at any time.

Michelle's Law (Pending Regulations)

Until guidance about Michelle's Law is issued, it is not known if a general, broad-based notice will be required. However, with the expansion of coverage to adult children up to age 26 under the Patient Protection and Affordable Care Act, the number of children who may be affected should be significantly less. As a result, we may not see regulatory guidance for some time. However, a notice may be needed in certain circumstances such as when a plan provides coverage to a child over age 26 who is a full-time student. Michelle's law generally requires group health plans to provide continuation coverage for student children who lose full-time student status as a result of a medically necessary leave of absence. It does not apply to health plans that qualify as HIPAA "accepted benefits" such as separate dental or vision plans or most health FSAs. In addition, self-insured nonfederal governmental plans are permitted to opt out of this requirement provided two annual notice requirements are satisfied – a notice to CMS and a notice to employees. It appears that COBRA rights may become available when a Michelle's Law continuation period ends, rather than when it first begins. Future regulatory guidance may (or may not) permit a health plan to run COBRA and Michelle's Law continuation periods concurrently. Following is sample wording that may be incorporated into a Michelle's Law notice to employees.

> Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under J M Smith Corporation's medical because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under J M Smith Corporation's medical, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under J M Smith Corporation's medical and was enrolled as a student at a post-secondary educational institution.
>
> A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that: (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.
>
> The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan – for example, by reaching age 26.
>
> If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.
>
> If you have any questions concerning this notice or your child's right to continued coverage under Michelle's law, please contact Kim Fleming at 864.582.1216.

A Final Note

This booklet is intended to provide an easy-to-read overview of the benefits available at J M Smith Corporation. Should there be any conflict between the explanations in this booklet and the actual terms of the plan documents and contracts, the terms of the plan documents and contracts will govern in all cases. You will not gain any new rights or benefits because of a misstatement or omission in this booklet.

Summary Plan Descriptions for the benefit plans are available by accessing the benefit website at www.jmsmithbenefits.com.

None of this information should be interpreted as a guarantee of employment. J M Smith Corporation reserves the right to amend, modify, suspend or terminate any benefit at any time.

Supplemental Life Insurance

You may purchase supplemental life insurance on your own life and on that of your spouse and/or child(ren). You must purchase supplemental employee life to be eligible to purchase spouse and/or child life. New employees may elect any available amount up to the plan maximum without providing Evidence of Insurability. EOI is required if you increase your own coverage by more than $25,000 or your spouse's coverage by more than $12,500 during any annual open enrollment. Late enrollees in Supplemental Employee & Spouse Life insurance must make an EOI application regardless of elected amount. If EOI is required, then the level of coverage will not change until the earlier of January 1, 2024 or the first of the month following approval of the new or increased amount. Online EOI application is available at the benefits enrollment website.

Supplemental life insurance plan maximums are:

- Employees: Three times your basic salary or $375,000, whichever is lower.
- Spouses: 50% of the employee's supplemental life coverage or $50,000, whichever is lower.
- Child(ren): $10,000

Supplemental Employee Life Rates** (Rates are monthly; divide by 2 for your per -paycheck cost.)

Age*	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000
29 and below	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00
30– 34	$1.75	$3.50	$5.25	$7.00	$8.75	$10.50	$12.25	$14.00
35– 39	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00
40– 44	$4.00	$8.00	$12.00	$16.00	$20.00	$24.00	$28.00	$32.00
45– 49	$7.50	$15.00	$22.50	$30.00	$37.50	$45.00	$52.50	$60.00
50– 54	$11.75	$23.50	$35.25	$47.00	$58.75	$70.50	$82.25	$94.00
55– 59	$19.25	$38.50	$57.75	$77.00	$96.25	$115.50	$134.75	$154.00
60– 64	$27.50	$55.00	$82.50	$110.00	$137.50	$165.00	$192.50	$220.00
65– 69	$47.50	$95.00	$142.50	$190.00	$237.50	$285.00	$332.50	$380.00
70 and above	$71.00	$142.00	$213.00	$284.00	$355.00	$426.00	$497.00	$568.00

Supplemental Employee Life Rates** (Rates are monthly; divide by 2 for your per -paycheck cost.)

Age*	$225,000	$250,000	$275,000	$300,000	$325,000	$350,000	$375,000
29 and below	$13.50	$15.00	$16.50	$18.00	$19.50	$21.00	$22.50
30– 34	$15.75	$17.50	$19.50	$21.00	$22.75	$24.50	$26.25
35– 39	$20.25	$22.50	$24.75	$27.00	$29.25	$31.50	$33.75
40– 44	$36.00	$40.00	$44.00	$48.00	$52.00	$56.00	$60.00
45– 49	$67.50	$75.00	$82.50	$90.00	$97.50	$105.00	$112.50
50– 54	$105.75	$117.50	$129.50	$141.00	$152.75	$164.50	$176.25
55– 59	$173.25	$192.50	$211.75	$231.00	$250.25	$269.50	$288.75
60– 64	$247.50	$275.00	$302.50	$330.00	$357.50	$385.00	$412.50
65– 69	$427.50	$475.00	$522.50	$570.00	$617.50	$665.00	$715.50
70 and above	$639.00	$710.00	$781.00	$852.00	$923.00	$994.00	$1,065.00

Supplemental Spouse Life Rates (Rates are monthly; divide by 2 for your per-paycheck cost.)

Age*	$12,500	$25,000	$37,500	$50,000
29 and below	$0.75	$1.50	$2.25	$3.00
30– 34	$0.88	$1.75	$2.63	$3.50
35– 39	$1.13	$2.25	$3.38	$4.50
40– 44	$2.00	$4.00	$6.00	$8.00
45– 49	$3.75	$7.50	$11.25	$15.00
50– 54	$5.88	$11.75	$17.63	$23.50
55– 59	$9.63	$19.25	$28.88	$38.50
60– 64	$13.75	$27.50	$41.25	$55.00
65– 69	$23.75	$47.50	$71.25	$95.00
70 and above	$35.50	$71.00	$106.50	$142.00

This benefit guide prepared by:

Important Note: The material in this benefits brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between your plan documents and this information, the plan documents will always govern. **Annual Notices:** ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The Company will distribute all required notices annually.

As of January 31, 2024