2026
PLAN YEAR

EMPLOYEE BENEFITS GUIDE

honeygrow

TM + SM EMPLOYEES

Carrier	Group #	Web	Phone / Email
Medical			
Meritain Health / Aetna	21526	www.meritain.com	1-888-324-5789
Dental			
Delta Dental	22671	www.deltadentalins.com	1-800-932-0783
Vision			
United Healthcare	933531	myuhcvision.com	1-800-638-3120
Flexible Spending Accounts and Parking / Transit			
The Harrison Group		www.theharrisongrouponline.com	1-610-853-9075
Employee Benefit Service Center			1-833-HNY-BENE (469-2363) honeygrow@assuredpartners.com

Please Note:

This booklet provides a summary of the benefits available. Honeygrow reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

INTRODUCTION

Honeygrow is pleased to provide a comprehensive employee benefits program designed to keep you healthy and to protect you and your family in case of serious illness, disability or death. This guide summarizes the key elements of the Benefits Program.

Employee Benefits Consultant and Partner

Honeygrow has partnered with AssuredPartners to assist with all aspects of the company Employee Benefits.

Honeygrow continues to pay a significant portion of the cost of your medical coverage, however, it is a shared responsibility. Healthcare costs continue to rise at an unprecedented pace. More than ever, we encourage wellness and healthier lifestyles for all members. **A healthier lifestyle (diet, exercise, etc.) will ultimately help you physically and financially by reducing your out-of-pocket costs for medical care and treatment.**

As always, your human resources representatives are also available to answer questions or clarify information in the 2026 Benefits Guide.

Table of Contents

Insurance information prepared by AssuredPartners. Other content provided by Honeygrow.

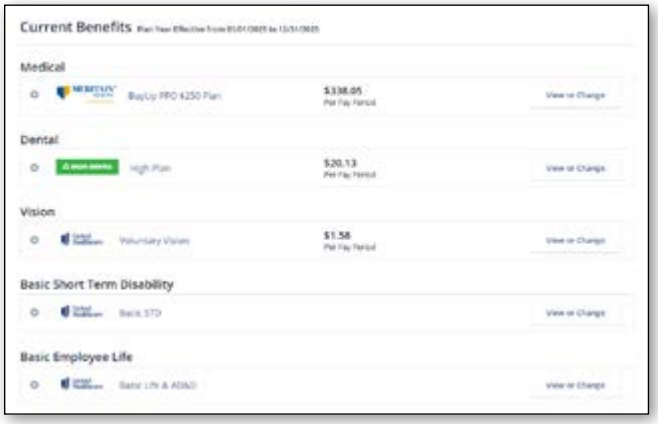
HOW TO ENROLL ONLINE

To access your benefits, you will login to your UltiPro/ UKG site (honeygrow.ukg.net) with your designated username and password. Once you have logged into UltiPro, you will now need to access your Benefits. To do this you will click on the **"Myself"** tab and click on the **"Manage My Benefits"** link in order to access the Benefits Dashboard.

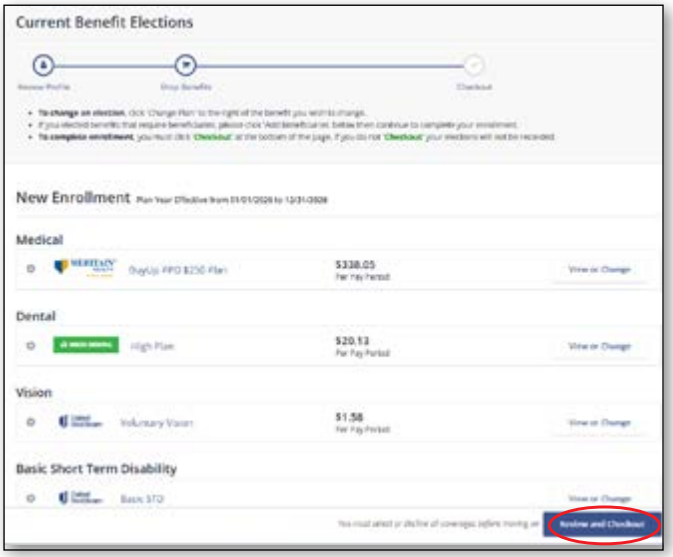
Please Note

Before you speak with a Benefit Counselor, please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

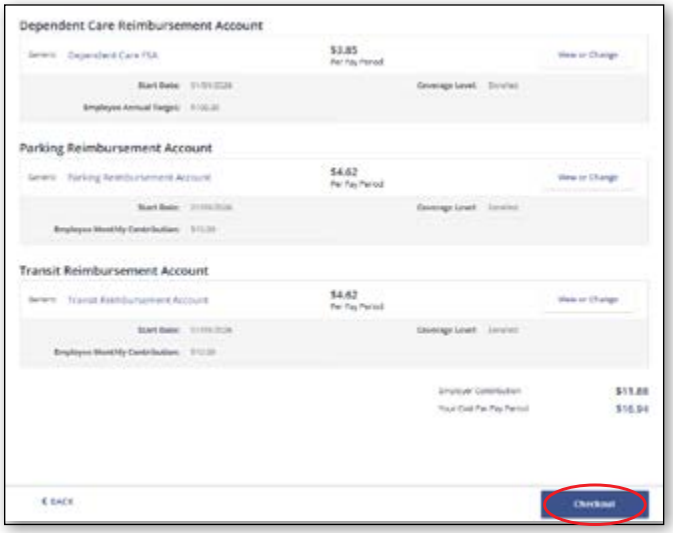
❶ Current Benefit Elections:



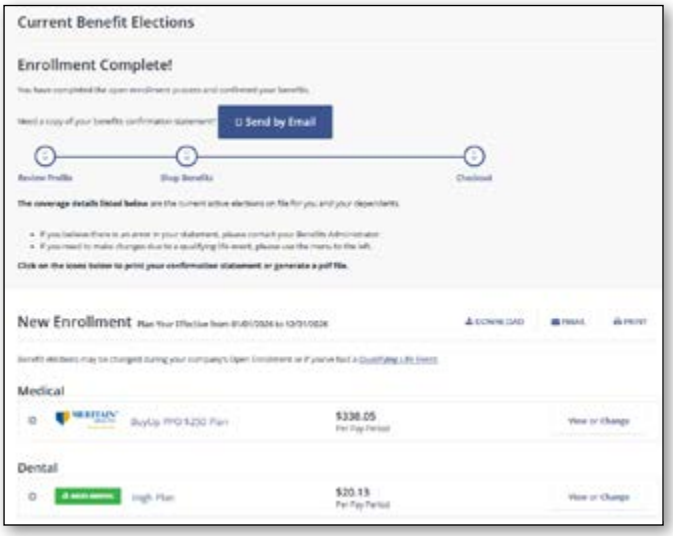
❷ Review and Checkout



❸ Confirm Your Benefits:



❹ New Hire Enrollment Completed



If you experience any problems with enrolling please call 1-833-HNY-BENE (469-2363) for assistance.

ELIGIBILITY REQUIREMENTS

Full-Time employees are eligible for health coverage starting on the first of the month following 60 days of employment.

Section 125

Certain benefits described in this guide may be purchased with pre-tax payroll deductions as permitted by Section 125 of the Internal Revenue Code.

When you purchase benefits with pre-tax dollars, you reduce your taxable income, so fewer taxes are taken out of your paycheck. You can actually have more spendable income than if the same deductions were taken on an after-tax basis.

For all participants in the benefits program, the following is the definition of a dependent unless otherwise stated:

- Your lawful spouse
- A domestic partner
- Any child who is less than 26 years old, (married or unmarried);
- 26 or more years old (unmarried) and primarily supported by the employee and incapable of self-sustaining employment by reason of mental or physical handicap.

Eligible children include the employee's natural children, adopted children, children who have been legally placed with the employee for adoption, step children and any children for whom the employee or the employee's spouse have legal guardianship issued by a U.S. court.

Changing Your Elections

Be sure to consider your choices carefully before you make your benefit elections. The benefits you choose will remain in effect from your date of eligibility through the plan year, unless you have a qualifying event during the year, such as:

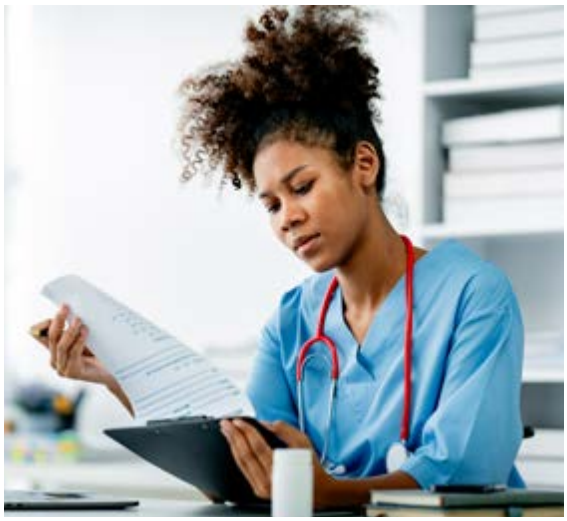
- Marriage, divorce or legal separation;
- Birth or adoption of a child;
- Death of a spouse or child;
- Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, dependent reaches age 26); or
- You or one of your covered dependents gains or loses other benefits coverage due to employment status (for example, beginning or ending a job).

Changes to your elections must be made within 31 days of the status change (eligibility change for CHIP is 60 days).

MERITAIN/AETNA MEDICAL COVERAGE

Meritain Health
an aetna company

Honeygrow is proud to offer you a choice between two different medical plans administered through Meritain with network access through Aetna. Coverage under all of the plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.



Meritain/Aetna PPO 2000 & 250 Options

Traditional PPO Plans are Preferred Provider Organization, or PPO for short. These plans offer you the freedom to receive care from any provider—in or out of your network. This means you can see any doctor or specialist, or use any hospital.

- ✓ Copays for most services, lower deductible to fulfill
- ✓ Does not require you to designate a Primary Care Physician (PCP)
- ✓ Specialist care does not require referral from your PCP
- ✓ Offers out-of-network coverage (although at greater cost to you)

These plans offer first dollar copays for office visits and prescription drugs, while larger medical expenses contribute towards your deductible and coinsurance.

Who is Meritain Health?

Meritain Health is one of the nation's largest third party administrators (TPAs), and a subsidiary of Aetna® and Fortune 400 company CVS Health®.

With access to over 1.6 million health care providers, competitive network discounts, leading point solutions and modern pharmacy plans, Meritain plans and members enjoy quality care how they want to receive it, without sacrificing savings.

With simplicity, transparency and versatility—Meritain will make your health benefit goals a reality.

What Network do I use for my Plan? **Aetna Choice POS II**

When you receive your member ID card, it will show the Meritain Health logo and the logo of the network you can use.

Use the portal to download your digital ID card.

Register your account on **www.meritain.com** to locate providers, monitor claims, and to view your ID Card.

Identify providers in the Aetna Choice POS II network.

MERITAIN/AETNA ADDITIONAL BENEFITS

MinuteClinic®

Now offering access to MinuteClinic at **NO COST*** to you.

High-quality care that's affordable and reliable

MinuteClinic makes it easy for you to get the care you need, when and where you need it. And now you can get access to all covered MinuteClinic services at no cost—not just preventive care.*

- MinuteClinic is a walk-in clinic inside select CVS Pharmacy® and Target stores, and is the largest provider of retail health care in the United States—with over 1,100 locations in 33 states and the District of Columbia.
- It's open every day, including evenings. MinuteClinic offers both walk-in and scheduled appointment options.
- MinuteClinic health care providers treat a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate.

**Visit minuteclinic.com for age and service restrictions. Video visits are not a covered service under this benefit. This is for informational purposes only. It is not medical advice and is not intended to be a substitute for proper medical care provided by a physician. Information is believed to be accurate as of the production date; however, it is subject to change. Includes access to all covered services at MinuteClinic.*

Your DocFind® Online Directory

Aetna Choice® Point of Service (POS) II

It's easy to find doctors and hospitals in your network

When you and your family need care, you can look for doctors and hospitals in the Aetna Choice POS II network. It's easy when you use the online DocFind directory from Aetna.* With up-to-date listings, you can search for providers by name, specialty, gender, hospital affiliations and more.

Find Aetna providers online in just a few quick steps

You can use the DocFind directory anywhere you have Internet access. Just:

1. Visit **http://www.aetna.com/docfind/custom/mymeritain/.**
2. Key in the ZIP code, city, county or state of the desired geographical area in the Enter location here field. Click **Search.**
3. Key in **Aetna Choice® POS II (Open Access)** under Select a Plan. OR you can select Aetna Choice® POS II (Open Access) from the list of plans. Click **Continue**.
4. There are two options available to search for providers. The guided flow search uses some of our most commonly searched terms and easily organizes them for our users to find. To use the guided search flow choose and click on one of the categories under **Find what you need by category.**

Or

5. Use the search box, which includes type-ahead suggestions and will present provider, facility, specialty, and condition search options based on what is entered. These suggested options will present an exact match or relevant providers. To use the search box, key in the type of provider, provider name, specialty or condition in the search field under **What do you want to search for near** (will display your chosen location).
6. Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.
7. Narrow your search results by using the **Filter & Sort** option. Choices include Gender, Languages, Hospital Affiliations, Office Detail, Individual Practice Association Affiliations, Group Affiliations, and Provider Type.

TELADOC HEALTH

Teladoc HEALTH

Talk to a Doctor Anytime & Save Money!

Use Teladoc™ Health when it's not an emergency, and you can't get to a doctor's office. It's available 24/7, and you'll typically pay less than you would for a visit to the office or urgent care clinic.

TeladocHealth.com
1-800-835-2362

Teladoc Health can be used for things like:

- Allergies, cold, fever and flu
- Earaches
- Nausea and vomiting
- Constipation or diarrhea
- Mental health support
- Pink eye
- Sinus or respiratory issues
- Urinary tract infections
- Skin conditions (rashes or insect bites)

How do I use Teladoc Health?

You can get started using online video chat or the free app. Just have your Member ID card ready. It's easy to get started.

MEDICAL PLAN COMPARISON

	PPO 2000 In-Network	PPO 250 In-Network
Lifetime Maximum	Unlimited	Unlimited
Deductible (Individual / Family)	**$2,000 / $4,000**	**$0 / $0**
Out-of-Pocket Maximum (Individual / Family)	$7,900 / $15,800	$7,900 / $15,800
Preventive Services	Covered in Full	Covered in Full
Doctor Office Visit Primary Care Services Specialist Services	 $30 copay, no deductible $60 copay, no deductible	 $20 copay $40 copay
Emergency Room	$300 copay, after deductible	$250 copay (copay not waived if admitted)
Urgent Care Centers	$100 copay	$85 copay
Maternity First OB visit Hospital	 $30 copay, no deductible 80%, after deductible	 $20 copay $250 / day (maximum of 5 copays / admission)
Inpatient Hospital Facility Physician/Surgeon	 80%, after deductible 80%, after deductible	 $250 / day (maximum of 5 copays / admission) Covered in Full
Hospice and Home Health Care	80%, after deductible	Covered in Full
Prescription Drugs Retail Copays (1-30 day supply) Generic Formulary Brand Formulary Non-Formulary Brand Self-Administered Specialty Drugs Mail Order Pharmacy (31-90 day supply)	 $20 copay $40 copay $60 copay 50% up to $500 2x Retail copay	 $15 copay $35 copay $50 copay 50% up to $500 2x Retail copay
	Out-of-Network	**Out-of-Network**
Deductible (Individual / Family)	$5,000 / $10,000	$2,500 / $5,000
Out-of-Pocket Maximum (Individual / Family)	$10,000 / $20,000	$10,000 / $20,000
Doctor Office Visit PCP Visit Specialist Visit	 50%, after deductible 50%, after deductible	 50%, after deductible 50%, after deductible

T*his Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.*

Per Paycheck Contribution	PPO 2000	PPO 250
Employee Only	$67.16	$116.94
Employee + Spouse	$154.55	$269.10
Employee + Child(ren)	$119.47	$208.52
Family	$201.22	$343.13

MERITAIN HEALTH SOLUTIONS

KISx — Now Valenz Surgical & Imaging

Quality Care, Close to Home at $0 Cost*

Our Care Navigation team will help you book your non-emergent surgery and imaging. With a nationwide network of 2,000+ locations, we'll help you choose a high-quality provider that best fits your needs and guide you through the process from referral to appointment. As part of your employer benefits, you can schedule your surgical and imaging services at no cost.

Getting Started is Easy!

1. Call: Contact (877) 438-5479 before scheduling with an outside provider.
2. Referral Received: Valenz receives your provider's order for review.
3. Confirm eligibility: We'll verify your benefits and confirm order details with your provider.
4. Scheduling: We'll suggest nearby options close to your home or work and assist in scheduling your appointment.
5. Receive your voucher: We'll email you a voucher to show the facility instead

We're here to support you every step of the way! Call (877) 438-5479 to get started.

**$0 Out-of-Pocket is subject to plan coverage requirements. To receive these benefits, members must schedule at the number provided; HSA Plans require first dollar coverage from patient before procedure up to IRS Minimum, before program incentives are received.*

Common Covered Procedures

- Ankle & Foot
- Arthroscopy
- Colonoscopy
- ENT
- Elbow
- Gastroenterology
- General Surgery
- Hernia Repair
- Hip
- Imaging
- Knee
- Shoulder
- Spine
- Urology
- Wrist & Hand
- And More

To learn more or schedule a procedure:

Phone: *(877) 438-5479*

Email: *nocostcare@valenzhealth.com*

Website: *surgicalimaging.valenzhealth.com*

MERITAIN HEALTH SOLUTIONS CONTINUED

CancerCARE+

CancerCARE+ is an oncology solution that reduces cancer claim costs while advocating for patients. With 25% of cancer cases mis-staged or misdiagnosed, unnecessary costs and suboptimal care are common. CancerCARE+ provides second opinions and reviews treatment plans to ensure compliance with best-in-class guidelines, helping employers avoid unnecessary expenses by confirming that the diagnosis and staging are accurate and the treatment is appropriate from the start.

Upon diagnosis, active plan participants are paired via a TPA with a CancerCARE+ coordinator to confirm staging and streamline care. The coordinator:

- Arranges second opinions with top national centers of excellence,
- Promotes evidence-based clinical pathways before treatment, and
- Ensures that cost-effective treatment is implemented promptly.

CancerCARE+ is available in three models. Depending on the TPA, an employer can select from the following three options:

- The Classic model[1], accessible to all, requires patients to register directly with CancerCARE+.
- The Hybrid model, available to employer Members on ICM (at $2 PEPM), involves CancerCARE+ handling case management for referrals received from the plan's utilization-review partner.
- The Pre-Treatment model, also for Members on ICM, integrates at the TPA level to enable early identification and proactive engagement, offering enhanced support from the outset.

HUSK Marketplace

HUSK is an online platform that provides employees with discounted access to top fitness, weight loss, and wellness programs nationwide, encouraging a proactive approach to health and well-being.

The HUSK Marketplace empowers individuals to design their own wellness journeys by offering tools and resources tailored to their needs. From discounted gym memberships and on-demand fitness programs to virtual health communities and premium wellness products, HUSK's offerings make a healthier lifestyle accessible. Through partnerships with leading brands, HUSK delivers exceptional value and industry-best pricing, putting top-tier wellness solutions within reach.

What HUSK Marketplace offers:

- **Exclusive membership pricing**: Discounted rates at major fitness and wellness providers
- **Variety of options**: Diverse memberships to fit every lifestyle
- **Flexible benefits**: Options like freeze, transfer, and virtual subscriptions
- **Equipment & technology**: Access to top fitness gear and wellness tech
- **Insurance-funded nutrition**: Affordable options to support healthy eating
- **Mental health services**: Resources to support emotional well-being

MERITAIN HEALTH SOLUTIONS CONTINUED

Lyra Select

Lyra Select is a comprehensive mental health and wellbeing solution that delivers fast access and evidence-based care for the whole family. Lyra combines an AI-powered technology platform with an exclusive provider network to prevent and treat a wide range of mental health needs while lowering costs for employers.

The program provides the following services as part of Lyra's platform PEPM fee:

- **Expert support**: Access to in-person and virtual coaching and therapy through an exclusive network of evidence-based providers serving children, teens, parents, couples, and caregivers
- **Care in less than two days**: Less than two days to the first appointment (virtual or in-person)
- **Continuity of care**: Seamless access to additional sessions as needed.
- **24/7 navigation and support**: Care navigation and crisis services via digital, phone, and chat
- **Personalized toolkits**: AI-driven wellness resources tailored to each member.
- **On-demand learning**: Courses on topics such as sleep and burnout, plus confidential live events
- **Work-life resources**: Financial counseling, legal consultations, care-giving support, and assistance with health-related social needs.
- **Manager consultations**: On-demand guidance for benefits teams and organizational leaders

Dental / Vision ID cards

No physical cards issued. Visit the Delta and UHC portals to download your digital cards.

DELTA DENTAL COVERAGE

Honeygrow employees are eligible for two different levels of dental coverage through Delta Dental. With both plans you will maximize your benefits by using an in-network provider. Delta Dental offers one of the largest networks through its Preferred Provider Organization. However, if you use a dentist outside of the Delta Dental network, you will be responsible for paying the difference between the dentist's charge and Delta's allowed benefit.

When selecting your dentist, don't do so on the basis of cost or advertisements alone. Dental appointments are likely to be less stressful if you know and like your dentist. Fearful patients usually experience less anxiety when they visit a dentist they trust. Don't wait until a problem forces you to find a dentist - acting before you have a serious problem may save you time, money, and discomfort.

To determine if your dentist participates in Delta Dental's network or to select a participating dentist in your area visit www.deltadentalins.com or call 1-800-932-0783.

	High Plan		Low Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Type A - Preventive	100%	100%	100%	100%
Type B - Basic Restorative	100%	100%	80%	80%
Type C - Major Restorative	50%	50%	0%	0%
Type D – Orthodontia	50%	50%	n/a	n/a
Orthodontia Maximum (child under 19 only)	$1,500	$1,500	n/a	n/a
Deductible (Individual / Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual Maximum Benefit (Per Individual)	$2,750	$2,750	$1,000	$1,000
Dependent Age:	Eligible for benefits until the day that he or she turns 26.		Eligible for benefits until the day that he or she turns 26.	

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Per Paycheck Contribution	High Plan	Low Plan
Employee Only	$6.64	$1.87
Employee + Spouse, Child(ren) or Family	$20.13	$5.79

If you have any questions regarding your dental plan coverage, contact Delta Dental at 1-800-932-0783 or visit www.deltadentalins.com.

UHC VISION COVERAGE

The UnitedHealthcare (UHC) Vision program offers members comprehensive benefits, including routine eye care, frames and lenses. This coverage is a separate enrollment from the medical plan. The vision program is easy to use. Benefits are maximized by using network Providers that are conveniently located throughout the area. Paid-in-full benefits for eyeglasses with standard lenses are possible when you choose from the preferred collection of frames. For plan specific details, please reference your plan summary through the online benefits portal.

Per Paycheck Contribution	Vision Plan
Employee Only	$0.63
Employee + Spouse, Child(ren) or Family	$1.58

If you have any questions regarding your vision plan coverage, contact UHC at 1-800-638-3120 or visit www.myuhcvision.com.

FLEXIBLE SPENDING ACCOUNTS

Now is the time to consider the tax savings advantage of using pre-tax dollars to pay for certain medical, dependent care, transit, and parking expenses with the various Flexible Spending Accounts (FSA's) offered by Honeygrow. Pre-tax dollars come "off the top" of your pay before federal income taxes or Social Security taxes are calculated.

Health Care FSA

This account may be used to pay for healthcare expenses not covered under any other plan. Qualified expenses may include deductibles and coinsurance, prescription and contact lenses, etc.

Contribution Limits: The maximum annual amount you may contribute to a HCFSA is **$3,400**. Any unused balances up to **$680** can be carried over to the next Plan Year.

Dependent Care FSA

This account may be used to pay for eligible dependent care expenses with pre-tax dollars. Eligible expenses include, but are not limited to, before and after school programs, nursery or preschool tuition, summer day camp, or in-home care by a licensed provider.

Contribution Limits: The maximum annual amount you may contribute to a DCFSA is **$7,500**, or **$3,750** if you are married and file a separate tax return.

Commuter Reimbursement Accounts

This account is a tax-favored program (Internal Revenue Code Section 132) that allows you to set aside pre-tax money from your paycheck to pay for eligible transportation expenses, which include a Mass Transit spending account and a Parking spending account. You can participate in one or both of these options.

Contribution Limits: The maximum monthly amount you may contribute to the Mass Transit Benefit is **$340**. The maximum monthly amount you may contribute to the Parking Benefit is **$340**.

"Use it or lose it" FSA Rollover Provision

Honeygrow has elected to participate in the FSA rollover provision, allowing employees to rollover up to $680 of unused 2025 HCFSA funds to 2026. The rollover amount of $680 does not impact the max election limit for 2026. The rollover provision applies to participants that enroll in the HCFSA plan for both the 2025 and 2026 plan years. You are still encouraged to consider your expenses carefully before you decide how much to contribute to each Flexible Spending Account. As a reminder, your election will cover the period from January 1 through December 31. You should not contribute more than you are reasonably certain to use.

90-Day "Run-Out" Period to Submit Claims

After the end of the FSA plan year, you will have an additional 90 days to file claims for expenses incurred during the previous plan year. This means as long as the expense was incurred before the plan year ends on December 31, you have until March 31 of the following year to submit claims for reimbursement.

If you have any questions regarding your flexible spending account, contact The Harrison Group at 610-853-9075 or visit www.theharrisongrouponline.com.

401(K) RETIREMENT

Honeygrow's 401k match makes it easier than ever to start saving for your future. At the end of the year, the first 3% of your pay that you contribute will be matched 1 for 1, while the next 2% will be matched at half that rate.

Your contribution	Honeygrow's contribution
1%	1%
2%	2%
3%	3%
4%	3.5%
5% or more	4%

You are eligible to take part if you:

- Are at least 21 years old
- Have been employed at least 1 year
- Have worked at least 1000 hours in that year

Eligibility is re-evaluated every year, so, if you were part time your first year and missed the 1000 hour mark, you can still become eligible the following year. Anyone who is about to become eligible should see correspondence from ADP come in the mail inviting you to participate.

Eligible employees can sign up for the 401k and change contribution levels at anytime through the following methods:

- ADP's Mobile app; just go to the "Retirement" section on the dashboard
- ADP's website (www.mykplan.com)
- Call 1-800-MYKPLAN (1-800-695-7526).

ADP has a few options to automatically invest your funds, but if you'd like more detailed guidance, you may contact our plan's financial advisors, Jeffrey Martinides or Craig Denham of Merrill Lynch at **267-757-1400**, **jeffrey_martinides@ml.com**, or **craig.denham@ml.com**

EMPLOYEE PERKS PROGRAM

Offered to you by Working Advantage.

We're here to support your personal and financial well-being through exclusive deals and limited-time offers on the products, services and experiences you need and love.

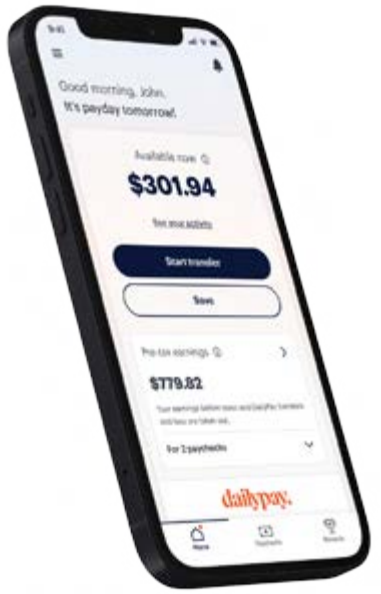
- Electronics
- Appliances
- Apparel
- Cars
- Flowers
- Fitness Memberships
- Gift Cards
- Groceries
- Hotels
- Movie Tickets
- Rental Cars
- Special Events
- Theme Parks and more!

New to Working Advantage? Getting started is easy.

1. Visit **honeygrow.savings.workingadvantage.com**
2. Click **Become a Member**
3. Enter your **personal email** to create an account.

DAILYPAY

Make the most of your hard-earned pay with the DailyPay Visa® Prepaid Card, a re-loadable Visa® card that allows you to access your earned pay whenever you want,* and puts all your banking1 needs at your fingertips. You can easily get your DailyPay Card in the app in just a few steps.



Your Pay, Your Way

- Instant no-fee* transfers from your DailyPay.
- Available Earnings to your DailyPay Card.

Safe and Secure

- Lock and unlock your card at any time in case it's lost or stolen.
- Zero liability for purchases you didn't make."
- Your funds are FDIC insured up to $250,000 through The Bancorp Bank, N.A. That means your funds are backed by the full faith and credit of the U.S. government.

Forget the fees

- No monthly fees or minimum balance requirements.
- No-fee withdrawals at 55,000+ Allpoint® ATMs.

Easy to Enroll

- Only ID verification needed.
- No existing bank account needed to sign up.

Simple and Convenient

- Track your income and spending in one place.
- Keep using your card even without DailyPay.
- Use wherever Visa debit cards are accepted.
- Add to Apple Pay®, Google Pay™, and Samsung Pay®

Apple Store Google Play

Download the DailyPay app or visit www.get.dailypay.com

ONE ELEVEN APP

Get started now and receive 100 bonus points!

Earn points and get gift cards to your favorite stores and restaurants by focusing on your finances in the OneEleven app. This financial wellness benefit is FREE for all employees of Honeygrow. Log in today to create a budget, learn about investing or start saving for the future.

What can you do in the OneEleven App?

- Watch short videos on must-know financial topics like credit scores, emergency funds and paying off debt.
- Get answers to your money questions confidentially by chatting 1-on-1 with your own dedicated Wealth Coach.
- See all your accounts organized in one place, create a spending plan and access budgeting tools.

For sign up help or questions about this benefit, email **hello@oneeleven.co.**

FAQs

IT Issues

Why can't I login into my benefits?

It's recommended that you login using a desktop or laptop computer instead of a mobile device. Click the weblink in your guide or **TYPE the EXACT URL** into your top browser bar. Do not type into Google search bar.

How can I tell if my computer has the Minimal Requirements?

If your computer has the latest browser updates you should be able to login. For most computers you can find the version being used by going to "Help > About" menu selection.

ID Cards

How do I get ID cards for my plans?

If you do not have an ID card, contact the carrier to order your ID card or go online to the carrier's website to download an ID card.

I have not received my member ID card but need to see my doctor. What should I do?

For most plans, you can go to your Carrier's website to view a digital version of your member ID card.

If you are unable to view on the Carrier's website, then contact Honeygrow's Benefits Helpline at 833-469-2363. If your application has been processed they will be able to give you your unique member ID number.

Preventive Care

What is considered preventive care and 100% covered at no cost?

Medical services that defend against health emergencies, illnesses, and diseases—like annual check-ups, immunizations and screening tests—are considered preventive. If you are enrolled in a medical plan, in-network preventive services are covered at 100%, with no payment needed from you.

Do I need a referral for my annual GYN exam?

No, this is considered preventive care. Female members may schedule an appointment for a routine annual exam with any OB/GYN in-network.

Enrolling or Life Event Status Change

Can I get health coverage outside Open Enrollment?

Outside Open Enrollment, you can only get health insurance 3 ways:

- With a life event status change, you qualify if you lose job-based coverage, have a baby, get married, or have certain other life changes, or based on estimated household income.
- Through Medicaid or the Children's Health Insurance Program (CHIP). Go to healthcare.gov for more information.
- HIPAA Special Enrollment due to loss of eligibility for other coverage and upon certain life events.

Can I enroll my spouse or dependent on one plan and myself on another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

What do I do for a life event status change?

You must notify the Benefits Helpline or HR Department within a limited number of days from the life event, in order to make a status change to your benefit selections.

If adding or removing dependents, you are required to submit specific documents, such as marriage license or birth certificate. The change will be inactive until proper documentation is received and approved.

See the full list of life event status changes listed on the Benefit Changes page in your benefit guide or defer to the plan documents.

What happens if I do not enroll within 30 days?

Benefits are subject to regulatory rules and if you do not enroll within the 30 days you will not be able to enroll again until next benefits open enrollment.

Explanation of Benefits (EOB)

What is an EOB?

EOB stands for Explanation of Benefits. This is a document sent to you to let you know a claim has been processed describing what costs it will cover for medical care or products received. The most important thing for you to remember is an EOB is NOT a bill.

To view the full FAQ list, click the link below or scan the QR code.

https://flipbooks.assuredpartners.com/30678/95470/index.html

ANNUAL NOTICES

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in Honeygrow-sponsored health and welfare benefit plan are reminded that Honeygrow's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, 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 dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, Honeygrow asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Notice to Covered Members

The plans you have selected through your employer-provided employee benefits program are insured by the carrier listed on the confirmation statement or are self-funded plans and the listed carriers is the Plan's claims payer. Administrative services for the billing and collection of premiums from your plan sponsor for the insurance coverages are provided by AP Benefit Advisors, LLC, a licensed Third Party Administrator, pursuant to the agreement previously entered into by AP Benefit Advisors, LLC and the insurer/claims payer. The insurer/claims payer is responsible for eligibility and benefit determination, payment of claims, and all other services associated with your coverage.

IMPORTANT NOTICE FROM HONEYGROW 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 Honeygrow 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. Honeygrow has determined that the prescription drug coverage offered and administered by OptumRX, 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 through 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 Honeygrow coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Honeygrow coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Honeygrow 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 Honeygrow 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:	12/1/2025
Name of Entity/Sender:	Honeygrow
Contact - Position/Office:	1429 Walnut Street 9th Floor Philadelphia, PA 19102

Information reflects 2026 Honeygrow Medical Plans.

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, 2025. Contact your State for more information on eligibility –

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

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

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

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

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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

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

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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

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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

HEALTH INSURANCE MARKETPLACE

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty (if applicable) to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in Honeygrow's medical plan, then PPACA may have little effect on you. Honeygrow's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by Honeygrow, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in Honeygrow's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered through the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 800-318-2596.

honeygrow