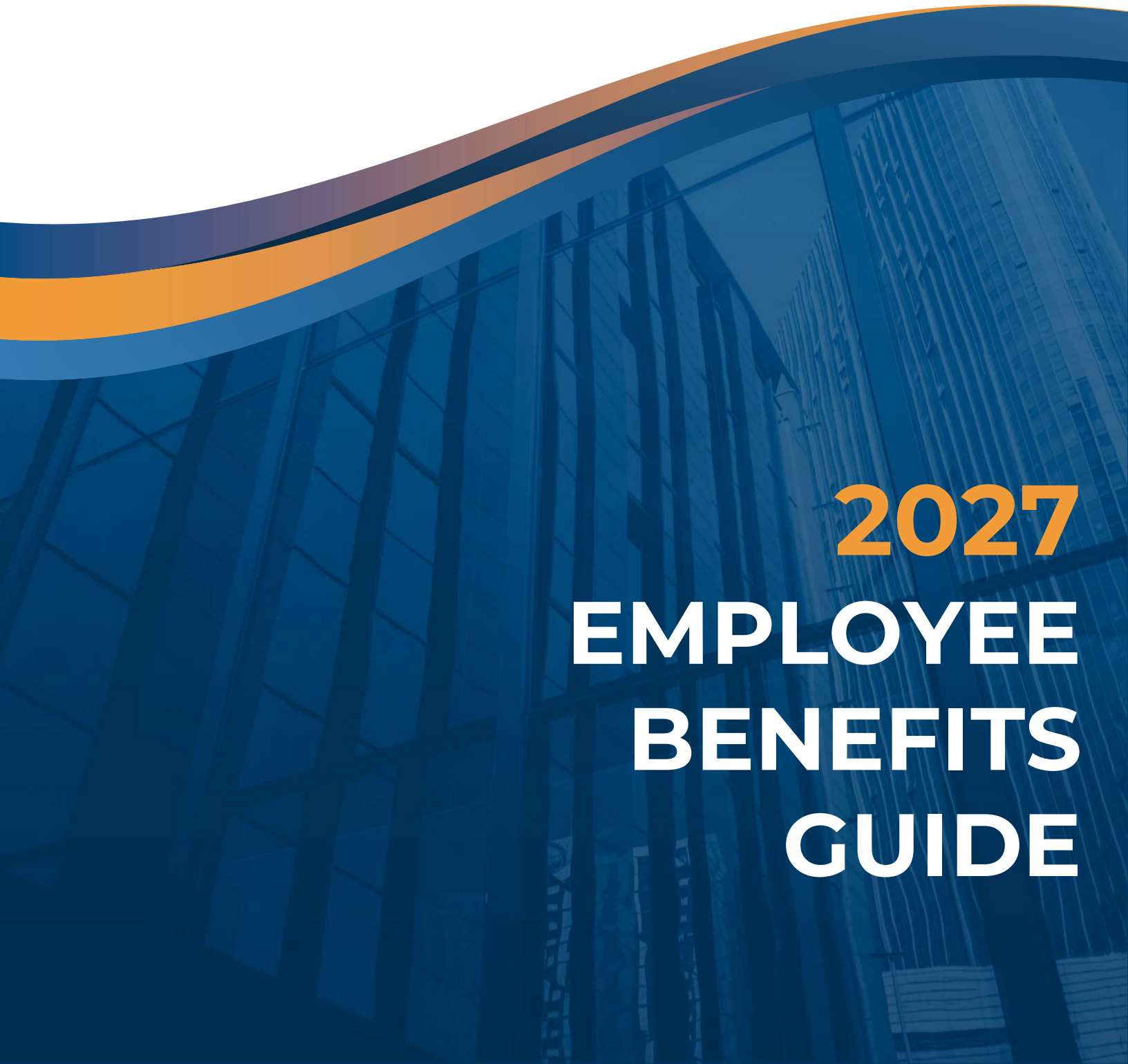
LIBERTY



2027 EMPLOYEE BENEFITS GUIDE

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Welcome to your **2027 Benefits Guide**

Whether you are new to The Liberty Company (*Welcome!*) or a current employee (*Thank you for your service!*), information you need for enrollment is available in this guide and on the microsite. This year's open enrollment (November 18–30) is passive — your current elections carry over unless you make a change — and our Cigna medical plans continue through February 28, 2027, with new medical plan options starting March 1.

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

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

Have questions?
We are here to help!

Email: benefits@libertycompany.com

Phone: 818-914-3986

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

Eligibility

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

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

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

Open enrollment runs November 18–30, 2026 and is passive — your current elections carry over unless you make a change. You must actively enroll to contribute to an FSA or HSA in 2027, change plans, or add or remove dependents. Cigna medical plans continue through February 28, 2027; new options begin March 1, with a second open enrollment in early February.

Eligible Dependents

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

Documentation Requirements for Dependents

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

Acceptable Forms of Documentation include but are not limited to:

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

Enroll Online

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

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

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

Enrollment is Easy...and Just a Click Away

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

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

- This is a passive enrollment: if you do nothing, your current elections carry over to 2027.
- You must actively enroll to contribute to an FSA or HSA in 2027, to change plans, or to add or remove dependents.
- If you are waiving medical but want to receive the semi-monthly $25 credit, you must opt into the credit.
- New hires must enroll within 30 days of their hire date. Newly benefit-eligible employees must enroll within 30 days of the date they become benefit eligible. Keep in mind that once the open enrollment window closes, changes cannot be made until the February 2027 medical open enrollment or the next annual enrollment period, unless you have a qualifying life event.
- Your selections are complete once you click the "Sign and Submit" button, however you may edit your selections while you are still in your open enrollment window.



Benefits Snapshot

01 **Cigna** – Medical PPO and HDHP (all states)

02 **Kaiser** – Medical HMO (CA only)

03 **MetLife** – Dental PPO

04 **VSP** – Vision

05 **Reliance Standard** – Life and AD&D

06 **Reliance Standard** – Disability, Accident, and Critical Illness

07 **HealthEquity** – HSA and FSA

08 **MetLife** – Legal Plan

09 **Allstate** – Identity Theft Protection

10 **MetLife** – Pet Insurance

11 **AllOne Health** – Employee Assistance Program

12 **Voya** – 401(k)

Premium Payment

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

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

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

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

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

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

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

Health Care Premiums

Premiums for Coverage

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

- The amount you pay is determined by whether you want to include just yourself, your entire family, or some combination in between.
- All employees have the option of selecting a medical plan from Cigna. There are three options: Cigna Base PPO, Cigna Buy-Up PPO, and Cigna HDHP. For those who reside in California, there are two additional options with Kaiser Permanente: HMO (Low) and HMO (High). The premiums for each of these plans vary, as do the benefits covered. You should consider both the premium amount and the amount of benefits coverage under each plan before making your selection. These Cigna plans continue through February 28, 2027; new medical plan options take effect March 1, 2027, with a second open enrollment in early February.
- You are free to choose any other health care coverage you wish and decline any coverage you do not need. For instance, you can select medical coverage but decline dental and vision. Or select dental, but no medical or vision. Any combination is acceptable.
- If you waive the medical coverage because you are enrolled in medical elsewhere, The Liberty Company provides a $25 semi-monthly medical opt out payment to your paycheck.

Full-Time Employees — 2027 Semi-Monthly Deductions (per paycheck)

Coverage	Cigna Base PPO	Cigna Buy-Up PPO	Cigna HDHP	Kaiser HMO - Low *($750 Ded)* CA Only	Kaiser HMO - High *($15/PCP Visit)* CA Only	Waive Medical	MetLife Dental	VSP Vision
Employee Only	$74.93	$97.01	$0.00	$0.00	$46.74	$25 credit	$2.03	$0.45
EE + Spouse/Domestic Partner	$487.22	$533.35	$281.83	$224.87	$327.19		$14.54	$2.08
EE + Child(ren)	$412.06	$454.22	$226.66	$187.43	$280.45		$18.45	$2.16
EE + Family	$824.49	$890.37	$531.08	$374.63	$514.16		$34.29	$4.60

Liberty pays 90% of employee-only and 50% of dependent premiums on the base plans (Cigna Base PPO, Kaiser HMO High, dental, vision); you pay the rest.



$25

per paycheck when you waive medical coverage

Waiving medical coverage?

If you are newly waiving medical, decline the plan in Paycom and opt in to the $25 semi-monthly credit — it is not automatic.

Waiving medical does not mean waiving everything. You can still enroll in dental, vision, FSA, life, and any other benefit.

Medical Plans & Pharmacy

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

Understanding Your Options:

Cigna PPO (Base & Buy-Up)

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

Cigna High Deductible Health Plan (HDHP)

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

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

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

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

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

Kaiser Permanente HMO (Low and High)

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

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

MEDICAL PLANS

	Cigna Base PPO		Cigna Buy-Up PPO		Cigna HDHP		Kaiser HMO $15 (High)	Kaiser HMO $750 (Low)
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network		
Health Savings Account								
Employer HSA contribution	Not applicable		Not applicable		Up to $500 individual / $1,000 family (employee + one or more)		Not applicable	Not applicable
Deductible (calendar year)								
Individual	$750	$2,000	$250	$750	$3,000 ($3,400 per person in a family)	$6,000	$0	$750
Family	$2,250	$6,000	$750	$2,250	$6,000	$12,000	$0	$1,500
Out-of-pocket maximum								
Individual	$3,000	$10,000	$2,500	$5,000	$4,000	$10,000	$1,500	$3,000
Family	$6,000	$20,000	$5,000	$10,000	$8,000	$20,000	$3,000	$6,000
Coinsurance and copays — what you pay								
Coinsurance	20%	50%	20%	40%	20%	50%	N/A	20%
Primary care visit	$30 copay	50% after ded	$20 copay	40% after ded	$30 copay after ded	50% after ded	$15 copay	$30 copay
Specialist visit	$30 copay	50% after ded	$20 copay	40% after ded	$30 copay after ded	50% after ded	$15 copay	$40 copay
Virtual visit (MDLIVE / Kaiser)	$30 copay	Not covered	$20 copay	Not covered	$30 copay after ded	Not covered	No charge	No charge
Preventive care	No charge	50% after ded	No charge	40% after ded	No charge	50% after ded	No charge	No charge
Urgent care and emergency								
Urgent care	$35 copay	50% after ded	$25 copay	40% after ded	20% after ded	50% after ded	$15 copay	$30 copay
Emergency room	$100 copay, waived if admitted		$100 copay, waived if admitted		$100 copay after ded, waived if admitted		$200 copay	20% after ded
Hospital								
Inpatient	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	$250 per admission	20% after ded
Outpatient surgery	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	$15 per procedure	20% after ded
MRI, CT, PET scans	20% after ded	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded	No charge	20% up to $150
Other services								
Mental health — inpatient	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	$250 per admission	20% after ded
Mental health — office visit	$30 copay	50% after ded	$20 copay	40% after ded	$30 copay after ded	50% after ded	$15 copay	$30 copay
Durable medical equipment	20% after ded	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded	20%	20%
Chiropractic (20 visits/yr)	$30 copay	Not covered	$20 copay	Not covered	20% after ded	Not covered	$15 copay	$15 copay

Out-of-network reimbursement is based on 110% of the Maximum Reimbursable Charge; you may be balance billed.

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MEDICAL PLANS - PHARMACY

	Cigna Base PPO		Cigna Buy-Up PPO		Cigna HDHP		Kaiser HMO $15 (High)	Kaiser HMO $750 (Low)
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network		
Retail pharmacy — 30-day supply								
Generic	$15 copay	Not covered	$15 copay	Not covered	$15 copay after ded	Not covered	$10	$15
Preferred brand	$30 copay	Not covered	$30 copay	Not covered	$30 copay after ded	Not covered	$30	$35
Non-preferred brand	$60 copay	Not covered	$60 copay	Not covered	$60 copay after ded	Not covered	$30	$35
Specialty	20%, $250 max	Not covered	20%, $250 max	Not covered	20%, $250 max after ded	Not covered	20%, $250 max	20%, $250 max
Mail order / 90-day retail — 90-day supply (Kaiser: 100-day)								
Generic	$45 copay	Not covered	$45 copay	Not covered	$45 copay after ded	Not covered	$20	$30
Preferred brand	$90 copay	Not covered	$90 copay	Not covered	$90 copay after ded	Not covered	$60	$70
Non-preferred brand	$180 copay	Not covered	$180 copay	Not covered	$180 copay after ded	Not covered	$60	$70
Specialty	30-day supply only	Not covered	30-day supply only	Not covered	30-day supply only	Not covered	N/A	N/A

How to read this: On the Cigna PPO plans, copays apply right away. On the Cigna HDHP, you pay the full cost of prescriptions until you meet the deductible, then the copays above apply; medical and pharmacy share one deductible and out-of-pocket maximum. 90-day fills must be done at a Cigna 90 Now pharmacy (including CVS and Walgreens) or through home delivery. On the PPO plans, if you request a brand drug when a generic is available you pay the difference unless your doctor writes "dispense as written." Specialty drugs are filled through Accredo.

Comparing the Options

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

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

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

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

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Medical Plans & Pharmacy

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

To locate an in-network provider:

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

Wellness/Preventive Benefits

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

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

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

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

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

Prescription Drug Coverage

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

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

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

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

Download the MyCigna® App

Cigna

Available on the App Store

GET IT ON Google Play

Download the Kaiser Permanente App

Available on the App Store

GET IT ON Google Play

Dental

The dental care plan is administered through **MetLife**. While you can visit any licensed dentist, your cost is lower when you visit a dentist in the MetLife network. See the chart below for the differences in coverage and benefit levels.

Please note that physical ID cards are not issued. Download the MetLife US mobile app to have your ID card and plan details at your fingertips! You can also log in to your MetLife account online to find your information, or the provider will look you up with your social security number.

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

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

MetLife Dental (PDP Plus network)		
Service	**In-Network**	**Out-of-Network***
Calendar-year deductible (Basic and Major only)	$25 individual / $75 family	
What you pay		
Preventive — exams, cleanings, X-rays	You pay 0%, no deductible	You pay 0%, no deductible*
Basic — fillings, root canals, extractions, gum treatment	You pay 20% after deductible	You pay 20% after deductible*
Major — crowns, bridges, dentures, implants	You pay 40% after deductible	You pay 50% after deductible*
Annual maximum the plan pays	$5,000 per person	
Orthodontia — adults and dependent children (to age 26)		
Braces and related treatment	You pay 50%	You pay 50%*
Lifetime maximum the plan pays	$1,000 per person	
Good to know		
Exams and cleanings	1 every 6 months	
Implants	Covered under Major — 1 per tooth every 10 years	
Crowns, bridges, dentures	1 per tooth / 1 replacement every 10 years	

**Out-of-network benefits are based on the Reasonable & Customary charge (90th percentile). A non-participating dentist may bill you for any amount above that.*

Value Added Benefits

- **Teledentistry options**- connect with a dentist from your smartphone, tablet, or computer
- **International Dental Travel Assistance** – 24/7 help in multiple languages, access to providers in 200 countries

Vision

The vision care plan is administered by **Vision Service Plan (VSP).** It covers routine eye exams and helps pay for prescription glasses or contacts. You can see any provider, but your benefit is higher with a VSP network doctor — find one at www.vsp.com or 800-877-7195.

VSP does not issue ID cards. Log in to your VSP account for a digital copy, or your provider can look you up, such as by name and date of birth.

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

VSP Vision (VSP Choice network)			
Benefit	**In-Network (VSP doctor)**	**Out-of-Network***	**How often**
Exams			
WellVision Exam	$10 copay. *Optional routine retinal screening, up to $39 ($0 for members with diabetes).*	Reimbursed up to $45	Every calendar year
Prescription glasses — $25 copay (covers frame and lenses together)			
Frame	$180 allowance ($200 on Featured Frame Brands; $180 at Walmart/Sam's Club; $100 at Costco), plus 20% off any amount over your allowance.	Reimbursed up to $70	Every other calendar year
Lenses	Single vision, lined bifocal, and lined trifocal lenses included. Impact-resistant lenses for dependent children.	Reimbursed up to $30 / $50 / $65	Every calendar year
Progressive lenses	Standard $0. Premium $95–$105. Custom $150–$175. About 30% off other lens enhancements.	Not covered	Every calendar year
Contact lenses — instead of glasses. Each calendar year you can get glasses OR contacts, not both.			
Contact lenses	$180 allowance, no copay. *Contact lens exam (fitting and evaluation) up to $60.*	Reimbursed up to $105	Every calendar year
VSP LightCare — instead of your frame/lenses allowance			
VSP LightCare	$180 allowance toward ready-made non-prescription sunglasses or blue-light glasses. $25 copay.	—	Every other calendar year
Value added benefits			
Sunglasses and extra pairs	20% off additional pairs of prescription or non-prescription glasses or sunglasses within 12 months of your WellVision Exam, plus an extra $20 allowance on Featured Frame Brands.		
Laser eye surgery	Average 15% off the regular price at contracted facilities.		
VSP Simple Values	Everyday discounts on health, wellness, and more; up to 60% off hearing aids through TruHearing; shop online at Eyeconic. See vsp.com/offers.		

**Out-of-network amounts are reimbursements after you pay the provider; submit a claim at vsp.com.*

GET IT ON Google Play

Available on the App Store

Savings and Spending Accounts

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

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

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

Flexible Spending Accounts (FSA) – Healthcare and Dependent Care

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

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

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



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Savings and Spending Accounts

Guidelines and Eligible Expenses*

Healthcare FSA	Dependent Care FSA	Limited Purpose FSA
$3,500 annual maximum. Your entire election is available immediately regardless of actual payroll deduction amounts. Carry over up to $700 for the following calendar year. Expenses can be for you or anyone you claim as a dependent on your Federal tax return** Expenses must be incurred by December 31st and submitted for reimbursement by March 31st of the following year	$7,500 annual maximum. Can only be reimbursed up to what has been deducted from payroll (pay as you go). There is no carryover allowance. Dependents include children under age 13 or dependents that are physically or mentally unable to care for themselves and who have lived with you for more than half a year. Expenses must be incurred by December 31st and submitted for reimbursement by March 31st of the following year	$3,500 annual maximum. Your entire election is available immediately regardless of actual payroll deduction amounts. Carry over up to $700 for the following calendar year. Expenses can be for you or anyone you claim as a dependent on your Federal tax return** Expenses must be incurred by December 31st and submitted for reimbursement by March 31st of the following year **Can be used with an HSA**
Eligible health care, vision, and dental expenses include but are not limited to: • Medical plan office visit copays, deductibles and coinsurance. • Dental care – cleanings, fillings, exams, orthodontia. • Eye care – eyeglasses, contact lenses, LASIK.	Used for dependent day care expenses while you (and your spouse) work, look for work. or attend school full- time. • Expenses for a day care center, summer day camp, or preschool for children under 13 years of age. • Expenses for an unlicensed day care center that cares for six or fewer children. • Expenses at an adult day care facility (but not expenses for overnight, nursing home facilities).	Eligible vision and dental expenses include but are not limited to: • Dental care – cleanings, fillings, exams, orthodontia. • Eye care – eyeglasses, contact lenses, LASIK.

**This is only an example of eligible expenses.*

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

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

Using Your FSA

How it Works

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

Filing Claims and the Reimbursement Process

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



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Health Savings Account (HSA)

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

Maximum contributions are set by the IRS. For 2027, the total (employer + employee) maximum contribution is $4,500 for single coverage, or $9,000 for family coverage (per household). An annual catch-up amount of $1,000 is available for employees age 55 and older who are not enrolled in Medicare.

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

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

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

HSA Plan Advantages

- ✓ Medical plan paired with a tax-exempt health care savings account
- ✓ Employer sponsored and funded; employee funded — you decide how much
- ✓ Employee-owned and portable
- ✓ No "use-it-or-lose-it" rule — funds roll over every year
- ✓ Change your contribution amount at any time
- ✓ Ability to invest
- ✓ Triple tax favored: funds go in pre-tax, grow tax free*, and come out tax free for health care

YOU benefit from flexibility, tax savings and retirement savings!

The Liberty Company is investing in your health and will deposit

up to $500/single or
up to $1,000/family

into a bank account YOU own
(paid incrementally each pay period)

IRS sets maximum contributions annually
2027: $4,500 individual | $9,000 family
"Catch-up" contribution for age 55 and older: $1,000

In addition to Liberty's contribution, you can contribute up to:
Under 55: $4,000 single | $8,000 family
55 and older: $5,000 single | $9,000 family

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



Health Savings Account (HSA)

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

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

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

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

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

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

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



Life and AD&D

Life and Accidental Death & Dismemberment (AD&D) coverage is through Reliance Standard. Liberty pays for a base amount of both; you can buy more for yourself and your family. All coverage is term insurance, and amounts reduce to 65% at age 70 and 50% at age 75.

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Basic Life and AD&D — $50,000, paid by Liberty
Every full-time employee gets $50,000 of life insurance and $50,000 of AD&D at no cost. Nothing to elect — just name your beneficiary in Paycom. Includes a seat belt benefit (10%) and air bag benefit (5%) for accidental death in a car, an education benefit for dependents, travel assistance, and bereavement counseling. You can convert or port this coverage if you leave.

Supplemental Life — you pay

Who	Coverage options	Guaranteed issue (no health questions)*
Employee	$10,000 to $750,000 in $10,000 increments, up to 5× annual earnings. Basic plus supplemental can't exceed 7× earnings.	$200,000 when first eligible; $50,000 at open enrollment or within 30 days of a qualifying life event
Spouse / domestic partner	$5,000 to $500,000 in $5,000 increments, not more than your amount. Requires employee coverage.	$50,000 when first eligible; $10,000 at open enrollment or within 30 days of a qualifying life event
Child(ren) to age 26	$2,000 to $10,000 in $2,000 increments. One premium covers all your children. Requires employee coverage.	$10,000

Features: Living benefit — if diagnosed with a terminal illness, you can receive 75% of your benefit (up to $500,000) while living. Premiums are waived if you become totally disabled before age 60. Coverage is portable and convertible if you leave Liberty.

Semi-monthly premium	18–29	30–39	40–44	45–49	50–54	55–59	60–64	65–69	70+
Employee, per $10,000	$0.33	$0.48	$0.70	$1.15	$1.95	$3.25	$3.95	$6.50	$10.80
Spouse, per $5,000	$0.16	$0.24	$0.35	$0.58	$0.98	$1.63	$1.98	$3.25	$5.40
Child(ren), per $2,000	$0.18 — all ages (under 18), all children								

Rates are by age at last birthday; spouse rates use the spouse's age. Example: a 42-year-old electing $100,000 pays $7.00 per paycheck.

Voluntary AD&D — you pay

Who	Coverage options
Employee	$10,000 to $750,000 in $10,000 increments (amounts over $250,000 limited to 5× earnings).
Spouse / domestic partner	$5,000 to $750,000 in $5,000 increments, not more than your amount. Requires employee AD&D.
Child(ren) to age 26	$2,000 to $10,000 in $2,000 increments. Requires employee AD&D.

Pays for accidental death or loss of limbs, sight, speech, or hearing, on top of any life insurance. **Extras:** seat belt and air bag benefits; education benefit for children (5% of your amount, $1,000–$5,000 a year, up to 4 years) and spouse tuition up to $3,000 a year; day care benefit up to $2,400 a year per child; loss-of-use benefit. AD&D is separate from life — amounts don't need to match.

Evidence of Insurability (EOI)
When first eligible, you can elect supplemental life up to $200,000 (spouse $50,000) with no health questions. At open enrollment, or within 30 days of a qualifying life event, you can add up to $50,000 (spouse $10,000) without EOI unless you were previously declined. Anything above those amounts requires EOI. Voluntary AD&D never requires EOI. **Complete EOI through Paycom or your HR Benefits team.**

Name your beneficiary
Paycom prompts you to name a beneficiary for basic life, supplemental life, and AD&D. If none is on file, benefits are paid according to the policy (spouse, then children, then parents, then siblings, then estate). You are automatically the beneficiary for any spouse or child coverage..

**Guaranteed issue applies under age 70. Reductions at ages 70 and 75 apply to basic, supplemental, spouse, and AD&D amounts.*

Disability

Liberty pays the full cost of Short-Term Disability (STD) and Long-Term Disability (LTD) through Reliance Standard. Together they replace part of your income when you can't work because of your own illness, injury, or pregnancy. Coverage starts the first of the month after your hire date; there is nothing to elect.

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Short-Term Disability (STD)

	Employees outside California	California employees
Benefits begin	8th consecutive day of disability (7-day waiting period)	
How long	Up to 12 weeks per disability	
Weekly benefit	60% of earnings, up to $2,500 per week	20% of earnings, up to $2,308 per week

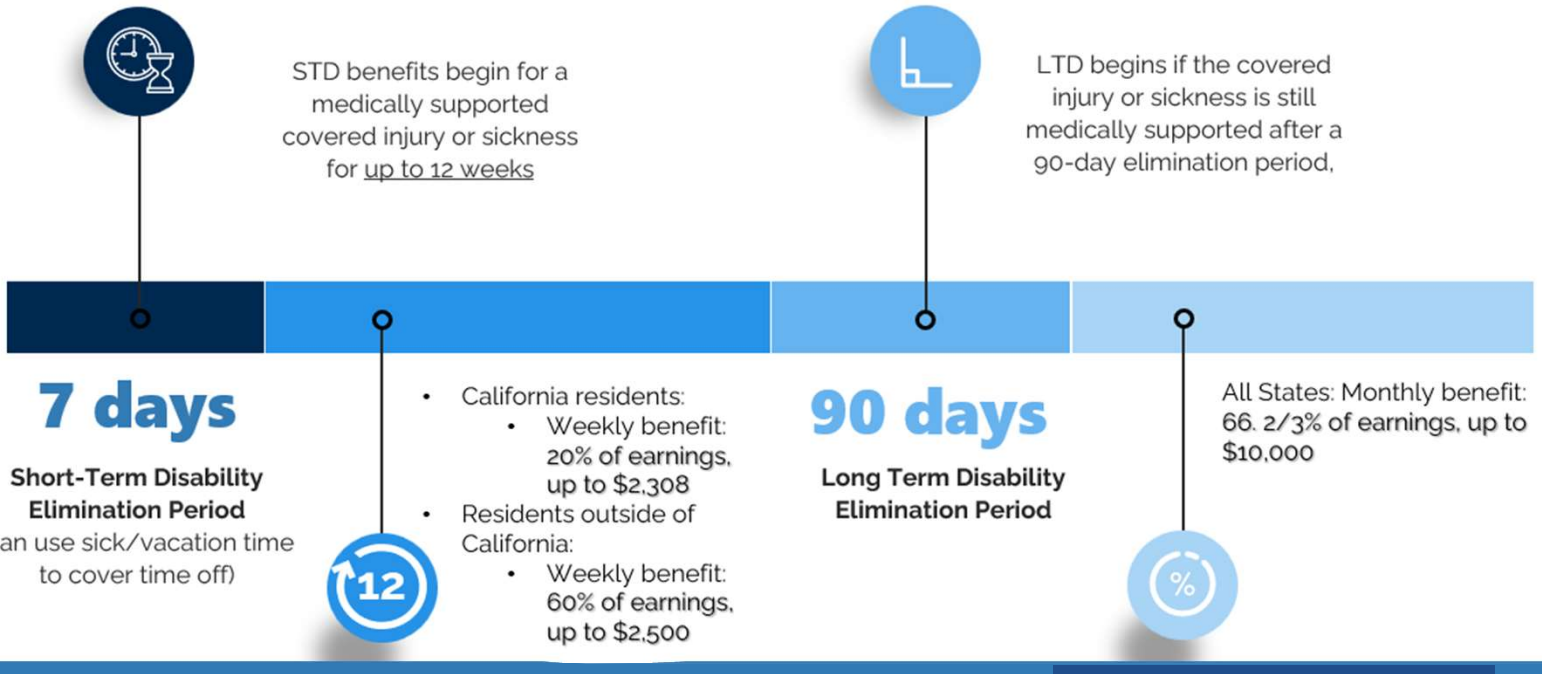
Why the difference? *California SDI pays the first portion of your income; Liberty's plan tops it up. File an SDI claim with the EDD as well.*

Long-Term Disability (LTD)

Benefits begin	After 90 consecutive days of disability — STD ends at 12 weeks
Monthly benefit	66⅔% of earnings, up to $10,000 per month, reduced by Social Security, workers' comp, and similar income for the same disability.
How long	To age 65 (or Social Security normal retirement age if later) based on disability
Also included	Return-to-work incentives, a child care benefit while working part-time, rehabilitation support, and a survivor benefit of 3× your monthly benefit.

Good to know: Because Liberty pays the premium, STD and LTD benefits are taxable income. A condition you were treated for in the 3 months before coverage began is not covered if it disables you in your first 12 months. LTD for mental health or substance use conditions is limited to 24 months. Work injuries go through workers' compensation.

Need to file a claim? Contact Reliance Standard as soon as you know you'll be out — don't wait for the waiting period to end. Call **877-202-0055** or file online at **www.matrixabsence.com**, and let HR know so your leave can be coordinated. Summary plan descriptions are on Workvivo.



Voluntary Benefits

Voluntary benefits add a layer of financial protection for you and your family. They pay cash directly to you to help with the out-of-pocket costs that come with an accident or a serious illness — deductibles, travel, lost time at work, or anything else.

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Accident Insurance

Reliance Standard's Accident Insurance pays a fixed cash benefit directly to you for each covered injury or treatment after a non-work-related accident. You choose how to use it. Because premiums are paid after tax, benefits are generally not taxable.

Accidental death and dismemberment is included: $17,500 for you, $8,750 for your spouse, and $5,000 per child, paid in addition to any other accident benefits. Coverage is portable — you can take it with you if you leave Liberty.

Accident Insurance Wellness Benefit
$50 per insured person per year for completing a routine wellness screening — up to 4 per family.

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

Some of the covered benefits

Benefit	Amount	Benefit	Amount
Hospital admission	$900	Emergency room visit	$203
Hospital confinement	$230 per day, up to 365 days	Physician office visit	$100/visit, up to 6 follow-ups
ICU confinement	$300 per day, up to 30 days	CT, MRI or PET scan	$150
Ambulance (ground / air)	$200 / $1,000	Physical therapy	$38/session, up to 10
Fractures	$30–$3,000; doubled if surgery	Crutches, wheelchair, walker	$300
Dislocations	$71–$2,272; doubled if surgery	Concussion	$350
Burns	$75 – $15,040	Family lodging (100+ miles)	$150 per day, up to 30

Example: broken ankle, no surgery

What happened	Benefit paid
Emergency room visit	$203
Non-surgical fracture, ankle	$180
Crutches (medical appliance)	$300
Physical therapy, 6 sessions	$228
Physician follow-up visit	$100
Total paid directly to you	**$1,011***

**Example only. Benefits are paid per covered accident and are subject to the limits in the certificate. Coverage is for off-the-job accidents; see the certificate for exclusions.*

Critical Illness Insurance

A serious diagnosis brings expenses a medical plan doesn't cover. **Reliance Standard's** Critical Illness insurance pays a lump sum directly to you when you or a covered family member is diagnosed with a covered condition, to use however you need.

Coverage amounts. Employees can elect $5,000 to $20,000 in $5,000 increments. A spouse or domestic partner can elect $5,000 or $10,000, not to exceed 50% of the employee amount. Child(ren) coverage is automatically included with no health question at 50% of the employee's benefit amount, maximum of $10,000. An employee must elect coverage for themselves to have coverage on dependents.

- No age-based reduction in benefits
- No waiting period
- No pre-existing condition limitation
- Portable — take it with you if you leave

Critical Illness Wellness Benefit
$100 per insured person per year for completing a routine wellness screening — up to 4 per family.

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



What's covered

Covered condition	Benefit
Heart attack	100%
Stroke	100%
Life-threatening cancer	100%
Major organ failure (transplant required)	100%
Coronary artery disease requiring bypass surgery	25%
Skin cancer (one time only)	5%

Recurrence of the same condition pays 100% again if diagnosed at least 6 months later. A different covered condition pays if diagnosed at least 3 months after the previous one. Lifetime maximum is 10 times your coverage amount.

Not covered as life-threatening cancer: *carcinoma in situ, early-stage prostate cancer, and most skin cancers. Stents and angioplasty do not qualify for the coronary artery benefit. See the certificate for full definitions.*

Example: how the plan pays

Donna suffered a heart attack and, four months later, a stroke. Both she and her husband missed work during her recovery, and bills piled up. Donna had elected $20,000 of Critical Illness coverage. Because the stroke was a different covered condition diagnosed more than 3 months after the heart attack, each diagnosis paid in full.

Example Amount Paid to Donna**	
Heart Attack	$20,000
Stroke (4 months later)	$20,000
Total Direct Benefit Payment to Donna	$40,000

**Premiums depend on coverage amount, age, and tobacco use. Spouse premiums are based on the employee's age. See Paycom for other coverage amounts.*

***Example only. Benefits are subject to the definitions, separation periods, and exclusions in the certificate. Benefits may be taxable..*

Identity Theft Protection

Allstate Identity Protection Pro+ Cyber watches your identity, finances, credit, and devices, alerts you when something looks wrong, and — if fraud happens — a U.S.-based specialist handles the cleanup and Allstate reimburses what it cost you.

Allstate Pro+ Cyber	Semi-Monthly Deduction
Employee Only	$3.75
Employee + Family	$6.75

You're covered from your effective date. Portable if you leave Liberty.

If fraud happens, Allstate pays
Up to $1 million (employee) or $2 million (family) for identity theft expenses — lost wages, legal fees, childcare, document fees, etc. Stolen funds reimbursed up to $1 million, including from your 401(k), HSA, and tax refund. Up to $500 cash if your wallet is stolen. Restoration covers fraud that started before you enrolled.

What it watches

Your identity and money	Dark web monitoring for your SSN, passwords, cards, driver's license, and medical ID. Alerts for new accounts, large withdrawals, wire transfers, and activity on bank, card, 401(k), and HSA accounts. Student loan activity alerts. Social media account takeover alerts.
Your credit	Monitoring at all three bureaus, unlimited TransUnion scores, an annual tri-bureau report and score, one-click credit lock for adults and minors, and help freezing or disputing.
Your devices	Antivirus, safe browsing and phishing protection, VPN, Wi-Fi scanning, firewall and webcam protection (Windows), and a password manager on up to 5 devices (10 on the family plan). Robocall and ad blockers. Locate, lock, alarm, or erase a lost phone (Android).
Your data	Allstate Digital Footprint shows where your personal information lives online and what to do about it. Breach notifications when a breach includes you. Help opting out of junk mail and credit offers.
Your risk	Identity Health Status gives you a monthly risk snapshot. Allstate Security Pro sends alerts about emerging scams and how to avoid them. Sex offender registry alerts for your area.

If something happens

Restoration	A U.S.-based, in-house specialist takes over your case — filing disputes, contacting creditors and agencies, and working it to resolution. Available 24/7. Covers fraud that began before you enrolled.
Fraud Resolution Tracker	Track your case status, message your specialist, and share documents securely from the app.
Unemployment and tax fraud	Dedicated Unemployment Fraud Center for benefit-claim fraud, and an advance on a stolen tax refund while the IRS sorts it out.

Who counts as family? Anyone who lives under your roof or depends on you financially, plus parents, in-laws, and grandparents age 65 or older whether or not they live with you. The family plan adds the Elder Fraud Center and scam support for them, and parental controls for kids — screen time limits, web filtering, location tracking, and alerts for cyberbullying or predators across 30+ apps.

Allstate

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Available on the App Store

Download the Allstate Identity Protection app

Questions or claims: www.myaip.com or 800-789-2720, 24/7. Some features require activation in the Allstate app or portal after you enroll.

Pet Insurance & Legal Plan



MetLife Pet Insurance

Covers bills for accidents and illnesses — exam fees, surgery, hospital stays, diagnostics, medications, hereditary and chronic conditions — for dogs, cats, birds, reptiles, rabbits, and other exotic pets. Use any licensed U.S. vet or emergency clinic.

You choose	Reimbursement of 50%, 70%, 80%, or 90% of the bill; an annual limit from $500 to $25,000 or unlimited; and a deductible from $0 to $2,500. Premium depends on your pet's age, breed, and location, and the options you pick.
When it starts	Accident coverage starts on your effective date. Illness coverage starts 14 days later. Pre-existing conditions are not covered unless they were covered by a prior pet policy you are switching from.
Family plans	Up to three dogs and cats on one policy with one shared deductible. Or insure pets separately and get 5% off the second policy and 10% off each additional one.
Extras	Your deductible drops $50 every year you don't file a claim. Optional preventive care rider for vaccines, flea and tick, heartworm, spay/neuter, and teeth cleaning. Up to 30% discount on pet care. The app also stores health records and has 24/7 live vet chat.

How to use it

Pay the vet, then submit the bill within 90 days through the MetLife Pet app, online, email, fax, or mail. Most claims are processed in 5–10 days; reimbursement by check or direct deposit.

Quote and enroll: **www.metlife.com/getpetquote** (select Liberty as your employer) or call **877-649-7351**. You pay MetLife directly (not through payroll), so the policy is yours — it stays in effect if you leave Liberty.

MetLife

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MetLife Legal Plan

Access to a network of 18,000+ attorneys for many personal legal matters, with no copays, deductibles, claim forms, or hour limits when you use a network attorney. Covers you, your spouse or domestic partner, and dependent children.

Estate planning	Wills, living wills, powers of attorney, trusts, and transfer-on-death deeds — online in about 15 minutes, or with an attorney.
Family & personal	Marriage and name changes, adoption, caring for aging parents, Medicare and Medicaid questions, sending kids to college.
Home & real estate	Buying, selling, or refinancing a home, lease review, security deposit disputes, and disputes with contractors or neighbors.
Money matters	Identity theft resolution, contacting creditors, debt collection defense, student loan help, and IRS audit representation.
Court matters	Civil lawsuits, small claims, consumer protection, and traffic violations (not DUI). For many matters your attorney can appear for you in court.
Not covered	Employment matters, business or landlord matters, matters against Liberty or MetLife, class actions, patents and trademarks, and court costs or fines.

How to use it

Pick an attorney at **members.legalplans.com** or call **800-821-6400** (M–F, 8 am–8 pm ET), then schedule a call, email, or visit. Billing is between MetLife and the attorney. You can use an out-of-network attorney and be reimbursed on a set fee schedule.

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Making Changes During the Year

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

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

Qualified life events include:

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

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

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

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



Employee Assistance Program (EAP)

Liberty offers an Employee Assistance Program (EAP) through AllOne Health at no cost to you, your dependents, and everyone in your household. It is confidential — Liberty never sees who uses it or why. Use it for stress, anxiety, grief, relationships, substance use, legal or money questions, or help finding child or elder care.

Call for support

Speak with the care team live, 24/7/365, for counseling, resources, and referrals.

(855) 775-4357

Request or schedule online

Book a virtual session with a licensed clinician, or submit a request for counseling, coaching, or work-life services.

allonehealth.com/member-support

Chat with Izzy

An AI guide on the member site that can assess your needs, share coping skills, and connect you to live counseling — any time.

What's included

Mental health sessions Up to 5 sessions per issue — in person, by video, or by phone — for stress, anxiety, depression, conflict, relationships, and any personal issue.	**Legal referral** Consultation with an attorney for wills, estate planning, divorce, custody, and other personal matters, with discounted continued services.
Financial consultation Budgeting, debt payoff, and saving for retirement, tuition, or major life events.	**Medical advocacy** Help navigating insurance, finding doctors, securing medical equipment, and planning transitional care or discharge.
Child care Referrals for daycare, before- and after-school programs, tutoring, babysitting, and enrichment activities.	**Elder and adult care** Referrals for meal services, transportation, in-home care, and community support programs for a loved one.
Housing Help with apartment searches, moving logistics, and temporary housing.	**Personal assistant** Help with travel, entertainment, home services, deliveries, pet care, and everyday tasks.
Life coaching Reach goals, manage transitions, and find balance in life and work.	**Work-life referrals** Personalized referrals for everyday services and community resources.

On the member site

Self-assessments, self-guided cognitive behavioral therapy, soft-skills courses, DIY legal forms, financial calculators, podcasts, and monthly webinars, plus a resource library on addiction and recovery, grief, caregiving, anger, stress and burnout, relationships, and resilience. And **discount deals** on everyday services, wellness programs, and lifestyle perks.

24-hour travel assistance — On Call International, through Reliance Standard, for medical and travel emergencies more than 100 miles from home. U.S. toll-free **800-456-3893** · Worldwide collect **603-328-1966**.

If you are in crisis or feel unsafe, call 911 or go to the nearest emergency room.

ALLONE HEALTH

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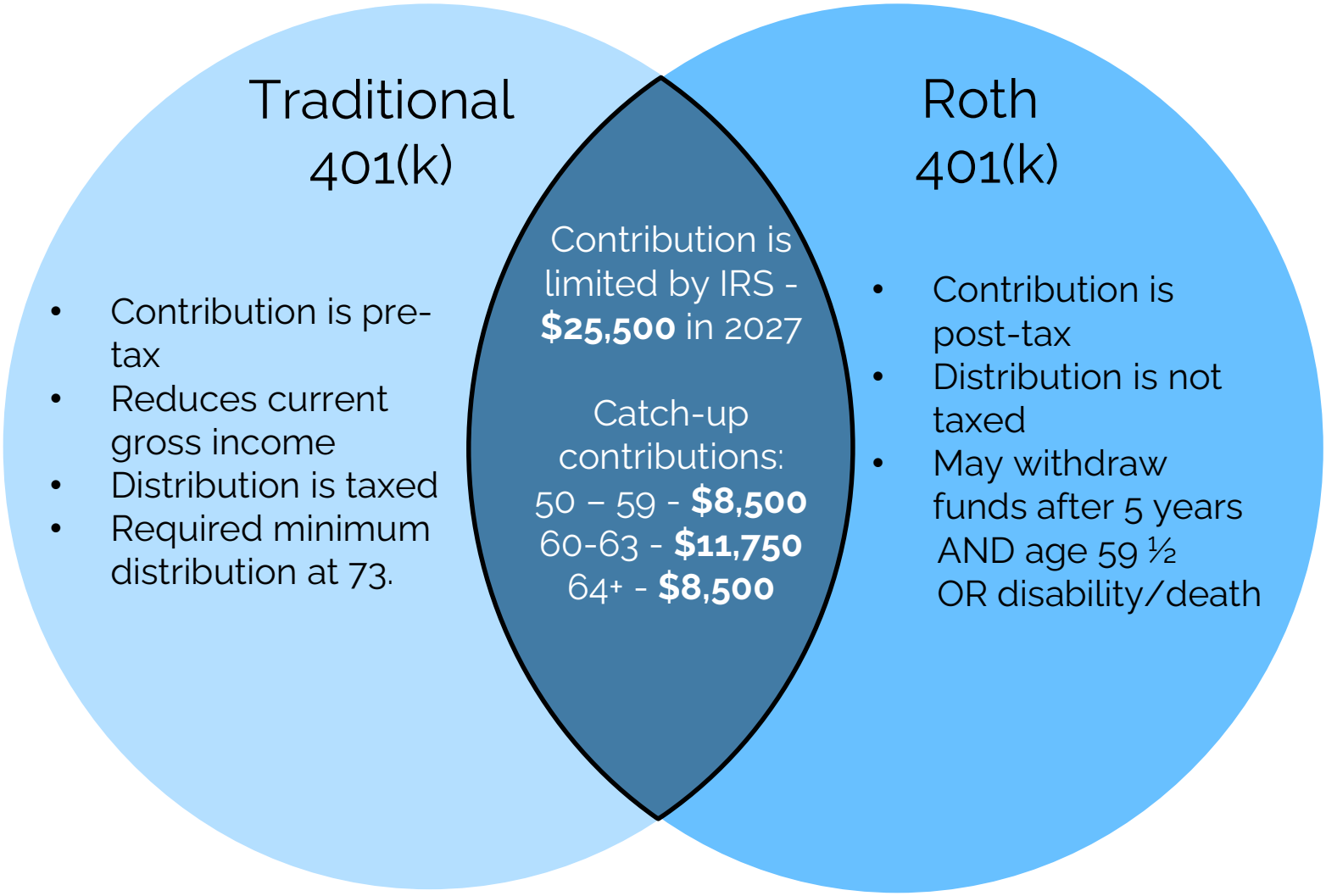
Available on the App Store

401(k) Retirement Savings

Liberty's 401(k) is administered by Voya. You can contribute to a traditional (pre-tax) account, a Roth (after-tax) account, or both, and roll in money from a prior employer's plan.

Who can join. Full-time employees age 21 or older can participate from their date of hire. Other employees can join after 1,000 hours in a 12-month period, or after 500 hours in each of two consecutive 12-month periods, and reaching age 21.

Company match. Liberty matches the first 3% you contribute, up to $3,000 a year, deposited after the end of the plan year. You are 100% vested in company contributions after 4 years. Executives, Partners, and Producers are not eligible. The match is discretionary and set each year — the formula, amount, and eligibility may change, and in some years, there may be no match. See the Discretionary Match Participant Notice for current details.



Ready to set yourself up for retirement?
Enroll here.

Click to enroll: myretirementbenefit.voya.com/t/Rb4z

Plan number: 864151

Plan verification number: 86415199

Need help enrolling? Call Voya at 888-311-9487, weekdays 8 a.m. – 9 p.m. ET. Once you're enrolled, Voya's tools and education help you set goals and stay on track.

VOYA

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Educational Benefit

Continuing Education through WebCE

Liberty pays for the continuing education you need to keep your insurance license, through our WebCE portal. Licensing and renewal fees are reimbursable too.

1. Request it	Fill out the **CE and Training Request Form** (also on the **Learning & Development page** in Workvivo). To see available classes and packages, browse **webce.com**: View Catalog › Continuing Education › Insurance CE › your state › your license type.
2. Register once	If you haven't already, register your Liberty account at **webce.com/libertycompany** — the /libertycompany is required. Single sign-on means no separate password if you're logged in to Outlook or Teams. The first time, enter your contact information and your license number/NPN under "My Licenses" so your CE is reported to the state correctly.
3. Take your classes	The L&D team reviews your request and loads your classes into your WebCE account, usually within 2 business days. If it's urgent (due within a week or so), also email **learning@libertycompany.com**.
4. Renew your license	After your CE is complete, renew through **Sircon** or **NIPR** — check your state Department of Insurance site if you're not sure which. Submit licensing fees for reimbursement in Paycom; see the **Expense Reimbursement documents** on the HR Workvivo space for how.

Franklin University - Tuition Discounts

Liberty has partnered with Franklin University, a nonprofit, accredited university that has taught working adults for more than 120 years. Degrees are 100% online, you can transfer up to 94 credit hours from prior coursework, and you get a 1:1 academic advisor.

Associate and bachelor's degrees	Tuition is capped at $5,250 per calendar year. Take as many classes as you can handle — after $5,250, additional courses that year are tuition-free. *(The average student's 8 classes would cost about $12,700 without the partnership.)*
Master's degrees and graduate certificates	20% tuition discount
Doctoral programs	10% tuition discount
Good to know	Textbooks and other fees are not included in the $5,250 cap. Students who enrolled before Spring 2027 keep the previous partnership terms.

How to get started

Learn more at **franklin.edu/lcib**, apply at **franklin.edu/apply-lcib**, and verify employment at **franklin.edu/verification**.

Questions? **partners@franklin.edu** or **614-947-6840**.

FRANKLIN UNIVERSITY

Makes It Possible



Important Information

Imputed Income for Domestic Partner Coverage

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

The amount of your imputed income depends on:

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

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



Contact Information

Liberty Benefits Team:
benefits@libertycompany.com

Provider	Group Number	Contact	Description	Registration
Dental Plan				
MetLife Dental	5780575	(800)-GET-MET8 www.metlife.com/dental	Dental claims, EOB, Provider ID Card	Member ID: Your SSN
Disability - Short & Long Term				
Reliance Standard	STD: 169859 LTD: 134251	(877) 202-0055 www.matrixabsence.com	Disability claims and covered benefits	
Employee Assistance Program (EAP)				
AllOne Health	N/A	(855) 775-4357 allonehealth.com/member-support	Counseling services, behavioral health, legal advice, and substance abuse issues	Company Code: RSLI859
FSA - Flexible Spending Account (*Health and Dependent Day Care*)				
HealthEquity	N/A	(866)346-5800 https://learn.healthequity.com/the-liberty-company	Flexible spending claims and covered benefits	Member ID: Your SSN
HSA - Health Savings Account				
HealthEquity	N/A	(866)346-5800 https://learn.healthequity.com/the-liberty-company	Savings account balance and covered benefits	Member ID: Your SSN
Identity Theft Protection				
Allstate	9004	(800) 789-2720 www.myaip.com	Helps provide peace of mind with comprehensive identity theft protection	
Legal Benefit				
MetLife	N/A	(800)-821-6400 members.legalplans.com	Plan assists you with legal matters such as divorce or estate planning	
Life Insurance (*Employer Paid and Optional*)				
Reliance Standard	Basic Life & AD&D, Optional Life: 166243 Optional AD&D: 210443	(877) 202-0055 www.reliancestandard.com	Life claims and covered benefits	
Medical Plans (PPO, HDHP, HMO)				
Cigna	634574	(888) 806-5094 www.mycigna.com	Medical claims, EOB, Provider Network, Temporary ID Card	
Kaiser (California Only)	Northern California: 722029 Southern California: 340983	(800) 464-4000 www.kp.org	Medical claims, EOB, Provider Network, Temporary ID Card	
Pet Insurance				
MetLife	N/A	(877) 649-7351 www.metlife.com/mybenefits	Plan offsets the overall cost of your pet's medical bills	
Retirement Savings Plans: 401(k)				
Voya	864151	(800) 584-6001 voyaretirementplans.com (enroll at enroll.voya.com)	Online enrollment, retirement plan dashboard, and customer service assistance	Plan verification number: 86415199
Vision				
VSP	30108173	(800) 877-7195 www.vsp.com	Vision claims and covered benefits	
Voluntary Accident Insurance & Critical Illness Insurance				
Reliance Standard	Accident: 874067 Critical Illness: 874849	(877) 202-0055 www.matrixabsence.com	Cover any extra out-of-pocket expenses if you suffer an unexpected, serious illness or qualifying accident	

LibWell



Anthony Dippolito
Chief Wellness Officer
760-994-6739

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

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

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

RESOURCES

LibWell in Workvivo

LibWell for Clients

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

Legal Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

The Health Insurance Marketplace is a way to buy health insurance. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for Marketplace coverage generally begins each fall; visit HealthCare.gov for current dates.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 10.22% (for plan years beginning in 2027) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources at 818-914-3986.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Legal Notices

PART B: General Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

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

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

As your employer, we offer a health plan to:

☐ All employees. Eligible Employees are:

☑ Some employees. Eligible employees are:

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

With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

- **Spouse, same-sex or opposite sex domestic partner (see Benefits Guide for specifics)**
- **Dependent children under the age of 26**
- **Dependent child with a physical or mental disability as defined by the Social Security Administration**

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.*

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Legal Notices

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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

Legal Notices

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

If you or your dependents lose eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or become eligible for premium assistance under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days after the loss of Medicaid or CHIP coverage or the determination of eligibility for premium assistance.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

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

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

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

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

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

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

Legal Notices

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

PATIENT PROTECTIONS NOTICE

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

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

What is COBRA continuation coverage?

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

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

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

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

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

Legal Notices

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

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

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

When is COBRA continuation coverage available?

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

The Liberty Company Insurance Brokers, LLC (Plan Administrator) · 5955 De Soto Ave, Suite 250, Woodland Hills, CA 91367 · benefits@libertycompany.com · 818-914-3986



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

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