2026 BENEFIT GUIDE

January 1 – December 31, 2026

meritage HOSPITALITY GROUP

OPEN ENROLLMENT

What's New for 2026

Effective on January 1, 2026, Blue Cross Blue Shield of Michigan will be replaced with:

- **Health Management Administrators (HMA)** – your first point of contact for medical coverage. HMA will:
    - Process medical claims, assist with finding in-network doctors and medical facilities, help you understand your coverage, provide access to the **Priority Health** provider network for employees in Michigan, and provide access to the **Cigna** provider network for employees in all other states.
- **DisclosedRx** – our new pharmacy benefit manager for retail and mail-order prescriptions. DisclosedRx will:
    - Process all prescription drug claims, help you find medications at the lowest possible cost, offer savings programs tailored to your needs.
- **Care Navigator Plus** – Healthcare can be confusing, but Care Navigator Plus makes it easier. This one-stop resource helps you and your family make better-informed healthcare decisions. This team is part of HMA, giving them secure access to your health. You'll be able to register through your member portal after January 1. Care Navigator can assist with finding a provider, understanding complex bills, provide tips to lower healthcare spending, help prepare for surgical procedures and more!

  Call Care Navigators at 1-833-865-0143 after January 1
- **MDLive** – We have a new partnership with MDLive to offer members access to board-certified doctors via secure online video or phone 24/7/365. MDLive is a convenient alternative to urgent care or emergency room visits for non-emergency medical conditions. MD Live doctors can diagnose illnesses and prescribe medications. Be on the lookout for more details regarding these low cost and convenient programs available to you and your covered family members.

You'll use a different provider network for medical care. The Priority Health and Cigna networks are extensive and cover the areas where our employees live. Find in-network providers at: https://mi.accesshma.com/find-a-provider

These changes will be reflected on a single ID card, which will be mailed to your home address in December 2025. Be sure to provide your new ID card to your medical and pharmacy providers the first time you seek services in 2026.

Support During Transition

Have questions? Dedicated support service phone lines are available now to assist with your medical coverage or pharmacy questions. They are here to help you feel confident and informed.

HMA Customer Care team (833) 842-2453 | DisclosedRx (480) 359-4878

TAKE A LOOK INSIDE

Health

PPO $1,500 Plan
PPO $2,500 Plan
HDHP Plan
Basic Plan
Dental Plan
Vision Plan

Wealth

Health Savings Account (HSA)
Flexible Spending Accounts (FSAs)
401k
Voluntary Benefits

Wellbeing

EAP

Perks

Employee Perks

Resources

Benefits Terminology
Benefits Help

IMPORTANT CONTACTS

Benefit	Carrier	Phone Number	Website/Email
Medical	HMA (Healthcare Management Administrators)	Transition Line: (833) 842-2453 General Customer Care: (833) 865-0141	www.accesshma.com
Pharmacy	Disclosed Rx	Transition Line: (480) 359-4878 General Customer Care: (888) 589-3340	https://portal.disclosedrx.com/Identity/Account/Login
Pharmacy	Disclosed Rx	Saving Advocate: (480) 690-5091	https://portal.disclosedrx.com/Identity/Account/Login
Care Navigator Plus	Healthcare Concierge	(833) 865-0143	mycarenav@accesspa.com
Dental	Delta Dental of Michigan	(800) 524-0149	www.deltadentalmi.com
Vision	Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
Health Savings Account (HSA)	Mercantile Bank	(866) 242-6420	www.mercbank.com
Flexible Spending Accounts (FSAs)	Flex Administrators	(800) 968-3539	www.flexadministrators.com
401k	Principal Financial	(800) 547-7754	www.principal.com/welcome
Life/AD&D	Unum	(888) 670-2551	www.meritagebenefits.com
STD	Benefits Department	(616) 988-8754	benefitsadmin@mhgi.net
LTD	Unum	(888) 670-2551	www.meritagebenefits.com
Voluntary Benefits	Unum	(888) 670-2551	www.meritagebenefits.com
Employee Assistance Program (EAP)	Unum	(800) 854-1446	www.unum.com/lifebalance

QUESTIONS?

If you have additional questions, you may also contact:

SMBO at (888) 670-2551

Click here for the benefits website.

BENEFIT ELIGIBILITY

Who Is Eligible?

Eligible Teammates can choose to enroll themselves and the following family members:

- Your legally married spouse
- Your dependent children up to age 26
- Your unmarried children aged 26 or older who are mentally or physically disabled and who rely on you for support and care

Dependent Information for Enrollment

To enroll your eligible dependents in benefits, you must provide their full legal names, Social Security numbers and dates of birth. Please have this information available when making your benefit elections.

Dependent Verification Disclaimer

Dependent Verification Required

You may be asked to submit proof of dependent status by providing a marriage certificate, birth certificate, tax return, etc. You are responsible for ensuring that any dependents who become ineligible are removed from the Company benefits. Dependents covered under the Teammate's benefits who are determined to be ineligible, or for whom sufficient proof of eligibility cannot be provided, will be removed immediately. Premiums will not be refunded, and you will be responsible for any claims that may have been paid on their behalf. You may also be subject to corrective action, up to and including termination.

ELIGIBLE TEAMMATES

Benefit Eligibility									
	Medical Plans	Dental Plan	Vision Plan	Flexible Spending Account/ Health Savings Account	Short Term Disability	Long Term Disability	Life Insurance	Voluntary Benefits	401(k)
GROUP 1									
- Restaurant Service Center (Full Time) - Area Director - Market Director - Area Manager - District Manager - General Manager - New Brands Manager - Facilities (Full Time)	X	X	X	X	X	X	X	X	X
GROUP 2									
- Assistant Manager - Shift Manager (Full Time) - New Brands Supervisor Hourly Teammate: (1-year employment and average of 30+ hours per week)	X	X	X	X				X	X
GROUP 3									
- Part Time Teammate (less than 30 hours/week) - Intern									X

BENEFIT ENROLLMENT

When Coverage Begins

New Hires: You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following 60 days of employment.

Promoted to Full-Time Eligible Position: If you have already completed 60 days of employment, you will be eligible to enroll on the date you become full-time. If not, eligibility begins the first of the month after 60 days of employment. You must complete enrollment within 30 days of becoming full-time.

If you fail to enroll on time, you will not have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period or if you experience a Qualifying Life Event.

Open Enrollment: Changes made during Open Enrollment are effective January 1st, 2026 – December 31st, 2026.

When Coverage Ends

All coverages for you and your family will end on the last day of your employment, or when you are no longer in an eligible class of employees.

When Coverage Ends for Your Children

Your children are eligible for medical, dental and vision coverage until the end of the year in which they turn 26. Other coverages, including any voluntary benefits will end when your child reaches age 26 unless the child is disabled and meets certain requirements.

COBRA

If your health care coverage ends, you and your covered family members will have coverage continuation rights under the federal law known as COBRA. If your coverage terminates, you will be notified of your COBRA rights.

First Time Enrolling?

Contact See My Benefits Online (SMBO) at (888) 670-2551 for assistance enrolling in benefits.

Enroll Online

Enrolling in benefits is easy and can be done in Workday for Open Enrollment and Qualifying Life Events (QLE).
Visit Workday to enroll.

Benefits Website

Our benefits website can be accessed on Inspire or Workday anytime you want additional information on our benefit programs.

Between Enrollment Periods

You may make changes to your benefit elections outside of the annual Open Enrollment ONLY if you experience a Qualifying Life Event (QLE), as defined by the IRS. Benefit changes must also be consistent with your event and made within 30 days of the QLE.

Examples of Common Qualifying Life Events:

- Change in legal marital status (Marriage or Divorce)
- Change in your eligibility (Gain or lose coverage under another plan)
- Death of spouse or dependent
- Change in the number of eligible children (Birth, Adoption, etc.)
- Child turns 26 years old
- Spouse/Dependent gains or loses coverage
  (ex: Spouse changes job and loses or gains coverage)

Click here to watch a video about QLEs.

HEALTH

MEDICAL COVERAGE

PPO PLANS

PPO $1,500 and PPO $2,500

The company offers two PPO plan options: PPO $1,500 and PPO $2,500. Meritage PPO plans utilize Health Management Administrators (HMA) for claims processing, with medical provider networks available through Priority Health (in Michigan) and Cigna (outside of Michigan). You can visit any doctor, hospital or other health care provider you want, with greater cost savings by finding an in-network provider. DisclosedRx administers prescription drug coverage.

How You Pay for Services

- You pay a flat dollar amount–or copay–for covered health care treatments and services, such as doctor's office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage–or coinsurance–of the cost of the visit, and the plan pays the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

Medical coverage or claims questions? Contact HMA:

Transition Line: (833) 842-2453

General Customer Service: (833) 865-0141

www.accesshma.com

Prescription questions? Contact DisclosedRx:

Transition Line (480) 359-4878

General Customer Service: (888) 589-3340

www.disclosedrx.com

Care Navigator Plus!

Healthcare can be confusing, but Care Navigator is here to help! A one-stop-shop to answer your questions and help you make better informed healthcare decisions.

Care Navigator can help with:

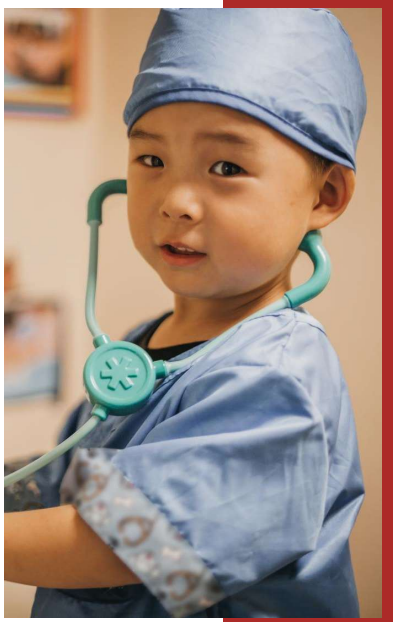
- Finding the best provider in the area
- Understanding complex bills
- Education on benefits and resources available in your plan
- Consults to help identify ways to lower your healthcare spending
- Preparing for surgical procedures

Call: (833) 865-0143

Email: mycarenav@accesstpa.com

To find an in-network provider, scan the QR code.

Click here to watch a video about comparing medical plan types.



MEDICAL COVERAGE

HDHP PLANS

Basic & HDHP

The HDHP Basic and HDHP HSA plans are High-Deductible Health Plans (HDHP) that offer lower premiums and higher deductibles. The highlight of these plans is that it allows you to open a Health Savings Account, which is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for any qualified health-related expenses (state taxation rules may apply). For more information on the HSAs, see Page 19 in this benefit guide.

Individuals with HDHPs pay a lower amount per paycheck for these plans but pay more on their yearly medical expenses before their medical plan begins paying.

Meritage's HDHP Basic and HDHP HSA plans utilize Health Management Administrators (HMA) for claims processing, with medical provider networks available through Priority Health (in Michigan) and Cigna (outside of Michigan). You can visit any doctor, hospital or other health care provider you want, with greater cost savings by finding an in-network provider. Disclosed Rx administers prescription coverage.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance) or copays for prescriptions, and the plan pays the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

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Prescription questions? Contact DisclosedRx:

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To find an in-network provider, scan the QR code.

Care Navigator Plus!

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- Preparing for surgical procedures

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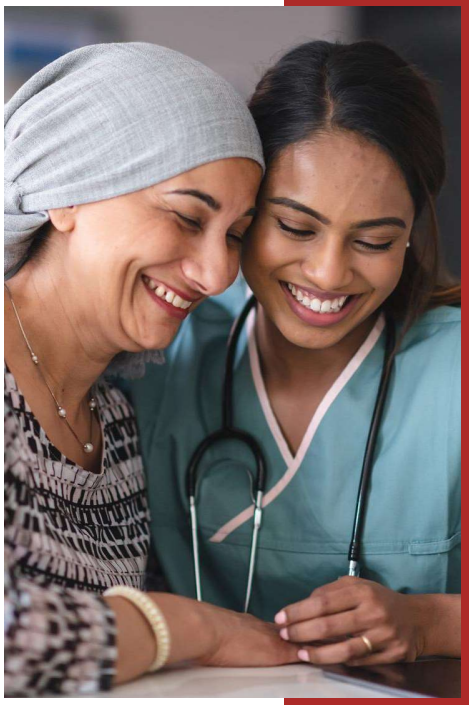
Email: mycarenav@accesstpa.com



Telehealth with MDLIVE

HMA

Medical Urgent Care

Available 24 hours a day, 7 days a week

Use phone, secure video, or through the MDLIVE App

Save time and money by seeing an MDLIVE doctor for non-emergency conditions

MDLIVE doctors may even send a prescription to your nearest pharmacy (if needed)

Common medical conditions include:

- Acne
- Allergies
- Cold / Flu
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever
- Headache
- Insect bites
- Nausea / Vomiting
- Pink eye
- Rash
- Sore throats
- Urinary problems / UTI
- And more

Activate your account by signing up through the Member Portal or by texting HMA to 635483

MDLIVE is a separate company providing telehealth services for HMA members

Get Started with MDLIVE

Register with the HMA Member Portal

1. Visit **accesshma.com**
2. Select the HMA Member Login button at the top of your screen
3. Log in to the member portal or create an account by selecting "Create an account" on the bottom of the login page.
4. Once logged in, scroll down your home dashboard to "Explore Your Benefits" and select the tile labeled "See a doctor now" to access MDLIVE.

Or Register with a Virtual Health Assistant

Meet Sophie, your virtual health assistant! Sophie makes creating an account quick and easy using your smartphone. See a doctor in minutes – anytime, anywhere!

To access Sophie, text **"HMA"** to **635483** and follow the link to register or call **1-877-596-0967**.

MDLIVE is a separate company that provides telehealth services for HMA members.

Visit accesshma.com to log in to your HMA account

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MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).
Note: The deductibles and out-of-pocket maximums are per calendar year.

Key Benefits	PPO $1,500		PPO $2,500	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000	$2,500 / $5,000	$5,000 / $10,000
Co-Insurance Amount	20%	50%	20%	40%
Co-Insurance Max	N/A / N/A	N/A / N/A	$2,500 / $5,000	N/A / N/A
Out-of-Pocket Max (Individual/Family)	$5,000 / $10,000	$10,000 / $20,000	$6,850 / $13,700	$13,700 / $27,400
Office Visits (Physician/Specialist)	$30 copay	50% after deductible	$30 copay	40% after deductible
Telehealth with MDLive	$30 copay	50% after deductible	$30 copay	40% after deductible
Routine Preventive Care	No charge	Not Covered	No charge	Not Covered
Mental Health Services	20% after deductible	50% after deductible	20% after deductible	40% after deductible
Diagnostics (Lab/X-ray)	20% after deductible	50% after deductible	20% after deductible	40% after deductible
Complex Imaging (CT/MRI)	20% after deductible	50% after deductible	20% after deductible	40% after deductible
Chiropractic	$30 copay (Combined max of 24 visits per year)	50% after deductible (Combined max 12 visits per year)	$30 copay (Combined max of 24 visits per year)	40% after deductible (Combined max 12 visits per year)
Ambulance	20% after deductible	20% after in-network deductible	20% after deductible	20% after in-network deductible
Emergency Room	$500 copay per visit	$500 copay per visit	$500 copay per visit	$500 copay per visit
Urgent Care Facility	$60 copay	50% after deductible	$60 copay	40% after deductible
Inpatient Hospital Stay	20% after deductible	50% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	40% after deductible
Prescription Drugs (Generic / Brand / Non-Formulary / Specialty)				
Retail Pharmacy (30-day supply)	$15 / $30 / $60 / $60	In-Network copay + 25% approved amount	$10 / $40 / $80 / 15% up to $150 / 25% up to $300	In-Network copay + 25% approved amount
Mail Order (90-day supply)	2x copay	Not covered	2x copay	Not covered

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).
Note: The deductibles and out-of-pocket maximums are per calendar year.

Key Benefits	HDHP HSA Plan		HDHP Basic Plan	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$3,400 / $6,800	$6,800 / $13,600	$6,350 / $12,700	$12,700 / $25,400
Co-Insurance Amount	20%	40%	N/A	20%
Out-of-Pocket Max (Individual/Family)	$6,900 / $13,800	$13,800 / $27,600	$6,350 / $12,700	$15,000 / $30,000
Company Contribution to your HSA (per calendar year; prorated for new hires/newly eligible)	$300 single / $500 two-person / $700 family		N/A	
Office Visits (Physician/Specialist)	20% after deductible	40% after deductible	No charge after deductible	20% after deductible
Telehealth with MDLive	20% after deductible	40% after deductible	No charge after deductible	20% after deductible
Routine Preventive Care	No charge	Not covered	No charge	Not covered
Mental Health Services	20% after deductible	40% after deductible	No charge after deductible	20% after deductible
Diagnostics (Lab/X-ray)	20% after deductible	40% after deductible	No charge after deductible	20% after deductible
Complex Imaging (CT/MRI)	20% after deductible	40% after deductible	No charge after deductible	20% after deductible
Chiropractic	20% after deductible (Combined max 12 visits per year)	40% after deductible (Combined max 12 visits per year)	No charge after deductible (Combined max 12 visits per year)	20% after deductible (Combined max 12 visits per year)
Ambulance	20% after deductible	20% after in-network deductible	No charge after deductible	20% after deductible
Emergency Room	20% after deductible	20% after in-network deductible	No charge after deductible	20% after deductible
Urgent Care Facility	20% after deductible	40% after deductible	No charge after deductible	20% after deductible
Inpatient Hospital Stay	20% after deductible	40% after deductible	No charge after deductible	20% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	No charge after deductible	20% after deductible
Prescription Drugs (Generic / Brand / Non-Formulary / Specialty)				
Retail Pharmacy (30-day supply)	$10 / $40 / $80 / $80 after deductible	In-Network copay + 20% of approved amount after deductible	No charge after deductible	20% after deductible + 20% of approved amount
Mail Order (90-day supply)	3x copay minus $10	Not covered	No charge after deductible	Not covered

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

PRESCRIPTION COVERAGE

DisclosedRx®
The Fiduciary and Fully Disclosed PBM™

Savings Program

Our DisclosedRx Savings Program can help you access the medications you need at the lowest possible cost. Through three savings options, we match you with the best program for your situation – with compassion, integrity, and no compromise on care. DisclosedRx Savings Advocates may reach out directly to you to start the process in finding you savings.

How It Works

- **Signing up is easy** – We walk you through every step.
- **We gather your information** – Your Savings Advocate will ask you questions to see which DisclosedRx savings programs are available to you.
- **We find the best program for you** – Based on your situation, we set you up with the program that gives you the lowest cost.
- **You save money** – In most cases, you will pay nothing out-of-pocket for your medications that are covered by the Savings Program.

Use Mail Order

DisclosedRx works closely with Postal Prescriptions Services for mail-order medications. It is easy to begin using Postal Prescription Services. You can register online at www.ppsrx.com. You have many options for mail-order pharmacy, as DisclosedRx does not require the use of Postal Prescription Services. If you currently have mail order prescriptions with Amazon, Pill Pack, Kroger, etc., you may continue to fill through those pharmacies by simply updating your prescription benefit information (found on your ID card) with your mail-order pharmacy. Please allow 10-14 calendar days from the day you submit your order to receive your medication(s).

Retail Pharmacy

When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day or 90-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network. To find a participating pharmacy near you, visit www.disclosedrx.com or call the Customer Care number on your ID Card.

Save Money on Medications

You can save money by asking for generic drugs. The FDA requires that generic drugs have the same high quality, strength, purity and stability as brand-name drugs. The next time you need a prescription, ask your doctor to prescribe a generic drug if it is available and appropriate.

After January 1, call (480) 690-5091 to speak with a Savings Advocate and start saving money!

DENTAL COVERAGE

Delta Dental PPO

The dental Preferred Provider Organization (PPO) plan, provided through Delta Dental, offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the Delta Dental network.

To find an in-network provider:

1) Scan the QR code and use the drop-down arrow to select "Delta Dental PPO and Delta Dental Premier"

2) Select the specialty you are looking for, and then select the Delta Dental PPO Network.

The deductible and annual benefit maximum are per calendar year.

Note: Delta Dental does not provide physical ID cards. You can view your coverage details here.

Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	PPO Plan	
	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$50 / $100	$50 / $100
Annual Benefit Maximum (per person)	$1,000	$1,000
Preventive Services	No Charge	No Charge
Basic Services	25% after deductible	25% after deductible
Major Services	50% after deductible	50% after deductible
Orthodontic Services	Not Covered	Not Covered

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

VISION COVERAGE

VSP

This plan, provided through VSP, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the VSP network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan.

Special discounts are offered on non-covered services, such as an additional pair of glasses, special lens options and LASIK.

To find an in-network provider, scan the QR code.

Note: VSP does not provide physical ID cards. You can view your coverage details here.

Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	VSP	
	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10	$10 copay, up to $45 reimbursement
Materials Copay	$25	$25 copay, up to $70 reimbursement
Frames (once every 24 months)	$25, $130 allowance	$25 copay, up to $70 reimbursement
Lenses (once every 12 months)	$25	$25 copay, up to $30 reimbursement
Single Vision		
Bifocal		$25 copay, up to $50 reimbursement
Trifocal		$25 copay, up to $65 reimbursement
Contact Lenses (in lieu of glasses; once every 12 months)	$130 allowance for exam and materials	Up to $105 reimbursement

FIND A PROVIDER

Find a Medical Provider

1. Visit HMA's website: https://mi.accesshma.com/find-a-provider
2. Select Michigan or All Other States
3. This will take you to the appropriate Network Portal for you to narrow your search appropriately.

(or)

Call: (833) 865-0141

Care Navigator Plus! Our Healthcare concierge team for all your medical questions!

Call: (833) 865-0143

Email: mycarenav@accesstpa.com

Find a Dental Provider

1. Visit Delta Dental of Michigan's website: www.deltadentalmi.com
2. Find a Dentist: From the "Find a Dentist" drop-down menu, select "Delta Dental PPO and Delta Dental Premier"
3. Enter Location and Plan: Enter your location and select Delta Dental PPO.

(or)

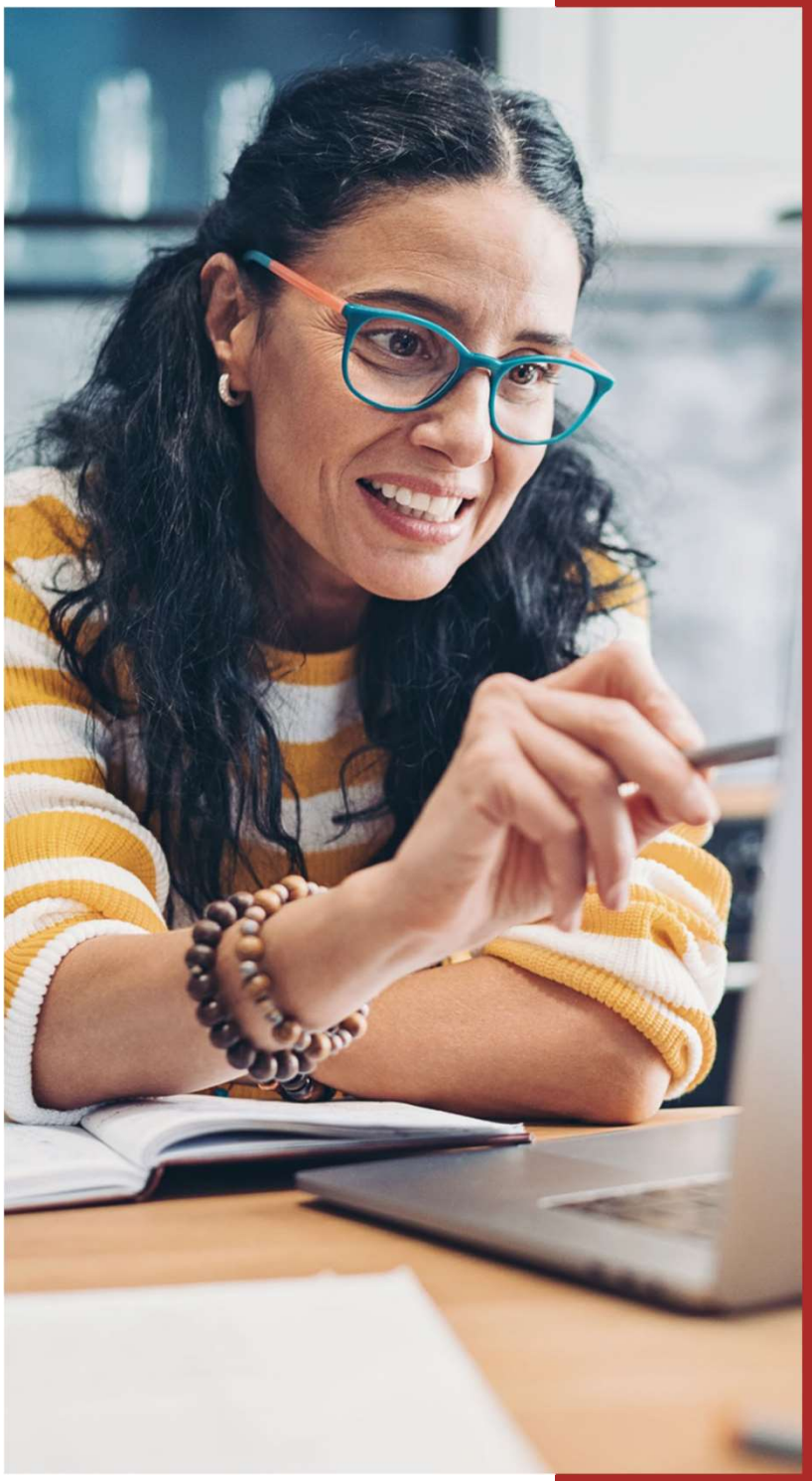
Call: (800) 524-0149

Find a Vision Provider

1. Visit VSP's Website: www.vsp.com
2. Find a Doctor: Click on the "Find a Doctor" tab.
3. Filter your search with the Advanced Search to view by Network.

(or)

Call: (800) 877-7195



WEALTH

HEALTH SAVINGS ACCOUNT (HSA)

Mercantile Bank®

The HDHP HSA and HDHP Basic Plans allow you to save in an HSA administered by Mercantile Bank. The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions.
- For those enrolled in the HDHP HSA medical plan, the company contributes the following amounts annually to your HSA account to help it grow:

NOTE: These contributions are not available for those enrolled in the Basic Plan.

Coverage Tier	2026	
	Per bi-weekly pay period	By year end
Employee	$11.54	$300
Employee + 1	$19.24	$500
Family	$26.93	$700

- You may change your contributions once per month.
- You can withdraw HSA funds tax free to pay for qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plan or leave your employer.
- Pay for HSA eligible expenses with your Mercantile bank HSA debit card.

Contribution Limits

Coverage Tier	2026
Individual	$4,400
Family	$8,750
Catch-up Contributions (age 55+)	$1,000

Key Features of the HSA

Triple-Tax Advantage

HSA contributions are deducted pre-tax, grow tax free, are not taxed when used for qualifying expenses, and roll over year to year.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free. Contact Mercantile Bank for more information on investing your HSA balance.

Portability

Your HSA is yours to keep. The money is yours to spend or save, even if you change health plans, retire or leave the company.

Qualified Health Care Expenses

You can spend your HSA dollars on qualified medical, dental and vision expenses as defined by the IRS in Publication 502

Important Notes

- You must enroll in the HSA plan in Workday each year to make contributions.
- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969.
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

Click here to watch a video about how an HSA works.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

FLEX ADMINISTRATORS

The Flexible Spending Accounts (FSAs), provided through Flex Administrators, are tax-advantaged accounts that can help you cover certain qualified out-of-pocket expenses.

	Health Care FSA (HCFSA)	Dependent Care FSA (DCFSA)
Eligibility Requirements	All benefits eligible teammates who are NOT enrolled in a HDHP medical plan.	All benefits eligible teammates
Examples of Qualified Expenses	• Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions	• Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school, summer camps, before or after school programs, or daycare centers • Care of household members who are physically or mentally incapable of caring for themselves and who qualify as your federal tax dependent
Annual Contribution Limit	$3,400	$7,500 per family (or $3,750 each if you are married and file separate tax returns)

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **You must enroll in the FSA plan each year to participate.**
- **HCFSA:** Unused funds of up to $680 from one year can carry over to the following year. Carryover funds will not count against or offset the amount that you can contribute annually. Unused funds over $680 will **not** be returned to you or carried over to the following year, you cannot be enrolled in a HDHP if you want to utilize the HCFSA.
- **DCFSA:** Unused funds will NOT be returned to you or carried over to the following year.

Click here to watch a video about how an FSA works.

401(K)

To help you save for retirement, the Company offers you a 401(k) provided through Principal Financial. Whether retirement is decades away or just around the corner, the time to save for retirement is today.

Eligibility	Available to all Teammates at the time of hire that are 21 years old or older.
Enrollment	Enrollment is available year-round • Enroll through Principal.com at www.principal.com/welcome or contact 1-800-547-7754
Vesting on Prior Company Match	Your contributions to the plan are always 100% vested (they belong to you immediately). Prior company contributions become vested based on your years of service as follows:
Annual Contribution Limits	$24,500 Age 50-60: $30,500 Age 60-63: $36,000 Future contribution limits may be adjusted by IRS regulations.

Years of Service	Vested Percentage of Prior Company Contributions
1 year	0%
2 years	20%
3 years	40%
4 years	60%
5 years	80%
6 years	100%

Click here to watch a video about how a retirement plan works.

LIFE INSURANCE

Life insurance, insured through Unum, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D (employer-paid)

Coverage Tier	Benefit Amount
Teammate	1x your pay up to a maximum of $250,000

*Waiting period for Class 1 is first of the month following 60 days after eligibility date. Waiting period for Class 2 is 12 months of active service after eligibility date.

Benefit amounts will be reduced starting at age 65. Please speak to the company's Benefits Administrator for further details.

CLASS 1

- Restaurant Service Center (Full Time)
- Area Director
- Market Director
- Area Manager
- District Manager
- Facilities Supervisor

CLASS 2

- General Manager
- New Brands Manager
- Facilities Technician

DISABILITY INSURANCE

Disability insurance provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

Short-Term Disability

Provided at NO COST to you by the Company	
Benefit	60% of base salary
Maximum benefit	Class 1: $10,000 per month Class 2: $4,000 per month
When benefit begins	After 1st day of accident or hospitalization/8th day sickness
Maximum benefit duration	Up to 180 days
Waiting period	Class 1: First of the month following 60 days Class 2: 12 months of active service

Long-Term Disability

Provided by Unum at NO COST to you by the Company.	
Benefit	60% of base salary
Maximum monthly benefit	Class 1: $10,000 Class 2: $4,000
When benefit begins	181st day
When benefit ends	Social Security Normal Retirement Age
Waiting period	Class 1: First of the month following 60 days Class 2: 12 months of active service

Click here to watch a video about how disability insurance works.

VOLUNTARY BENEFITS

Accident Insurance

Accident Insurance, provided through Unum, can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: you visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But treating a broken leg can cost thousands of dollars. When your medical bill arrives, you'll be relieved you have Accident Insurance on your side.

Accident insurance pays a fixed cash benefit directly to you when you have a covered accident-related injury, like a sprain or bone fracture. Examples of covered expenses include:

- Doctor's office visits
- Diagnostic exams
- Broken leg rehab treatment
- Physical therapy sessions

Critical Illness Insurance

About half of U.S. adults report being unable to pay an unexpected medical bill of $500 without going into debt. With Critical Illness insurance provided through Unum, you won't have to. This benefit provides a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition such as a heart attack or stroke. You can use this benefit however you like, including to help pay for:

- Increased living expenses
- Prescriptions
- Travel expenses
- Treatments

Hospital Indemnity Insurance

When you or a dependent need to be hospitalized, your family deserves to focus on their well-being, not the stress of a hospital stay, which can cost an average of $3,025 per inpatient day. Hospital indemnity, provided through Unum, pays a fixed cash benefit directly to you when you experience:

- Hospital admissions
- Hospital stays
- Intensive care unit stays

QUESTIONS?

To learn more, check out Unum Voluntary Benefits

WELLBEING

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is full of challenges, and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our Teammates and their families. The Employee Assistance Program (EAP) is provided at NO COST to you through Unum.

The EAP can help with the following issues, among many others:

- Mental health
- Relationships
- Substance use
- Child and eldercare
- Grief and loss
- Legal or financial issues

EAP Benefits

- Assistance for you and your household members
- Up to 3 in-person or virtual sessions with a counselor per event, per year, per individual
- Unlimited toll-free phone access and online resources

QUESTIONS?

To learn more, visit www.unum.com/lifebalance or

Call: 1-800-854-1446 for help.

Click here to watch a video about how an EAP works.

PERKS

EMPLOYEE DISCOUNTS

Employee Meal Discount Card

- 50% discount (up to $10) at any company restaurant for Teammates and up to one guest.
- The discount does not include alcoholic beverages.
- Meal discount card may only be used by the designated Teammate of the company.
- Discount will not be used in combination with any other discounts or promotional offers.
- Present the discount card prior to placing your food order.
- A 20% gratuity must be calculated and paid based on the pre-discounted price at any Casual Dining restaurant.

ELIGIBLE TEAMMATES: All Restaurant Service Center Teammates, General Managers and above, and Casual Dining Managers and above.

- ## Tickets at Work

  Savings on products, travel, gift cards, groceries and more! Visit the SMBO website.

- ## Theme Park Tickets

  We occasionally receive FREE theme park tickets that we give to our Teammates and their families! Make a request for available tickets in **Workday** by searching 'Create Request'. Ticket availability is dependent upon vendor partnership with Wendy's Corporation.

RESOURCES

BENEFIT TERMINOLOGY

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is $100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is $30.

Copayment

Oftentimes referred to as a "copay," this is the flat dollar amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $1,500, your plan will not pay anything for certain medical services until you have paid $1,500. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance plan.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, PPO $1,500 features an in-network family deductible of $3,000. If one member of the family satisfies the individual $1,500 deductible, the medical carrier will pay 80% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining $1,500, the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, PPO $1,500 features a family out-of-pocket maximum of $10,000. If one member of the family satisfies the individual out-of-pocket maximum of $5,000, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

BENEFIT TERMINOLOGY

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts. (These are typically "Generic" drugs in the Company's medical plans.)

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order prescription

You have many options for mail-order pharmacy, as DisclosedRx does not require the use of Postal Prescription Services. If you currently have mail order scripts with Amazon, Pill Pack, Kroger, etc., you may continue to fill through those pharmacies by simply updating your prescription benefit information (found above and on your ID card) with your mail-order pharmacy. Please allow 10 to 14 calendar days from the day you submit your order to receive your medication(s).

*DisclosedRx works closely with Postal Prescription Services for mail-order medications. It is easy to begin using Postal Prescription Services. You can register online at www.ppsrx.com.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic. (These are typically "Non-Formulary" drugs in the Company's medical plans.)

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

BENEFIT TERMINOLOGY

Out-of-pocket maximum

The most you pay during a calendar year before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs. (These are typically "Brand" drugs in the Company's medical plans.)

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Company, though there are insurance benefits the Company pays for entirely, while there are others that you pay for yourself.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

Click here to watch a video about benefits terms.

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.