

MOORE



2026

BENEFITS ENROLLMENT GUIDE

A COMPREHENSIVE PACKAGE OF BENEFITS
FOR OUR EMPLOYEES AND FAMILY MEMBERS

— This page intentionally left blank—

Enrollment Checklist

Information You Need to Know:

- You can enroll in benefits during your initial enrollment period as a newly eligible associate, during Annual Open Enrollment, or if you experience a Qualifying Life Event (QLE).
- The plan year is January 1 through December 31.
- Choose your elections carefully. Section 125 of the IRS Internal Revenue Code (IRC) governs how employers provide benefits to employees on a pre-tax basis. Employers may choose to permit mid-year elections based on specified Qualified Life Events (QLE) defined by IRS regulations. After an employee has made an initial enrollment election, Section 125 permits changes outside of annual Open Enrollment for specific reasons as outlined in the Permitted Election Changes Regulation of Section 125 (1.125-4). WB Moore has chosen to permit QLE changes as outlined in benefit SPDs and Certificates. WB Moore is required to follow the IRC consistently, or all WB Moore employees could become immediately responsible for paying taxes on benefits, therefore WB Moore adheres to the IRC for the protection of all employees. Contact Human Resources if you have questions on mid-year benefit election changes.
- Before enrollment begins, take the time to educate yourself on all of the benefit options that are available to you. Review this Benefits Guide carefully as you consider your plan choices.
- If you are electing coverage for your eligible dependents, proof of dependent eligibility may be required.

Current Employees:

- This will be a passive enrollment, this means if you are not making any changes your benefits will rollover to 2026. If you have an Flexible Spending Account or Health Savings Account you must re-enroll your elections will not rollover. Enroll between December 11, 2025 and December 17, 2025.
- Verify your 2026 benefits elections and deductions on the first paycheck you receive after your January 1 effective date to confirm everything is correct. If you see any errors, notify Human Resources immediately, otherwise corrections will not be honored.

New Hires:

- Be sure to make your elections **before your benefits effective date**. If you do not make elections, then you may not be able to enroll until the next open enrollment period.
- When you elect certain benefits, you may receive an ID card in the mail. Your ID card contains important information about you, your employer group and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.
- If you need to replace your ID card, or need an additional card, you can request another by contacting the carrier or by visiting the carrier's website online to print another copy.
- Verify your 2026 benefits elections and deductions on the first paycheck you receive after your January 1 effective date to confirm everything is correct. If you see any errors, notify Human Resources immediately, otherwise corrections will not be honored.

If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices for your prescription drug coverage. See page 32 in the Required Annual Notices section for more details.

Eligibility & Enrollment

WB Moore is proud to offer a comprehensive program of benefits to service the diverse needs of our workforce, and we are committed to continually enhancing and expanding our offerings. The information in this document is meant to familiarize you with the benefits and programs currently in place. During the Annual Open Enrollment period, the benefits you elect will be effective January 1, 2026. For new hires, benefits are effective next day following 90 day of continuous employment. Please remember that this guide is not intended to cover all provisions of all plans, but rather is a quick reference tool to help answer most of your basic questions. Please see each carrier's benefits Summary Plan Description or Certificate of Coverage for complete details of the benefits.

Am I Eligible?

Eligibility and required contributions for these benefits and programs depend on both your employee classification and whether you elect to extend coverage to your dependents.

Individuals eligible for coverage under the plans include:

- Your legal spouse
- Your dependent child(ren) up to age 26, regardless of full-time student status or marital status
- Your unmarried child(ren) of any age who, prior to age 26, has been declared incapable of self-support due to mental or physical disability

You will enroll in benefits using the online portal called
BamboohR

Qualifying Life Events (QLE)

Once you have made your benefit elections and your enrollment is closed, you cannot make changes until the next open enrollment period unless you experience a QLE such as:

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan
- Gain or loss of eligibility for CHIP or Medicare*

*You have 30 days from the date of the QLE to notify Human Resources and provide appropriate documentation to change your benefits. The exception to this rule is in the case of CHIP or Medicare benefits which allow a 60-day notification period.

Please note: Not every QLE permits a change in benefit plan elections. A change in election is permitted only when it is determined that the QLE affects eligibility for coverage of the employee, a spouse or a dependent under a benefit plan and in accordance with Section 125 regulations.

Plan	Eligibility	Benefits Effective Date
Medical & Prescription	Full-time, actively at work and scheduled to work 30+ hours per week	Benefits are effective the next day following 90 days of employment
Dental		
Vision		
Flexible Spending Accounts (FSA)		
Health Savings Account (HSA)		
Basic & Voluntary Life		
Voluntary Short-Term & Long-Term Disability		
Supplemental Critical Illness & Accident Insurance & Hospital Indemnity		
EAP		
401(k)	After 90 days of employment	

Medical Plans — PPO and High Deductible Health Plan (HDHP)

Services	PPO — In-Network (You Pay)	HDHP — In-Network (You Pay)
Calendar Year Deductible Individual / Family	\$1,000/ \$2,000	\$3,400 / \$6,800
Calendar Year Out-of-Pocket Maximum Individual / Family	\$5,000/ \$10,000 (includes deductible, coinsurance and copays)	\$7,500 / \$15,000 (includes deductible, coinsurance and copays)
Coinsurance	20%	20%
Preventive Care Services*	100% covered, no charge	100% covered, no charge
Virtual Visits through Teladoc	No charge	20% after deductible
Primary Care Office Visit (in-person or virtual)	\$35 copay	20% after deductible
Specialist Office Visit	\$70 copay	20% after deductible
Urgent Care Facility	\$70 copay	20% after deductible
Emergency Room	\$500 copay	20% after deductible
Inpatient Services	20% after deductible	20% after deductible
Outpatient Services	20% after deductible	20% after deductible
Prescription Drugs		
- Tier 1 / Generic - Tier 2 / Preferred Brand Name - Tier 3 / Non-Preferred Brand Name - Tier 4 / Specialty	\$15 copay \$45 copay \$85 copay 25% to a maximum of \$200	20% after deductible

Medical Plan Differences

PPO PLAN

This plan has copays for doctor, specialist and ER visits. This plan also caps the cost of prescriptions at \$200 per fill, but can be as low as \$15 for generic drugs. The premium is the highest and, after the deductible is met, there will be an additional co-insurance up to the out-of-pocket maximum.

- Higher cost out of your paycheck
- Deductible does **not** have to be met before the plan begins to pay
- Copays for doctor visits and prescriptions
- Eligible for a Flexible Spending Account (FSA)
- This plan may be right for you if you have several doctors appointments or need maintenance medication multiple times throughout the year

HDHP PLAN

In this plan you pay all discounted medical costs until your deductible is met. After that, all approved expenses are covered 70% until the out-of-pocket maximum amount is met, then approved expenses are covered 100%. This plan allows you to set aside pre-tax dollars into a Health Savings Account to be used to pay for your deductible and prescriptions. This fund never expires and can be carried forward year over year.

- Less money out of your paycheck each week
- Higher cost when care is utilized
- Eligible for Health Savings Account (HSA)
- Must meet the deductible before insurance plan begins paying
- Preventive care covered at 100%
- This plan may be right for you if you don't expect much medical cost throughout the year
- Will receive bills in the mail if not paid in full at time of service.

Things to consider when choosing your health plan:

- How often do you go to the doctor?
- Do you have a chronic health condition that requires frequent treatments?
 - Do you have a planned surgery coming up?
 - Are you expecting a baby this year?

How our Medical Plans Compare

The following examples help illustrate how each plan may vary based on different situations. Keep in mind that these scenarios are examples only and actual cost may vary depending on your specific situation.

EXAMPLE #1 — Dave (Single Coverage)

Dave is in his mid-20s and pretty active. He rarely gets sick but goes for his annual preventive exam every year. During the summer, he gets an infection and visits his primary care physician. He is prescribed generic antibiotics for a month for treatment.

How would the plans compare for Dave?*

Medical Service/Supply	PPO Plan	HDHP Plan
Annual Premium	\$3,484.00	\$2,132.00
Annual Preventive Exam	No cost to Dave Plan covers 100%	No cost to Dave Plan covers 100%
Primary Care Doctor Visit	\$25 copay	\$150** (full cost up to deductible paid with HSA Debit Card)
Generic Prescription	\$15 copay	\$30.00** (paid with HSA Debit Card)
Total Medical Expenses	\$40.00	\$180.00
Amount WB Moore contributes to your HSA	N/A	\$500.00
Balance in your HSA	N/A	\$320.00
Total Dave Paid out of pocket this plan year	\$3,524.00	\$2,132.00

*Assumes deductible has not been met. HSA employer contributions of \$500 is available in full and no additional employee contributions.

**Assumes primary care charges \$150/visit, \$30 generic prescription cost

In this example, Dave's total out-of-pocket costs for medical coverage and services (including his annual premiums) would be lower under the HSA Plan.

How our Medical Plans Compare

EXAMPLE #2

Tina and Paul Jones are in their mid-30s and have 2 children, ages 3 and 6. The whole family takes advantage of preventive care by seeing their doctor and getting appropriate screenings and checkups. The children also get their immunizations twice a year. This year, both children caught a few colds that resulted in 4 visits to the doctor and 4 generic prescriptions. Paul had an accident at home requiring a trip to urgent care, but it turned out to be a minor sprain. After a follow-up visit to his primary care doctor, including a diagnostic x-ray, he gets a clean bill of health. But there is big news in the Jones household; Tina learns that she is pregnant again! So, she will have 2 prenatal visits with her OB/GYN this year.

How would the plans compare for the Jones Family?*

Medical Service/Supply	PPO Plan	HDHP Plan
Annual Premium	\$11,336.00	\$8,476.00
Preventive Care Office Visit	\$0 per visit	\$0 per visit
Primary Care Office Visits	\$125 (5 visits—\$25 copay)	\$750** (paid with HSA); \$150/visit, 5 visits
Generic Prescriptions	\$60 (4—\$15 copays)	\$120** (paid with HSA); \$30/4 fills
Urgent Care Visit	\$40 copay	\$380** (\$380 paid with remaining HSA of \$130 and member cost \$250.00)
Diagnostic X-ray	\$500 (pay full cost up to deductible \$500 per x-ray)	\$500 (pay full cost up to deductible \$500 per x-ray)
OB/GYN prenatal visit	\$80 (2 visits—\$40 copay)	\$400 member pays full cost up to deductible; \$200/visit, 2 visits)
Total Medical Expenses	\$805.00	\$2,150.00
Amount WB Moore contributes to your HSA	N/A	\$1,000
Balance in Your HSA	N/A	\$0
Total Tina & Paul paid out of their own pocket this plan year	\$12,141.00	\$9,626.00

*Assumes deductible has not been met. HSA employer contributions of \$1,000 is available in full and no additional employee contributions.

**Assumes primary care charges \$150/visit, urgent care charges \$380/visit, \$30 generic prescription, and OB/GYN charges \$200/visit

In this example, the Jones family would pay less out of their pocket if they participated in the HSA Plan.

Health Savings Account (HSA)

If you enroll in a High Deductible Health Plan (HDHP) you should consider contributing to a Health Savings Account (HSA), administered by Health Equity. WB Moore will contribute \$500 for employee only and \$1,000 for employee/spouse, employee/child and employee/family. With an HSA, you can gain more control over your health care expenses because contributions, interest and withdrawals for qualified health care expenses are all tax-advantaged. **This plan is not available for those enrolled in a PPO Plan.**

Why have an HSA?

- Contributions are pre-tax
- Withdrawals to pay for eligible expenses are never taxed
- Accumulated interest earnings are tax-deferred, and if used to pay for eligible expenses, are not taxed upon withdrawal
- Use the money in the account to pay for eligible health care expenses throughout your life– including retirement, there is no time limit on spending your HSA funds
- The balance in your HSA account can be invested

Eligibility Requirements for Contributing to an HSA:

- Must be enrolled in a High Deductible Health Plan (HDHP)
- Must not be enrolled in Medicare
- Must not be covered by other medical insurance(s) which do not meet the definition of a HDHP such as a Health Care Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA), Tricare, VA benefits (including your spouse's)

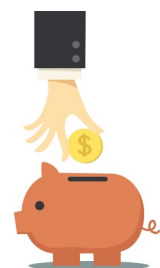
Health Savings Account (HSA)			
Coverage Level	IRS 2026 Contribution Limits*	EMPLOYER 2026 Contribution	Employee 2026 Maximum Contribution**
Employee Only	\$4,400	\$500	\$3,900
Employee + Spouse	\$8,750	\$1000	\$7,770
Employee + Child(ren)	\$8,750	\$1000	\$7,750
Family Coverage	\$8,750	\$1000	\$7,750

*If you are married and your spouse is enrolled in an HDHP and has an HSA, the combined total of you and your spouse's HSA cannot exceed the federal maximum for family level coverage.

**If you are age 55 or older, you may make an additional pre-tax catch-up contribution of \$1,000 per year.

All HSA participants will receive an HSA debit card from Health Equity. Use your Debit Card for doctor's office visits, prescription drug copays, or any other valid medical, dental or vision expenses. Please retain all receipts to verify expenses, if required.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.



Health Savings Account (HSA)

Health Savings Account

An HSA lets you save money for future healthcare costs while also saving on taxes. How? HSAs are the only benefit with a triple-tax advantage:¹ Tax-free contributions. Tax-free account growth. And tax-free spending on HSA-qualified expenses. It's your healthcare emergency safety net.

- ✔ No use-it-or-lose-it rule, HSAs rollover every year
- ✔ Available tax-free investing, just like a 401(k)²
- ✔ Requires an eligible high-deductible health plan (HDHP)



Don't tax your money. Max your money.

Get \$20 tax savings for every \$100 you contribute.³

HSA

Tax-free

No HSA

Taxed

2025 HSA Contribution Limits



\$4,300
Individual plan



\$8,550
Family plan



See how much
you can save.

HealthEquity.com/Learn/HSA

¹HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | ²Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. | ³Example for illustration only. Estimated savings are based on an assumed combined federal and state income tax bracket of 20%. Actual savings will depend on your taxable income and tax status. HealthEquity does not provide legal, tax or financial advice.

Copyright © 2024 HealthEquity, Inc. All rights reserved. OE HSA Standard Flyer 5.14.2024

Spend tax-free.

There are thousands of HSA-qualified expenses. Here are just few:

- Medical
- Dental
- Vision
- Pharmacy
- Over-the-counter (OTC) medications
- Mental health services
- Lab fees

Health Savings Account (HSA) - Myths, Debunked

10 HSA MYTHS, DEBUNKED

From tax savings to retirement savings to health savings, here's the truth about Health Savings Accounts.

MYTH 1

HSA's are too complicated.

REALITY

If you can manage a traditional checking or savings account, you can use an HSA.

Health Savings Accounts (HSAs) work just like traditional savings accounts but confer several tax advantages that your savings account doesn't provide. And just like checking accounts, an HSA uses a debit card that you can use to pay for qualified medical expenses.¹

MYTH 2

If I don't spend my HSA money, I lose it at the end of the year.

REALITY

HSA funds never expire.

HSA	vs	FSA
HSA-qualified health plan		Traditional health plan
Lower premiums		Higher premiums
Higher deductibles		Lower deductibles
Investable		Not investable
Funds never expire		Funds expire

Unlike Flexible Spending Account (FSA) funds, you keep your HSA dollars forever, even if you change employers, health plans, or retire.

MYTH 3

If I change jobs, I'll lose my HSA funds.

REALITY

HSAs are member-owned accounts—and your funds stay with you.

Unlike FSAs, which are employer-owned accounts, an HSA is your account to keep forever—regardless of whether you change jobs or retire. A real advantage of an HSA is that employer contributions are yours immediately. Contrast that to retirement accounts, which sometimes take years to vest employer contributions.

MYTH 4

The HSA is a spending account, not a savings account.

REALITY

The HSA's triple-tax advantage empowers you to accelerate long-term health savings.

First, you save when you spend. Because you use tax-deductible contributions to pay for qualified medical expenses, your annual HSA tax savings can add up fast.

Second, you can invest your HSA funds and enjoy tax-free account growth. This is the real power of the HSA and what makes it the ultimate long-term health savings account.

MYTH 5

HSAs are only for healthy people.

REALITY

Members with chronic medical conditions can significantly benefit from annual HSA tax and retirement savings.

Many people calculate their healthcare costs principally based on annual health plan deductibles. They see that high-deductible health plans (HDHPs) require more out-of-pocket spending before insurance kicks in. And if you have comparatively high expected healthcare costs, it seems logical to prefer the health plan that covers more costs with less out-of-pocket expenses.

But this calculation is limited for three reasons.

HSA triple-tax savings



Make pre-tax payroll contributions



Invest HSA funds tax-free



Take tax-free distributions for qualified medical expenses

Save big on thousands of qualified medical expenses, including:



Pain relievers



Doctor visits



Dental cleaning



Sleep aids



Eyeglasses/contacts



Cold/cough medicine



Chiropractic care



Insulin testing supplies

Health Savings Account (HSA) - Myths, Debunked Cont'd

MYTH 6

HSAs are only available through your employer.

REALITY

Anyone who is enrolled in an HSA-qualified health plan can open an HSA.

Because HSAs are member-owned accounts, you don't have to rely on your employer to access an HSA. Unlike FSAs, anyone can open—and contribute to—an HSA, provided they are enrolled in a qualifying health plan.

Most employers that offer an HSA work with a preferred administrator. However, members are at liberty to open an HSA with any administrator they want. Just be aware you could lose the ability to make pre-tax payroll contributions (though tax-deductible contributions are always available).

MYTH 7

I'm too young or old to benefit from an HSA.

REALITY

HSAs bring significant advantages to members of all ages.

Our younger members love their HSA because it lets them set aside a second nest-egg for healthcare expenses in retirement. Because most young people don't have a lot of healthcare expenses today, they can stash the money away for long-term needs tomorrow.

Our wiser, more senior members also love their HSA because it empowers them to catch up on their retirement savings. Members love the fact that HSAs enable tax-free spending in retirement (when used for qualified medical expenses).

Best of all, the IRS allows members 55 and older to make \$1,000 additional annual catch-up contributions.

MYTH 8

You can't contribute to your HSA after age 65.

REALITY

Anyone at any age can contribute to an HSA, provided they're enrolled in an HSA-qualified health plan.

Because Medicare is not an HSA-qualified health plan, you cannot enroll in Medicare and contribute to an HSA. Since most people become eligible for Medicare when they turn 65, they assume the age cutoff for HSA contributions is 65 also.

But you can get your own HSA-qualified health plan directly from plan providers and continue to make HSA contributions as long as you want, provided you do not enroll in Medicare.

MYTH 9

HSAs are too expensive and only work for wealthy people.

REALITY

HSAs empower families at all income levels to put more money in their pocket and stretch every dollar further.

HSA-qualified health plans usually confer significant premium savings. Then, whatever you don't spend on annual health insurance premiums can be put away for a future healthcare emergency.

HSAs also let you use pre-tax contributions to pay for qualified medical expenses. When it comes to healthcare spending, your HSA works very much like an FSA. The difference is that HSAs also give you added flexibility to save funds that you don't spend in a plan year.

MYTH 10

HSA contributions don't grow.

REALITY

HSAs enjoy tax-free investment growth, year after year.

One of the biggest differences between FSAs and HSAs is that you can invest your HSA funds into mutual funds—just like you can with a 401(k). Once invested, any potential earnings grow tax-free. Tax-free earnings can supercharge your long-term health savings.

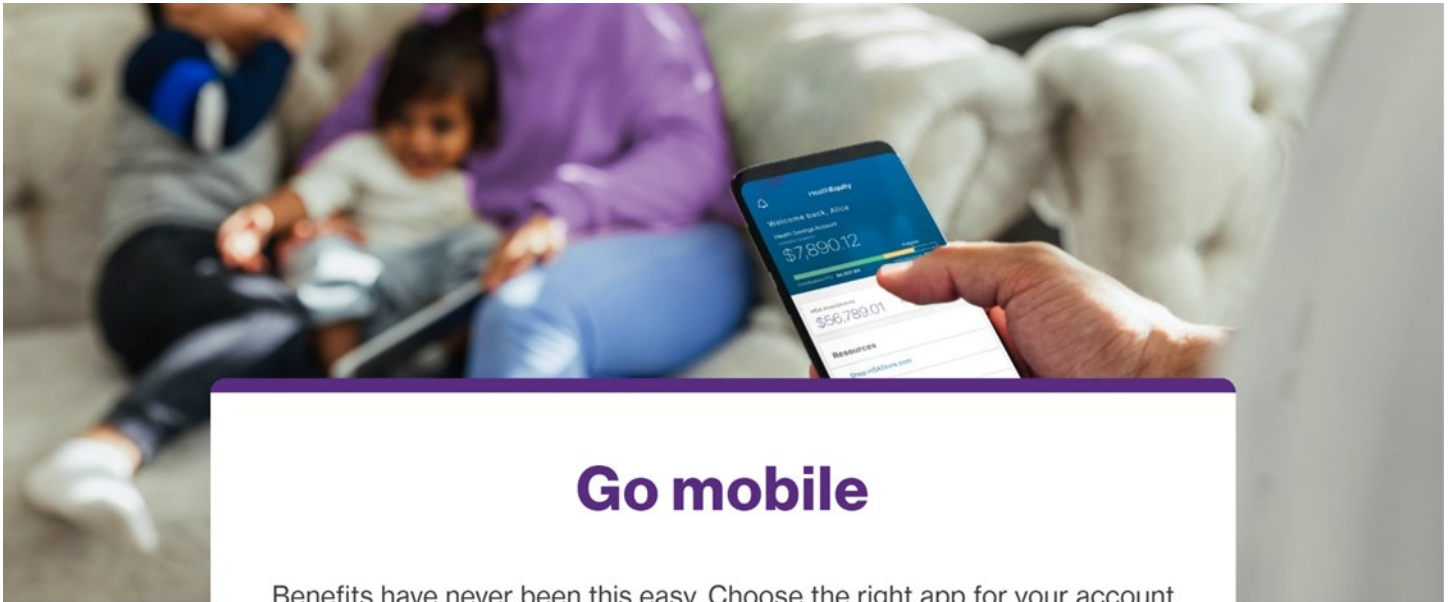
Don't let HSA myths hold you back from realizing your health, wellness, and financial goals. HSAs are designed to empower every American—at any income level—to connect health and wealth. Join the movement. Enroll today!

Questions? We're here for you 24/7
866.346.5800 | my.HealthEquity.com

*Estimated savings are based on an assumed combined federal and state income tax bracket of 30%. Actual savings will depend on your taxable income and tax status.

HealthEquity does not provide legal, tax, financial or medical advice. Always consult a professional when making life changing decisions. Copyright © 2021 HealthEquity, Inc. All rights reserved.
10_HSA_Myths_Debunked_August_2021.pdf

HealthEquity Mobile App



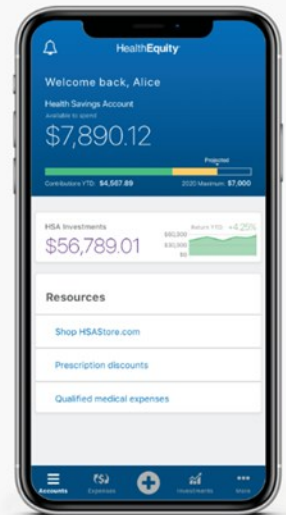
Go mobile

Benefits have never been this easy. Choose the right app for your account type, then manage everything in only a few taps and swipes.



HealthEquity Mobile For HSA

Download this app if you use **HealthEquity** to log into your account online.



HealthEquity Mobile
4.5 stars¹



Convenience at your fingertips



On-the-go access and history

Access all account types wherever you go.



Photo documentation

Take a photo with your device to initiate claims and payments.



Send payments and reimbursements

Send payments to providers or reimburse yourself for out-of-pocket expenses.



Send payments and reimbursements

Send payments to providers or reimburse yourself for out-of-pocket expenses.



Initiate claims and view their status

View the status of claims as well as link payments and documentation to claims.



General Medical

24/7 access to doctors
from anywhere

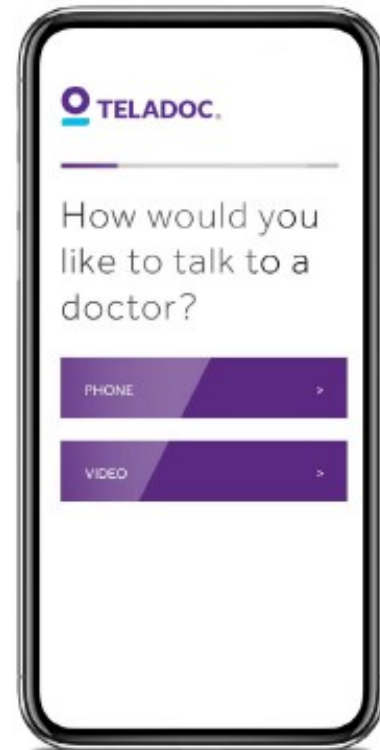


Talk to a U.S.-licensed doctor for non-emergency conditions 24/7 from anywhere you are. We treat:

- Bronchitis
- Flu
- Rashes
- Sinus infections
- Sore throats
- And more

How it works:

- 1 Download the app, go online or call us to set up your account or log in
- 2 Complete or update a brief medical history
- 3 Request a visit and talk to a doctor within minutes



Learn more
Teladoc.com

When and Where to Get Health Care



Telehealth Virtual Visits

- Average wait time: 5 minutes
- Available 24/7/365
- Basic physician care from your PC, phone, laptop



Retail Health Clinics

- Average wait time: 15 minutes
- Available extended hours
- Basic care from a nurse practitioner



Primary Care Physician

- Scheduled visits
- Diagnose & treat a range of issues for the whole family
- Refer you to the right care when you need a specialist



Urgent Care Clinic

- Average wait time: 45 minutes
- Immediate quality care on a walk-in basis when your doctor is unavailable



Emergency Room

- Average wait time: 4 hours
- Available 24/7/365
- Emergency care when your life or health is threatened

Things to think about

- Non-emergency care delivered in the ER costs 5 times more than in a doctor's office or clinic
- Research studies indicate that between 8-27% of ER visits could have been treated in a less expensive care setting
- ER doctors do not typically have your full medical history, so they must order expensive tests to determine a diagnosis and course of treatment.
- Patients, when possible, should be treated by their primary care physician for non-emergency conditions in order to promote consistent, preventive and quality care.

Prescription Drug Plan Highlights

National Preferred Formulary Drug List

A preferred drug list helps keep healthcare costs down for everybody. It's a list of medicines that have been reviewed and approved for safety, effectiveness and cost by a panel of doctors and pharmacists. This list is continually reviewed and updated as new medicines become available.



Generic Drug Program

At Wal-Mart, Sam's Club, Target, and Walgreens you can get generics that are on their "approved" list for a lower cost than your normal drug copay. Some of them offer \$4.00 per prescription, per month. This list is available on each of their respective websites (Walmart.com, Samsclub.com, Target.com, Walgreens.com) for further information.



Mail Order Program

The mail order program offers the convenience of obtaining home delivery of certain covered maintenance Prescription Drugs and Related Supplies through designated mail order Pharmacies. You can save money and take advantage of 24/7 access to a pharmacist. Order refills online, on the phone, or register for auto-refills. For more information contact Blue Cross Blue Shield at 877-275-9787.

Dispense as Written

When your doctor writes a prescription for you or a covered family member, unless the doctor specifically designates "DAW" (Dispense As Written), the pharmacist will dispense a generic medication, if one is available. Your doctor must write DAW on your prescription to avoid incurring a higher cost. Always talk to your doctor about what is right for you and your family.

Prior Authorization (PA)

The PA Program encourages safe and cost-effective medication use. The program applies to certain high-cost drugs that have the potential for misuse. Before medications in the PA Program can be covered under your benefit plan, your doctor will need to receive approval. If you are already taking or are prescribed a drug from the PA listing, your doctor must submit a request for consideration for coverage. Be sure to visit www.blueconnectnc.com for a listing of the drugs requiring PA.

Step Therapy

Step Therapy helps you choose the most cost effective and appropriate medicine for certain medical conditions. The first step in the step therapy process, "first-line therapy," is usually a simple, inexpensive treatment that is known to be safe and effective for most people. First-line therapy is usually a generic drug in the same therapy class. If the first-line therapy does not work, the next step is to try second-line therapy.

Specialty Pharmacy

A specialty pharmacy provides medicine and therapy for patients with serious, chronic conditions like cancer, rheumatoid arthritis and hepatitis C. These medications normally have to be stored or handled in special ways. Your Specialty Pharmacy offers specialized teams of pharmacists, nurses and clinicians who are specially trained on your condition. This level of specialization gives you the most comprehensive and customized care available. Specialty medications must be filled through the specialty pharmacy.

Mobile Apps for Prescription Savings

There are free mobile apps for your iPhone, Android, or Windows phone. These apps will compare prescription drug costs in your area. You provide the drug name and quantity and it compares the costs at various pharmacies in your area. Rx Saver and Good Rx are just two available mobile apps.

Partnership for Prescription Assistance

As the cost of prescription drugs rise, Partnership for Prescription Assistance (PPA) is a free service that connects individuals with payment assistance programs for prescriptions and other medical supplies. PPA provides a single point of access to more than 475 patient assistance programs. For a full list of patient assistance programs visit www.pparx.org/.

Wellness Credit

WELLNESS “CASH” PROGRAM



WB Moore acknowledges the significant contributions you make to the organization and we are committed to providing you with the best programs available. We will continue to offer a Wellness Credit incentive in 2026 to encourage our covered members to take advantage of preventive care and health awareness programs that lead to a healthier lifestyle and better health. Healthier members help us keep down plan costs which benefits everyone at WB Moore.

Who can participate?

- All employees and spouses covered on our BCBSNC medical plan
- To be eligible for the credit, you must be employed by WB Moore as of January 1, 2026 and participate in the health plan from 1/1/26 through 12/31/26. Employees hired between October 1, 2025 and December 31, 2025 must be enrolled in the health plan as soon as eligible in 2026.

How much is the credit?

- The credit is awarded in December, 2026 as a credit on your paycheck.
- The credit for an employee meeting the goal is **\$260** (equivalent to \$5 per week).
- The credit for a covered spouse meeting the goal is **\$260** (equivalent to an additional \$5 per week).

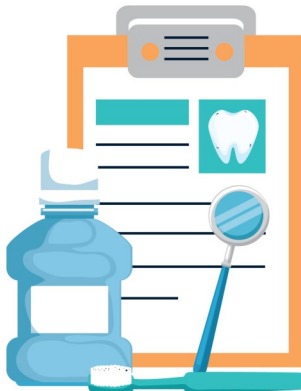
What do I need to do to get the credit?

- You and your spouse (if covered and participating) must complete ONE goal:
- **Goal:** Before November 1, 2026, you and your spouse (*if covered and participating*) must visit your physician for an annual routine exam and recommended preventive screenings. BEFORE YOUR VISIT, contact Human Resources for a copy of our wellness form to take with you to your routine exam. During this exam, your physician will need to sign our **wellness form** which you will return to Human Resources. (*If you were a participant in 2025 on the WB Moore Health Plan and had these screenings performed in November or December 2025, you will receive credit for this goal*)

Dental Insurance

WB Moore's dental plan administrator is MetLife. You may continue to seek treatment from the dentist of your choice, but you will always realize your biggest savings by visiting in-network providers whenever possible. The chart below provides a summary of your dental benefits.

Dental Plan		
Services	In-Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible Individual / Family	\$50 / \$150	\$50 / \$150
Calendar Year Maximum	\$1,500	\$1,500
Preventive Services (Covered services include oral exams, cleanings and x-rays)	Covered at 100%, not subject to deductible	Covered at 100%, not subject to deductible
Basic Services (fillings, root canals, endodontics, periodontics, extractions)	20% after deductible	20% after deductible
Major Services (inlays, onlays, bridgework, dentures)	50% after deductible	50% after deductible
Orthodontia child(ren) up to age 19	50% with a lifetime maximum of \$1,000	50% with a lifetime maximum of \$1,000
Benefit Payment Schedule	In-Network paid according to Pre-determined Fee	Out-of-Network paid at 90% of Reasonable and Customary





Discover the benefits of MetLife Dental

Did you know MetLife Dental benefits come with features designed to help you get maximum value delivered out of your employer-sponsored benefits? Brush up on the benefits listed below that are included when you enroll in MetLife Dental.



Digital servicing capabilities make dental care easy

MetLife's mobile app¹ puts your ID card, plan details, and claim information at your fingertips. For added convenience, it also includes features like:

- A Find a Dentist tool with easy access to provider ratings
- Online appointment scheduling for select dentists
- Convenient claim status notifications via text messaging

Our digital tools available on MyBenefits also include:

- **Access to a Dental Cost Estimator²** so you can view personalized, plan-specific, and zip code-based cost estimates for most common procedures – as well as the deductibles, plan maximums, and frequency limitations that apply.
- **A digital virtual assistant** that's available 24/7 to help you with common tasks like accessing coverage information, getting personalized estimates, or viewing claims.



Dental benefits go with you as you travel

Our International Dental Travel Assistance program provides international assistance tied to your out-of-network benefits, including:

- 24/7 help in multiple languages
- Access to dental providers (based on strict credentialing criteria) in approximately 200 countries
- Toll-free calling within the U.S., or collect calling outside the U.S.



TakeAlongSM Dental provides a lifelong, individual dental plan that employees can take with them

With MetLife TakeAlong Dental, employees that are no longer eligible under the group plan can continue to have access to exceptional dental care—including the same high-quality network and servicing experience. All with no administrative work or additional cost for you.

With our industry-leading, portable dental solution employees can choose from a variety of individual dental programs to meet their unique needs, including PPO, DHMO, and Discount Plans.

Navigating life together

ADF# D2636.21

Dental information available through the MetLife Mobile App

Viewing your dental plan just got easier with the MetLife Mobile App.¹



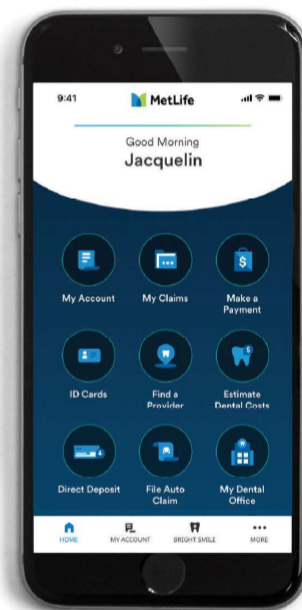
You can:

- Find a dentist
- [Get estimates for most procedures enhanced to display personalized, plan specific costs and additional information such as percent covered, applicable deductible, Plan Maximum and Frequency Limits]
 - Both in-network and out-of-network estimates available] **PPO Plan Only**
- View your plan summary with quick links to important information on deductibles and Plan Maximums as well as Covered Services
- View detailed coverage information for your dental policy such as benefit sharing percentage, applicable deductibles, Plan Maximum and Frequency Limits
- View your claims
- Track your brushing and flossing
- Access and save ID card to photo library or mobile app

It's easy! Search "MetLife" at iTunes App Store or Google Play to download the MetLife US Mobile App, or scan the QR codes. Search our network of thousands of dentists and specialists to find a provider near you.

Or log-in to MyBenefits to access your plan information.¹

It's available 24 hours a day, seven days a week.



1. To use the MetLife mobile app, employees can choose to register at metlife.com/mybenefits from a computer or directly through the app. Certain features of MetLife US Mobile App are not available for some MetLife Dental Plans.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

Navigating life together

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
L1222028050[exp0124][All States][DC, GU, MP, PR, VI] © 2022 MetLife Services and Solutions, LLC.

Vision Insurance

WB Moore's vision plan is administered by MetLife. You may seek treatment from the provider of your choice, but you will realize your biggest savings by visiting in-network providers whenever possible. Please see the summary below for an outline of covered services.

Vision Plan		
Services	In-Network (You Pay)	Out-of-Network (You Pay)
Eye Exam	\$15 copay	Up to \$45
Standard Lenses (instead of contacts) <ul style="list-style-type: none"> - Single - Bifocal - Trifocal - Lenticular - Progressive 	\$25 copay \$25 copay \$25 copay \$25 copay \$50 allowance	Up to \$30 Up to \$50 Up to \$65 Up to \$110 \$50 allowance
Frames (instead of contacts)	\$200 retail allowance; \$110 Costco, Walmart and Sam's Club allowance; additional 20% off amount over allowance except Costco, Walmart and Sam's Club	Up to \$70
Contact Lenses (instead of glasses) <ul style="list-style-type: none"> - Elective - Medically Necessary 	Up to \$200 allowance Covered in full	Up to \$105 Up to \$210
Frequency <ul style="list-style-type: none"> - Exam - Lenses - Contacts - Frames 	Based on Date of Service 12 months 12 months 12 months 12 months	



Cost of Coverage

BCBS Medical– HDHP	Weekly Payroll Deductions
Employee Only	\$46.00
Employee + Spouse	\$113.00
Employee + Child(ren)	\$104.00
Family	\$168.00

BCBS Medical– PPO Plan	Weekly Payroll Deductions
Employee Only	\$76.00
Employee + Spouse	\$169.00
Employee + Child(ren)	\$144.00
Family	\$221.00

MetLife Dental Plan	Weekly Payroll Deductions
Employee Only	\$7.00
Employee + Spouse	\$10.00
Employee + Child(ren)	\$10.00
Family	\$15.00

MetLife Vision Plan	Weekly Payroll Deductions
Employee Only	\$1.92
Employee + Spouse	\$3.46
Employee + Child(ren)	\$3.65
Family	\$5.58

Basic Life and AD&D Insurance

Basic Life Insurance

WB Moore provides full-time employees with Basic Term Life and Accidental Death and Dismemberment (AD&D) Insurance administered through MetLife. Please remember to review and update your beneficiary designation annually.

Benefit	Basic Life and AD&D Insurance
Employee Life	\$50,000
Basic AD&D Amount	Matches Employee Life amount
Age Reduction Schedule	35% at age 65 60% at age 70 75% at age 75
Conversion	Included
Portability	Included

Voluntary Life and AD&D Insurance

Voluntary Life and AD&D Insurance

WB Moore is offering employees who would like to supplement their Basic Term Life and AD&D insurance benefits the opportunity to purchase additional coverage through MetLife. You may elect Voluntary Life & AD&D for yourself, your spouse and your dependents in the amounts shown in the table below. Please note, you must elect Voluntary Life for yourself in order to enroll your spouse and/or eligible dependents. Dependent children are eligible for coverage through age 26.

If you did not purchase voluntary coverage when you first became eligible and would like to purchase coverage now, or you are increasing your coverage to an amount that exceeds the guarantee issue amount, you will need to complete an Evidence of Insurability form. Coverage is subject to approval by MetLife and may be denied.

Benefit Detail	Voluntary Supplemental Life Insurance	
Employee Amount	\$10,000 increments, up to \$500,000	
Employee Guarantee Issue Amount	\$100,000 when initially eligible	
Spouse Amount	\$5,000 increments, up to 50% of employee amount to a maximum of \$100,000	
Spouse Guarantee Issue Amount	\$25,000 when initially eligible	
Child(ren) Amount	Flat amounts of \$1,000, \$2,000, \$4,000, \$5,000 or \$10,000 Child(ren) rate: \$0.20 of per \$1,000 of coverage	
Monthly Rates for Employees and Spouses (per \$1,000 of benefit)		
Per \$1,000 of Benefit based on age To calculate your monthly amount: $\frac{\text{table rate} \times \text{desired life amount}}{1000}$ Then, to make it a weekly amount: $\text{Monthly amount} \times \left(\frac{12 \text{ months}}{52 \text{ weeks}} \right) = \text{weekly amount}$	<35	\$0.08
	35-39	\$0.10
	40-44	\$0.16
	45-49	\$0.26
	50-54	\$0.41
	55-59	\$0.70
	60-64	\$1.20
	65-69	\$1.44
	70+	\$3.56
	For example: 38-year-old employee, \$80,000 desired life amount $\frac{\$0.10 \times 80,000}{1000} = \8.00 monthly amount Then, $\frac{\$8.00 \times 12}{52} = \1.85 weekly amount	
Voluntary AD&D <i>When Voluntary Life is elected, AD&D amount will equal Supplemental Life Amount</i> <i>Benefit Reductions apply to age-bands.</i>	Employee: Benefit amount is the same as Voluntary Supplemental Term life coverage. Spouse & Child: Benefit amount is the same as Voluntary Supplemental Term life coverage. Employee and Spouse: \$0.035 per \$1,000 of Benefit Child: \$0.05 per \$1,000 of Benefit	

Voluntary Short-Term Disability

Voluntary Short-Term Disability

Disability benefits protect a portion of your income in the event of any injury, accident or illness that keeps you from working.

Employees have the option to purchase Short-Term Disability (STD) Benefits through MetLife.

Current Option 1—Base Plan Benefits are provided in the event of becoming disabled for more than 7 days due to a non-work related illness, or on day one in the case of a non-work related accident or injury. The plan pays 60% of an eligible employees' pre-disability base weekly earnings, to a **maximum of \$750** per week for a qualified disability for the current base plan.

NEW Option 2—Buy-Up Plan is available for any employees with a salary of over 65,000. Benefits are provided in the event of becoming disabled for more than 7 days due to a non-work related illness, or on day one in the case of a non-work related accident or injury. This new plan pay 60% of an eligible employees' pre-disability base weekly earnings, to a **maximum of \$1,500** per week for a qualified disability.

Benefit Detail	Voluntary Short-Term Disability Option 1—Base salary under 65K	Benefit Detail	Voluntary Short-Term Disability Option 2—Buy-Up salary Over 65k
Elimination Period	7 days for accident or illness	Elimination Period	7 days for accident or illness
Benefits Duration	25 weeks (including elimination period)	Benefits Duration	25 weeks (including elimination period)
Benefit Percentage	60% of weekly income	Benefit Percentage	60% of weekly income
Maximum Benefit	\$750 per week	Maximum Benefit	\$1,500 per week
Pre-Existing Conditions *	Pre-existing conditions may not be covered by this plan.	Pre-Existing Conditions *	Pre-existing conditions may not be covered by this plan.
Weekly Rate	\$0.486 per \$10 of covered benefit	Weekly Rate	\$0.644 per \$10 of covered benefit

**A pre-existing condition is a condition, regardless of cause, for which a medical device, diagnosis, care or treatment was recommended or received in the 3 months prior to your enrollment date. The plan will not pay benefits for any pre-existing conditions that result in disability during your first 12 consecutive months of coverage.*

Voluntary Short-Term Disability Base Sample Premium Calculation	
Voluntary STD Rate	\$0.486
Yearly Salary	\$30,000
Weekly Income (\$30,000 / 52 weeks)	\$576.92
Weekly Benefit Amount (\$576.92 x 60%)	\$346.15
Monthly Premium (\$346.15 x \$0.486 / \$10 of benefit)	\$16.82
Weekly Premium (\$16.80 x 12 months / 52 weeks)	\$3.88

Voluntary Short-Term Disability Buy-Up Sample Premium Calculation	
Voluntary STD Rate	\$0.644
Yearly Salary	\$80,000
Weekly Income (\$80,000 / 52 weeks)	\$1,538.46
Weekly Benefit Amount (\$1,538.46 x 60%)	\$923.08
Monthly Premium (\$923.08 x \$0.644 / \$10 of benefit)	\$59.45
Weekly Premium (\$59.49 x 12 months / 52 weeks)	\$13.72

Voluntary Long-Term Disability

Voluntary Long-Term Disability

Voluntary Long-Term Disability (LTD) Benefits provide continued protection if you are still deemed disabled when STD benefits are exhausted, or for a specified period of time for a qualified disability if you did not elect STD coverage.

Employees have the option to purchase Voluntary Long-Term Disability (LTD) Benefits through MetLife. Benefits are provided on the 180th day of disability, payable up to Social Security Normal Retirement Age (SSNRA). Income loss is replaced at 50% of your base monthly earnings, to a maximum of \$8,000 per month for a qualified disability.

Benefit Detail	Voluntary Long-Term Disability
Elimination Period	180 days
Benefits Duration	Benefits are paid to the later of either age 65 or Social Security Normal Retirement Age (SSNRA)
Benefit Percentage	50% of monthly income
Maximum Benefit	\$4,000 per month
Definition of Disability	Loss of 80% of earnings
Pre-Existing Conditions	Pre-existing conditions may not be covered by this plan

**A pre-existing condition is a condition, regardless of cause, for which a medical device, diagnosis, care or treatment was recommended or received in the 12 months prior to your enrollment date. The plan will not pay benefits for any pre-existing conditions that result in disability during your first 12 consecutive months of coverage.*

Voluntary Long-Term Disability	
Employee Age	Monthly Rate per \$100 of covered payroll
< 29	\$0.060
30-34	\$0.060
35-39	\$0.142
40-44	\$0.293
45-49	\$0.443
50-54	\$0.738
55-59	\$0.778
60-64	\$0.732
65-69	\$0.710
70+	\$0.710

Voluntary Long-Term Disability

(Based on Employee, age 33)

Sample Premium Calculation

Voluntary LTD Rate	\$0.060
Yearly Salary	\$30,000
Monthly Salary (\$30,000 / 12 months)	\$2,500
Monthly Covered Payroll	\$2,500
Monthly Premium (\$2,500 x \$0.060 / \$100 of monthly salary)	\$1.50
OR Semi-Monthly Premium (\$1050 x 12 / 24 pay periods)	\$.75

Flexible Spending Accounts (FSAs)

WB Moore continues to offer Health Care and Dependent Care Flexible Spending Accounts (FSAs), administered by Catapult formerly The Employers Association. FSAs allow you to pay for eligible health care and dependent care expenses with pre-tax dollars which can increase your take-home pay. The Dependent Care FSA is offered to everyone, no matter what medical plan you may be covered under, through WB Moore.

There are two types of FSAs to choose from:

Health Care FSAs may be used to pay for eligible medical, prescription, dental and vision expenses not fully covered by your insurance plans for you and your tax eligible dependents. If you are enrolled in the HDHP Plan, you are not eligible to participate in the Health Care FSA.

Dependent Care FSAs may be used to pay for eligible expenses related to the care and supervision of your child (to age 13) or adult dependent on your tax return. Eligible expenses include child or adult daycare, after school care, nursery school, nanny or babysitter. You must accumulate the funds in your Dependent Care FSA before you can be reimbursed.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.

2026 IRS Contribution Limits	Minimum	Maximum	Rollover
Health Care FSA	\$100	\$3,400	\$680
Dependent Care FSA	\$100	\$7,500 (or \$3,750 if married and filing separately)	N/A

FSA Rollover: WB Moore allows participants to carry over up to \$680 in unused money in the Health Care at the end of the plan year to be used to reimburse expenses incurred in the next year. Any amount in excess of \$680 will be forfeited, so plan accordingly.

FSA HEALTH CARE and DEPENDENT CARE WORKSHEET TO ESTIMATE FSA CONTRIBUTIONS							
Medical, Dental and Vision Expenses						Dependent Care Expenses	
Deductibles	\$	Exams	\$	Routine Exam	\$	Child(ren)	\$
Copays	\$	Eye Surgery	\$	Fillings and Crowns	\$	Adults	\$
Prescriptions	\$	Lenses and Frames	\$	Orthodontia <i>(Not included in dental plan)</i>	\$	Other	\$
Other	\$	Contacts and So-lutions	\$	Other	\$	Other	\$
Total	\$	Total	\$	Total	\$	Total	\$

Voluntary Critical Illness

WB Moore provides eligible full-time employees with the opportunity to purchase Critical Illness Insurance through MetLife. You pay the full cost of this coverage. Critical Illness insurance helps you cover the costs associated with being diagnosed with a specified condition. The table below outlines some of the conditions that are covered, as well as the benefit amount. The benefit is paid as a lump sum to you.

Benefit Category	Condition	Percentage of Payout
Heart/Circulatory	Heart Attack	100%
	Heart Transplant	
	Stroke	
Organ	Major Organ Transplant	100%
	End Stage Renal Failure	
Cancer	Cancer (Invasive)	100%
	Bone Marrow Transplant	50%
	Carcinoma in Situ	25%
	Benign Brain Tumor	

The maximum amount that you can receive through your Critical Illness Insurance plan is called the Total Benefit and is 3 times the amount of your Initial Benefit. Keep in mind, some Certain Illness may not qualify.

Benefit	Voluntary Critical Illness
Employee	\$5,000 increments of \$50,000
Spouse (under age 70)	50% of employee's Initial Benefit
Dependent Child	50% of employee's Initial Benefit
Guarantee Issue Amount	Employee- \$50,000 when initially eligible Spouse & Dependents - \$25,000 when initially eligible
Wellness Benefit	\$50 per year (for eligible employees and their dependent spouses)

Monthly Age Based Rate per \$1,000				
Age	Employee	Employee + Spouse	Employee + Children	Employee + Family
< 25	\$0.62	\$1.01	\$0.93	\$1.33
25-29	\$0.65	\$1.07	\$0.97	\$1.38
30-34	\$0.85	\$1.33	\$1.17	\$1.64
35-39	\$1.00	\$1.56	\$1.32	\$1.88
40-44	\$1.19	\$1.83	\$1.51	\$2.14
45-49	\$1.82	\$2.62	\$2.13	\$2.93
50-54	\$2.79	\$3.87	\$3.11	\$4.18
55-59	\$4.14	\$3.58	\$4.45	\$5.89
60-64	\$5.77	\$7.66	\$6.08	\$7.98
65-69	\$8.14	\$10.65	\$8.45	\$10.96
70-74	\$11.67	\$15.28	\$11.98	\$15.59
75+	\$11.67	\$15.28	\$11.98	\$15.59

Voluntary Accident

WB Moore provides eligible full-time employees with the opportunity to purchase Accident Insurance through MetLife. You pay the full cost of this coverage. Accident Insurance helps you cover the costs associated with being in a covered accident. The table below highlights some of the accidents and conditions that are covered, as well as the benefit amount. This benefit is paid as a lump sum to you.

Initial Care and Emergency– within 72 hours of accident; Once per accident		
	Low Plan	High Plan
Emergency Room	\$75-\$100	\$100-\$200
Initial Physician Office Visit	\$75	\$100
Ambulance	\$300 Ground, \$1,000 Air	\$400 Ground, \$1,250 Air
Specified Injuries		
Fractures (Surgical/Non-surgical)	\$100 up to \$8,000	\$200 up to \$10,000
Dislocations (Surgical/Non-surgical)	\$100 up to \$8,000	\$200 up to \$10,000
Lacerations	\$50 up to \$400	\$75 up to \$700
Burns	\$70 up to \$10,000	\$100 up to \$15,000
Dental	\$200 Crown, \$25 Filling, \$100 Extraction	\$300 Crown, \$50 Filling, \$150 Extraction
Hospital, Surgical and Diagnostic		
Admission	\$1,000	\$1,500
Daily Confinement	\$200 per day max 15 days/acc	\$300 per day max 15 days/acc
Wellness Benefit		
\$50 per year (for eligible employees and their dependent spouses)		

MetLife Accident Insurance	Low Plan Weekly Cost	High Plan Weekly Cost
Employee Only	\$3.15	\$4.71
Employee + Spouse	\$6.23	\$9.24
Employee + Child(ren)	\$7.02	\$10.38
Family	\$8.70	\$12.88

Hospital Indemnity

WB Moore provides eligible full-time employees with the opportunity to purchase Voluntary Hospital Insurance through MetLife. You pay the full cost of this coverage. Hospital insurance is for treatment for injury or sickness and helps you cover the costs associated with being injured or sick. The table below highlights some of the benefits that are covered, as well as the benefit amount. This benefit is paid as a lump sum to you.

IMPORTANT: This is a fixed indemnity policy, NOT health insurance - This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

Hospital Admission & Confinement—due to injury or sickness	
Hospital Admission—4 times per calendar year	\$1,000
ICU Supplemental Admission— (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	\$1,000
Hospital Confinement —31 days per confinement ICU Supplemental Confinement will pay an additional benefit for 31 of those days	
Daily Hospital Confinement—31 days per confinement	\$100 per day
Daily ICU Confinement—31 days per confinement	\$100 per day
Well Child Visits (up to 4 times for the first year of life)	\$75 per day

MetLife Hospital Injury or Sickness Insurance	Per Pay Period Deductions
Employee Only	\$2.82
Employee + Spouse	\$7.02
Employee + Child(ren)	\$5.22
Family	\$9.42

Additional Benefits

Employee Assistance Program (EAP)



We all face difficulties in our life. During those times, having outside help can make the difference between solving a problem and continuing to struggle through periods of confusion, indecision and personal crisis. WB Moore is pleased to offer an Employee Assistance Program (EAP) administered by LifeWorks. Your EAP gives you confidential access to a licensed professional counselor who will provide short-term assistance with issues that are having an impact on your life and ability to focus on work. Some highlights of the EAP include:

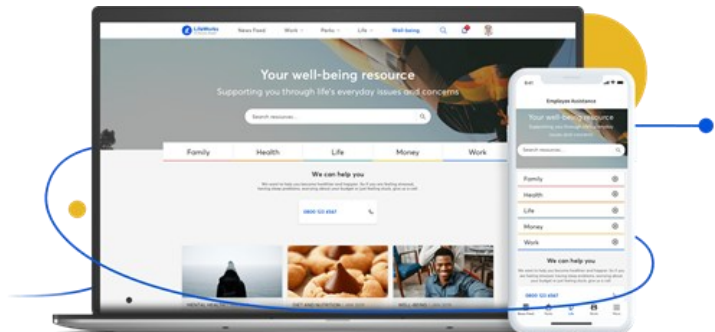
- Unlimited confidential telephone access to EAP professionals 24/7
- Child and Eldercare Assistance
- Legal assistance and financial services
- Daily Living Services

Your Licensed Professional Counselor can help address:

- Anger, grief, loss, depression
- Job stress, burnout, work conflicts
- Marital relationships, family and parenting issues
- Addiction, eating disorders, mental illness
- And much more!

Website
Metlifeeap.lifeworks.com
User Name: metlifeeap
Password: eap

Phone
888-319-7819



401(k) Retirement Savings Plan

WB Moore's 401(k) Retirement Savings plan represents one of the best opportunities available for building your retirement nest egg. The plan makes investing easy, convenient and flexible. Employees make contributions on a pre-tax basis reducing current Federal, State, and Social Security taxes. Taxes are deferred until you are ready to withdraw from the account. You may elect to contribute 1% to 100% of your pay up to the IRS Contribution Limits.

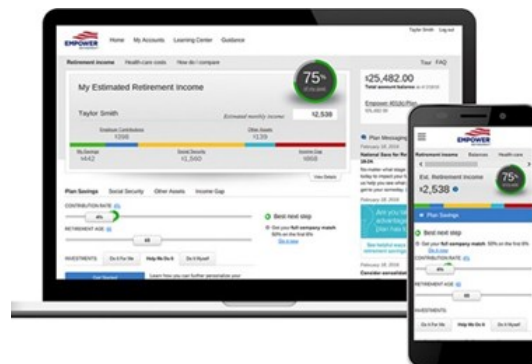
Internal Revenue Service (IRS) regulations limit the annual amount of your salary deferral contributions to \$23,000 for 2026. Associates who are age 50 or older by the end of the calendar year may defer an additional \$7,500 in catch-up contributions for a total contribution limit of \$30,500.

IRS Contribution Limits	2026
Pre-Tax Contributions	\$24,500
Catch-Up (Age 50+)	\$8,000

Benefit Detail	401(k) Retirement Savings Plan
Eligibility	Full-time employees
Enrollment	You may enroll and begin contributing on the first day after 90 days from your date of hire
Automatic Contribution Arrangement	Associates are automatically enrolled at 3% and automatically increased by 1% each year until a max of 10% has been reached unless they opt-out or make their own elections.
Contributions	1% - 100% up to IRS Contribution Limits
Employer Match	100% on the 1st 3% of deferrals, 50% on the next 2%
Vesting Schedule	
Employee Contributions	Immediately, 100%
Employer Match	2 years of service 20% 3 years of service 40% 4 years of service 60% 5 years of service 80% 6 years of service 100%

For additional information about your plan including Roth Contributions, Transfers, Rollovers, Withdrawals, Fees, Investment Options and Advisory Services, etc., visit the Web site at www.empower-retirement.com/participant or call the Voice Response System, toll free at 1-800-338-4015 for more information.

The Web site provides information regarding your Plan, as well as financial education information, financial calculators and other tools to help you manage your account. You may also contact WB Moore Human Resources for any assistance.



Terminology Tip Sheet

Patient Protection and Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Annual Limit: A cap on specific benefits your insurance plan will pay for services in a year while you're enrolled in a particular health insurance plan. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for that particular service for the rest of the year.

Out-of-Pocket Maximum: The most a Plan member must pay towards covered medical expenses in a benefit period for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the remainder of the benefit period.

Coinsurance: Your share (a percentage) of costs of a covered health care service you must pay after you have met your deductible.

Copayment: A fixed amount (\$20, for example) you pay for a covered health care service.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest. Many plans pay for in-network preventive care before you meet your deductible or may pay the balance for a service, after you pay a copayment, prior to satisfying the deductible. Some of your dental options also have a deductible, generally for basic and major dental care services only.

Brand Formulary Drugs: The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Generic Drugs: These drugs are usually the most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non-formulary brand name drugs.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Non-Formulary Drugs: These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of-pocket cost to you.

Specialty Drugs: Prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions. Injectable drugs are an example of Specialty Drugs.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. These providers agree to accept pre-determined rates when servicing members, and will cost you the least out-of-pocket.

Qualifying Life Event: An occurrence that qualifies the subscriber to make an insurance coverage change, most often to pre-tax benefits, outside of Open Enrollment.

For a full glossary of terminology visit: <https://www.healthcare.gov/glossary/>

Contact Information

Service	Vendor	Phone Number	Website
Human Resources	Stevie Newton	704-331-9300	wbmr@wbmoore.com
Medical Plan or Prescription Drugs	Blue Cross Blue Shield of North Carolina	877-275-9787	www.blueconnectnc.com
Health Savings Account (HSA)	HealthEquity	866-346-5800	https://my.healthequity.com
Flexible Spending Account (FSA)	Catapult formerly The Employers Association	800-528-2398	www.teafsa.com
Dental	MetLife	800-GET-MET8 (438-6388)	www.metlife.com/mybenefits
Vision	MetLife	855-MET-EYE1 (438-3931)	www.metlife.com/mybenefits
Life, Disability and Voluntary Benefits	MetLife	800-GET-MET8 (438-6388)	www.metlife.com/mybenefits
401(k)	Empower Retirement	800-338-4015	www.empower-retirement.com/participant
Employee Assistance Program	LifeWorks	888-319-7819	www.metlifeep.lifeworks.com

Find the nearest Retail Health Clinic locations at:

- www.ccaclinics.org/membership/clinic-locations
- www.cvs.com/minuteclinic/clinic-locator
- www.walgreens.com/pharmacy/healthcare-clinic/locations
- www.riteaid.com/shop/info/pharmacy/services/reditclinic

The information in this Enrollment Guide is presented for illustrative purposes and was taken from various summary plan descriptions and benefit information. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Enrollment Guide, contact Human Resources.

Holidays and Personal Time Off (PTO)

HOLIDAY SCHEDULE

Holiday	Day of Week	Date
New Year's Day	Thursday	January 1, 2026
Memorial Day	Monday	May 31, 2026
Independence Day	Friday	July 3, 2026
Labor Day	Monday	September 7, 2026
Thanksgiving Day	Thursday	November 26, 2026
Christmas Day	Friday	December 25, 2026
Floating Holiday	TBD	TBD

PERSONAL TIME OFF (PTO) - *New Policy*

Anniversary	Total Personal Time Off (PTO) Days Awarded
90 Days of Employment	10 PTO days
3 years of Employment	15 PTO days
10 years of Employment	20 PTO days
You are allowed to roll over up to 5 days each year	

- All PTO requests must be entered in BambooHR and approved through the current channels.
- Holiday and PTO time are not considered "hours worked" in terms of overtime.
- To be eligible for Holiday Pay, you must work the day before and after or have scheduled time off.
- PTO must be taken within one year. Unused PTO will expire after a year.
- PTO can be used in half-day (4 hour) increments

Required Annual Notices

Women's Health and Cancer Rights Act Enrollment 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; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. The deductibles and coinsurance that apply can be found on pages 5-7 of this guide.

If you would like more information on WHCRA benefits, call your Plan Administrator Stevie Newton, HR Manager at 704-331-9300.

Newborns' and Mothers' Health Protection Act Model Language

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).

Required Annual Notices– CHIP

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

State	Program	Website	Phone Number
Alabama	Medicaid	http://myalhipp.com/	1-855-692-5447
Alaska	Medicaid	The AK Health Insurance Premium Payment Program: http://myakhipp.com/ CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861
Arkansas	Medicaid	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
California	Medicaid	http://dhcs.ca.gov/hipp hipp@dhcs.ca.gov	916-445-8322
Colorado	Medicaid and CHIP	https://www.healthfirstcolorado.com/ https://www.colorado.gov/pacific/hcpf/child-health-plan-plus https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	1-800-221-3943 1-800-359-1991 / State Relay 711 1-855-692-6442
Florida	Medicaid	https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html	1-877-357-3268
Georgia	Medicaid	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	678-564-1162 ext 2131
Indiana	Medicaid	http://www.in.gov/fssa/hip/ https://www.in.gov/medicaid/	1-877-438-4479 1-800-457-4584
Iowa	Medicaid and CHIP	https://dhs.iowa.gov/ime/members http://dhs.iowa.gov/Hawki https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas	Medicaid	https://www.kancare.ks.gov/	1-800-792-4884
Kentucky	Medicaid	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KIHIP.PPROGRAM@ky.gov https://kidshealth.ky.gov/Pages/index.aspx https://chfs.ky.gov	1-855-459-6328 1-877-524-4718
Louisiana	Medicaid	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488 (LaHIPP)
Maine	Medicaid	https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 TTY: Maine relay 711 1-800-977-6740

Required Annual Notices – CHIP pg 2

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

State	Program	Website	Phone Number
Massachusetts	Medicaid and CHIP	https://www.mass.gov/info-details/masshealth-premium-assistance-pa	1-800-862-4840
Minnesota	Medicaid	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri	Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	Medicaid	http://www.ACCESSNebraska.ne.gov	Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
Nevada	Medicaid	https://dhcfp.nv.gov	1-800-992-0900
New Hampshire	Medicaid	https://www.dhhs.nh.gov/oii/hipp.htm	603-271-5218
New Jersey	Medicaid and CHIP	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ http://www.njfamilycare.org/index.html	609-631-2392 1-800-701-0710
New York	Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	Medicaid	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota	Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma	Medicaid and CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon	Medicaid	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania	Medicaid	https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	1-800-692-7462
Rhode Island	Medicaid and CHIP	http://www.eohhs.ri.gov/	855-697-4347, or 401-462-0311
South Carolina	Medicaid	https://www.scdhhs.gov	1-888-549-0820
South Dakota	Medicaid	http://dss.sd.gov	1-888-828-0059
Texas	Medicaid	http://gethipptexas.com/	1-800-440-0493
Utah	Medicaid and CHIP	https://medicaid.utah.gov/ http://health.utah.gov/chip	1-877-543-7669
Vermont	Medicaid	http://www.greenmountaincare.org/	1-800-250-8427
Virginia	Medicaid CHIP	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp	1-800-432-5924
Washington	Medicaid	https://www.hca.wa.gov/	1-800-562-3022 ext. 15473
West Virginia	Medicaid	http://mywvhpp.com/	1-855-MyWVHIPP (1-855-699-8447)
Wisconsin	Medicaid CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming	Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

Required Annual Notices– Medicare Part D

Medicare Part D – Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with WB Moore and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. WB Moore has determined that the prescription drug coverage offered by the company is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current WB Moore coverage will not be affected. Please see your current plan design(s) for a description of current coverage. Your current coverage pays for other medical expenses, in addition to prescription drugs. You will still be eligible to receive all of your current medical and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. However, your prescription benefits will not coordinate with the Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current WB Moore coverage, be aware that you and any covered dependents will not be able to get this medical/prescription coverage back until the next annual open enrollment period for the following January effective date of coverage, and/or if a qualifying event or HIPAA special enrollment event occurs.

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

You should also know that if you drop or lose your current coverage with WB Moore and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About this Notice or Your Current Prescription Drug Coverage: Contact the Health Plan administrator for further information. **NOTE:** You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug

Required Annual Notices– Medicare Part D

For More Information About Your Options Under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: November 1, 2023

Name of Entity/Sender: WB Moore

Contact: Position/Office: Stevie Newton, HR Manager

Address: 916 N Poplar St, Charlotte NC 28206

Phone Number: 704-331-9300

Required Annual Notices– HIPAA SERs

HIPAA Notice of Special Enrollment Rights

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).

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

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Stevie Newton, HR Manager at 704-331-9300.

Required Annual Notices— GINA

Genetic Information Nondiscrimination Act “GINA”

On November 9, 2010, the Equal Employment Opportunity Commission (“EEOC”) issued the final rule implementing Title II of the Genetic Information Nondiscrimination Act (“GINA”), which applies to all employers with fifteen or more employees, as well as unions, employment agencies and labor management training programs. This final rule is effective January 10, 2011, and prohibits the use of genetic information in the employment context, restricts an employer’s deliberate acquisition of genetic information, requires employers to maintain employee genetic information as confidential, and strictly limits employers from disclosing genetic information.

Prohibition on Use of Genetic Information by Employers

According to GINA, an employer may not discriminate against an applicant, employee or former employee on the basis of genetic information in hiring, compensation, promotion or demotion, seniority, discipline, employment termination, or any other term, condition or privilege of employment. GINA also prohibits employers from limiting, segregating, or classifying employees based on genetic information and prohibits entities from causing an employer to discriminate based on genetic information.

What is Genetic Information?

Genetic information is defined broadly to include:

- Genetic tests of an individual or a family member
- The manifestation of a disease or disorder in an individual’s family medical history
- An individual’s request or receipt of genetic services
- Participation in genetic clinical research by an individual or a family member
- The genetic information of a fetus carried by an individual or a pregnant family member
- The genetic information of any embryo held by an individual or a family member using assisted reproductive technology

information about the sex or age of an individual or a family member; however, is specifically excluded from the definition of genetic information

The Practical Effects of GINA

The following guidelines are designed to help employers comply with GINA’s requirements:

1. Post the revised Equal Employment Opportunity (“EEO”) poster, which includes GINA information and can be found at <http://www1.eeoc.gov/employers/poster.cfm>.
2. Update medical requests, such as Family and Medical Leave Act (“FMLA”) and fitness-for duty forms, to include the new safe harbor language.
3. Review and revise employee handbooks or other EEO statements and anti-discrimination/anti-retaliation policies to include genetic information in the list of protected traits.
4. Review and revise, as necessary, social media policies to prevent GINA liability for inadvertent acquisition of information from employee social media profiles.
5. Train managers about casual conversations/communications with employees concerning their health or the health of their family members.
6. Maintain all genetic information in a separate and confidential medical file. However, there is no need for a separate GINA section if a medical file already exists, as genetic information can be kept in an ADA file.

MOORE