Greenville Meats, Inc.
Columbia Meats, Inc.

Wholesale / Retail Meat

12-01-24

TO: FULL TIME EMPLOYEES

RE: HEALTHCARE BENEFITS - OPEN ENROLLMENT

We are pleased to provide you with an opportunity to enroll in our group healthcare plan during the month of December, to be effective 1-1-2025. Your enrollment is subject to the timely receipt of your completed enrollment form (by 12-30-24). You may elect to enroll yourself and your eligible spouse and/or children (to Age 26).

> ***To enroll, please complete the enclosed enrollment form(s) and fax or email to our broker no later than 12-30-24*** (Resource Equity Group, **FAX 864-242-0698**; **EMAIL: mailbox@regroupusa.com**. Shortly after processing, you will receive benefit booklet(s), ID card(s), and further information.

Our health care coverage is a comprehensive major medical plan through Allied National (www.alliednational.com), as outlined in the enclosed summary of benefits.

Greenville/Columbia Meats, Inc. will finance the majority of the cost of your coverage, including dependents, and your share will be payroll deducted weekly on a pre-tax basis, as follows....

	Weekly payroll deduction (subject to change)
Employee only -	$ 48.15
Employee+Spouse -	138.03
Employee+Children -	98.44
Employee+Family -	156.22

You may go to any doctor or provider for full benefits, i.e., and referrals are not required. Providers will file your claim....simply present your ID Card...claims forms are not necessary.

If there are any questions about the benefits, or you need assistance completing your enrollment form, feel free to contact our broker, *Resource Equity Group*, at 864-235-9999, or 800-527-1397. You may also access our benefits website at www.gmibenefits.com for additional information.

Agent: Resource Equity Group
P.O. Box 5556, Greenville, SC 29696
864-235-9999 | 800-527-1397 | Fax 864-242-0698
Email: mailbox@regroupusa.com
www.regroupusa.com

Freedom Hybrid Plan™
Group Plan Summary (2025)

Effective 1-1-25

BENEFITS & FEATURES	FREEDOM PLAN	
Deductible* (Indiv / Family Max)	$2500 / 2 x Indiv	
Coinsurance**	70% / 2 x Indiv	
Out of Pocket Max (Indiv / Family) (includes deduct, copays, coinsurance) 100% coverage thereafter	$5000 / 2 x Indiv	
Lifetime Benefit Maximum	Unlimited	
Physician's Services		
Primary physician	$ 30 Copay	
Specialist	$ 30 Copay	
Urgent Care	$ 50 Copay	
Preventive Services	100%	
Inpatient Hospital	Deduct / Coins.	
Outpatient Hospital & Surgery	Deduct / Coins.	
Emergency Room	Deduct / Coins.	
Diagnostic Testing & Imaging	Deduct / Coins.	
Lab charges at LabCorp & Quest Diag.***	100% no deduct	
Prescription Drugs (Copay)	Retail 30 Day	Mail Order 90 Day
Generic:	$ 10	$ 20
Preferred Brand:	$ 30	$ 60
Non-Formulary:	$ 50	$100
Specialty Rx:	10% up to $200	
Free listed brand name medications under **INTL**MailOrder program (see right)		
Home health care	Deduct / Coins.	
Rehabilitation & Habilitation	Deduct / Coins.	
Skilled nursing care	Deduct / Coins.	
Durable Medical Equipment	Deduct / Coins.	
Hospice Service	Deduct / Coins.	

The member is free to see any provider in the country for full coverage. The plan uses the PHCS (Private Healthcare Systems) PPO network for physicians services. Out of network and "facility" services are paid at a level above the Medicare allowable charges.

Members will be responsible for normal copays, deductible and out-of-pocket expenses. The plan will protect members from a balance bill from a provider for any amount in excess of the allowable reimbursement.

- Coverage is guaranteed to all eligible full time employees (30+hrs/wk) and eligible dependents (spouse/children to age 26).
- Pre-existing conditions are covered (no waiting period).

Coverage includes....

--Maternity and routine nursery care
--Orthopedic Manipulation (to 20 visits per year)
--Nervous & emotional or mental disorders incl alcohol and chemical
  - Up to 31 Inpatient Treatment Days per calendar year
  - Up to 26 Outpatient Visits per calendar year
--Office Visits, incl Urgent Care, covered at 100% after copay, up to $500 per visit. Charges in excess of $500 subj to deductible/coins.
--Preventive Services, ofc visits, and Prescription Rx not subj to deduct.
--Access to Cura Telehealth providers. www.cura.com (620-740-2872)
--Membership in Abenity Discount program included.
--INTLMailOrder program. No cost for listed brand name prescription drugs. Call 866-488-7874 for Rx eligibility). Forms available at www.IntlMailOrder.com.

Allied Self Service™
Your online information and customer service center. Manage your health care from the comfort of home. *www.alliednational.com*

* Deductible does not apply to Preventive care, office visits, and Prescription Rx.
-Benefits subject to the deductible begin as soon as one person in family has met the deductible.
** Coinsurance is the percentage we pay after you have satisfied the deductible (100% after your out-of-pocket maximum). The out of pocket maximum includes the deductible, copays, and coinsurance.
***If your doctor/provider uses a different outside lab, go to your local LabCorp or Quest lab for 100% coverage.

Services not covered: Acupuncture, Bariatric Surgery, Cosmetic Surgery, Dental Care, Hearing Aids, Infertility treatment, Long-term care, Private Duty Nursing, Residential and custodial care, weight loss programs.

EMPLOYEE LEVEL-FUNDED HEALTH PLAN
20+ ENROLLMENT FORM

May be Photocopied or Duplicated for use. Please complete in ink and initial any alterations.

SECTION 1 – EMPLOYEE INFORMATION

FULL NAME OF EMPLOYEE			SOCIAL SECURITY NUMBER	MARITAL STATUS	**ADM. USE ONLY**
RESIDENCE ADDRESS		EMAIL			CASE NO.
CITY	STATE	ZIP	TELEPHONE NUMBER (include area code)	BEST TIME TO CALL	EMPLOYEE NO.
GENDER	DATE OF BIRTH	HEIGHT	WEIGHT	TOBACCO USE ☐ YES ☐ NO	CLASS
AVG. NO. HOURS WORKED WEEKLY	OCCUPATION AND DUTIES			DATE BEGAN FULL TIME (mm/dd/yy)	EFFECTIVE DATE
EMPLOYED BY Greenville Meats, Inc.	CITY	STATE	ZIP		OCC ☐ YES ☐ NO
☐ I AM ☐ I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER					MHX EMPLOYEE DEPENDENTS ☐ YES ☐ NO

I Am Enrolling for (check one): ☐ SELF ONLY ☐ SELF AND SPOUSE ☐ SELF AND CHILD(REN) ☐ SELF, SPOUSE & CHILD(REN)

DEPENDENT WAIVER

If you have dependents (spouse and/or children) and are not enrolling **all** of them, please complete the following:

I AM NOT ENROLLING MY (check one or both): ☐ **SPOUSE** ☐ **CHILD(REN)**

BECAUSE (check one): ☐ Covered by another group/individual health plan ☐ Other (explain) ____________

I understand I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been encouraged or pressured by anyone to decline such coverage. I understand that if I do not enroll my dependents at this time, and they do not have other qualifying coverage, their right to enroll in the future may be restricted, with a delayed effective date.

DEPENDENT INFORMATION Complete for each dependent to be enrolled. (use additional sheet if necessary).

NAMES OF DEPENDENTS	M/F	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	WEIGHT	TOBACCO USE	EMAIL & PHONE NUMBER (for spouse and dependents 18 & older)
	☐ M ☐ F						☐ YES ☐ NO	
	☐ M ☐ F						☐ YES ☐ NO	
	☐ M ☐ F						☐ YES ☐ NO	
	☐ M ☐ F						☐ YES ☐ NO	

Complete information on all pages online or use ink. Sign and date the bottom of Section 3.

SECTION 2 – MEDICAL INFORMATION

This information is required. Any material misrepresentation or omission may result in termination of your coverage and may constitute fraud. Please answer completely.

Please check "YES" or "NO" for each item.

1. Has any person to be covered been treated in the last 12 months; currently diagnosed with; being treated for; or recommended to seek treatment for the following:
   a. Brain tumor or cancer, except basic cell carcinoma .... ☐ YES ☐ NO
   b. Hemophilia, Factor 5, leukemia, sickle cell anemia, or hereditary angioedema .... ☐ YES ☐ NO
   c. Stage III or IV renal disease, chronic kidney disease, or end-stage liver disease .... ☐ YES ☐ NO
   d. Organ transplant in the past, currently on a transplant list or attempting to get on a transplant list .... ☐ YES ☐ NO
   e. Birth defects, abnormalities, or other conditions such as ALS or MS that leaves the person confined at home, incapacitated, confined in a treatment facility or incapable of self-support .... ☐ YES ☐ NO
2. Required hospitalization in the last 12 months for any of these conditions: Mental/nervous disorder, substance abuse, Crohn's, diverticulitis, or chronic fatigue .... ☐ YES ☐ NO
3. Is any person to be covered currently receiving any medication administered at a doctor's office, hospital, or outpatient facility or available only from a specialty pharmacy? .... ☐ YES ☐ NO
4. Has any person to be covered been recommended to have surgical treatment in the next twelve months including joint replacements, back surgery, or other orthopedic surgery? .... ☐ YES ☐ NO

SECTION 3 – EMPLOYEE STATEMENT AND SIGNATURE

I HEREBY: Request enrollment in the level-funded Group Health Plan (Plan) established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: This is <u>not</u> an insured benefit plan; All Plan benefits are self-funded (self-insured) by the Employer; The Employer is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under, and all required contributions for such coverage have been received by, the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent may be delayed. A full description of the medical expense benefits under the Plan appears in the Summary Plan Description, which summarizes the official Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms, or adjust claims; The Employer has delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied); However, the Sponsoring Employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments; Allied does not insure the Plan and is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who, knowingly and with intent to defraud, submits an enrollment form, or files a claim, containing a materially false statement, or omitting materially false information, may be found guilty of fraud in a court of law.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage, and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage), he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination of coverage; If you decline enrollment for any dependent (including your spouse) and that

dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer or Allied Client Services at 800-825-7531.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re-disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Employee Name ______________________________ Date ______________
(Type Name as signature authorization)

Spouse ______________________________ Date ______________
(Type Name as signature authorization)

Additional Dependent Information

NAMES OF DEPENDENTS	M/F	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	WEIGHT	TOBACCO USE	EMAIL & PHONE NUMBER (for spouse and dependents 18 & older)
1.	☐ M ☐ F						☐ YES ☐ NO	
2.	☐ M ☐ F						☐ YES ☐ NO	
3.	☐ M ☐ F						☐ YES ☐ NO	
4.	☐ M ☐ F						☐ YES ☐ NO	

3120s0921

RETURN ENROLLMENT CARD TO ALLIED NATIONAL • UNDERWRITING • P.O. BOX 29187 • SHAWNEE MISSION, KS 66201-9187
Electronic copies of this enrollment card submitted via facsimile, email, or other electronic means shall be deemed an original.