

HOURLY TEAM MEMBERS



2027

BENEFITS GUIDE

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COVERAGE & ELIGIBILITY



2027 PLAN YEAR

Sweet Oak's coverage runs from January 1, 2027 — December 31, 2027. Sweet Oak's benefits program provides coverage to team members, spouses and children who meet Sweet Oak's eligibility requirements.

2027 PLAN YEAR OPEN ENROLLMENT

The decisions you make during the 2027 Open Enrollment period will impact your benefits for 2027 plan year, which is January 1, 2027 through December 31, 2027. Once you make your 2027 elections, most will remain in effect until the next open enrollment period, unless you experience a qualifying life event.

You must adjust your benefits elections within 30-days of a qualified family status change event. It is your responsibility to contact Sweet Oak HR to request a change as soon as you are aware of an event.

You may add/drop a dependent from your coverage as long as the changes are consistent with the type of family status change you have had recently.

WAIVE COVERAGE

You may waive coverage offered through Sweet Oak for the 2027 plan year. Please note that if you waive coverage, you will not be able to enroll until the next annual enrollment period or unless you experience an IRS-approved qualifying life event.

NEW HOURLY TEAM MEMBERS

Eligibility and required contributions for the benefits and programs described in this guide depend on both your employment classification and whether you elect to extend coverage to your dependents. You are considered full-time if you are scheduled to work 30 or more hours per week.

- Full-time hourly team members are eligible for the Sweet Oak benefits program on the 1st of the month following 60-days of employment.
- Full-time hourly team members are eligible for the Flexible Spending Account plan on the 1st of the month following one year of employment.

ELIGIBLE DEPENDENTS

Once you elect coverage for yourself as an active team member, you may enroll your eligible dependents in certain benefits as described in this guide. Eligible dependents include your spouse, your children or your spouse's children up to the age of 26, including:

- Your natural children or step-children
- Legally-adopted children or foster children
- Children covered by a Qualified Medical Child Support Order (QMCSO)
- Child(ren) of whom you have legal guardianship

MAKING CHANGES DURING THE PLAN YEAR — QUALIFYING LIFE EVENTS

Unless you experience a Qualifying Life Event, you cannot make changes to your benefits until the next Open Enrollment period. Qualifying Life Events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- 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

You must notify Sweet Oak Human Resources within 30 days of experiencing a Qualifying Life Event.

REVIEW, CHOOSE, ENROLL

At Sweet Oak, we recognize the hard work and dedication that goes into your work every day. That's why as a Sweet Oak team member, you have access to a comprehensive and competitive benefits package. Get to know your plan options — how they work, what they cost and what they cover.



REVIEW

Read this guide to learn about the plan options available to Sweet Oak team members for the 2027 plan year.



CHOOSE

Choose the benefits options that work best for you, based on your needs, budget and family situation. All team members may use the Benefits/Open Enrollment portal via UKG, to either decline coverage or make benefits elections for the 2027 plan year.



ENROLL

Direct links to your enrollment platform are easily accessible through your organization's BenePortal, or UKG. From here you can review plans, premiums and make your 2027 Open Enrollment benefit elections. All benefit elections will be effective January 1, 2027.

Reminder: You must actively enroll each year to choose how much you want to contribute to your Health Savings Account or Flexible Spending Account. If you do not enroll, your contributions and enrollment in these plans will end on December 31.



BENEFIT CHANGES FOR 2027

CHANGES FOR 2027

Regulatory Changes

HSA Limits

The HSA maximum contribution limits for 2027 set by the IRS will increase to \$4,500 for team member coverage and \$9,000 for family coverage. The age 55+ catch up provision of \$1,000 remains unchanged

FSA Contribution Limits

The annual Healthcare FSA contribution limit for 2027 is projected to be \$3,500 with \$680 rollover provision.*

Dependent Care FSA

The maximum that you can contribute to the Dependent Care FSA is \$7,500 if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is \$3,750.

Sweet Oak Benefit Changes

Team Member Contributions

Contributions for medical and dental health plans are changing for the 2027 plan year.

Medical & Prescription Drug Plan

For 2027, Medical & Prescription coverage will continue to be administered by **Cigna** through the Cigna Open Access Plus network of providers. Minor benefit changes have been made to the High-deductible health plan (HDHP), Base plan and Buy-Up plan, please refer to page 8 to review Sweet Oak's 2027 Medical & Prescription plan offerings.

Basic Life and AD&D Insurance

Sweet Oak will be transitioning to provide coverage through **New York Life** for the 2027 plan year beginning on January 1, 2027.

Flexible Spending Account (FSA)

Sweet Oak will be transitioning administration of FSA benefits to **Baker Tilly Vantage (BTV)** for the 2027 plan year effective January 1, 2027.

Voluntary Employee, Spouse, and Child Life Insurance

Sweet Oak employees will have access to voluntary employee, spouse, and child life insurance for the 2027 plan year through **New York Life** beginning on January 1, 2027.

Additional Benefits

For the 2027 plan year beginning on January 1, 2027, Sweet Oak employees will have access to Accident, Critical Illness, and Hospital Indemnity Insurance through **New York Life**.

* pending IRS confirmation

GET TO KNOW YOUR MEDICAL PLAN OPTIONS

Regardless of which plan you choose, you will have access to Cigna's same provider network.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

The HDHP allows you to select care from in-network and out-of-network providers each time you or a covered dependent needs medical care. You do not need to select a primary care physician (PCP) to direct your care.

Sweet Oak's Cigna HDHP features a high annual deductible for those wishing to minimize their monthly premium. If you elect to participate in the HDHP, you will automatically be enrolled in a Health Savings Account (HSA) so that you may pay for eligible expenses on a tax- advantaged basis.

Plan highlights:

- Lowest weekly contributions, higher deductible
- Preventive care is covered at 100% in-network
- Access to dedicated virtual provider visits
- Includes Sweet Oak's pro-rated HSA contribution of \$500 for team member only and \$1,000 for all other team member rate tiers towards the IRS annual HSA contribution maximum of \$4,500
- You can budget for your out-of-pocket expenses by funding a Health Savings Account (HSA)
- You will automatically be enrolled in a Cigna HSA where you will receive Sweet Oak's HSA contributions and may make additional contributions up to the 2027 IRS HSA contribution maximum

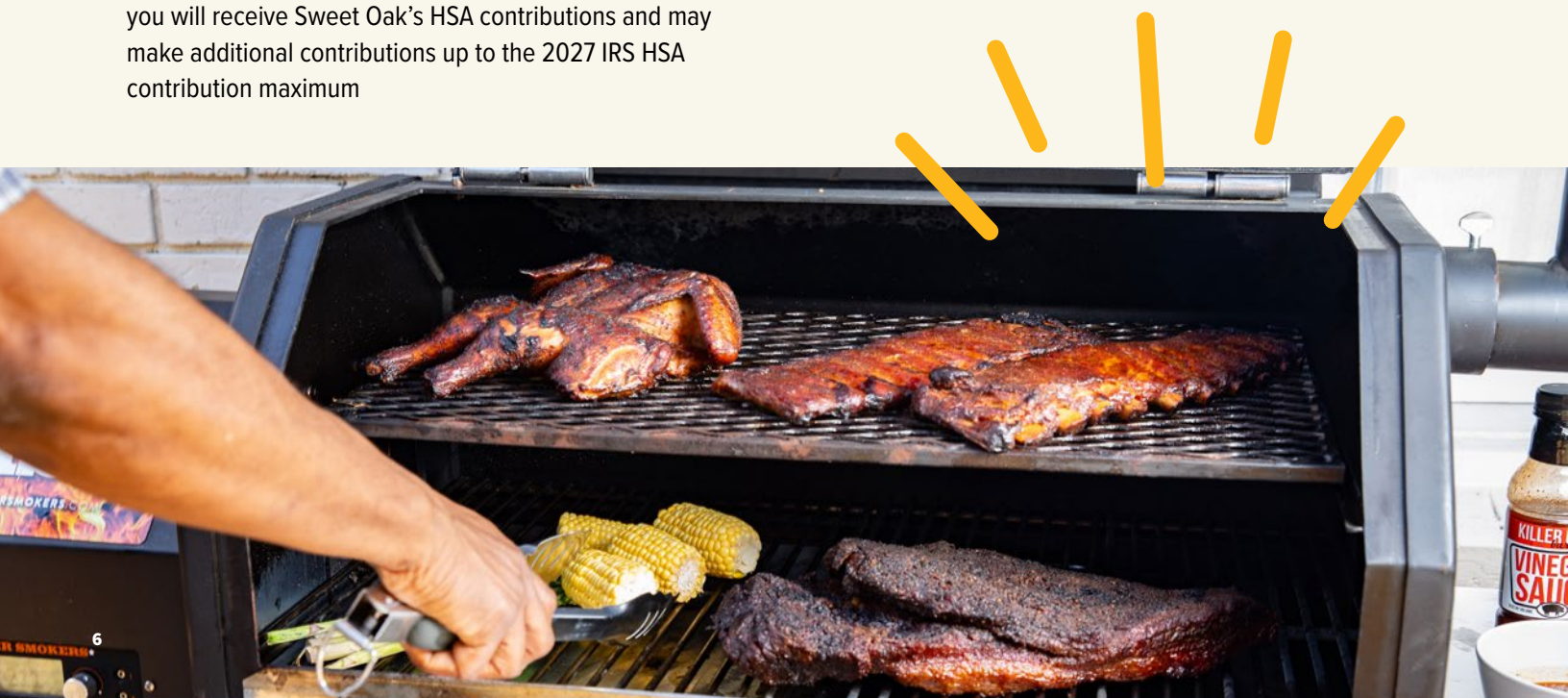
CIGNA BASE AND BUY-UP PLANS

Sweet Oak's Cigna base and buy-up health plans give you the freedom to choose the doctor or hospital you want to see for covered services. You do not need to select a primary care physician (PCP) in order to see a specialist.

While you are not required to use an in-network provider, seeking out-of-network care will most likely result in higher out-of-pocket costs for you and your family.

Plan highlights:

- Higher premiums, lower deductible
- Lower out-of-pocket maximum annually
- Preventive care is covered at 100%
- Access to dedicated virtual provider visits
- Includes copays for "routine" services – doctors office visits, urgent care
- Not subject to Rx deductible
- You can budget for your out-of-pocket expenses by funding a Health Care Flexible Spending Account (FSA)



MEDICAL PLAN FEATURES

Choosing the right medical plan for you

IMPORTANT PLAN FEATURES:

HDHP

With the exception of preventive care, the HDHP plan will begin paying benefits after the annual deductible has been satisfied.

Base Plan and Buy-Up Plan

The Base and Buy-Up plans offer a copay cost share structure for many services offered under the plan prior to satisfying your plan's annual deductible.

Embedded Deductible and Out-of-Pocket Maximum

The family deductible and out-of-pocket maximum can be met by a combination of family members, however, no single individual within a team members family will be subject to more than the individual deductible or out-of-pocket maximum.

Maximum Out-of-Pocket

The annual out-of-pocket maximum for the HDHP and POS plans include the annual deductible, coinsurance and copays.

Sweet Oak HDHP HSA Contributions

Sweet Oak makes an annual pro-rated contribution towards the 2027 IRS maximum HSA contribution amount for team members enrolled in the Sweet Oak HDHP of \$500 for team member only and \$1,000 for all other enrolled team member rate tiers.

CHOOSING THE RIGHT PLAN FOR YOU:

These three plans are administered by Cigna and are serviced by the **Cigna Open Access Plus Network**.

The Base and Buy-Up plans offer discounted rates when you obtain medical care in-network. You may use providers outside of the network, but your deductible and coinsurance will be higher.

The HDHP option offers the most value when combined with the Health Savings Account (HSA). The HDHP also offers discounted rates when you use the plans network of providers. You may use providers outside the network, but your deductible and coinsurance will be higher.



MEDICAL BENEFITS AT-A-GLANCE

Administered by Cigna

Medical and prescription drug coverage is offered through Cigna. The basic medical plan details are listed below. Prescription coverage is outlined on the following page.

	HDHP		BASE PLAN		BUY-UP PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	\$3,500/\$6,600	\$7,000/\$14,000	\$2,500/\$5,000	\$6,000/\$12,000	\$1,500/\$3,000	\$5,000/\$10,000
Out-of-Pocket Maximum (Individual/Family)	\$6,600/\$13,200	\$14,000/\$28,000	\$6,000/\$12,000	\$12,000/\$24,000	\$5,000/\$10,000	\$10,000/\$20,000
Preventive Care Services	Covered 100%; no deductible	You pay 50%*	Covered 100%; no deductible	You pay 50%*	Covered 100%; no deductible	You pay 50%*
Primary Care Physician (PCP) Office Visit	You pay 20%*	You pay 50%*	\$35 copay	You pay 50%*	\$30 copay	You pay 50%*
Specialist Office Visit	You pay 20%*	You pay 50%*	\$70 copay	You pay 50%*	\$50 copay	You pay 50%*
Virtual Care • PCP • Specialist	You pay 20%* You pay 20%*	You pay 50%* You pay 50%*	\$35 copay \$70 copay	You pay 50%* You pay 50%*	\$30 copay/ \$50 copay	You pay 50%* You pay 50%*
MDLIVE Virtual Care	Covered 100%; no deductible	Not Covered	Covered 100%; no deductible	Not Covered	Covered 100%; no deductible	Not Covered
Laboratory and Radiology Services: Physician's Services/Office Visit	Covered same as Physician Services Office visit		Covered same as Physician Services Office visit		Covered same as Physician Services Office visit	
Laboratory or Radiology Services: Independent Lab/Outpatient Facility	You pay 20%*	You pay 50%*	You pay 20%*	You pay 50%*	You pay 10%*	You pay 50%*
Advanced Radiological Imaging (ARI): Physician's Services/Office Visit	Covered same as Physician Services Office visit		Covered same as Physician Services Office visit		Covered same as Physician Services Office visit	
Advanced Radiological Imaging (ARI): Outpatient Facility	You pay 20%*	You pay 50%*	Plan pays 100%*	You pay 50%*	Plan pays 100%*	You pay 50%*
Emergency Room	You pay 20%*	You pay 20%*	\$300 copay		\$300 copay	
Ambulance (Mental Health covered 100% under the Base/Buy-up plans)	You pay 20%*	You pay 20%*	You pay 20%*	You pay 20%*	You pay 10%*	You pay 10%*
Urgent Care Center	You pay 20%*	You pay 50%*	\$35 copay	You pay 50%*	\$30 copay	You pay 50%*
Inpatient • Hospital Facility Services • Professional Services/Physician Consult	You pay 20%* You pay 20%*	You pay 50%* You pay 50%*	\$500 copay You pay 20%*	You pay 50%* You pay 50%*	\$200 copay You pay 10%*	You pay 50%* You pay 50%*
Outpatient • Hospital Facility Services • Professional Services	You pay 20%* You pay 20%*	You pay 50%* You pay 50%*	\$500 copay You pay 20%*	You pay 50%* You pay 50%*	\$200 copay You pay 10%*	You pay 50%* You pay 50%*
Skilled Nursing Facility (60 days/year)	You pay 20%*	You pay 50%*	Covered 100%*	You pay 50%*	Covered 100%*	You pay 50%*
Home Health Care	You pay 20%*	You pay 50%*	You pay 20%*	You pay 50%*	You pay 10%*	You pay 50%*
Outpatient Therapies (PT, OT, Chiro)	Covered same as Physician Services Office visit		Covered same as Physician Services Office visit		Covered same as Physician Services Office visit	
Inpatient Mental Health/Substance Abuse	You pay 20%*	You pay 50%*	\$500 copay	You pay 20%*	\$200 copay	You pay 50%*
Outpatient Mental Health/Substance Abuse	You pay 20%*	You pay 50%*	\$70 copay	You pay 50%*	\$50 copay	You pay 50%*
Durable Medical Equipment	You pay 20%*	You pay 50%*	You pay 20%*	You pay 50%*	You pay 10%*	You pay 50%*

* After deductible

PRESCRIPTION PLAN

Administered by Cigna



Team members who have elected medical coverage through any Sweet Oak sponsored Cigna medical plan will automatically be enrolled in prescription drug benefits. Review the most up-to-date formulary list at www.cigna.com.

PRESCRIPTION DRUG PLAN		
	HDHP*	BASE PLAN / BUY-UP PLAN
Prescription Deductible (Individual/Family)	Must meet medical deductible (\$3,500/\$6,600)	N/A
Retail Pharmacy (Up to a 30-day supply)		
Tier 1 (Generic)	You pay 20%	\$15 copay
Tier 2 (Preferred Brand)	You pay 20%	\$40 copay
Tier 3 (Non-Preferred Brand)	You pay 20%	\$80 copay
Tier 4 (Specialty)	Retail ONLY – No Mail Order	Retail ONLY – No Mail Order
• Specialty Generic	You pay 20%	\$150 copay
• Specialty Preferred Brand	You pay 20%	\$150 copay
• Specialty Non-Preferred Brand	You pay 20%	\$150 copay
Mail Order Pharmacy (Up to a 90-day supply)		
Tier 1 (Generic)	You pay 20%	\$30 copay
Tier 2 (Preferred Brand)	You pay 20%	\$80 copay
Tier 3 (Non-Preferred Brand)	You pay 20%	\$160 copay
Tier 4 (Specialty)	Not covered (Retail only)	Not covered (Retail only)

* **HDHP Participants:** Coinsurance applies once you satisfy your annual plan deductible. However, many drugs (generic and brand) are discounted at or below coinsurance cost-share amounts based on the drug tier and where the drug is purchased.

CHOOSE A GENERIC AND SAVE!

Generic medications work just as well as their brand-name versions. Generics have the same active ingredients, strength, dosage form, effectiveness, quality and safety. Generics typically cost much less than brand-name medications.

CONSIDER A 90-DAY SUPPLY FOR MAINTENANCE MEDICATIONS

Cigna members can use Express Scripts Pharmacy (home delivery pharmacy) for greater savings.

Not all pharmacies participate in 90-day prescription fills. Prior to filling your 90-day prescription, please verify that your pharmacy is in the 90-day network by visiting www.mycigna.com.

SPEND SMARTER WITH THE PRICE A MEDICATION TOOL!

Compare the price of your medication at in-network retail pharmacies and through the home delivery pharmacy (for Cigna members). Use this tool to:

- View lower-cost alternatives, if available
- View your costs for a 30-day and 90-day supply, depending on your plan
- Find out if your medication needs approval before your plan will cover it
- Log into www.mycigna.com to utilize this tool

TELEMEDICINE/URGENT CARE SUPPORT

Available to medical-enrolled team members at no cost!

Get access to convenient care when you need it most! TextCare services are available via text message and video chat. Simply send us a text message to initiate care. it's that easy!

WITH TEXTCARE, YOU CAN:

- Discuss primary and urgent care needs, chronic condition management, and routine medication needs
- Get support finding high-quality, high-value specialists

24/7 HEALTHCARE SUPPORT

If you need access to medical care, TextCare provides access to One to One Health board-certified providers via text message — 24/7:

- Receive direct access to on-demand high-quality care
- Appointments are not required. Simply send a text to initiate care
- TextCare is available at no cost to Sweet Oak medical plan participants and their households

To get started with TextCare, simply text **678.890.0199**. Scan the QR code to save TextCare's contact info!





CONVENIENT WAYS TO ACCESS YOUR CIGNA PLAN



MYCIGNA ONLINE TOOLS

Access your account at mycigna.com or download the MyCigna app to:

- Find in-network doctors, dentists, and medical services
- View, print, and email ID cards
- Review your coverage
- Manage and track claims, account balances, and deductibles
- Compare cost and quality information for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Receive alerts when new plan documents are available
- Manage your home delivery prescription orders or talk with a pharmacist
- Use the Price a Medication feature to explore medication costs
- Access Health Savings Account information

CIGNA ONE GUIDE

Cigna One Guide helps you make informed choices and get the most from your plan, offering personalized support to help you stay healthy and save money.

During enrollment, Cigna is just a call away to help:

- Answer questions about the basics of coverage for medical plans and products as well as Cigna Healthcare pharmacy
- Identify the types of health plans available to you to help you choose the one that best meets your needs
- Find out if your doctors are in network to help you avoid unnecessary costs
- Get answers to any other questions you may have about the plans or provider networks available to you

SWEET OAK'S WELL-BEING BENEFITS

The following well-being benefits are available to all eligible full-time Sweet Oak team members and eligible dependents.

TEAM MEMBER EMPLOYEE ASSISTANCE PROGRAM (EAP)

All Sweet Oak team members experience times when you need a little help with life's challenges. Sweet Oak understands this and provides a supplemental Employee Assistance Program (EAP) to all full-time eligible team members and eligible dependents at no cost.

The Sweet Oak New York Life EAP plan includes:

- Free confidential help 24/7 which includes three (3) free face to face or virtual visits.
- Assistance with life, family, financial or work issues.

Team members, their dependents, or their beneficiaries can call to discuss any situation perceived as a major loss including:

- Death of a loved one, spouse, or partner
- Receiving a serious medical diagnosis
- Divorce
- Losing a pet
- Loss of a job

You can access your employer provided EAP by visiting guidanceresources.com or by calling (800) 344-9752.

- **Registration Code:** NYLGBS

All team member and dependent EAP services are confidential and provided at no cost to you and your family.

ADDITIONAL ONLINE EAP SERVICES

To access the many forms of assistance available to you as a Sweet Oak team member, visit the Guidance Resources website guidanceresources.com.

Here you may access programs to assist with everything from general support to will and funeral planning, crisis mitigation, financial assistance, and more!



HSA VS. FSA

Maximize your healthcare savings and avoid taxes!

HSA and FSA accounts help you save on healthcare expenses while reducing taxes. Compare their key features, including eligibility, contribution limits, and benefits, to choose the best option for your needs.



COMPARING THE HSA AND FSA

	Health Savings Account	Healthcare Flexible Spending Account	Limited Purpose FSA
Health Plan Enrollment Requirement	HDHP Plan with HSA	Base and Buy-Up Plans	Typically paired with an HDHP/HAS
Eligible Expenses	IRS-approved medical, prescription, dental, and vision expenses	IRS-approved medical, prescription, dental, and vision expenses	IRS-approved dental and vision expenses only
Annual Election Available on the First Day of the Plan Year	No, funds are only available once deposited in account.	Yes, entire annual election available on January 1st even if not yet deducted from pay.	Yes, entire annual election is generally available on January 1st even if not yet deducted from pay.
Sweet Oak Contribution	Team Member Only: \$500 All Other Levels: \$1,000	None	None
Funds Roll Over from One Year to the Next	Yes, your HSA dollars are yours to keep, even if you change plans or jobs.	You may roll over up to \$680 of unused funds.	Funds do NOT roll over

ENROLLED IN THE HDHP WITH HSA?

Health Savings Account (HSA)

An HSA is an individually-owned bank account that allows you to pay for eligible health care expenses with pre-tax dollars, for current or future health care needs into retirement.

You own your account, and there are no “use-it-or-lose-it” restrictions like with Flexible Spending Accounts.

Your contributions to this account cannot exceed the IRS annual contribution limits, however your balance can grow with no limit. See page 14 for more details.

ENROLLED IN THE BASE OR BUY-UP PLANS?

Health Care Flexible Spending Account (HCFSA)

An HCFSA is a company-sponsored account that allows you to pay for eligible health care expenses with pre-tax dollars. You can contribute up to \$3,500* for the 2027 plan year.

You may carry over up to \$680* per year in HCFSA funds to use in the following year.

* pending IRS confirmation

HEALTH SAVINGS ACCOUNT (HSA)

Administered by Cigna HSA Bank

An HSA is a personal health care savings account that you can use to pay out-of-pocket health care expenses with pre-tax dollars. Your contributions are tax free, and the money remains in the account for you to spend on eligible expenses no matter where you work or how long it stays in the account.

HSA ELIGIBILITY

You must enroll in the HDHP to be eligible to participate in the HSA. You will be eligible to contribute to your HSA and receive Sweet Oak contributions, provided you are enrolled in the HDHP plan on the 1st of the month, and provided your HSA banking account is active.

You are ineligible for the HSA if you:

- Are enrolled in a government health plan, such as Medicare or Medicaid.
- Are claimed as a dependent on someone else’s tax return.
- Have other non-high deductible health plan coverage (for example, a Health Care Flexible Spending Account, a separate prescription drug plan, or a spouse’s Non-High Deductible Health Plan that covers you.).
- Have a spouse with a health care Flexible Spending Account that could reimburse your medical expenses.

WHAT IS AN ELIGIBLE EXPENSE?

For a complete list of eligible HSA expenses, you may access Publication #502 online at [irs.gov](https://www.irs.gov). **Note:** Expenses incurred before you establish your HSA are not qualified medical expenses.



CONTRIBUTIONS

When you participate in the Sweet Oak HDHP, Sweet Oak will make a pro-rated contribution to your HSA for each month that you are enrolled in an HDHP. The amount Sweet Oak contributes is based on the medical plan coverage level in effect on the first of each month. You do not need to make HSA contributions yourself to receive your firm’s contributions.

You may choose to make pre-tax contributions to your HSA, and the amount you are allowed to contribute is regulated by federal law. If you are age 55 or older, you may make additional pre-tax catch-up contributions of up to \$1,000 a year. Contribution amounts are generally indexed each year for inflation. You can start, stop or change the amount of your HSA contributions anytime during the year.

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 HSAs cannot exceed the federal maximum for family level coverage.

2027 HSA CONTRIBUTIONS*		
	Team Member Only	All Other Levels
Sweet Oak Contribution	\$500	\$1,000
Team Member Maximum Contribution	\$4,000	\$8,000
2027 Maximum Deposit to HSA**	\$4,500	\$9,000

* You are not required to contribute to the HSA, however, Sweet Oak contributions cannot be posted to your account unless your HSA Bank HSA is active.

** These amounts do not reflect additional catch-up contributions for team members age 55 or older.

USING YOUR HSA

THE BENEFITS OF YOUR HEALTH PLAN PLUS A HEALTH SAVINGS ACCOUNT:

- Combines a medical plan with a health savings account
- Provides coverage for current health care expenses with the option to save for future expenses
- Offers in-network preventive care by the plan at 100%
- Provides flexibility as you own the account; contributions can come from you, your employer, or both
- Encourages greater savings; contributions are generally not taxable
- Provides investment options

YOUR HSA EXPERIENCE ON MYCIGNA.COM

Easy, at-a-glance web and mobile view under Spending Accounts

- Check balances
- Get account updates
- Use the calculator tool to determine your contribution
- Order or cancel debit cards
- Learn about investment options
- Access educational information and videos

FIRST-TIME HDHP PARTICIPANTS:

If you have a balance in the Sweet Oak medical healthcare Flexible Spending Account on January 1 (including pending claims that have not been cleared from your Flexible Spending Account by December 31), you cannot begin your own HSA contributions until April 1 and are not eligible for Sweet Oak HSA contributions for January, February and March. This is an IRS legal requirement under the HSA regulations.



IMPORTANT HSA REMINDERS

KNOW YOUR PERSONAL HSA RESPONSIBILITIES

- You must actively enroll each year to choose how much you want to contribute to your HSA. If you do not enroll, your contributions and enrollment will end on December 31.
- By accepting Sweet Oak's HSA contributions and/or making your own contributions, you certify that you meet the HSA eligibility requirements.
- If you no longer meet the HSA eligibility requirements, including Medicare entitlement, it is your responsibility to notify Sweet Oak Employee Benefits immediately.
- You are solely responsible for ensuring that you do not contribute amounts above the federally mandated limits. If you do, you may be subject to adverse tax consequences.

TIPS FOR HSA TAX REPORTING

Following are some tips to help you fulfill the tax reporting requirements for your HSA:

- Keep your receipts for expenses you pay from your HSA, in case you need to provide this information to the IRS.
- Review IRS Form 1099-SA, provided by Cigna, which states the distributions made from your HSA during the tax year.
- Review IRS Form 5498-SA, also provided by Cigna, which states your contribution amount for the tax year.
- Complete the HSA contribution IRS Form 8889 and attached it to your federal income tax return.
- Consult your tax advisor for more information about HSA tax requirement.

AVOID PAYING UNEXPECTED FEES AND TAXES

While the HSA offers important tax savings and other advantages, if you don't use your account properly, you could be assessed fees. Here's how to avoid this:

- Check online for your available HSA balance before you withdraw funds or use your HSA debit card.
- Use your HSA debit card at the point of service.
- Issue a check to yourself and/or provider through online bill pay. Contribute no more than the IRS mandated annual HSA limits.



FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by Baker Tilly
Vantagen (BTV)

FSAs let you set aside pre-tax dollars each pay period to pay for covered expenses. You don't pay federal income tax or Social Security tax on your FSA contributions. You can use FSA funds to pay for expenses incurred between January 1, 2027 – December 31, 2027.

SAVE MONEY WITH AN FSA!

The money you contribute to a FSA comes out of your paycheck before taxes. You end up with funds you can use to pay for health and dependent care expenses — and pay less in taxes annually.

MEDICAL HEALTHCARE FSA

If you choose the Base or Buy-up plans, you can open a general-purpose healthcare FSA. You pay into your account through pre-tax paycheck deductions all year and can contribute up to \$3,500* for the 2027 plan year.

* pending IRS confirmation

You can use the account to pay for:

- Medical, dental and vision expenses, including deductibles, copayments and coinsurance
- Prescription drugs
- Over-the-counter drugs
- Medical supplies like bandages and contact lens supplies
- Products like diabetic supplies, hearing aids and wheelchairs
- Services like orthodontia and laser eye surgery

For a complete list of eligible medical care expenses, you may access Publication #502 (healthcare) online at [irs.gov](https://www.irs.gov). You'll receive an FSA debit card you can use to make eligible purchases. Your debit card is loaded with your full account on day one.

HOW DO I PAY ELIGIBLE FSA EXPENSES?

You may pay for eligible expenses in one of two ways, using a debit card or filing a manual claim.

HEALTHCARE FSA DEBIT CARD

Use the debit card to pay for eligible health care expenses at any health care provider or approved merchant. Funds will be taken directly from your health care FSA.

Over-the-counter medicines may only be reimbursed through an FSA if they are prescribed by a physician. There are some exceptions. Insulin and certain other eligible over-the-counter equipment, supplies and diagnostic devices do not require a prescription. However, in most cases, you may not use your FSA debit card for over-the-counter expenses. You will need to use another form of payment and then file for reimbursement.

FSA CLAIM FORM

If you are not able to pay your provider using your FSA debit card, you can submit a claim online, via fax or by mail. You will need your receipts, and for over-the-counter expenses, you must include your prescription. The FSA claim form is available by logging on to myflexdollars.com or by calling **1 (800) 307-0230**

FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by Baker Tilly Vantagen (BTV)

DEPENDENT CARE FSA

The Dependent Care FSA is used to reimburse expenses related to the care of eligible dependents.

- The maximum that you can contribute to the Dependent Care FSA is \$7,500 if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is \$3,750.
- Reimburse for expenses to allow you to work such as after school programs, babysitting/dependent care or adult/eldercare, day camps, and pre-school.

LIMITED PURPOSE FSA

If you are enrolling in the High Deductible Health Plan (HDHP) and elect the HSA, the IRS rules prohibit you from participating in the Healthcare FSA. However, you may elect up to \$3,400 in a Limited Purpose FSA, which can be used for dental and vision expenses only.

FLORES RUNOUT

Please Note: Flores will be handling run-out claims into 2027. Run-out for an FSA is the period after the plan year ends when you can still submit claims for eligible expenses you incurred during that plan year. You may continue to submit reimbursement requests to Flores until 3/31/2027.



DENTAL BENEFITS

Administered by Cigna



	CIGNA HIGH PLAN		CIGNA LOW PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (Individual/Family)	\$0/\$0		\$50/\$150	
Calendar Year Maximum (Per person)	\$1,500		\$1,500	
Preventive & Diagnostic Care	100% covered; no deductible		100% covered; no deductible	
Basic Restorative Care	100% covered; no deductible		100% covered after deductible	
Major Restorative Care	You pay 50%; no deductible		You pay 50% after deductible	
Orthodontia (Eligible children only)	You pay 50%; no deductible		Not covered	
Orthodontia Lifetime Maximum	\$1,500		N/A	
Implants	You pay 50%; no deductible		You pay 50% after deductible	
Reimbursement Levels	Based on contracted fees	90th percentile of submitted charges	Based on contracted fees	90th percentile of submitted charges
Additional Member Responsibility in excess of coinsurance	None	Yes, the difference between the member's dentist's billed charges and the dental plan reimbursement level	None	Yes, the difference between the member's dentist's billed charges and the dental plan reimbursement level

DENTAL PREFERRED PROVIDER ORGANIZATION (DPPPO)

- **Network:** Select any licensed dentist, but see bigger savings if you use a dentist in the Cigna Dental network.
- **Specialist:** See a specialist without a referral
- **Deductible:** An annual amount that may apply to covered services before your plan begins to pay.
- **Coinsurance:** Once you meet your deductible and satisfy any applicable waiting period, this is the portion you will pay of your covered dental care costs.
- **Coverage:** The amount paid by your plan depends on the coinsurance level for the service you receive, the dentist you visit, and whether you've paid your deductible and/or reached your maximum.
- **Maximums:** Once you reach the plan's calendar year dollar and/or any applicable lifetime maximum, your plan will no longer pay a portion of your costs during that plan year.

CIGNA DENTAL VIRTUAL CARE

Get the care you need without leaving home:

If you need dental care and are unable to reach your regular provider, you now have the option to consult with a licensed dentist through a video call. Simply log on to your [myCigna.com](#) account and follow the prompts to the virtual care portal.

- Available 24/7, 365 days a year
- Helps address urgent dental situations like toothaches, infection, gum inflammation, broken teeth and more
- Identifies whether more involved procedures are needed, and helps guide care
- Medications prescribed with guided follow-up care
- Processed as in-network claim on your plan, with no copay or coinsurance costs (but does apply to your plan's annual maximum, if applicable)
- Can be referred to a network dentist for any additional care required.

VISION BENEFITS

Administered by EyeMed

Once enrolled in the EyeMed vision plan, it’s easy to find an eye doctor that fits your needs. Use the Provider Locator at eyemed.com, check your Welcome Kit for a list of nearby providers, or download the EyeMed Members App (available in the App Store and Google Play) to search on the go.

EYEMED VISION PLAN		
	In-Network	Out-of-Network Reimbursement
Vision Exam (Once every plan year)	\$10 copay	Up to \$40
Frames (Once every plan year)	\$0 copay; 20% off balance over \$120	Up to \$84
Lenses <ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal/Lenticular • Standard Progressive • Premium Progressive (Tier 1, 2, or 3) • Premium Progressive (Tier 4) • Premium Progressive (Tier 5) 	\$25 copay \$25 copay \$25 copay \$90 copay \$110, \$120, \$135 copay \$210 copay \$250 copay	Up to \$30 Up to \$50 Up to \$70 Up to \$50 Up to \$50 Up to \$50 Up to \$50
Contact Lenses (in lieu of eyeglasses) <ul style="list-style-type: none"> • Conventional or Disposable • Medically-Necessary 	\$0 copay; 15% off balance over \$140 No charge	Up to \$98 Up to \$300
Lens Options <ul style="list-style-type: none"> • Standard anti-reflective coating • Premium anti-reflective coating (Tier 1, 2, or 3) • Standard polycarbonate (<19 years of age) • Scratch coating (standard plastic) 	\$45 copay \$57, \$68, or \$85 copay \$0 copay \$0 copay	Up to \$23 Up to \$23 Up to \$20 Up to \$8

EXPERIENCE MORE WITH MEMBER TOOLS!

You’ll receive an in-home Welcome Kit detailing your new vision benefits and the closest eye doctors. And using your benefits couldn’t be easier with access to convenient digital tools.



EyeMed Members App

- Benefits, eligibility and claims at-a-glance
- Find an eye doctor and get door-to-door directions
- Grab special offers
- Load and save prescriptions
- Set exam and contact lens reminders
- Pull up ID card and add to your wallet (for iOS only)

Member Website

- See benefits, claims, and eligibility status
- View Savings Dashboard
- Estimate out-of-pocket costs before your visit
- Download ID cards and EOBs
- Find an eye doctor
- Get special offers

LIFE AND AD&D BENEFITS

Administered by New York Life



HOURLY BASIC LIFE AND AD&D

Sweet Oak provides Basic Life insurance to all full-time hourly team members with a payout benefit equal to \$25,000. Accidental Death and Dismemberment (AD&D) provides benefits on serious injury or death if a result of a covered accident. You are provided with AD&D insurance in the amount equal to your Basic Life insurance benefit.

You are automatically enrolled, and this policy is effective upon completion of your new hire waiting period. When making your plan selections, be sure to designate a beneficiary for this benefit.

SUPPLEMENTAL LIFE

In addition to your Basic Life insurance, you may elect to enroll in additional life insurance for yourself in \$10,000 increments up to the lesser of \$500,000 or 5x annual earnings. Supplemental coverage up to \$250,000 does not require evidence of insurability at initial eligibility. The cost of the coverage is based on your age and the amount of coverage elected. Coverage is also available for spouses with coverage amounts between \$5,000 and \$250,000 in increments of \$5,000; not to exceed 50% of employee's coverage amount. Rates are based on the age of the employee at the beginning of the plan year. For children, coverage is available in either the amount of \$5,000 or \$10,000. See Rate Sheet or physical forms for more information.

Any request to add or increase Voluntary Life/AD&D coverage outside of initial eligibility within the 2027 Open Enrollment period will require formal application to be made by completing a New York Life Evidence of Insurability Form. Please contact Human Resources for a copy of this form. Coverage is not effective unless approved by New York Life.

Supplemental Life Age Reduction

Benefit amount reduces to 50% of original coverage when you or your spouse reach age 70; Your payroll deductions will be adjusted to pay premium based on the new benefit amount(s).

TEAM MEMBER / SPOUSE SUPPLEMENTAL LIFE COST PER \$1,000

Age	Cost
Child	\$0.21
<20	\$0.06
20-24	\$0.06
25-29	\$0.06
30-34	\$0.09
35-39	\$0.10
40-44	\$0.12
45-49	\$0.18
50-54	\$0.31
55-59	\$0.51
60-64	\$0.79
65-69	\$1.52
70-74	\$2.46.
75-79	\$2.46.
80-84	\$2.46.
85-89	\$2.46.
90-94	\$2.46.
95-99	\$2.46.

ADDITIONAL VOLUNTARY BENEFITS

Administered by New York Life

Sweet Oak Employees have the option to enroll in several supplemental voluntary benefits through New York Life.

ACCIDENT INSURANCE

Accidents happen and they can affect more than just your physical health. With Accident Insurance, you get a benefit to help pay for costs associated with a covered accident or injury. You may utilize the payments as you best see fit.

Accident Insurance covers:

- Initial & emergency care
- Hospitalization
- Fractures & Dislocation
- Follow-up care

CRITICAL ILLNESS

We know that everyone has different needs when coping with a critical illness. With Critical Illness insurance, you get a benefit paid directly to the covered person, unless otherwise assigned, if they are diagnosed with a covered critical illness, such as:

- Cancer
- Heart attack
- Stroke

This plan can help ease some of your financial worries so you can stay focused on your health. You choose how to spend or save your benefit. It can be used for expenses, such as:

- Paying for childcare or help around the house
- Travel costs to see a specialist
- Medical treatment and doctor visits
- Copays and deductibles
- Prescription drug costs

HOSPITAL INDEMNITY

A hospital stay can happen at any time, and it can be costly. Hospital Indemnity insurance helps you and your loved ones have additional financial protection.

With hospital indemnity insurance, a benefit is paid directly to the covered person, unless otherwise assigned, after a covered hospitalization resulting from a covered injury or illness.

It can be used for expenses, such as:

- Copays
- Deductibles
- Coinsurance
- Unexpected costs
- Childcare
- Follow-up services
- Help for the home

SUPPLEMENTAL DISABILITY

If you had a disabling injury or illness, how much of your income would be at risk? Supplemental Disability Insurance can provide an additional monthly benefit if you experience a covered disability, so you can focus on your recovery — not your finances. The premium is 100% employee paid with post-tax dollars but, under current tax laws, benefits are tax free

BENEFITS MAC

Administered by Conner Strong & Buckelew

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits Member Advocacy Center (Benefits MAC) can help guide the way!

ABOUT BENEFITS MAC

The Benefits MAC, provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company, such as bill, claim or explanation of benefits (EOB)
- Guide you through the enrollment process or how you can add or delete coverage for a dependent
- Rescue you from a benefits problem you've been working on
- Discover all that your benefit plans have to offer

You can contact a Member Advocate Monday through Friday, 8:30 am to 5:00 pm EST at **800.563.9929** or go to connerstrong.com/memberadvocacy and complete the fields.



GLOSSARY OF TERMS

Allowed Amount Maximum

Amount on which payment is based for covered medical services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If an out-of-network provider charges more than the allowed amount, you may be subject to pay the difference. (See Balance Billing).

Balance Billing

When an out-of-network provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. An in- network provider cannot balance bill you for the covered services.

Beneficiary

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

Co-insurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. For example, if your plan has a 30% co-insurance rate, the Carrier will pay 70% of the allowed amount while you pay the balance.

Co-payment

A fixed amount that you pay at the time of service. Copays are most common for emergency room, urgent care and prescription drugs. In some cases, you may be responsible for paying a copay as well as percentage of the remaining charges.

Co-payment Diagnostic Test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

Deductible

The amount you must pay for eligible expenses before your plan begins to pay for benefits. A deductible may be per service/test, per visit, per supply or per coverage year. For example, many plans require an individual to pay \$1,000 in cumulative deductibles before they begin paying out.

Eligible Expense

Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “negotiated rate.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing).

Explanation of Benefits (EOB)

Every time you use your health insurance, your health plan sends you a record called an “explanation of benefits” (EOB) or “member health statement” that explains how much you owe. The EOB also shows the total cost of care, how much your plan paid and the amount an in- network doctor or other healthcare professional is allowed to charge a plan member (called the “allowed amount”).

Generic Drugs

Medications that are comparable to brand name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand name counterparts.

Health Savings Account (HSA)

Similar to a FSA and funded through pre-tax payroll deductions by the employee (and sometimes employer contributions), HSAs are only available to people enrolled in a high-deductible health plan. Unlike a FSA, you don’t “use-it-or-lose-it” – unused balances will roll over and accumulate over time and can be “cashed-out” (taxable implications may apply).

GLOSSARY OF TERMS

Mail Order

Many carriers offer this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can usually obtain a 90-day supply at one time at a lower cost vs. a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your co-pay is almost always cheaper through mail order.

Medically Necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Negotiated Rate

Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “eligible expense.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing).

Non-Preferred Brand Name Drugs

Typically, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand name drug or a generic.

Out-of-Pocket Limit

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

Payment Allowance

Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “negotiated rate” or “eligible expense.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing).

Precertification or Prior Authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable

medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn’t a promise your medical plan will cover the cost.

Preventive Care

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

This information offers a brief outline of benefits and covered services. A complete explanation of covered services, exclusions and limitations is available in your Summary Plan Descriptions.

CARRIER CONTACTS

Have questions about your benefits? We're here to help!

COVERAGE TYPE	CARRIER	PHONE	WEBSITE
Medical	Cigna <i>Group Number: 3347162</i>	800.853.2713	my.cigna.com
Pharmacy	Cigna <i>Group Number: 3347162</i>	800.853.2713	my.cigna.com
Dental	Cigna <i>Group Number: 3347162</i>	800.853.2713	my.cigna.com
Vision	EyeMed	844.873.7853	eyemed.com
Health Savings Account (HSA)	Cigna (Partnered with HSA Bank)	800.244.6224	account.hsabank.com
Flexible Spending Accounts	Baker Tilly Vantagen (BTV)	800.307.0230	myflexdollars.com
Life/AD&D	New York Life	800.225.5695	www.mynyl.newyorklife.com
401(k)	Empower	855.756.4738	participant.empower-retirement.com
Member Advocacy (Benefits MAC Team)	Conner Strong & Buckelew	800.563.9929	connerstrong.com/memberadvocacy
Employee Assistance Program (EAP)	Guidance Resources	800.344.9752	guidanceresources.com <i>Registration Code: NYLGB</i>
Telemedicine	Textcare	678.890.0199	onetoonehealth.com/textcare

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



Sweet Oak reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken 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. If you have any questions about your guide, contact Human Resources.

[Click here](#) or scan the QR code to access legal and compliance notices, including information regarding your prescription drug coverage and Medicare.

