MERCURY INSURANCE
WE ARE ONE TEAM

YOUR CALIFORNIA BENEFITS GUIDE

welcome!

Check it Out!

This electronic and interactive guide will not only help you find information easily, but it's environmentally friendly. The guide works like a website. Click underlined words to jump to more information about that topic. You can also use the arrows in the lower right hand corner to move through the guide at your pace.

This guide provides information about your Mercury benefits … at the click of a mouse! Use this guide as your go-to source when you're first enrolling for your benefits, when changing your benefits at Open Enrollment, or throughout the year as a benefits resource.

You can also visit **mymercurybenefits.com** for links to important resources and contacts, and for more information about the plans.

Questions about benefits enrollment?

Email **mybenefits@mercuryinsurance.com** or call the Benefits Hotline at 877-716-6372, option 3.

This guide provides general benefit plan and enrollment information only. For specific details, conditions, and exclusions; please refer to the official summary plan descriptions (SPD). If there is a discrepancy between this guide and an official SPD, the official document will govern.

Your Benefits

Benefits are an important part of your overall compensation, and we're proud to offer a comprehensive benefits program to our eligible team members. Click the benefit name below for more information about your Mercury benefits:

- Medical
  - Blue Shield PPO $aver/HSA
  - Blue Shield PPO Super $aver/HSA
  - Blue Shield HMO
  - Blue Shield HMO Trio
  - Kaiser Permanente Deductible HMO
- Dental
  - DeltaCare USA DHMO
  - Delta Dental PPO
- Vision
- Lyra
- Work-Life Services
- Health Advocate
- Virta
- Teladoc (for Blue Shield members)
- FSAs
  - Health Care FSA
  - Dependent Care FSA
- Disability Coverage
  - Long-Term Disability
- Life and Accident Insurance
  - Life Insurance
  - Accidental Death and Dismemberment (AD&D) Insurance
- Voluntary Benefits
- My Health

Check out your benefits website! Go to mymercurybenefits.com

This site is your go-to resource for benefits information. It includes plan details, contact information, and links to helpful tools and resources.

Who's Eligible

You're eligible for benefits through Mercury if you work 30 or more hours per week. Eligibility begins on the 1st of the month following your date of hire.

Your Dependents

When enrolling in your benefits, you can also add your eligible dependents. Eligible dependents include:

- Your spouse[1]
- Your registered domestic partner[2]
- Your children up to age 26
- Your children of any age who are permanently disabled.

[1] *Includes both opposite-sex and same-sex spouses.*
[2] *Includes both opposite-sex and same-sex registered domestic partners. Registered domestic partnership certified by the state of California.*

When to Enroll

When You're First Eligible

When you first become eligible for benefits coverage, you must enroll within 30 days of your hire date. If you don't enroll within that time frame, you'll only be enrolled for coverage that's automatically provided (such as long-term disability and basic life and AD&D insurance).

During Open Enrollment

You can enroll during Open Enrollment, which occurs during November of each year. Benefits elected during Open Enrollment will become effective on January 1 of the following year.

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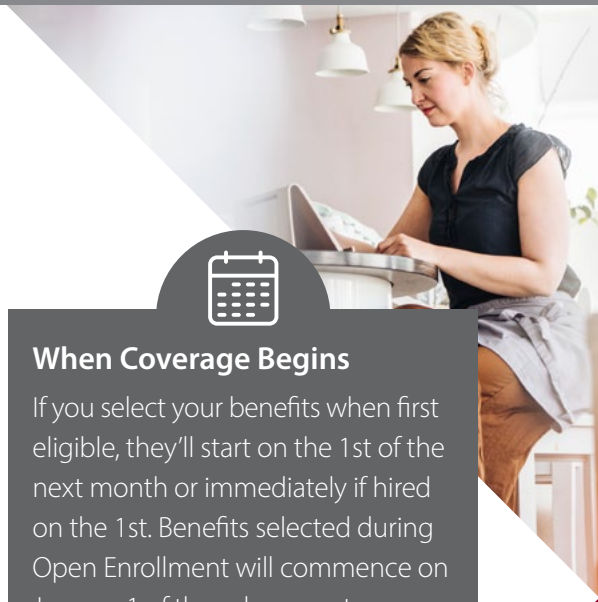

When Coverage Begins

If you select your benefits when first eligible, they'll start on the 1st of the next month or immediately if hired on the 1st. Benefits selected during Open Enrollment will commence on January 1 of the subsequent year.

After a Qualified Family Status Change

During the year, you can only change your benefits when you experience a qualified life event. Qualified life events include:

- Marriage, divorce, or legal separation
- Addition of eligible registered domestic partner, or termination of registered domestic partnership
- A dependent becomes ineligible for coverage elsewhere
- Birth or adoption
- Death of your covered spouse/ registered domestic partner or one of your children
- Change in work status for you or your spouse/registered domestic partner.

You must make the change within 30 days of experiencing a qualified life event. You must provide necessary documentation when applicable (for example, a marriage certificate, birth certificate, or proof of loss of coverage).

If you fail to make a change within 30 days of a qualified life event, you won't be eligible to make a change until the next Open Enrollment period, unless you experience another qualified life event.

YOUR MEDICAL BENEFITS

Mercury offers several medical plan options that provide comprehensive and cost-effective coverage. Click the plan name for more details:

- Blue Shield PPO $aver/HSA
- Blue Shield PPO Super $aver/HSA
- Blue Shield HMO
- Blue Shield HMO Trio
- Kaiser Permanente Deductible HMO

Blue Shield PPO $aver/HSA Plan and Blue Shield PPO Super $aver/HSA Plan

The Blue Shield PPO $aver/HSA plan and the Blue Shield PPO Super $aver/HSA plan are designed to encourage you to be an active participant in your health care decisions. As a result, you'll be more engaged in determining what kind of care you receive, how much, where, and why. This can save money while also increasing the quality of care you receive.

The Blue Shield PPO $aver/HSA plan and the Blue Shield PPO Super $aver/HSA plan have two main components:

High deductible health plan with provider network and features + Health Savings Account = Blue Shield PPO $aver/HSA plan or Blue Shield PPO Super $aver/HSA plan

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Find a Network Provider

To search for providers in the Blue Shield PPO network, go to **blueshieldca.com**.

Check it Out! Visit mymercurybenefits.com for Tips on Using the Blue Shield PPO $aver/HSA Plans

Want to find out how you can use these medical plans to save money and meet your health care needs? Take a look at the resources under the Learn tab at **mymercurybenefits.com**, for ways to maximize your savings and use the medical plan and HSA wisely.

What is a PPO?

A PPO (Preferred Provider Organization) plan provides comprehensive coverage and flexibility for enrollees. With a PPO plan you can go directly to any provider you like within the network, including specialists. However, the plan pays a higher level of benefits when you use providers and health care facilities that participate in the PPO network. This means you'll pay less. The Blue Shield PPO $aver/HSA plans combine this PPO plan with additional cost-saving features, as detailed below.

For details on what the plans cover, see Medical Plans at a Glance.

What are the key features of the PPO $aver/HSA plans?
• The PPO $aver/HSA plans come with a higher deductible.
• These plans let you set up a tax-advantaged Health Savings Account (HSA) for health care expenses.
• They provide 100% coverage for preventive drugs for conditions like asthma and diabetes. Click here to check out a list of eligible prescription drugs.
• Deductibles must be met before these plans cover prescription drugs, excluding certain preventive drugs.
• Deductibles also apply before covering non-preventive doctor visits.
• In the PPO $aver/HSA plans, an individual in a family plan doesn't need to meet the full family deductible. After contributing $3,200, they can access covered services.

To learn more about the Blue Shield PPO $aver/HSA plans, go to the medical plan carrier's website for Mercury enrollees: blueshieldca.com.

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Important Note about Prescription Drugs

Before the Blue Shield PPO $aver/HSA plans cover prescription drugs, you must meet the deductible. Preventive prescription drugs are fully covered at 100%.

Blue Shield PPO $aver/HSA Plan vs. the Blue Shield PPO Super $aver/HSA Plan

Mercury offers two HSA-eligible plans: the Blue Shield PPO $aver/HSA plan and the lower cost Blue Shield PPO Super $aver/HSA plan. The key differences between these plans are how much you pay (for monthly contributions and when you use the plan).

How the Blue Shield PPO $aver/HSA Plan Works

How do your health care expenses get paid? Let's start at the bottom of our Blue Shield PPO Super $aver/HSA "house" and work our way up …

Start Here

Roof: In-Network Annual Out-of-Pocket Maximum[1] (This is the most you pay each year before the plan pays 100%.)		
Team Member Only	$4,500	
Team Member + Spouse/ Registered Domestic Partner[2]	$6,850	
Team Member + Child(ren)[2]	$6,850	
Family[2]	$6,850	
2nd Floor: Coinsurance (If available, you may utilize funding from your HSA to pay your share of the coinsurance amount.)		
In-Network	The plan pays 80%, you pay 20%	
Out-of-Network	The plan pays 60%, you pay 40%	
1st Floor: In-Network Annual Deductible[1]		
Team Member Only	$1,600	• You're responsible for 100% of the deductible. • You may use money in your HSA to pay the deductible amount. • If the deductible amount exceeds the balance in your HSA, you're responsible for the difference.
Team Member + Spouse/ Registered Domestic Partner[3]	$3,200 (or $3,200 for an individual enrolled in team member + spouse/registered domestic partner[3] coverage)	
Team Member + Child(ren)[3]	$3,200 (or $3,200 for an individual enrolled in team member + child(ren)[3] coverage)	
Family[3]	$3,200 (or $3,200 for an individual enrolled in family coverage)	
Foundation: Preventive Care		
All eligible preventive services — such as annual physicals, routine tests and screenings, and well baby care — are 100% covered and **free** to you when you visit Blue Shield in-network providers. And eligible prescription drugs that treat asthma, diabetes, high cholesterol, and hypertension are 100% covered by the Blue Shield PPO $aver/HSA plans — with no deductibles or copays to meet.		

[1] *Includes coinsurance and deductible amounts.*

[2] *Individuals who are enrolled in team member + spouse/registered domestic partner, team member + child(ren), or family coverage will receive 100% coverage for eligible services once the individual out-of-pocket maximum amount is met.*

[3] *An individual enrolled in team member + spouse/registered domestic partner, team member + child(ren), or family coverage won't be responsible for paying more than $3,200 toward the deductible.*

NOTE: Example shows how the Blue Shield PPO $aver/HSA plan works when using in-network providers.

Continued ▶

How the Blue Shield PPO Super $aver/HSA Plan Works

How do your health care expenses get paid? Let's start at the bottom of our Blue Shield PPO Super $aver/HSA "house" and work our way up …

Start Here

Roof: In-Network Annual Out-of-Pocket Maximum[1] (This is the most you pay each year before the plan pays 100%.)		
Team Member Only	$5,000	
Team Member + Spouse/ Registered Domestic Partner[2]	$10,000	
Team Member + Child(ren)[2]	$10,000	
Family[2]	$10,000	
2nd Floor: Coinsurance (If available, you may utilize funding from your HSA to pay your share of the coinsurance amount.)		
In-Network	The plan pays 70%, you pay 30%	
Out-of-Network	The plan pays 50%, you pay 50%	
If funds are available, you may utilize funding from your HSA to pay your share of the coinsurance amount.		
1st Floor: In-Network Annual Deductible[1]		
Team Member Only	$3,200	• You're responsible for 100% of the deductible. • You may use money in your HSA to pay the deductible amount. • If the deductible amount exceeds the balance in your HSA, you're responsible for the difference.
Team Member + Spouse/ Registered Domestic Partner[2]	$6,000 (or $3,200 for an individual enrolled in team member + 1 coverage)	
Team Member + Child(ren)[2]	$6,000 (or $3,200 for an individual enrolled in team member + child(ren) coverage)	
Family[2]	$6,000 (or $3,200 for an individual enrolled in family coverage)	
Foundation: Preventive Care		
100% covered by the plan when you use in-network providers		

[1] *Includes coinsurance and deductible amounts.*

[2] *Under the PPO Super $aver/HSA plan, individuals who are enrolled in team member + spouse/registered domestic partner, team member + child(ren), or family coverage can receive benefits for covered services once the individual deductible is met. In addition, individuals who are enrolled in team member + spouse/registered domestic partner, team member + child(ren), or family coverage will receive 100% coverage for eligible services once the individual out-of-pocket maximum amount is met.*

NOTE: Example shows how the Blue Shield PPO Super $aver/HSA plan works when using in-network providers.

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Health Savings Account (HSA)

The most unique feature of the Blue Shield PPO $aver/HSA plan and the Blue Shield PPO Super $aver/HSA plan is the Health Savings Account (HSA). This is a special bank account that allows you to pay for current and future health care expenses with pre-tax dollars. Here are just a few of the benefits of enrolling in an HSA:

- **You get a contribution from Mercury**
- **Team member contributions are tax-free or tax-advantaged in some states; contributions can be changed on a monthly basis** (contributions are free from federal taxes, but the state of California taxes HSA contributions)
- **Investment earnings are tax-free**
- **Withdrawals are tax-free (for qualified medical expenses)**

The HSA is offered through HealthEquity and is FDIC-insured.

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You receive the Mercury HSA contribution:

- In January, if you're enrolled in the Blue Shield PPO $aver/HSA plan or PPO Super $aver/HSA plan on January 1, 2024.
- On a quarterly basis, if you enroll in either plan during the year as a new hire or due to a qualifying event.

Additional HSA Eligibility Rules

- If you're Medicare-eligible and you choose to enroll in Medicare, Mercury won't be able to make any HSA contributions on your behalf, and you won't be eligible to make HSA contributions either. This is because of tax regulations. If you want to enroll in Medicare, consider enrolling in a non-HSA medical plan to avoid tax issues.
- If you or your spouse are enrolled in your Mercury-sponsored HSA medical plan, neither you nor your spouse can be enrolled in a Health Care Flexible Spending Account (FSA) through Mercury or though your spouse's employer. The government doesn't allow a household in which taxes are filed jointly to use both an HSA and a Health Care FSA.

How the HSA Works

Start It	Build It Up	Use It	Let It Grow	Take It With You
• **Mercury automatically makes a contribution to your HSA.** This contribution will continue each year you enroll in one of the HSA-compatible medical plans.	• **You can deposit your own dollars into your HSA. Contributions are tax-advantaged through payroll contributions!** (Limits apply.*) • You can change the amount you contribute on a monthly basis. • You can also make post-tax contributions.	• You can use the money in your HSA to pay for covered health care with an HSA debit card. • **Withdrawals from your HSA (for qualified expenses) are tax free!** • You don't need to save your receipts for reimbursement — you only need to save them for tax purposes.	• **Unused money in your account will roll over to the next year.** • Your account will earn interest and grow over time. • Once your account reaches $2,000, you may invest your HSA account balance in available mutual funds. • Any interest and other investment earnings are yours to keep.	• **You always own the money in your HSA, including any contributions from Mercury.** • You can take the account with you if you leave Mercury.

** California and New Jersey don't allow HSA contributions to be deducted from state income taxes. New Hampshire and Tennessee tax dividend and interest earnings after a certain dollar amount. Check with your financial advisor to determine how HSA contributions, earnings, and distributions are taxed in your state.*

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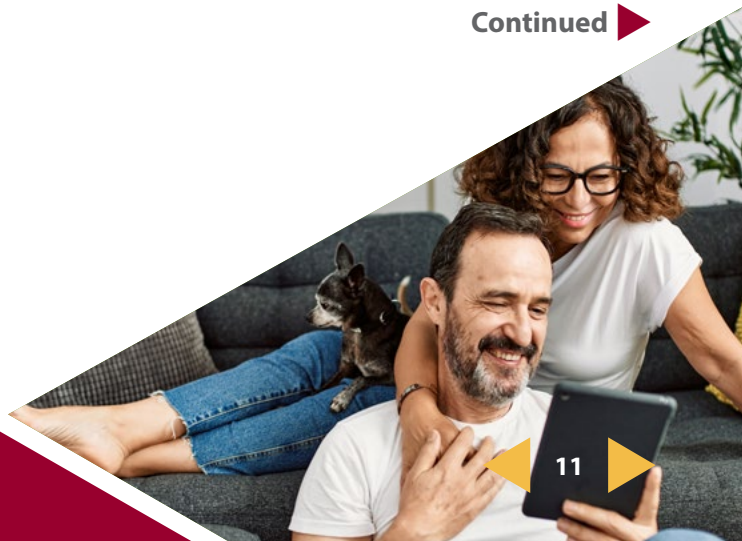


Contribution Limits

Contributions to your HSA come from two sources. All the money in your account is yours to spend on health care. The table below shows the maximum amount that can be contributed to your HSA in 2024.

Tier Level	2024 HSA Contribution Limit	Mercury contributes…	So you can contribute up to…
Team Member Only	$4,150	$600	$3,550
Team Member + Spouse/Registered Domestic Partner*	$8,300	$950	$7,350
Team Member + Child/Children	$8,300	$950	$7,350
Family*	$8,300	$1,200	$7,100

** IRS doesn't consider a registered domestic partner to be a spouse, regardless of state law exceptions. Therefore, you can't withdraw funds tax free to pay for your registered domestic partner's qualified expenses.*

Each year, the maximum amount you can contribute to your HSA may change, per IRS regulations.

Visit healthequity.com for details on the HSA, including lists of eligible and ineligible expenses.

Important! Note for new hires and mid-year enrollees

If you enroll during the year as a new hire or due to a qualified life event, Mercury's contribution to your HSA will be prorated. If you're age 55 or older, you can contribute an additional $1,000 per year.

Did You Know?

It's your responsibility to ensure contributions don't exceed the annual limit. Tax penalties may apply on excess contributions. You should consult your personal tax advisor for questions regarding your HSA and the filing of your tax returns.

Blue Shield and Kaiser Permanente HMO Plans

The HMO plans offer affordable health care for you and your family through a network of health care providers. There are three HMO plans available:

- Blue Shield HMO
- Blue Shield HMO Trio
- Kaiser Permanente Deductible HMO

Plan Features:

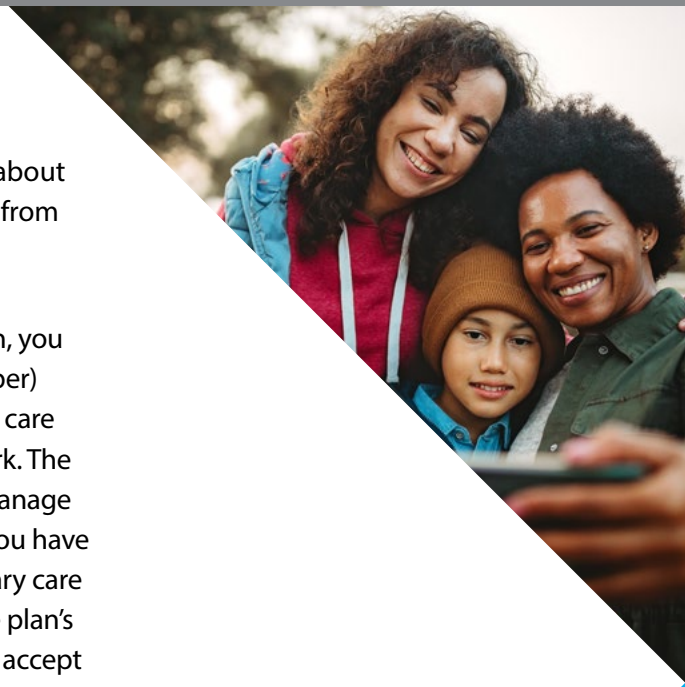
1. Most HMOs have no deductibles or coinsurance, instead, you pay a copay when you visit a provider. Note: The Kaiser Deductible HMO has a $750 deductible, as well as coinsurance for some services. Be sure to review the Medical Plans at a Glance.
2. If you use doctors, hospitals, labs, pharmacies, or other health care facilities outside the HMO, you're responsible for paying the full cost (except in an emergency).
3. There are no claim forms to file.

Here's what you need to know about the difference in receiving care from the plans:

Blue Shield HMO

When you enroll in an HMO plan, you (and each enrolled family member) will be asked to select a primary care physician (PCP) from the network. The PCP you choose will help you manage all aspects of your health care. You have the right to designate any primary care provider who participates in the plan's network and who is available to accept you or your family members.

You must receive all of your non-emergency care from doctors and hospitals in the Blue Shield HMO network, and the care must be under your PCP's direction or the plan won't pay benefits. Women may go directly to a gynecologist in their PCP's medical group or practice association without a referral from their PCP. Care received from an out-of-network provider will not be covered (except for emergency care).



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Blue Shield HMO Trio

The Blue Shield HMO Trio is an accountable care organization, or ACO, plan. Under an ACO, you have a coordinated care team dedicated to your treatment, resulting in many aspects of your care being connected. The result is more consistent, efficient treatment.

With an ACO, you may only see providers in-network. However, you will benefit from integrated care across quality in-network teams who are in communication with each other and committed to supporting your health needs.

When you enroll in the plan, you must select a primary care physician, and that person will communicate directly with any specialists, hospitals, or local doctors you may need to see.

The Blue Shield HMO Trio offers the same medical benefits as the Blue Shield HMO; however, the Blue Shield HMO Trio has lower paycheck contributions. In addition, the Blue Shield HMO Trio features a smaller network of plan providers than the Blue Shield HMO, so it's important to confirm your provider is in network.

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Kaiser Permanente Deductible HMO

Kaiser Permanente Deductible HMO offers lower paycheck contributions with the addition of a deductible and higher annual out-of-pocket maximums.

- **Calendar year deductibles:** $750 team member only or $1,500 ($750 individual) team member + spouse/registered domestic partner, team member + child, or family.
- **Annual out-of-pocket maximums:** $3,000 team member only or $6,000 team member + spouse/registered domestic partner, team member + child, or family.

For most office visits and procedures (e.g. X-ray/lab), the deductible is waived and you only pay a copay similar to other HMO plans. However, for hospital, outpatient, and emergency care, a deductible and coinsurance will apply.

For details on what the plans cover, see Medical Plans at a Glance.

MEDICAL BENEFITS AT A GLANCE

The chart below provides a high-level overview of the most commonly used benefits and the amount you'll pay for certain services.

	Blue Shield PPO $aver/HSA		Blue Shield PPO Super $aver/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Mercury HSA Contribution				
Team Member Only	$600		$600	
Team Member + Spouse/ Registered Domestic Partner	$950		$950	
Team Member + Child(ren)	$950		$950	
Family	$1,200		$1,200	
Calendar Year Deductible				
Team Member Only	$1,600		$3,200	
Team Member + Spouse/ Registered Domestic Partner	$3,200 (or $3,200 for an individual enrolled in team member + spouse/registered domestic partner coverage)		$6,000 (or $3,200 for an individual enrolled in team member + spouse/registered domestic partner coverage)	
Team Member + Child(ren)	$3,200 (or $3,200 for an individual enrolled in team member + child(ren) coverage)		$6,000 (or $3,200 for an individual enrolled in team member + child(ren) coverage)	
Family	$3,200 (or $3,200 for an individual enrolled in family coverage)		$6,000 (or $3,200 for an individual enrolled in family coverage)	
Annual Out-of-Pocket Maximum				
Team Member Only	$4,500[1]		$5,000[1]	$10,000[1]
Team Member + Spouse/ Registered Domestic Partner	$6,850[1,2]		$10,000[1,2]	$20,000[1,2]
Team Member + Child(ren)	$6,850[1,2]		$10,000[1,2]	$20,000[1,2]
Family	$6,850[1,2]		$10,000[1,2]	$20,000[1,2]
Lifetime Maximum	Unlimited		Unlimited	

[1] *Includes the calendar year deductible.*

[2] *If you're enrolled in Team Member + Spouse, Team Member + Child(ren), or Family coverage and you or one of your enrolled dependents meets the individual out-of-pocket maximum amount, the plan will pay 100% of eligible benefit costs for that individual.*

Continued

MEDICAL BENEFITS AT A GLANCE (continued)

	Blue Shield PPO $aver/HSA		Blue Shield PPO Super $aver/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical Care				
Preventive Care[3]	No charge; deductible waived	40% after deductible	No charge; deductible waived	50% after deductible
Office Visits	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Specialist Office Visits	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Hospital Room and Board	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Outpatient Facility	20% after deductible	40% after deductible	30% after deductible	50% after deductible
X-ray/Laboratory	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Chiropractic	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Emergency Room	20% after deductible		30% after deductible	
Urgent Care	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Maternity Care	20% after deductible	40% after deductible	30% after deductible	50% after deductible

[3] *Coverage for preventive health care also includes women's preventive care (e.g., coverage for specified contraceptive methods and counseling; breast-feeding support and equipment; prenatal care; gestational diabetes screening; annual well-woman exam; and annual mammogram).*

Continued ▶

MEDICAL BENEFITS AT A GLANCE (continued)

	Blue Shield PPO $aver/HSA		Blue Shield PPO Super $aver/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs – Retail (30-day supply)[4]				
Generic Formulary	$10 copay after deductible	Not covered	$10 copay after deductible	Not covered
Brand Formulary	$30 copay after deductible	Not covered	$30 copay after deductible	Not covered
Brand Non-formulary	$50 copay after deductible	Not covered	$50 copay after deductible	Not covered
Prescription Drugs – Mail Order (90-day supply)[4, 5]				
Generic Formulary	$20 copay after deductible	Not covered	$20 copay after deductible	Not covered
Brand Formulary	$60 copay after deductible	Not covered	$60 copay after deductible	Not covered
Brand Non-formulary	$100 copay after deductible	Not covered	$100 copay after deductible	Not covered

[4] *The Blue Shield PPO $aver/HSA and the Blue Shield PPO Super $aver/HSA are the only Mercury medical plans that offers 100% coverage for eligible prescription drugs that treat asthma, diabetes, high cholesterol, and hypertension. This means that for eligible prescription drugs, team members and their families will receive free preventive prescriptions — with no deductibles or copays to meet.*

[5] *You can have a 90-day supply delivered through Blue Shield's mail service pharmacy, CVS Caremark.*

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MEDICAL BENEFITS AT A GLANCE (continued)

	Blue Shield HMO	Blue Shield HMO Trio	Kaiser Deductible HMO
Calendar Year Deductible			
Team Member Only	None	None	$750
Team Member + Spouse/ Registered Domestic Partner	None	None	$1,500 (or $750 for an individual enrolled in team member + SP/DP coverage)
Team Member + Child(ren)	None	None	$1,500 (or $750 for an individual enrolled in team member + child(ren) coverage)
Family	None	None	$1,500 (or $750 for an individual enrolled in family coverage)
Annual Out-of-Pocket Maximum			
Team Member Only	$1,500	$1,500	$3,000
Team Member + Spouse/ Registered Domestic Partner	$4,500[1]	$4,500[1]	$6,000[2]
Team Member + Child(ren)	$4,500[1]	$4,500[1]	$6,000[2]
Family	$4,500[1]	$4,500[1]	$6,000[2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited

[1] *If you're enrolled in team member + spouse/registered domestic partner, team member + child(ren), or family coverage and you or one of your enrolled dependents meets the individual out-of-pocket maximum, the plan will pay 100% of eligible benefit costs for that individual. If any enrolled members individually or collectively meet the family out-of-pocket maximum, the plan will pay 100% of eligible benefit costs for all enrolled family members.*

[2] *If you're enrolled in team member + spouse/registered domestic partner, team member + child(ren), or family coverage and you or one of your enrolled dependents meets the individual out-of-pocket maximum amount, the plan will pay 100% of eligible benefit costs for that individual.*

Continued

MEDICAL BENEFITS AT A GLANCE (continued)

	Blue Shield HMO	Blue Shield HMO Trio	Kaiser Deductible HMO
Medical Care			
Preventive Care[3]	No charge	No charge	No charge
Office Visits	$25 copay	$25 copay	$25 copay; deductible waived
Specialist Office Visits	$25 copay	$25 copay	$25 copay; deductible waived
Hospital Room and Board	$250 copay per admission	$250 copay per admission	20% after deductible
Outpatient Facility	$150 copay	$150 copay	20% after deductible
X-ray/Laboratory	No charge	No charge	$10 per encounter; deductible waived
Chiropractic	$15 copay	$15 copay	Not covered
Emergency Room	$150 copay per visit; waived if admitted	$150 copay per visit; waived if admitted	20% after deductible
Urgent Care	$25 copay per visit	$25 copay per visit	$25 copay; deductible waived
Maternity Care Office Visits	No charge	No charge	No charge

[3] *Coverage for preventive health care also includes women's preventive care (e.g., coverage for specified contraceptive methods and counseling; breast-feeding support and equipment; prenatal care; gestational diabetes screening; annual well-woman exam; and annual mammogram).*

Continued ▶

MEDICAL BENEFITS AT A GLANCE (continued)

	Blue Shield HMO	Blue Shield HMO Trio	Kaiser Deductible HMO
Prescription Drugs – Retail (30-day supply)[4, 5]			
Generic Formulary	$10 copay	$10 copay	$10 copay; deductible waived
Brand Formulary	$40 copay	$40 copay	$30 copay; deductible waived
Brand Non-formulary	$70 copay	$70 copay	$30 copay; deductible waived
Prescription Drugs – Mail Order (90-day supply)[4, 5]			
Generic Formulary	$30 copay	$30 copay	$20 copay; deductible waived (up to 100-day supply)
Brand Formulary	$120 copay	$120 copay	$60 copay; deductible waived (up to 100-day supply)
Brand Non-formulary	$210 copay	$210 copay	$60 copay; deductible waived (up to 100-day supply)

[4] *Coverage for preventive health care also includes women's preventive care (e.g., coverage for specified contraceptive methods and counseling; breast-feeding support and equipment; prenatal care; gestational diabetes screening; annual well-woman exam; and annual mammogram).*

[5] *You can have a 90-day supply delivered through Blue Shield's mail service pharmacy,* **CVS Caremark**.

Dental Benefits

Dental coverage is key to your overall health. Eligible team members are offered a choice of two dental plans:

- DeltaCare USA DHMO
- Delta Dental PPO

DeltaCare USA DHMO

The DeltaCare USA DHMO plan works much like the medical HMO plans. When you enroll in a DHMO, you (and each enrolled family member) will be asked to select a primary care dentist (PCD) from the network. To receive benefits, you must see your PCD. When you need to see a specialist, your PCD must refer you to a dentist in the DeltaCare USA network.

Plan Features:

1. You must select and use a primary care dentist (PCD) from the DeltaCare USA network to coordinate your care.
2. There is no deductible or annual dental benefit maximum.
3. Preventive and basic services are covered at 100% with the exception of prophylaxis cleaning, resin restoration, sealants, and space maintainers.
4. If you use a dentist outside the DHMO, you're responsible for paying the full cost because services won't be covered by the plan (except in an emergency).

How the DHMO Works		
Choose Your PCD		
See your PCD or a network provider referred by your PCD	See a DHMO network provider without your PCD's approval	See a provider outside the DHMO network without your PCD's approval
Plan benefits cover services	You won't be covered: You pay 100%	

Find a DHMO Network Dentist

To search for providers in the DeltaCare USA network, go to **deltadentalins.com** or call 800-422-4234.

Continued

Delta Dental PPO

The Delta Dental PPO gives you the freedom to choose any licensed provider. **But keep in mind that you'll save the most money when you use a Delta Dental PPO dentist.** Check out the chart below — it can help you understand the difference between in- and out-of-network providers, so that you can choose the most cost-effective option for you and for your family.

The Dental PPO Path to Care	
See any PPO network provider	See a provider outside the PPO network
After the deductible you'll pay 20% for basic services and 50% for major services	Pay a deductible and coinsurance and get lower plan benefits for covered services

Lowest Costs		Highest Costs
If you go to a dentist in the PPO Network…	**If you go to a dentist in the Delta Dental Premier Network …**	**If you go to an out-of-network dentist …**
• You'll pay the lowest out-of-pocket costs. In-network dentists charge discounted fees, which means you'll save money! • You don't need to complete any claim forms. • You can choose from more than 200,000 dentists nationwide who participate in the PPO Network.	• If there aren't any PPO Network dentists available, you can choose from this network. • You'll pay more out-of-pocket than you would with a PPO Network dentist, but still less than you would with an out-of-network dentist. • You don't need to complete any claim forms. • Nearly 80% of dentists nationwide participate in the Delta Dental Premier Network.	• You'll pay the highest out-of-pocket costs. Delta Dental will only reimburse you for costs that are considered "usual, customary, and reasonable" for a particular dental service in your provider area. This is called the UCR limit. • You'll need to complete claim forms for reimbursement.

Continued ▶

Plan Features:

1. You can choose any dentist, but you'll pay less if you choose a dentist in the PPO network.
2. The plan will pay benefits once you've met the annual deductible. The annual deductible amount varies depending on the type of provider you use and whether you have individual or family coverage.
3. Preventive services are covered at 100%* and aren't subject to the deductible.
4. Once you meet the annual deductible, the plan pays a percentage of the cost of services. The amount the plan pays depends on the type of provider you use.
5. The Delta Dental PPO Plan pays up to $1,500 for covered dental expenses per covered family member each year.
6. The Delta Dental PPO Plan has a lifetime maximum of $1,500 per covered family member for orthodontia services.

Quick Guide to Dental Services	
Diagnostic and preventive services	Regular check-ups (including X-rays), cleanings, and fluoride treatments (for children)
Basic services	Fillings, extractions, sealants, and gum treatments
Major services	Bridges, crowns, and dentures
Orthodontia	Covered for adults and children

** When you use PPO network and Premier Network dentists, this is a percentage of lower, negotiated rates. If you use out-of-network dentists, this is a percentage of UCR limits, which are typically lower than negotiated rates. For all covered services with out-of-network dentists, you must also pay any amount over the UCR limit.*

Continued

Find a PPO Network Dentist

To search for providers in the Delta Dental network, go to **deltadentalins.com** or call 800-765-6003.

Dental Benefits at a Glance

The chart below provides a high-level overview of the most commonly used dental benefits.

Benefit	DeltaCare USA DHMO	Delta Dental PPO	
	In-Network	In-Network	Out-of-Network
Annual Deductible[1]	None	Individual: $40 / Family: $120	Individual: $50 / Family: $150
Annual Maximum Benefit[1]	None	Plan pays up to $1,500 per person/year	
Preventive/Diagnostic			
Routine Examination and Fluoride Treatment	No cost	Plan pays 100%; deductible does not apply	Plan pays 80%; deductible does not apply
Basic Services (Restorative)			
Fillings: Amalgam Composite/Resin	Many services paid at 100% — some subject to copays	Plan pays 80% after deductible	Plan pays 80% after deductible
Simple Extractions	Many services paid at 100% — some subject to copays	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services			
Caps, Crowns, Dentures	Copay as listed in the schedule of covered services and copays	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontia			
Adults	$350 initial diagnostic fees plus $1,800 copay[2]	Plan pays 50% up to $1,500 lifetime maximum benefit; deductible does not apply	Plan pays 50%, up to $1,000 lifetime maximum benefit; deductible does not apply
Children	$350 initial diagnostic fees plus $1,600 copay[2] (for children up to age 19)		

[1] *When you use in-network dentists, this is a percentage of lower, negotiated rates. If you use out-of-network dentists, this is a percentage of UCR limits, which are typically lower than negotiated rates. For all covered services with out-of-network dentists, you must also pay any amount over the UCR limit.*

[2] *Additional fees may apply, please refer to the 2024 DeltaCare USA summary of benefits document for full details.*

PPO members have access to the PPO and Premier network dentists. Premier network dentists cost more than PPO network dentists, but less than non-network dentists. Delta Dental Premier network dentists have agreed not to charge more than the maximum allowed fee for any given procedure — and they've also committed not to balance bill their patients for the difference between the allowed fees and their customary fees.

Vision Benefits

Eligible team members can enroll for vision coverage through VSP. Both plans include coverage for eye exams and eyeglasses or contact lenses, and the Premier Plan offers increased allowances for frames and contact lenses. VSP uses a network of nationwide providers, and you receive a higher level of coverage when you use network providers.

Find a Network Vision Provider

Find the right VSP doctor for you at **vsp.com** or by calling 800-877-7195.

Continued

Vision Benefits at a Glance

The chart below provides a high-level overview of the most commonly used vision benefits.

	Base Plan		Premier Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Exam (Once every calendar year)				
Exam	Plan pays 100% after $20 copay	Plan pays up to $45	Plan pays 100% after $20 copay	Plan pays up to $45
Materials Copay (Once every calendar year)				
Materials Copay	You pay $20 copay before plan pays benefits for frames or lenses		You pay $20 copay before plan pays benefits for frames or lenses	
Frames (Once every two calendar years)				
Wide Selection of Frames	$150 allowance	Plan pays up to $70	$200 allowance	Plan pays up to $70
Featured Frame Brands	$200 allowance		$250 allowance	
Costco Frames	$80 allowance		$110 allowance	
Computer Frames	$140 allowance		$140 allowance	
Discount on Amount Over Allowance	20% discount		20% discount	
Lenses (Once every calendar year)				
Single Vision	Plan pays 100%	Plan pays up to $30	Plan pays 100%	Plan pays up to $30
Lined Bifocal		Plan pays up to $50		Plan pays up to $50
Lined Trifocal		Plan pays up to $65		Plan pays up to $65
Computer Lenses		Plan pays up to scheduled allowance		Plan pays up to scheduled allowance
Contact Lenses (Once every calendar year)				
Contact Lenses	• $150 allowance • You pay up to $60 exam copay	Plan pays up to $105	• $200 allowance • You pay up to $60 exam copay	Plan pays up to $105

Lyra

Lyra offers mental health and emotional well-being services for you and your eligible dependents, all at no cost to you. Services include up to 16 free sessions of therapy, coaching programs, self-care apps, and more. Whether you're feeling stressed, overwhelmed, are struggling in a relationship, or have a child who needs support, Lyra can help.

Support is available online, via live video, and in person. Appointments can be booked online or via email. Just visit mercury.lyrahealth.com to get started.

Work-Life Services

ACI Specialty Benefits Work-Life Services provide a variety of benefits and professional services related to work-life to reduce stress and make life easier. Work-life benefits are free of charge, 100% confidential, and available to all team members and eligible family members regardless of location.

Health Advocate

Health Advocate provides many important services to help you and your family members resolve health care-related issues, balance your life and work and make healthy lifestyle changes. You don't need to enroll in a Mercury medical plan to use Health Advocate. For more information, go to Health Advocate, call 866-695-8622, or email answers@healthadvocate.com. You can also download the Health Advocate mobile app in the App Store or Google Play.

Virta

Virta is a clinically proven treatment that reverses type 2 diabetes. Patients reduce blood sugar and diabetes medications, while losing weight. Virta is available to employees and spouses enrolled in a Mercury medical plan. Learn more at Virta.

Did you know?

Lyra, Work-Life, and Health Advocacy Services are 100% paid by Mercury!

Call Lyra!

Specially trained counselors are available 24/7. Call 877-266-3209.

Contact ACI

Personalized assistance available 24/7. Call 800-932-0034.

Teladoc (for Blue Shield Members)

Available to Blue Shield members, Teladoc is here for you when you need care and can't get to your doctor. You can connect with a board certified doctor via video chat or phone, without leaving your home or office. You can get the care you need, including prescriptions when appropriate, for a wide range of minor conditions, including:

- Colds and flu
- Allergies
- Rashes
- Acne
- Bronchitis
- Urinary tract infections
- Mental health support for depression, stress, addiction, and child/adolescent issues
- And more

The cost of a phone call or visit per consult is:

- Blue Shield HMO: $0
- Blue Shield HMO Trio: $0
- Blue Shield PPO $aver/HSA Plan: $0 ($60 before deductible)
- Blue Shield PPO Super $aver/HSA: $0 ($60 before deductible)

Follow these steps to connect with a doctor:

- Login at blueshieldca.com
- Complete a medical history on the virtual clipboard
- Download the Blue Shield app to access both services on-the-go

Flexible Spending Accounts (FSAs)

FSAs help you make your money go further. You can set aside before-tax dollars to pay for certain out-of-pocket eligible expenses and dependent care costs. Here's how they work:

- You make contributions from your pay on a pre-tax basis. Contributions aren't subject to federal income tax, Social Security tax, and, in most cases, state income tax. This reduces your taxable income.
- The tax savings help offset the cost of eligible health care and dependent are expenses.
- You're not taxed on reimbursements from your FSAs.

Mercury offers two types of FSAs:

- **Health Care FSA** — for all team members **not** enrolled in the Blue Shield PPO $aver/HSA plan or Blue Shield PPO Super $aver/HSA plan. Contribution amounts may not exceed $3,200.
- **Dependent Care FSA** — for all team members with eligible dependents. Funds can be used for child care expenses for dependents under age 13. Contribution amounts may not exceed $5,000 per household.

Continued

Remember!

If you're making contributions to a Health Savings Account (HSA), you can't contribute to a Health Care FSA.

Making FSA Contributions

The annual amount you contribute to your FSA is deducted from your paychecks in equal installments, on a pre-tax basis, from January through December, and credited to your FSA account(s). Reimbursement will be paid through direct deposit or check by PayFlex, the FSA third-party administrator. You don't pay federal, state income, or Social Security taxes on FSA expenses.

Continued ▶

Important! No grace period for 2024 funds.

If you have money left over in your FSA after the 2024 plan year ends, you'll lose the funds. There won't be a grace period, which means you won't have an opportunity to continue incurring and filing claims for eligible expenses into the next plan year. All claims must be incurred by December 31, 2024 and submitted by March 15, 2025.

When estimating your annual expenses, consider only those that you're reasonably certain to incur. Any amount left in your FSA at the end of the year is forfeited. This is called the "use it or lose it" rule.

Health Care FSA

You can use the funds in your Health Care FSA to pay for eligible expenses like deductibles, copays, and coinsurance for you and your eligible dependents. You can contribute up to $3,200 per plan year, before tax. You don't have to have medical, dental, or vision coverage through Mercury to enroll in a Health Care FSA. Be sure to plan your paycheck contributions to coincide with expenses you'll incur during the plan year.

Here are a few common examples of expenses you can reimburse from your Health Care FSA, and others that are ineligible:

Eligible Expenses		Ineligible Expenses
• Ambulance services • Artificial teeth • Chiropractor • Contact lenses • Copays • Crutches • Deductibles and coinsurance	• Hearing aids • Insulin • Laser eye surgery • Long-term care • Menstrual care products • Over-the-counter medications • Prescription drugs • Stop-smoking programs	• Cosmetic surgery (if not medically necessary) • Teeth bleaching • Health care premiums

For a full list of eligible and ineligible expenses, go to payflex.com.

Continued ▶

Health Care FSA (continued)

Remember! If you're enrolled in the Blue Shield PPO $aver/HSA plan or Blue Shield PPO Super $aver/HSA plan, which includes a Health Savings Account (HSA), you **aren't** eligible to enroll in the Health Care FSA. This also applies for your spouse. If your spouse is enrolled in your Mercury-sponsored HSA medical plan, they can't be enrolled in a Health Care FSA through their employer.

Continued ▶

Reimbursements

If you enroll in the Health Care FSA, you'll receive a special debit card you can use for eligible health care expenses. You generally won't need to submit receipts, but you should keep them in case you need to prove your claims for IRS tax audit purposes.

If you don't use your debit card to pay for expenses, you may submit a claim for any eligible expenses. You'll also need to submit receipts. Reimbursements are generally paid through direct deposit or check by a third-party administrator. You do not pay federal, state income, or Social Security taxes on FSA expenses.

Dependent Care FSA

The Dependent Care FSA may be used to pay for expenses you incur for care, which is necessary for work, of dependent children under the age of 13, or any disabled tax dependent who's living with you. In any calendar year, you can contribute before tax, up to $5,000 ($2,500 if married and filing separately). The limit applies to all contributions made by you and your spouse to any dependent care spending accounts through Mercury and any other employer.

Eligible/Ineligible Expenses

You can use your Dependent Care FSA for expenses you pay that allow you (or you and your spouse, if you're married) to work, such as:

- At-home child and elder day care
- Before- or after-school care
- Care at certain child and elder day care centers
- Charges from certain child and elder day care providers
- Pre-school and nursery schools
- Summer day camp

Here are some examples of ineligible expenses:

- Child or elder day care provided by someone living in your home
- Tuition
- Overnight camp

Reimbursements

To be reimbursed, you must save your receipts and submit a claim for any eligible expenses. Reimbursements are generally paid through direct deposit or check by a third party administrator. You do not pay federal, state income, or Social Security taxes on FSA expenses.

Eligible Dependents

An eligible dependent is a person who shares the same primary place of residence with you for more than six months each year and is:

- Your child under age 13 whom you can claim as a dependent on your federal income tax return;
- Your spouse who is mentally or physically disabled; or
- Your dependent who is mentally or physically disabled and whom you can claim on your federal income tax return.

In most cases, your registered domestic partner and children of your registered domestic partner are not considered eligible dependents for purposes of your Dependent Care FSA.

Disability Coverage

Eligible team members are automatically enrolled for long-term disability on the day you become eligible for benefits.

Long-Term Disability

After you have been disabled for 180 days, long-term disability benefits begin. This benefit pays 66 $^{2}/_{3}$% of your salary, up to a maximum monthly benefit of $15,000. (The minimum benefit is the greater of $100 per month, or 10% of the gross benefit.)

Did you know?

Long-term disability coverage is 100% paid by Mercury!

Life Insurance

All benefits eligible team members automatically receive basic coverage. You also have the option to purchase additional coverage for yourself and your eligible dependents.

Basic Life Insurance

Basic Life Insurance is fully paid by Mercury. Coverage is automatic — you don't have to enroll in it. However, you do need to select a beneficiary, who will receive your benefit amount in the event of your death.

The benefit amount is equivalent to your annual salary, rounded up to the nearest $1,000.

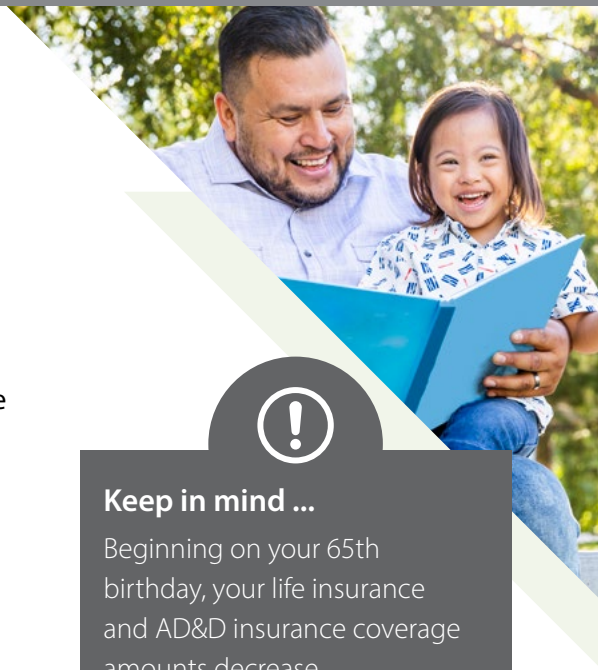
Supplemental Life Insurance

You may choose to purchase additional insurance coverage for yourself through New York Life on a post-tax basis. You can also purchase supplemental coverage for your eligible dependents, however in order to do so, you must purchase supplemental coverage for yourself.

Coverage for supplemental life insurance is available in the following amounts:

Eligible Member	Coverage Amount
Team member	$10,000 increments, to a maximum of $1.5 million
Spouse	$10,000 increments, to a maximum of $50,000 or 100% of the team member's Supplemental Life Insurance amount, whichever is less
Child(ren)*	$2,500 increments, to a maximum of $10,000

** Eligible children include unmarried dependent children under age 21, or under age 24 if the child is a full-time student and primarily supported by the team member. A child who is 21 or older and is incapable of self-sustaining employment due to mental or physical handicap is also considered an eligible dependent.*



Keep in mind ...

Beginning on your 65th birthday, your life insurance and AD&D insurance coverage amounts decrease.

- Age 65 to 79 = 65%
- Age 80+ = 40%

Continued

Evidence of Insurability (EOI)

When you purchase Supplemental Life Insurance for yourself or your spouse, you may need to provide Evidence of Insurability (EOI). EOI is "proof of good health" and certifies to New York Life that you're generally healthy at the time of purchasing coverage.

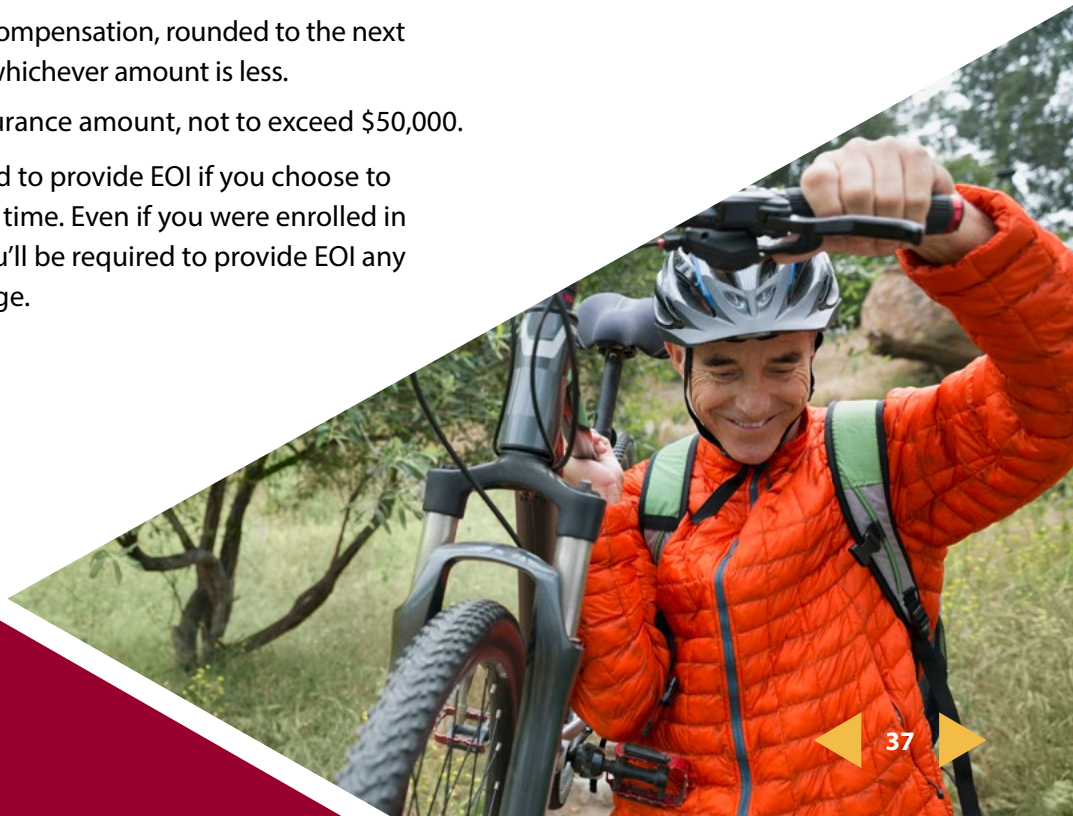
If you purchase supplemental life insurance coverage for you or your spouse when you are first eligible (within 30 days of your hire date), you don't need to provide Evidence of Insurability (EOI) unless you purchase coverage above the guaranteed issue amount:

- **For yourself:** Three times your annual compensation, rounded to the next lower $10,000 increment, **or** $300,000; whichever amount is less.
- **For your spouse:** Equal to your life insurance amount, not to exceed $50,000.

After this 30-day period, you'll be required to provide EOI if you choose to enroll in or increase your coverage at any time. Even if you were enrolled in Supplemental Life Insurance last year, you'll be required to provide EOI any time you request a higher level of coverage.

Important for this Open Enrollment only!

You can elect up to the guaranteed issue amount without providing EOI.



Accidental Death & Dismemberment (AD&D) Insurance

Basic AD&D Insurance

Basic AD&D Insurance is fully paid by Mercury. You must select a beneficiary, who will receive your benefit amount in the event of your death.

The benefit amount is equivalent to your annual salary, rounded up to the nearest $1,000. The maximum coverage amount is $100,000.

Supplemental AD&D Insurance

You may choose to purchase additional insurance coverage for yourself through New York Life on a post-tax basis. This coverage would be in addition to the basic benefit provided by the Company. You can also purchase supplemental coverage for your eligible dependents.

Coverage for supplemental AD&D Insurance is available in the following amounts:

Eligible Member	Coverage Amount
Team member	$10,000 increments, to a maximum of $1.5 million (not to exceed six times your annual salary)
Spouse	$10,000 increments, to a maximum of $50,000
Child(ren)*	$2,500 increments, to a maximum of $10,000

** Eligible children include unmarried dependent children under age 21, or under age 24 if the child is a full-time student and primarily supported by the team member. A child who is 21 or older and is incapable of self-sustaining employment due to mental or physical handicap is also considered an eligible dependent.*

Keep in mind ...

Starting from your 65th birthday, both your and your spouse's supplemental life insurance and AD&D insurance amounts will decrease. Premiums will then be adjusted based on this reduced coverage amount.

- Age 65 to 79 = 65%
- Age 80+ = 40%

Remember to Update Your Beneficiaries

You can update your beneficiaries for life insurance coverage any time in UKG Pro by going to **Myself > Life Events > Add/Change Beneficiary**.

Voluntary Benefits

Mercury offers voluntary benefits for personal legal services, pet insurance, college savings program, hospital care insurance, critical illness insurance, and accident insurance.

Be sure to check out the voluntary benefits video on **mymercurybenefits.com** to learn about optional benefits that offer extra savings and security.

MetLife Legal Plan

MetLife Legal Plan offers access to a national network of over 10,000 professional attorneys. The plan provides coverage for attorney fees for a wide variety of legal services at the price of a low monthly payroll deduction.

If you enroll, this plan covers you and your family members for the following types of personal legal services:

- Personal, confidential legal consultation from an attorney, by office visit, or telephone.
- Family matters, estate planning, debt matters, juvenile matters, traffic matters, consumer protection, and real estate matters.
- Wills, codicils, living trusts, deeds, affidavits, notes, powers of attorney, and other personal legal document review.
- Identity theft protection, privacy management services, unlimited resolution support to fight identity theft and fraud, and replacement services.
- Up to four hours of attorney time and services per year for non-covered matters that are not otherwise excluded under the MetLife Legal Plan, such as divorce, reproductive assistance, and DUI. Time and services exceeding four hours are team member-paid.

If you use an in-network attorney for covered services, the attorney's fees are fully covered by the plan.

For more information about the MetLife Legal Plan, visit info.legalplans.com/6090104/sponsor. You can also access this website by visiting legalplans.com. Click **Thinking About Enrolling?** and enter the password **6090104**.

Continued ▶

Pet Insurance

You can purchase pet insurance to ensure health care coverage for your dog, cat, bird, hamster, or other exotic pet.

With pet insurance, your pets are protected if they are injured or become ill. VPI policies are easy to use and reimburse you for eligible veterinary expenses related to surgeries, hospitalization, X-rays, prescription medications, and more. Best of all, you're free to visit any veterinarian, anywhere in the world.

For more information or to enroll, call 877-738-7874 or visit petsnationwide.com.

Continued

Critical Illness

The group critical illness coverage available from Cigna is an affordable way for you and your family to offset out-of-pocket expenses in the event of a serious health issue. It pays a lump-sum benefit directly to you or your chosen beneficiary upon the first diagnosis of a covered condition (see list below). You can also get a $50 incentive annually for a wellness treatment, health screening test, or preventive care benefit.

Some of the critical illnesses covered under this benefit include:

- COVID-19
- Heart attack
- Major organ failure
- Benign brain tumor
- Blindness
- End-stage kidney failure
- Coronary artery bypass surgery
- Stroke
- Coma
- Permanent paralysis
- Newborn neonatal intensive care

Important! Some of these illnesses have payment and time limitations.

You may choose from the following coverage levels:

- **Team member coverage:** $5,000, $10,000, $15,000, or $20,000
- **Spouse/registered domestic partner coverage:** May be covered at up to 50% of your chosen benefit amount
- **Children up to age 26:** May be covered at up to 50% of your chosen benefit amount.

You can enroll or change your coverage amount only as a new hire or during Open Enrollment. No evidence of insurability (EOI, also known as proof of good health) is required. In the event of a critical illness, you can use this money in any way you choose.

Continued ▶

COVID-19 Services

Critical illness, accident insurance, and hospital care insurance all include coverage for COVID-19 immunization and testing.

Accident Insurance

Cigna's accident insurance is an affordable way to help offset out-of-pocket expenses from life's unexpected events. Even with medical coverage, out-of-pocket expenses such as rehabilitation, transportation, and child care can add up quickly. Accident insurance pays a cash benefit directly to you or your chosen beneficiary in the event of a covered accident. In addition, the plan covers COVID-19 immunization and testing.

You can enroll or change your coverage amount only as a new hire or during Open Enrollment. No evidence of insurability is required.

It's up to you to choose the coverage that's right for you and your family. You can choose from three plans, and your monthly cost will depend on the coverage level and amount you select. No evidence of insurability is required.

Continued

Enrolling for Cigna Critical Illness, Accident, and Hospital Care Insurance

If you're an active team member, you may enroll yourself, as well as your spouse and dependent children up to age 26, in Cigna's critical illness, accident insurance, and/or hospital care. The full benefit cost will be deducted from your paycheck. If you have questions about this coverage or how to submit claims, call Cigna's Customer Contact Center at 800-754-3207.

Hospital Care Insurance

Hospital care coverage through Cigna pays a benefit for medical costs associated with a hospital stay for an illness or injury. Hospital admissions are covered for a maximum of one day, every 90 days. For hospital stays, the benefit is limited to 30 days, every 90 days.

You can select between two plan options, and will pay a different contribution amount on each paycheck depending on which plan you choose and whether you include any family members on your coverage (eligible dependents include your spouse up to age 70, and dependent children up to age 26). You can enroll or change your coverage amount only as a new hire or during Open Enrollment. No evidence of insurability (EOI, also known as proof of good health) is required. The plan details are noted in the table below:

	Plan 1	Plan 2
Hospital Admission	$1,000 per day	$500 per day
Hospital Chronic Condition Admission	$50 per day	$50 per day
Hospital Stay	$100 per day	$100 per day
Hospital Intensive Care Unit (ICU) Stay	$200 per day	$200 per day
Hospital Observation Stay	$100 per 24-hour or pro-rata period	$100 per 24-hour or pro-rata period

My Health

Welcome to My Health, the well-being program that supports you and your loved ones in being the healthiest you can be. Keep reading for details.

This program offers confidential tools and resources for you to track your personal health goals, participate in well-being challenges, have fun, and be rewarded for your efforts.

Check out below and the next page for reward details, and visit myhealthatmercury.limeade.com for more information.

Your Rewards

By participating in *My Health* in 2024, you have a chance to earn big rewards toward your 2025 health care costs. The points you collect during the program year will translate into a dollar incentive (either as supplemental income or an additional HSA contribution from Mercury, depending on your medical enrollment).

There are five reward plan levels available for team members who complete the Wellbeing Assessment (*My Health* activity) during the 2023/2024 program year (October 30, 2023 – October 13, 2024).

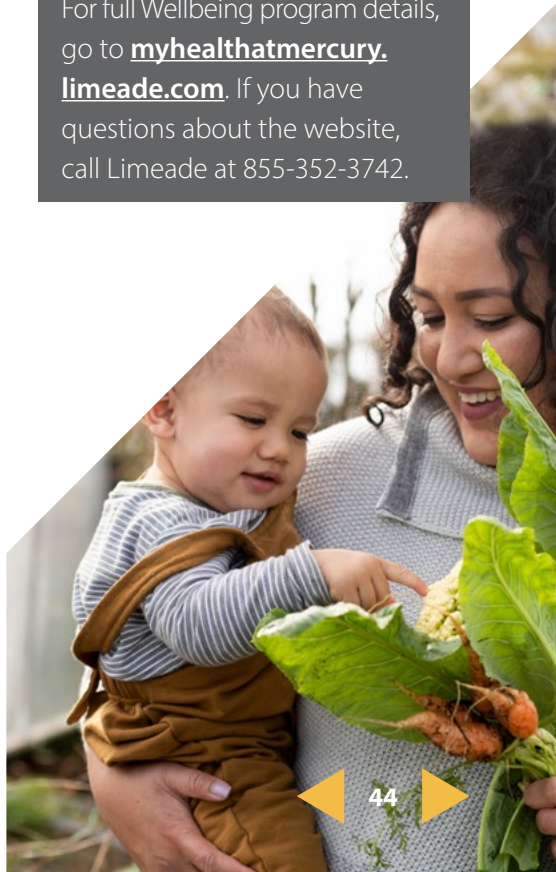
Spouses can participate, too! If your spouse is completes the Wellbeing Assessment (*My Health* activity), he/she can earn up to $200 in incentives.

Continued

Questions?

Contact your local Wellbeing Ambassador or email **myhealth@mercuryinsurance.com**.

For full Wellbeing program details, go to **myhealthatmercury.limeade.com**. If you have questions about the website, call Limeade at 855-352-3742.



My Health

Your Rewards

TEAM MEMBER who completes the Wellbeing Assessment can earn:		
Level	Points	Incentive
Get Started	500	$250 Wellbeing Incentive
Pick Up the Pace	1,000	Total of $350 Wellbeing Incentive
Go the Distance	1,500	Total of $500 Wellbeing Incentive
Lead the Way	2,000	*My Health* item and entry into a drawing for a wellness day off! (3 winners)
Wellbeing Champion	5,000	*My Health* Wellbeing Champion Certificate

SPOUSE who completes the Wellbeing Assessment can earn:		
Level	Points	Incentive
Get Started	500	$100 Wellbeing Incentive
Pick Up the Pace	1,000	Total of $150 Wellbeing Incentive
Go the Distance	1,500	Total of $200 Wellbeing Incentive
Lead the Way	2,000	*My Health* item
Wellbeing Champion	5,000	*My Health* Wellbeing Champion Certificate

MyHealth

2024 Plan Rates

2024 Plan Rates

Mercury is dedicated to providing affordable, comprehensive benefits for our team members.

As you review the 2024 rates, keep in mind that Mercury pays a majority of the cost for all your medical benefits. This cost-sharing arrangement remains very competitive when compared to the cost-sharing arrangement at other companies.

To see the 2024 rates, click here.

How to Enroll or Change Your Benefits

Want to enroll for coverage? You'll need to take action online. Follow these steps to complete the process:

1. Log in through the Intranet or at UKG.
2. Hover the cursor over **Myself** and click **Life Events**.

Verify Your Dependents and Beneficiaries on File

Through UKG, you can verify your dependents and life insurance beneficiaries on file. If you haven't added any dependents or beneficiaries to the system, you must do so before you begin the enrollment process. You can add dependents and beneficiaries in the Contacts section of UKG.

Required Notices

NOTICES

Federal laws require that Mercury provide you with certain notices that inform you about your rights regarding eligibility, enrollment, and coverage of health care plans. The following sections explain these rules; please read them carefully and keep them where you can find them. Click the notice below for more information.

- Availability of Summary Health Information
- Special Enrollment Rights
- Women's Health and Cancer Rights Act of 1998
- Newborns' and Mothers' Health Protection Act
- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Medicaid and the Children's Health Insurance Program (CHIP) Notice

Medicare Creditable Coverage Notice

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. See Your Prescription Drug Coverage and Medicare for details.

This notice advises you that the prescription drug coverage you have through Mercury is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2024. (This is known as "creditable coverage.") Please read this notice carefully and keep it where you can find it.

Health Care Reform and the Individual Mandate

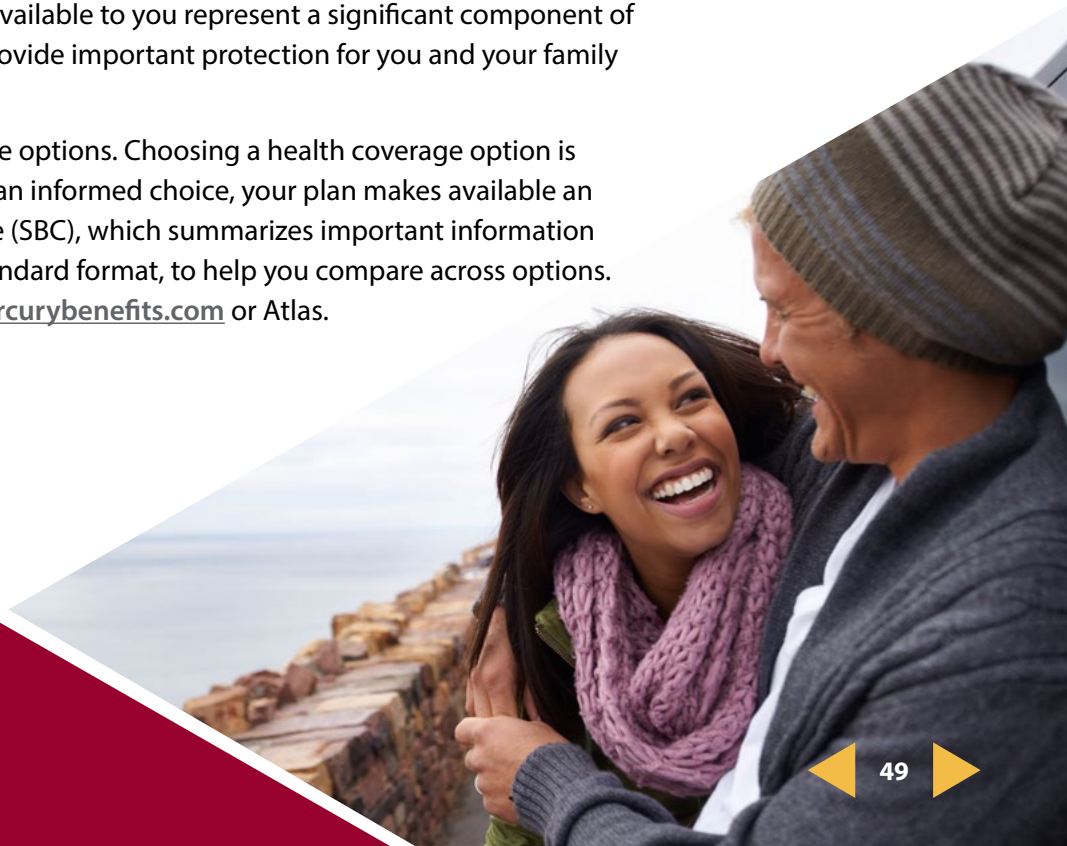
"Health care reform" refers to the Affordable Care Act (ACA), which was passed in 2010. The law is intended to extend access to medical coverage to nearly everyone in the United States, eliminate restrictions on key benefits, and help control the country's rising health costs.

The attached Health Insurance Marketplace Exchange Notice provides information about the individual mandate and your coverage options.

Availability of Summary Health Information

As an team member, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available an online Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. You can access your online SBC on mymercurybenefits.com or Atlas.



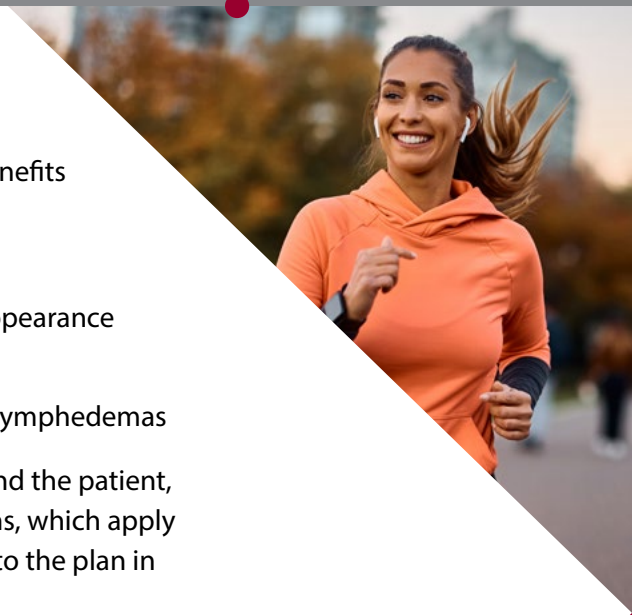
Special Enrollment Rights

Special enrollment events allow you and your eligible dependents to enroll for health coverage outside the Open Enrollment period under certain circumstances if you lose eligibility for other coverage, become eligible for state premium assistance under Medicaid or the State Children's Health Insurance Program (S-CHIP), or acquire newly eligible dependents. This is required under the Health Insurance Portability and Accountability Act (HIPAA).

If you decline enrollment in a Mercury medical plan for you or your dependents (including your spouse/registered domestic partner) because of other health insurance coverage, you or your dependents may be able to enroll in a Mercury medical plan without waiting for the next Open Enrollment period if you:

1. Lose other coverage. You must request enrollment within 31 days after the loss of other coverage.
2. Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
3. Lose Medicaid or Children's Health Insurance Program (S-CHIP) coverage because you are no longer eligible. You must request enrollment within 60 days after the loss of such coverage.

In addition, you may enroll in a Mercury medical plan if you become eligible for a state premium assistance program under Medicaid or S-CHIP. You must request enrollment within 60 days after you gain such coverage.



Women's Health and Cancer Rights Act of 1998

The act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions, which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the plan descriptions.

Newborns' and Mothers' Health Protection Act

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Consolidated Omnibus Budget Reconciliation Act (COBRA)

If you are a team member with medical, dental or vision coverage through Mercury, you have the right to choose continuation coverage if you lose your group health coverage due to reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct. Your eligible dependents may also have the right to elect and pay for continuation of coverage for a temporary period in certain circumstances where coverage under the plan would otherwise end, such as divorce, or dependent children who no longer meet eligibility requirements.

Important Note: This brief summary of the right you and your dependents have to continue insurance is not intended as the official notice of your rights required by federal and state law. We've included this brief summary to inform you that you have these rights. You'll receive a separate, detailed explanation of your right to continue health insurance coverage when applicable. Specific information is also available from Benefits Administration at 909-607-3195.

You can also call 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can contact your state Medicaid or CHIP office or dial 877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at askebsa.dol.gov or by calling toll-free 866-444-EBSA (3272).

If you live in one of the states listed on the following page, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. You should contact your state for further information on eligibility.

Continued ▶

Required Notices

Notices

State / Carrier	Phone	Website
COLORADO — Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**Health First Colorado:** 800-221-3943/State Relay 711 **CHP+:** 800-359-1991/State Relay 711 **HIBI Customer Service**: 855-692-6442	**Health First Colorado:** healthfirstcolorado.com **CHP+:** hcpf.colorado.gov/child-health-plan-plus **Health Insurance Buy-In Program (HIBI):** mycohibi.com
FLORIDA — CHIP	877-357-3268	flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
GEORGIA — Medicaid and CHIP	**Medicaid:** 678-564-1162, press 1 **CHIP:** 678-564-1162, press 2	**Medicaid:** medicaid.georgia.gov/health-insurance-premium-payment-program-hipp **CHIP:** medicaid.georgia.gov/programs/third-party-liability/childrens-healthinsurance-programreauthorization-act-2009-chipra
KANSAS — Medicaid	**Medicaid:** 800-732-4884 **HIPP:** 800-967-4660	kancare.ks.gov
NEVADA — Medicaid	800-992-0900	dhcfp.nv.gov
NEW JERSEY — Medicaid and CHIP	**Medicaid:** 609-631-2392 **CHIP:** 800-701-0710	**Medicaid:** state.nj.us/humanservices/dmahs/clients/medicaid **CHIP:** njfamilycare.org/index.html
NEW YORK — Medicaid	800-541-2831	health.ny.gov/health_care/medicaid
NORTH CAROLINA — Medicaid	919-855-4100	medicaid.ncdhhs.gov
OKLAHOMA — Medicaid and CHIP	888-365-3742	insureoklahoma.org
PENNSYLVANIA — Medicaid	800-692-7462	dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
TEXAS — Medicaid	800-440-0493	gethipptexas.com
VIRGINIA — Medicaid and CHIP	800-432-5924	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select **CHIP:** coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
WASHINGTON — Medicaid	800-562-3022	hca.wa.gov

To see if any more states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa | 866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov | 877-267-2323, Menu Option 4, Ext. 61565

Contact Information

Contact Information

If you have questions about your benefits, contact the appropriate carriers below.

Benefits Plan	Description	Carrier	Website / Contact
Company Paid			
Company Wellbeing Program: *My Health*	Total wellbeing program for TM's and spouses with rewards and dollar Incentives	Limeade	myhealthatmercury.limeade.com myhealth@mercuryinsurance.com 855-352-3742
Mental/Behavioral Health	Addresses stigma, drives awareness, up to 16 free therapy sessions per year	Lyra	mercury.lyrahealth.com 877-266 3209
Basic AD&D Life Insurance	Life Insurance, 1x annual salary up to a 100K	New York Life	myNYLGBS.com 800-362-4462
Long-Term Disability	Pays portion of salary when TM is unable to work due to illness/injury. Disability waiting period is six months.	New York Life	myNYLGBS.com 800-362-4462
Short-Term Disability	Available to TM's outside of CA. Disability waiting period is seven days.	New York Life	myNYLGBS.com 800-362-4462
Employee Assistance Program	Work-Life Services	ACI Specialty Benefits	acispecialtybenefits.com 800-932-0034
Health Advocate	Help with provider network, appointments, claims, medical records transfer, eldercare, medicare, cost estimate, etc.	Health Advocate	healthadvocate.com 866-695-8622
Financial Wellness Program	Assisting TM's with finances	Morgan Stanley	Welcome to Morgan Stanley Financial Wellness 866-885-8016
Shared Cost			
Medical	HMO and PPO High Deductible Plan options	Blue Shield & Kaiser Permanente	blueshieldca.com/mercury 855-747-5800 kp.org 800-464-4000
Virtual Medical Care	Teladoc (for Blue Shield members)	Blue Shield	blueshieldca.com/teladoc 800-TELADOC (835-2362)

Continued

Contact Information

Benefits Plan	Description	Carrier	Website / Contact
Shared Cost (continued)			
Dental	DHMO and PPO Dental Plan options	Delta Dental	deltadentalins.com DHMO: 800-422-4234 PPO: 888-335-8227
Vision	Basic and Premier Vision Plan options	VSP	vsp.com 800-877-7195
401(k) Plan	Retirement Plan with Employer Match Contribution (401(k), Roth)	Fidelity	netbenefits.com 800-835-5095
Prediabetes and Type 2 Diabetes	Reversing type 2 diabetes and prediabetes	Virta	virtahealth.com/join/mercury support@virtahealth.com
Health Savings Account (HSA)	Available only with High Deductible Medical Plans	Health Equity	healthequity.com 877-857-6810
Voluntary			
Pre-Paid Legal	Provide access to legal expertise for both expected and unexpected events	MetLife Legal	info.legalplans.com 800-821-6400
Pet Insurance	My Pet Protection Mercury Discount Plan	Nationwide	petsnationwide.com 877-263-6008
Critical Illness	Provides cash benefits when person is diagnosed with critical illness	Cigna	cigna.com 800-754-3207
Accident Insurance	Provides cash benefits when person is injured due to accident	Cigna	cigna.com 800-754-3207
Hospital Indemnity	Provides cash benefits when person incurs hospital stay due to illness/injury	Cigna	cigna.com 800-754-3207
Supplemental Life and AD&D (TM and Family)	Voluntary Life Insurance	New York Life	myNYLGBS.com 800-362-4462
Health Care and Dependent Day Care Flexible Spending Accounts (FSA)	Pre-tax, IRS regulated. The simple way to save for dependent day care and health (excluding HDHP) care expenses.	PayFlex	payflex.com 844-729-3539
College America — 529 College Savings Program	Saving for qualified higher education expenses for TM/Dependent	American Funds Service Co.	americanfunds.com 800-412-4225