SENIOR SERVICES

2026

BENEFITS GUIDE

Welcome!

We are pleased...

to announce the launch of our annual benefits program, a time when we come together to review and select the benefits options for the upcoming year.

We understand the importance of providing comprehensive and competitive benefits that support the well-being and financial security of our valued employees. This guide has been designed to assist you in making informed decisions about your benefits.

We encourage you to take the time to explore the various benefits available, share with family members in your household, and make choices that align with your personal goals and priorities. **Your well-being is our priority, and we are committed to providing you with a benefits package that supports your overall health, happiness, and success.**

Sincerely,

Senior Services

Check out the quick highlights for the 2026 plan year

Medical	Medical will remain as an ICHRA plan.
Spending Accounts	IRS contribution amounts for Flexible Spending Accounts have increased.
Dental	Dental coverage is now through Pacific Life.
Vision	Vision coverage is now through Pacific Life.
Life Insurance	There are no changes to carrier or plan design.
Additional Benefits	Accident, Critical Illness, Hospital Indemnity are now through The Hartford.

Eligibility & Enrollment

Who is eligible for benefits?

Full-time employees working 30 hours or more per week and their eligible dependents are eligible to enroll in the benefits outlined in this guide. Part-time employees who regularly work at least 40 hours per pay period (20 hours/week) will be eligible to elect Voluntary Vision, Voluntary Dental, Voluntary life, Voluntary Short-Term Disability, Accident, Hospital Indemnity and Critical Illness benefits for themselves and their eligible dependents. All employees are eligible for the Employee Assistance Program.

Eligible dependents may include:

- Your legal spouse
- Your children up to age 26

Can I make a change after submitting my benefit elections?

Unless you experience a qualified event, you cannot make changes to your benefit elections until next year's open enrollment period. Please notify SureCo and your HR Representative within 30 days of your qualifying event or for questions about qualifying events.

Examples of qualifying life events:

- ✓ Marriage or divorce
- ✓ Aged off parent's plan
- ✓ Birth or adoption
- ✓ Change in dependent status

This Benefit Guide gives you a summary of your benefit offerings for the new year. It's sourced from summary plan descriptions and benefit details, but keep in mind that there might be some differences. If there's any confusion, the actual plan documents are the final word.

Eligibility & Enrollment

When do I enroll?

The annual open enrollment period is November 13 – 20th, 2025.

If you are enrolling during the open enrollment period, this is an **active enrollment,** meaning you must elect benefits to be enrolled in 2026 year, or you must decline if you wish not to enroll.

If you are hired after the open enrollment period of November 13 – 20th, 2025, your benefits will begin the first of the month following 30 days from your date of hire.

The benefits you elect either during open enrollment or the new hire period will be effective through December 31, 2026.

How do I enroll?

For Medical enrollment, please see page 6 for more detailed instructions.

For Ancillary Benefit enrollment follow the below instructions:

1. Login to https://www.employeenavigator.com/benefits/account/login using your existing username and password if you've logged into the system before. If you are a new user, click on "Register as a new user" and provide the following information:
2. Your first and last name
3. Company Identifier: SeniorServices
4. The last 4 digits of your Social Security Number / ID
5. Birth Date in (mm/dd/yyyy) format
6. Click "Start Enrollment" to begin the enrollment process and enter your personal and dependent information.
7. Walk through each step of the enrollment and click "Save & Continue" at the bottom of each screen to save your elections.
8. If there is a benefit you do not wish to enroll in, click "Don't want this benefit?" at the bottom of the screen.
9. Once you have finished, review the benefits you have elected and click to sign and complete your enrollment.

employee NAVIGATOR

Additional enrollment instructions can be found here!

Core Benefits

ICHRA

Senior Services offers an Individual Coverage Health Reimbursement Arrangement (ICHRA) plan for you and your eligible dependents.

Senior Services has partnered with a third-party administrator, SureCo, to provide our employees with the "Power of Choice" regarding your medical benefits. SureCo's Enrollment Platform leverages the existing direct to carrier market to provide you with the most plan choices as possible. You will be able to choose from a selection of individual plans offered in your state for you and your dependents with your portion of the premium withheld from your paycheck as pre-tax payroll deduction.

The Power of Choice

INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENT

With the introduction of Individual Coverage HRA, you can purchase your own individual plan and your employer can still contribute to the cost –all pre-tax.

With SureCo's Enrollment Platform, you will have access to the right coverage for the right price that fits your needs.

Choose from a variety of medical carriers with various plan structures and premiums (pre-tax), in the individual market.

Shop and Enroll Online

SURECO ENROLLMENT PLATFORM

SureCo's Enrollment Platforms makes it easy to browse and make your choices. All medical plan descriptions are available on the platform.

Depending upon which medical carrier and plan you elect; your pharmacy services will accompany that carrier's pharmacy policies, preferred vendors, and formularies.

Please log into SureCo's Enrollment Platform to view all Summary Plan Disclosure Documents and Pricing.

Senior Services Employer Monthly Contribution

Senior Services contributes a set percentage to each eligible and enrolling employee's medical insurance. The amount contributed will vary by employee and is based on the available plan costs given the age and location of the employee, as described below.

Senior Services contributes 114% of the lowest cost silver plan for each employee.

**LCS = lowest cost silver plan. Monthly premiums for all ICHRA plans are calculated based on the age and rating area of employee. SureCo's Enrollment Platform will identify the LCS tier plan available for employee and calculate the corresponding percentage. That amount will be used as the employer contribution.*

SureCo's Enrollment Platform – Medical Benefits Enrollment Instructions

Senior Services will be utilizing separate enrollment portals for its medical and ancillary enrollments. The following pages contain important information about SureCo's Enrollment Platform that will be exclusively utilized for our employees' medical benefit elections. Please refer to the Ancillary Benefits section of this guide on Page 4 for details about the Employee Navigator platform to complete your ancillary elections.

enrollme.sureco.com

HOW TO REGISTER:

- A welcome email and log in instructions for the Enrollment Platform will be sent on the first day of your open enrollment period.
- Go to the link above during your scheduled open enrollment period.
- If you have a previous login and password, you may use that. If forgotten password, click forgot password link.
- For new users, click the "*New User? Sign up here*" link which will advance you to the sign-up page.
- Enter the following information to register your account:
    - Email address
    - Phone number
    - Zip code
    - Date of birth
    - Last 4 digits of social security number (SSN)
- Create your password!

If you do not visit the Enrollment Platform by 5pm on the final day of your open enrollment period, you will automatically decline health coverage for the remainder of the calendar year and will be asked to sign the employee health insurance waiver form.

THINGS TO CONSIDER BEFORE CHOOSING A PLAN

To help you find the plan that's right for you, consider more than just the plan's monthly premium. We have prepared the following FAQ's to better prepare you for making your medical elections.

What matters the most to you? Here's a list of things to consider when choosing a plan that works for you:

- Referral required to see a specialist **vs.** Can see a specialist without a referral
    - **Why It Matters:** Some plans require you to get a referral from your primary care physician before seeing a specialist. This can slow down your access to necessary care, especially in urgent situations. On the other hand, having the freedom to see a specialist without a referral means quicker access to specialized treatment, which can be vital for managing health issues effectively.
- 20% coinsurance (% of the bill you pay) **vs.** 50% coinsurance
    - **Why It Matters:** Coinsurance is the percentage of costs you pay after meeting your deductible. A plan with 20% coinsurance means you'll pay a smaller share of your healthcare costs, making it more affordable when you need care. Conversely, a 50% coinsurance means you'll be responsible for a larger portion of your bills, which can add up quickly, especially if you require frequent medical attention.
- Copays from the beginning **vs.** Pay full cost until you reach the deductible
    - **Why It Matters:** Plans that require copays allow you to know upfront what you'll pay for a doctor's visit or prescription, providing more predictable healthcare expenses. If your plan has no copays and requires you to pay the full cost until you reach your deductible, it can be challenging to budget for healthcare costs, especially if you need care early in the year.
- Low premium with high costs for care **vs.** High premium with low costs for care
    - **Why It Matters:** A low premium might seem attractive, but it can come with high out-of-pocket costs when you seek care. This can lead to financial strain if unexpected medical expenses arise. conversely, a higher premium often means lower costs when you do need care, which can be a better option for those who anticipate needing more medical services.

- Your doctor in network **vs.** Finding a new doctor
  - **Why It Matters:** Staying with your current doctor can be important for continuity of care, especially if you have an established relationship and ongoing health issues. If your preferred healthcare provider is out of network, you may face higher costs or need to switch to someone new, which can disrupt your care and require adjustments to your treatment plan.

Is it important to you to keep your current providers?

- If you are interested in trying to elect a new plan that has your current providers in network, make sure to make a list of those providers/hospitals before OEP starts.
- A lot of employees have questions about which plans their existing provider or hospital will accept: The Enrollment Platform will allow you to search for plans that your current provider(s) are in network for, and participating in. This will help you weed out plans that may not suit you.; however, it is recommended that YOU CALL your doctor to confirm eligibility in the specific Individual Health Plan.
- SureCo uses a 3rd party network database to populate provider data – and they cannot guarantee that all plan and provider data has been updated at the time an employee is researching. Since providers leave and join plans often, we highly recommend that you play it safe and call your doctor to confirm they currently accept your plan.

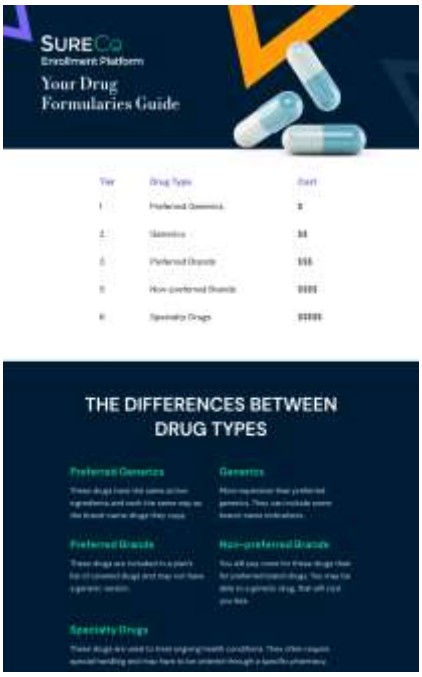
Are your medications covered?

- Health insurance plans vary on which medications they cover and how much they will charge. Each insurance company has a list of prescriptions they cover (called a formulary or drug list) on their website. Whether you pay a copay or have to pay full price for a drug will depend on which plan you choose.

NEED HELP? SURECO IS HERE FOR YOU:

For questions related to the Enrollment Platform, your ICHRA medical plan coverage or for support enrolling in a medical plan, please contact SureCo's Employee Experience Team.

- Email: employee.experience@sureco.com
- Phone: 949-989-4906



SureCo's Enrollment Platform Step-by-Step Process

1. Log in and acknowledge user agreement
2. Start by confirming your personal information
3. Then edit/add any dependents
4. Select a Provider (if desired)
5. Next... start shopping for a medical plan by scrolling through available options
6. Lastly...confirm your selections and electronically sign and check out your cart

PERSONAL INFORMATION:

- It is critical that you verify the demographic details for yourself and any dependents. Key fields that will impact your health plan selections and rates include date of birth, zip code and county.
- Please make sure that you are using your physical address where you reside – health providers will verify and reject addresses that are mailing addresses, business addresses or PO Box.
- If you want to include dependents such as spouse, domestic partner, or child on your health plan, please click the "Add a Dependent" button to add everyone's details into the system. Just like with your account, the pricing for the available plans will be based on the age and address of the dependent.
- The Platform is equipped to "split" families into groups when family members live in different rating areas. This will allow you to shop for separate health plans by "group" to ensure each member gets the best coverage available to them in their area.

PROVIDER SEARCH:

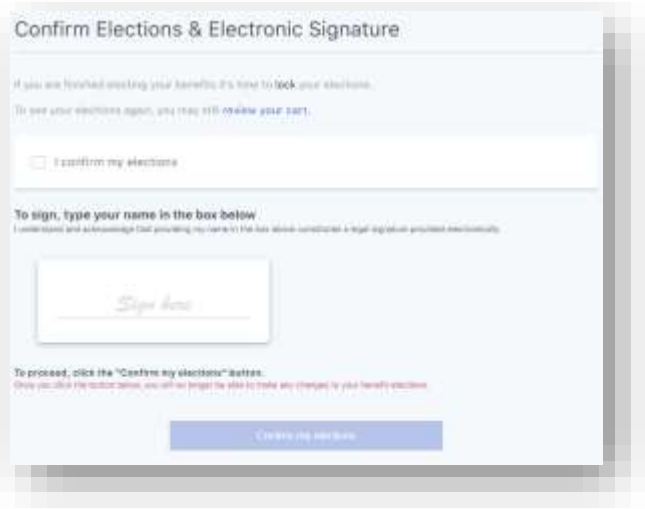
- If you are interested in keeping your current providers, the Enrollment Platform will allow you to search for plans that your current provider(s) accepts. Since providers leave and join plans often, we highly recommend that you play it safe and call your doctor to confirm they currently accept the plan you select.
- **If you prefer, you can also contact the specific carrier (such as Florida Blue or United Healthcare) or visit their website to view a list of participating providers.**

BENEFIT SELECTIONS:

- When you log into the Enrollment Platform, the plans and prices that you see will be based on the demographic details you entered in the personal profile.
- The per paycheck cost displayed in the Platform will include your employer's contribution.
- When shopping for medical plans in the individual market, you'll notice they are classified by metallic colors—Bronze, Silver, Gold, and Platinum. These colors represent different coverage tiers, each designed to meet varying healthcare needs and budgets. A Bronze plan typically has lower premiums but higher out-of-pocket costs when you access care, while a Gold plan generally has higher premiums but lower costs when you need to use your insurance. The best choice for you will depend on how frequently you expect to utilize your healthcare services."
- To fully understand what each plan covers and what you would pay for covered services under that plan, you should view the (SBC) Summary of Benefits and Coverage available by clicking the Benefits Summary button.
  It is very important for every employee to educate themselves on health terminology. Now, more than ever, it is important that you take time to learn about your health benefits.

FINISH ENROLLMENT AND CONFIRM BENEFITS:

- This is the final step in the enrollment process. Please make sure to confirm your elections!
- Even if you declined health coverage, or have elected Medicare, it is important to electronically sign the acknowledgement on this page to Confirm and Submit your Elections for the year.



Spending Accounts

Flexible Spending Accounts (FSA)

FSAs provide you with an important tax advantage that can help you pay for expenses on a pre-tax basis. By anticipating your family's costs for the next year, you can actually lower your taxable income. If you were previously enrolled in an FSA with Flores, you will not get a new FSA card unless the card is set to expire.

You must enroll in your FSA every year to contribute. Your FSA plan options are shown below.

Healthcare FSA

- Allows employees who are not enrolled in an HDHP or contributing to an HSA to pay for certain IRS-approved medical care expenses with pre-tax dollars.
- **Employees are eligible to contribute a minimum of $200 up to the maximum contribution of $3,400. Funds can be used for eligible health care related expenses, including medical, dental and vision expenses.**
- **$680 Roll Over Amount**

Dependent Care FSA

- Allows employees to use pre-tax dollars toward qualified dependent care such as caring for children under age 13 or caring for elders.
- **The annual contribution maximum is $7,500 (or $3,750 if married and filing separately).**

Health & Wellness

Employee Assistance Program (EAP)

All employees are eligible for this benefit!

Reach out to Guardian 24/7 toll free at +1855-239-0743, or you can visit their website at www.guidanceresources.com.

The App: GuidanceNow and Web ID: Guardian

Dental

Below provides an overview of your available dental plan. Using an in-network provider will offer you the lowest service pricing. Age and frequency limits may apply to some services. Please refer to your plan document for specific details and note that out-of-network providers can balance bill you the difference between what they charge and the carrier's **reasonable and customary amount.**

	Dental Plan PPO
Benefits	In-Network
Calendar Year Deductible Individual / Family	$50 / $150
Calendar Year Benefit Maximum	$1,500 per covered member
Preventive Services Routine Oral Exams, Cleanings, Bitewing X-rays, Fluoride Application, Sealants, Space Maintainers	Covered at 100% of usual and customary Deductible does not apply
Basic Services Routine Fillings, Simple Extractions, Endodontics, Periodontics	Covered at 80% of usual and customary $50 deductible applies
Major Services Crowns, Inlays and Onlays, Dentures, Implants	Covered at 50% of usual and customary $50 deductible applies

Your Cost - Biweekly Employee Deductions				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Dental Plan	$16.19	$32.39	$39.56	$60.60

Locate an in-network provider at www.pacificlife.com

Rollover Benefit

The rollover benefit is determined at the beginning of a new benefit year and may be used to pay for services. To qualify for the Rollover benefit, in the previous benefit year: benefits were paid and the member has at least one cleaning and benefits paid for services did not exceed the rollover threshold. If there is a break in coverage for any reason, the rollover benefit amount accumulated will be lost.

- Rollover Threshold: $700
- Rollover Amount: $325
- Rollover Maximum: $1,300

Vision

Below provides an overview of your available vision plan. Using an in-network provider will offer you the lowest service pricing. Frequency limits may apply to some services. Please refer to your plan document for specific details and note that out-of-network providers can balance bill you the difference between what they charge and the carrier's reasonable and customary amount.

	Vision Plan EyeMed Insight Network
Benefits	**In-Network***
Exam	$10 copay
Frames	$130 allowance + 20% off balance
Lenses	$25 copay
Contact Lenses Conventional Medically Necessary	 $130 max no copay $25 copay
	Frequency of Services
Exams	Once per calendar year
Frames	Once per calendar year
Lenses or Contacts	Once per calendar year

Your Cost - Biweekly Employee Deductions				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Vision Plan	$2.99	$5.69	$5.98	$8.80

Locate an in-network provider at www.pacificlife.com/vision

You have the freedom to choose any provider within the EyeMed Insight network. Pacific Life's network offers the right mix of independent providers, regional retailers, and national retailers including:

- LensCrafters
- Pearle Vision
- Target Optical

Shop online and stay in-network at LensCrafters.com, Glasses.com Ray-ban.com Targetoptical.com, Contactsdirect.com.

Supplemental Health Benefits

The supplemental health benefit options below can be used to customize your coverage to complement your medical plan options. If you elect any of the voluntary options below, you will be responsible for the cost of the benefit. For more information on rates, please see your enrollment site. Accident, Critical Illness, and Hospital Indemnity all offer a wellness benefit of $50 as an incentive for completing an annual preventive screening exam. Submit your EOB to The Hartford and receive your $50 check in the mail.

Accident Insurance

Accident Insurance pays a lump-sum benefit directly to you based on the type of injury sustained and treatment needed. This policy includes a Wellness Benefit Amount for you and your dependents. Accident coverage can help to reimburse you for expenses like:

- ✓ Ambulance transportation
- ✓ Coverage for medical expenses, hospital stays, and surgeries
- ✓ Therapy charges and rehabilitation costs
- ✓ Income protection in the event of temporary or permanent disability
- ✓ No medical exam required for quick and easy coverage

Wellness Benefit:
$50

Your Cost - Biweekly Employee Deductions			
Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
$2.13	$3.37	$3.62	$5.68

Critical Illness Insurance

Critical Illness pays a lump sum benefit directly to you upon diagnosis of a covered illness after the plan's effective date of coverage. There are multiple payouts automatically included and a benefit can be paid for each covered condition. Coverage includes a Wellness Benefit Amount for you and your spouse/dependents. Critical illness coverage helps cover expenses related to the diagnosis of:

- ✓ Cancer
- ✓ Heart attack
- ✓ Kidney failure
- ✓ Blindness
- ✓ Coma

Wellness Benefit:
$50

Hospital Indemnity Insurance

This plan works as a supplemental insurance plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. This plan pays cash directly to you to cover out-of-pocket expenses. The payments can be used for any purpose including medical copays, deductibles, or regular expenses (food, rent, utilities). There is a $50 Wellness Benefit for you and your dependents once per year!

Wellness Benefit:
$50

Your Cost - Biweekly Employee Deductions			
Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
$4.55	$8.68	$7.23	$11.86

Life & Disability

OneAmerica Basic Life and AD&D Insurance

Full-time employees receive employer-paid group life and accidental death and dismemberment (AD&D) insurance in the amount of $25,000. Your benefit amount does not reduce with age! Don't forget to keep your beneficiaries up to date.

OneAmerica Voluntary Life and AD&D Insurance

In addition to the Basic Life and AD&D Insurance provided to employees by Senior Services. you have the option to purchase additional voluntary life and AD&D insurance in the increments listed below through the convenience of payroll deduction. Employee and spouse benefits begin to reduce at employee age 65; employee and spouse rates are based on employee age. Employees must be enrolled to enroll dependents.

Voluntary Life & AD&D Insurance	
Evidence of Insurability	If you elect when first eligible, you may elect coverage up to the Guaranteed Issue amount without having to answer any medical questions. Therefore, if this is outside of when you were first eligible and want to add or increase coverage, then you will need to complete an Evidence of Insurability (EOI) form.
Guaranteed Issue	Employee: $100,000 Spouse: $20,000 Dependent Child: $20,000
Employee Coverage	You may elect coverage in $1,000 increments up to a maximum of 5x your base annual earnings or $300,000, whichever is less.
Spouse Coverage	You may elect coverage for your spouse in $5,000 increments up to 50% of the employee elected amount or $100,000, whichever is less.
Child Coverage	You may elect coverage for your dependent child(ren) (6 months to 26 years) in the amount of $20,000.

Life & Disability

Guardian Disability

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits. The premium for this coverage will be taken out of your paycheck after taxes. This means that if you ever need to make a disability claim, the benefit you receive will be tax-free.

	Short-Term Disability	Long-Term Disability
Percentage of Income Replaced	60% of weekly income	60% of monthly income
Benefits Begin	15th day accident/illness	After 90 days
Benefits Duration	11 weeks	SSNRA
Standard Maternity Benefits Duration	6 weeks vaginal delivery 8 weeks C-section	N/A
Maximum Benefit	$1,500	$8,000 monthly
Evidence of Insurability Requirement	None if enrolled when first eligible as a new hire	None

Pre-Existing Exclusions	
Short-Term Disability*	Any disability that occurs within the first 12 months of coverage as a result of a pre-existing condition which was treated within 3 months prior to the coverage effective date will be excluded. This also includes a 2-week limitation**
Long-Term Disability	If you are treated for a medical condition 3 months prior to effective date, it will not be covered unless you are treatment free for 6 months after the effective date of coverage or after they have been insured and are still actively at work for 12 months.

**The 2-week limitation means if someone is disabled for the duration of the elimination period plus 2 additional weeks but is denied due to the Pre-Existing Limitation, Guardian will still pay a benefit of 2 weeks despite it being a Pre-Existing Condition Limitation.

Things to know

Important Terms

Actively at Work	Being physically present at your place of employment and actively performing the duties of one's occupation on a full-time basis, often a qualifying factor in coverage.
Coinsurance	A percentage of a health care cost that the covered employee pays after meeting the deductible.
Copayment (Copay)	A fixed dollar amount for each doctor visit that the covered employee pays for a health care service, usually when the service is received. For example, a primary care doctor may charge a nominal copay per visit.
Deductible	A fixed dollar amount that the covered employee must pay out-of-pocket each calendar year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits for individual and other coverage tiers.
Embedded vs. Non-Embedded Deductibles	An embedded deductible refers to a deductible that applies to each individual within a family plan, while a non-embedded deductible applies to the entire family as a whole.
Explanation of Benefits (EOB)	A record of a person's past and current health events. A "detailed receipt." Ask for this whenever you have a medical service performed for your records. FSAs, HSAs, HRAs, and Wellness Benefit Incentives will sometimes need this additional verification.
Evidence of Insurability (EOI)	Is a record of a person's past and current health events. It is used by insurance companies to verify whether a person meets the definition of good health. Some voluntary benefits may require you to complete an EOI in order for your coverages to become effective.
Guaranteed Issue (GI)	A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, GI doesn't limit how much you can be charged if you enroll.
In-Network	Doctors, clinics, hospitals, and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.
Out-of-Network	A health plan will cover treatment for doctors, clinics, hospitals, and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than in-network providers.
Out-of-Pocket Maximum	The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including copayments and coinsurance.
Preventive Care	Most health plans must cover a set of preventive services – like shots and screening tests – at no cost to you. Visit https://www.healthcare.gov/coverage/preventive-care-benefits/ to view free preventive services for all adults, women, and children.
Premium	The amount the employee pays for health insurance.
Reasonable and Customary	Refers to the standard charges for medical services or treatments that are considered reasonable and customary within a specific area and are used as a basis for determining the amount of coverage provided by an insurance policy.

Key Contacts

Benefit	Whom To Call	Phone Number	Email or Website
Benefit Enrollment Specialists	The Cason Group (Health Insurance)	844-452-0404	https://calendly.com/healthreach/seniorservices
Third Party Administrator of the ICHRA Plans	SURECO – ICHRA	949-989-4906	employee.experience@sureco.com
Dental	Pacific Life Network: National PPO	855-810-3301	www.pacificlife.com
Vision	Pacific Life Network: EyeMed Insight	855-810-3301	www.pacificlife.com
Life Insurance	OneAmerica	800-553-5318	www.oneamerica.com lifeclaims.employeebenefits@oneamerica.com
Disability Insurance	Guardian	800-268-2525	www.guardianlife.com
Accident, Critical Illness, & Hospital Indemnity	The Hartford	866-547-4205	www.thehartford.com
Flexible Spending Account (FSA)	Flores	800-532-3327	www.flores247.com
Employee Assistance Program	Guardian	855-239-0743	www.guidanceresources.com App: GuidanceNow Web ID: Guardian

Have Questions?

If you have any questions about benefit offerings or the enrollment process, you can contact your Human Resources team.

Employee Benefits Services Team

For medical questions, contact your medical carrier directly. For all other questions, your dedicated Employee Benefits Services Team is your benefits resource throughout the year. Unlike a call center, this team of experienced client benefits specialists has the knowledge and skills to provide you with personal support regarding your group benefit plans. The Employee Benefits Services Team can help with inquiries about your medical, dental, vision, short-term disability, and voluntary benefits plans.

Call when you have questions about:

- Concerns or issues with claims
- How to obtain ID Cards
- General benefit coverage

The Employee Benefits Services team is available Monday through Friday 8am to 5pm EST.

Contact by phone or email:

- Toll Free: 855-313-1075
- EBServices@marshmma.com

MarshMcLennan Agency