





2026 Benefits Overview

SOUTHERN EAGLE DISTRIBUTING

Important Contacts

COVERAGE	CONTACT	PHONE	WEBSITE
Medical	SisCo Member Services (HealthCheck360)	833-986-0432	Member Portal: https://siscoconnect.com/logon/Client=BevCap Email: mysupport@siscobenefits.com
Prescription Drug Benefits	WellDyne	855-876-5483	www.WellView.WellDyne.com
Virtual Visits	Galileo	888-613-4254	http://galileohealth.com/welcome/ bevcapbeer
Dental	Guardian	888-600-1600	www.guardiananytime.com
Vision	Guardian	888-600-1600	www.guardiananytime.com
Life and AD&D	Guardian	888-600-1600	www.guardiananytime.com
Disability	Guardian	888-600-1600	www.guardiananytime.com
Employee Assistance Program	Guardian	1-800-386-7055	worklife.uprisehealth.com Access code: worklife
Spring Health	BevCap Management	855-629-0554	bevcap.springhealth.com Worklife code: bevcap

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Welcome to your Benefits!

We're excited to offer you a comprehensive selection of competitive benefits that play an essential role in your overall compensation package. You have the freedom to choose from a variety of options to ensure the health and well-being of you and your family, as well as to provide financial security in unexpected situations. This guide has been created to address common questions you may have regarding your benefits. We encourage you to take the time to review it thoroughly, ensuring you fully understand the benefits available to you and your family, and remember to take action before the enrollment deadline.

In this guide you will find:

If you (and/or your dependents) 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. Please see Required Notices for more details.

HEALTH CARE COVERAGE REMINDER

You may purchase insurance through the Marketplace only if you experience a Qualifying Life Event or during Open Enrollment. The federal Marketplace Open Enrollment dates are from November 1 through January 15. Refer to the Required Notices in this guide for additional details.

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Eligibility

If you work at least 30 hours per week, you are eligible for benefits. Your benefits are effective 1st of the month following 60 days from your date of hire. You may also enroll your eligible dependents for coverage. Eligible dependents could be:

- Your legal spouse or qualified domestic partner
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

CHANGING BENEFITS AFTER ENROLLMENT

During the year, you cannot make changes to your medical and dental coverage unless you have a Qualified Life Event. If you do not contact Human Resources within 31 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

QUALIFIED LIFE EVENT		DOCUMENTATION NEEDED
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal Separation	Copy of divorce decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full time to part time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

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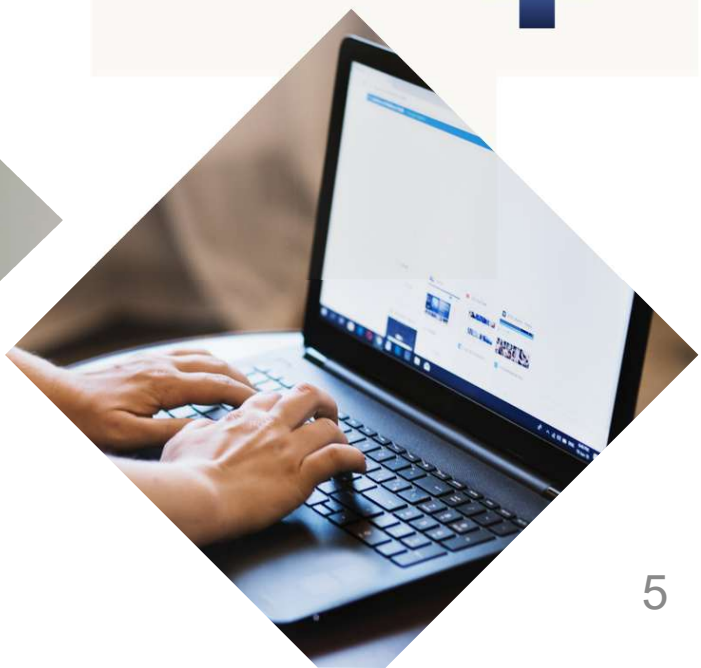
How to Enroll

WELCOME TO BENEFITS ENROLLMENT THROUGH PAYLOCITY

To ensure a smooth enrollment process, please have your dependent and beneficiary information available. If you have not entered dependents before, you will need their social security number and date of birth to add them.

- Enter your username and password in the appropriate fields and click the “Log In” button.

- Click the “Benefits” tab at the top of the page.
- Click the “Enroll” button in the left-hand menu.
- Select the benefits you would like to enroll in and click the “Continue” button.
- If you have any questions or need assistance with enrolling, please refer to your HR department.



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Medical Plan

SOUTHERN EAGLE OFFERS TWO MEDICAL PLANS, MANAGED BY BEVCAP MANAGEMENT AND ADMINISTERED BY SISCO.

SisCo serves as your Health Plan Administrator, working closely with your employer to handle all administrative aspects of their plan. SisCo will be issuing your ID Cards, handling the Care Management aspects of your health care journey, processing your medical claims, and more. You can reach SisCo at (833) 986-0432 .

Fairos will serve as your plan's Medical Open Access "Network." You may also seek services from any doctor, hospital, or facility of your choice. The Fairos Advocacy Team is available to answer any questions relating to your providers and plan acceptance as well as assist in resolving issues related to provider billing issues. If you have any questions about your benefit plan call SisCo at (833) 986-0432 .

Disclaimer: Your plan uses an Open Access Network. All providers are eligible, but services may be billed as Out-of-Network under Reference-Based Pricing (RBP). Because of this, additional time may be needed for billing review, negotiations, or balance bill resolution.

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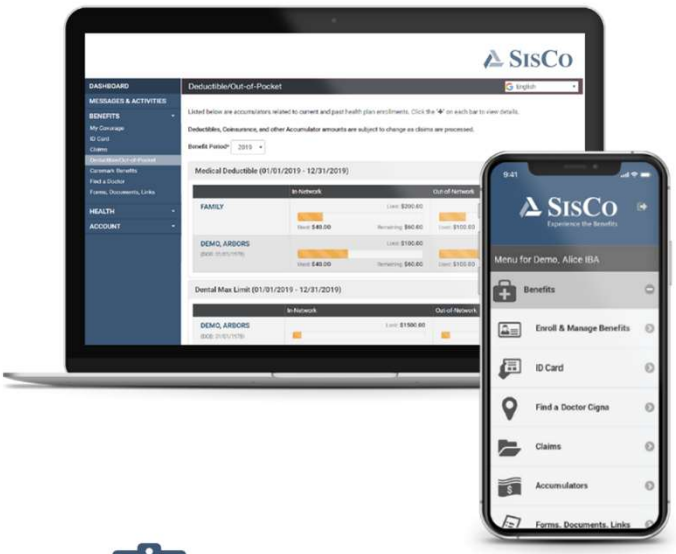
SISCO

All Your Benefits Questions Answered *Quickly and Reliably*

With the advocacy program, you have access to one-on-one guidance to help you understand and utilize your healthcare benefits effectively. With one call or email, you can connect with on-demand advocates who can help you find in-network providers, understand your available benefits, compare treatment options, and more.



Cost Savings
Significantly reduce your healthcare expenses with a personal guide to informed decision-making.

Quick Responses
Get your questions answered from a knowledgeable person, typically within 15 seconds.

Convenience
All your benefit details, insurance cards, provider directories, and one-on-one support in one place.

Rewards
If you select a guided benefit provider for your care, you may qualify for reduced coinsurance, copays, and deductibles.

Register for the SISCO Connect App or Member Portal

1. Scan the QR Code to get started.
2. Or visit https://siscoconnect.com/logon/Client=BevCap to access the SISCO Member Portal.
3. Click ***Register Now*** in the upper right corner
4. Fill out the registration form and click ***Submit.*** Your ID Number can be found on your ID Card.

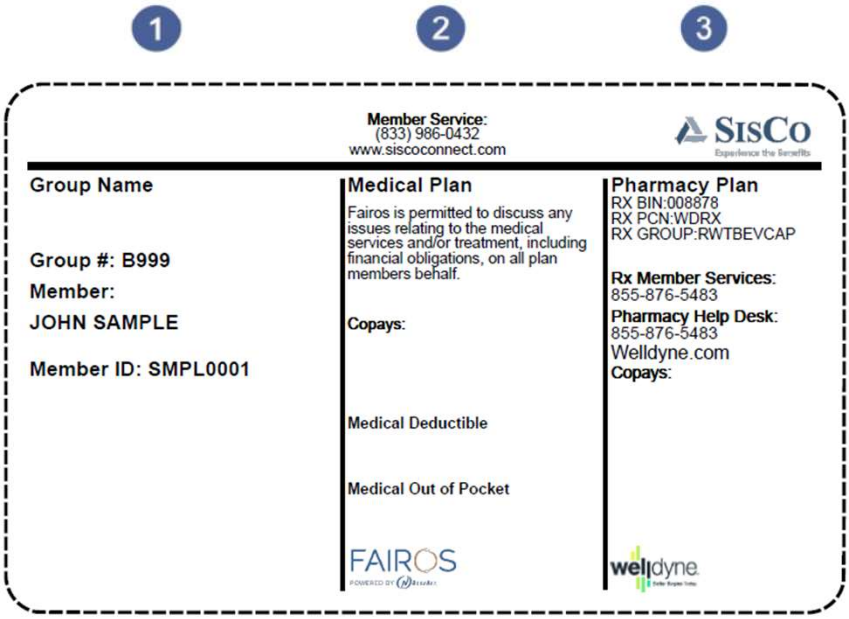
Logging In To Your Account

Once you've registered for the SISCO Connect App or Member Portal, use your username and password to log in. The Login button is in the upper right corner of the screen.

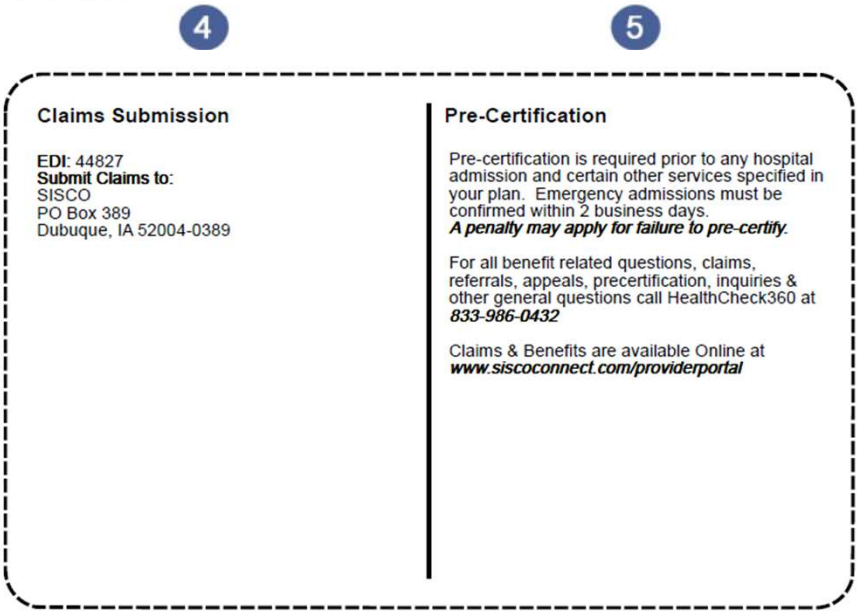
Get In Touch

Email: mysupport@siscobenefits.com
Call: (833) 986-0432
Monday–Thursday | 7 am–7 pm (CST)
Friday | 7 am–5 pm (CST)

Understanding Your Medical ID Card



*** SAMPLE ID CARD ONLY***



1) Member Name & ID Number
The name of the Member is listed here
The Member ID is a unique identifier to you

2) Deductible, Co-Insurance, & Copays
These are the specific benefits of your plan, for quick reference

3) Pharmacy Information
This section includes the necessary information to access your pharmacy benefits via Pharmacy Benefit Manager. Pharmacy Copays are also listed based on their tier of coverage:
Generic / Non-Formulary / Brand Name / Specialty

4) Claim Submission Information
The address you as a member or the provider will submit your claims for reimbursement

5) Plan Information
Information about your plan

MEDICAL PLAN OVERVIEW

SISCO	PLAN A	PLAN B
BASIC INFORMATION		
Deductible (Single/Family)	$250/ $750	$1,500/ $4,500
Coinsurance (You Pay)	0%	20%
Out-of-Pocket Limit (Single/Family)	$3,000/ $6,000	$5,000/ $10,000
	YOU PAY	
ROUTINE SERVICES		
Virtual Care/Telehealth	$0	$0
Physician Office Visit	$20 copay	$25 copay
Specialist Office Visit	$45 copay	$50 copay
Preventive Services (Adults/Children)	$0	$0
OTHER SERVICES		
High Tech Radiology (CT, PET, MRI) performed at Preferred Advanced Imaging Provider (Preferred Provider)	$0 Through Direct Contract Provider; Otherwise, Ded + Coinsurance (Must be coordinated through HealthCheck360)	$0 Through Direct Contract Provider; Otherwise, Ded + Coinsurance (Must be coordinated through HealthCheck360)
Surgery Centers (Free Preferred Surgical Centers)	$0 Through Preferred Surgical Center; Otherwise, Ded + Coinsurance (Must be coordinated through HealthCheck360)	$0 Through Preferred Surgical Center; Otherwise, Ded + Coinsurance (Must be coordinated through HealthCheck360)
HOSPITAL AND FACILITY SERVICES		
Emergency Room Visits	$750 copay (Waived if True Emergency)	$750 copay (Waived if True Emergency)
Urgent Care Visits	$50 copay	$55 copay
PRESCRIPTION DRUGS		
Tier 1 / Tier 2 / Tier 3	$10/$30/$50	$10/$30/$50
Mail-Order Prescriptions	$20/$60/$100	$20/$60/$100
Specialty Preferred / Non-Preferred	20% max of $150 / $200	20% max of $150 / $200

*After Deductible

MEDICAL PLAN COSTS

MEDICAL (BI-WEEKLY RATES)	PLAN A	PLAN B
Employee	$206.94	$107.28
Employee + Spouse	$527.30	$276.80
Employee + Child(ren)	$376.54	$197.39
Employee + Family	$638.47	$334.70

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Prescription Drug Benefits

- Contact WellDyne Customer Care team at **855-876-5483**
- 24/7 Access to Manage prescriptions, setup mail order, drug formulary and pricing, pharmacy locator and more by logging into WellDyne WellView Member Portal at **WellView.WellDyne.com**
- Health and Prescription updates, sign-up for WellConnect text messages through the WellView Member Portal
- **Important Note: Pharmacy Network Does NOT include Walgreens**

Download the WellView mobile app!

Find the WellView icon in Apple or Google Play

Prescription Drug Savings with Cost Plus Drugs

- Fill a 90 day supply – shipped to your home
- What you pay accumulates towards your deductible and out of pocket
- If you're signed up for WellDyne WellConnect; WellDyne will send you a text message if your medication is available through Cost Plus.

Scan the QR code or visit costplusdrugs.com to get started

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Where to Seek Care

TELEMEDICINE

Use telemedicine to seek treatment for minor and easily diagnosable medical conditions. Text/message with a board-certified physician / pediatrician over the phone.

- Colds & flu
- Sore throats
- Headaches
- Stomach aches
- Fever
- Allergies & rashes
- Pink Eye

- FREE! No cost to you!
- Your insurance covers the cost of the consultation.
- Registration takes 5–10 minutes. Consultation calls can take 10–15 minutes. No need to leave home or work.

PRIMARY CARE

See a general practitioner or your primary care physician for routine or preventive care, to keep track of medications and health maintenance.

- General health, immunizations, screenings
- Preventive care
- Routine check-ups

- Physician office visit copay.
- You usually need an appointment.
- Wait times vary based on their appointment schedule.

URGENT CARE CLINIC

Visit an urgent or convenience care clinic to seek treatment for minor medical conditions that may be more urgent or that should be diagnosed in-person. Note: Free-standing ERs are growing in popularity. They look like urgent care clinics, but bill as ERs.

- Colds & flu
- Rashes or skin conditions
- Sore throats, earaches, sinus pain
- Minor cuts or burns
- Pregnancy testing
- Vaccinations
- X-ray

- Urgent care copay.
- It ultimately depends on what codes the facility uses when submitting claims.
- Some clinics take appointments, but walk-ins are most common.

EMERGENCY ROOM

Only visit the ER for immediate treatment of critical or life- threatening injuries or illnesses.

If truly life-threatening, call 911.

- Uncontrolled bleeding
- Compound fractures
- Sudden numbness or weakness
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain
- Head injury or other major trauma
- Blurry vision or loss of vision
- Severe cuts or burns

- ER copay.
- Depending on the extent of services provided, you may be balanced billed.
- Wait times vary but can often be extensive for ERs.

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FREE BENEFITS PROGRAM

Virtual Visits: Galileo

HOW IT WORKS

Galileo is your doctor's office - on your phone. With Galilleo, you can:

- Consult with real doctors via chat or video anytime on the Galileo app - available in English and Spanish.
- Get access to primary care doctors and specialists: Galileo can diagnose most health care concerns, including acne, anxiety, diabetes, hypertension, cold and flu, and more.
- Have an annual welless exam via video.

24/7/365	Quality Doctors	No ER Wait	100% Covered

GET STARTED

Galileo is committed to medical care that thoughtfully and patiently listens to your questions and concerns. To get started, visit **galileohealth.com/welcome/bevcapbeer** and use access code **bcbeer2023**. If you need registration help, call **888-613-4254**.

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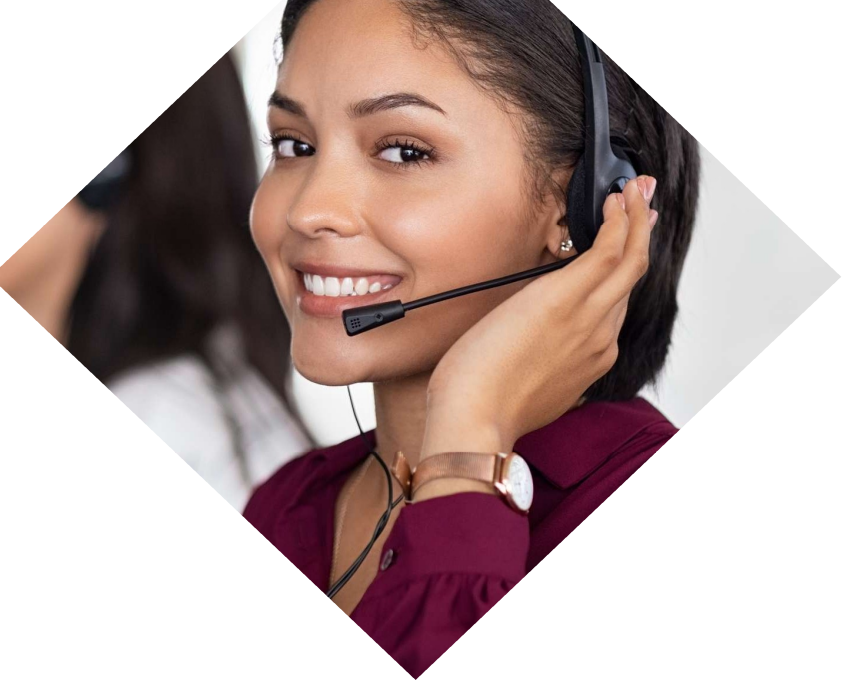

FREE BENEFITS PROGRAM

HealthCheck360

The HealthCheck360 Advocate delivers a higher level of customer service than you've ever experienced and is provided for your insurance needs. The Advocate team is available to answer your health care questions and guide you through the complexities of your medical plan — at no cost to you.

UNDERSTAND INSURANCE BENEFITS

Receive guidance in understanding your benefits throughout the year.

GET HELP WITH MEDICAL BILLS

Have your medical bills reviewed to make sure you are not overcharged.

FIND A NETWORK PROVIDER

Find in network doctors in your area who meet your personal preferences and health care needs.

FREE MEDICAL CARE

If you require surgery or imaging, contact the Advocate team to see if the services are eligible for one of the contracted surgery centers for a zero out-of-pocket cost to you.

FOR QUESTIONS OR ADDITIONAL INFORMATION

Contact the Advocate team at mysupport@siscobenefits.com or call 833-986-0432.

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Preferred Surgery Centers

Need surgery? No out-of-pocket costs? Contact the Advocate team at 833-986-0432 or mysupport@siscobenefits.com.

We are constantly evaluating and improving the benefits plans to provide you and your family with access to the highest quality care and the best patient experience available.

WHAT ARE THE BENEFITS TO USING A PREFERRED SURGERY CENTER?

- Receive high-quality post-op care from top-rated surgeons
- A superior patient experience and outstanding customer service
- Pay nothing out-of-pocket! Your health costs (deductible and coinsurance) are waived*
- Travel expenses for you and an adult caregiver are reimbursable

The following expenses for member and an adult caregiver who travel to the surgery center are covered: mileage, hotel, per diem food allowance during stay and first post-surgery prescription paid.

Member must elect to have surgical procedure performed at one of the plan's Preferred Surgical Centers. A wide range of procedures can be performed at our Preferred Surgical Centers.

BENEFITS

- Access top surgeons & anesthesiologists
- Beautiful, state-of-the-art facilities
- No copay/deductible*
- Dedicated Advocate
- Care Coordination
- Travel Arrangements

PROCESS

- Outreach to members
- Obtain medical records
- Assist with diagnostic testing
- Coordinate surgery schedule
- Arrange travel (Flight, Hotel, Car Service)
- Facilitate post-op care (PT/Wound Care)

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FREE BENEFITS PROGRAM

Preferred Advanced Imaging Providers

You have access to a concierge scheduling program for advanced radiology including MRI, CT and PET scans.

WHY USE A PREFERRED IMAGING PROVIDER?

Imaging costs are 100% covered* when you utilize an advanced imaging provider by scheduling with an Advocate, at a time and place convenient to you. By utilizing an advanced imaging network, you have access to a national network with over thousands of facilities.

HOW IT WORKS

- Pre-certification is required so either you or your provider will contact the Advocate team
- When the procedure has been pre-certified, the Advocate team will contact you to make sure you want to use Advanced Imaging
- An advanced imaging representative will call you to inform you of your authorized imaging and arrange for an appointment at a time and date convenient for you
- An advanced imaging representative can provide education about your test including quality and safety information
- An advanced imaging representative provides a written appointment confirmation and directions
- After your imaging has been completed, an advanced imaging representative sends a satisfaction survey to ensure an excellent level of service

For more information about Advanced Imaging, please contact the Advocate team at 833-986-0432 or mysupport@siscobenefits.com.

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Digital Physical Therapy

FREE BENEFITS PROGRAM

Digital Physical Therapy Network uses technology to provide quality, convenient and connected care to patients in the comfort of their own homes. No need to worry about transportation, traffic or the weather. You can safely recover from home, on your schedule, with your licensed physical therapist always available.

HOW IT WORKS

1. When you receive an order for physical therapy, you or your provider may contact the Advocate team at 833-986-0432 or mysupport@siscobenefits.com to authorize therapy.
2. The Advocate team will submit authorization and referral to Digital Physical Therapy Network.
3. Digital Physical Therapy Network will contact you to schedule your initial evaluation.

TELLS US WHERE IT HURTS

HAVE YOU HAD A RECENT INJURY OR ACCIDENT?

Let's address that acute pain from sprains, strains, twists, and more.

DO YOU HAVE PAIN THAT KEEPS FLARING UP?

We'll get to the bottom of those periodic aches and pains that set you back.

ARE YOU LIVING IN PAIN MOST DAYS?

Together, we'll treat the long-term issues that keep you from doing what you love.

WITH YOUR BENEFIT, GET ACCESS TO:

- » Convenient video visits
- » Medical Evaluation & diagnosis
- » Personalized treatment including physical therapy & more
- » Non-opiod pain medication & imaging if needed
- » Support to help you manage pain, regain strength, & enjoy life

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FREE BENEFITS PROGRAM

Maternity Advocates

Even with health insurance and a good doctor, pregnancy is stressful, complicated and a unique experience every time. To make the pregnancy in your life easier, your group offers a benefit called the Maternity Advocates program. This unique benefit allows you to have on-demand access to Maternal Fetal Medicine specialists — physicians trained to deal with pregnancies of all kinds — and other pregnancy support services such as lactation consultants, behavioral health specialists, and nurse navigators.

The Maternity Advocates employee benefit is available to you free of charge. Book an appointment today by contacting the Advocate team at 833-986-0432 or mysupport@siscobenefits.com.

WHAT IS INCLUDED

- **Unlimited On-Demand Visits** – Meet with board-certified, U.S.-trained Maternal Fetal Medicine physicians on-demand, however much you want.
- **Care Team Built for Pregnancies** – Looking to meet with a lactation consultant, behavioral health specialist or nurse navigator? They're available too.
- **Teleperinatal Mobile App** – Track and learn about your pregnancy with our tracker and content library provided by Mayo Clinic.
- **Personalized Pregnancy Roadmap** – Following every visit, you'll receive a roadmap with everything to expect in your pregnancy, personalized to you.

***Upon completion of the program you will receive a 1-Year subscription of free diapers.**

***Diaper incentive requires registration into program prior to first day of 3rd trimester (28 weeks).**

ROADMAP TO A SUCCESSFUL PREGNANCY EXAMPLE

Here's a look at what a successful pregnancy utilizing the specialists in the Maternity Advocates program looks like:

4 WEEKS
Patient notifies provider she's pregnant
10 WEEKS
Patient visits with provider
14 WEEKS
Patient consults with MFM physician
20 WEEKS
Anatomy scan
28 WEEKS
Diabetic screen
36 WEEKS
Delivery planning meeting with MFM
40 WEEKS
Baby is born! Mother and baby go home

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Disease Management

Disease Management program assists members in managing chronic conditions with a goal of improving their clinical condition and reducing unnecessary health care costs while improving quality of life. Our program promotes participant self- care by providing patient education, coaching and monitoring, facilitates collaboration within the health care team (patient, physician and health plan), and coordinates services as appropriate across the health care continuum.

MANAGED CHRONIC CONDITIONS INCLUDE:

- Diabetes
- Hyperlipidemia
- Hypertension

SERVICES

- Access to Registered Nurses
- Evidence-based Highly Personalized Care
- Member Engagement, Coaching and Monitoring
- Advanced Risk Scoring and Analytics
- Review of Reports, Lab Results, Screenings and Assessments
- Patient Education Tools and Resources

Contact the Advocate team at 833-986-0432 or mysupport@siscobenefits.com.

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FREE BENEFITS PROGRAM

Personalized Specialty Infusion Care

Quantify is a national infusion provider that offers local and home-based specialty therapy services. Their integrated model makes specialty therapy care easier and more accessible.

What makes Quantify Different?

- **$0 yearly out-of-pocket expenses***
- **$0 copays for each treatment***
- **In-home infusions available in all 50 states**
- **We provide 24/7 nursing support for all your health needs**

What's Included?

- **Expert care, wherever you are**
- **24/7 clinical support and real-time health insights**
- **Support for your whole health**
- **Precision treatment and medication**

1. If eligible, you will receive a call with information on setting up a consultation to learn more.
2. A dedicated team member will reach out to discuss, and help you enroll in, your treatment plan — whether at home or at one of our 65+ locations nationwide.
3. Our team will work with your current provider to ensure an easy transition to your new specialty care.
4. We'll send you everything you need to prepare for your first home or in-clinic appointment, including simple step-by-step guides to get started.
5. When it's time for your treatment, we make sure everything is ready for an easy experience. Your care team will be there to answer any questions and keep you comfortable.
6. Experience ongoing support with regular check-ins, 24/7 access to your care team, and continuous monitoring to enhance your overall well-being.

Contact the Advocate team at 833-986-0432 or mysupport@siscobenefits.com.

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FREE BENEFITS PROGRAM

Spring Health

Life is easier with the right support.

You don't need to wait for a crisis to prioritize your mental health. BevCap partners with Spring Health to provide personalized care and resources to support you through any of life's challenges.

Spring Health can support your mental health with easy access to:

Free therapy

Get convenient, confidential support from a therapist of your choice. Each member (age 6+) gets 6 sessions per year.

Free coaching

Build new skills, create healthy habits, and reach personal goals. Each member (13+) gets 6 free sessions per year.

Care guidance and support

A Care Navigator can walk you through your care plan, help you find the right provider, and support you along the way.

Family Care

Get support for your family with fast access to providers who specialize in care for couples, families, children (age 6+), and teenagers.

Personalized care

Take a short online assessment to get care and provider options that support your unique needs, goals, and preferences.

Substance use support

Get connected with alcohol or substance use programs that fit your needs and lifestyle.

Contact Spring Health:
springhealth.com/support
1-855-629-0554
General support: M-F, 8am-11pm ET
Crisis support: 24/7 (press 2)

Learn more and get started:
bevcap.springhealth.com
Spring Health mobile app
Work-life code: bevcap

Spring Health is available at no cost to all employees enrolled in the medical plan and their covered dependents.

Your care with Spring Health is private and confidential.

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FREE BENEFITS PROGRAM

Rest Easy.

YOU NOW HAVE ACCESS TO VIRTUAL SLEEP APNEA CARE THROUGH:

GEM·SLEEP

Sleep Evaluation

GEM has removed the starts, stops and hidden costs in getting a sleep apnea diagnosis. Order a home sleep test to evaluate your sleep from the comfort of your own bed.

GEM sleep test includes:

» Testing
» Clinician Review
» Diagnosis
» Treatment recommendation & prescription (if needed)

Sleep Apnea Treatment

Based on your sleep test evaluation, you'll receive recommendations from GEM clinicians.

GEM makes it easy to get the right treatment:

» Virtual mask fitting
» Multiple treatment options
» Mask & machine guarantee
» CPAPs ready to ship

Sleep Evaluation

GEM's team of experts will help you track your progress and provide guidance to make your transition smooth.

» 1:1 Support
» Live virtual visits available

How to get started: Contact the Advocate team at 833-986-0432 or mysupport@siscobenefits.com.

If you have a concern of sleep apnea or if you have been diagnosed but not treated, you might qualify for this program.

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FREE BENEFITS PROGRAM

FEDlogic

Federal and State Benefit Navigation

A team of experts, ready to help.

FEDlogic is an advocacy service provided by your employer that gives you access to a team of experts who can assist you in understanding federal and state benefit options. FEDlogic's experts have worked for Social Security Administration and have spent years mastering these policies from the inside out. Without education, and advocacy, many individuals don't take advantage of all benefits available to them. FEDlogic's experts can provide you with a peace of mind ensuring that you identify and maximize all your benefits. FEDlogic does not sell, endorse, or promote any products or services. FEDlogic is a team of unbiased advocates with decades of experience.

Key Programs FEDlogic can assist with:

- Medicare
- Medicaid
- Healthcare.gov
- COBRA
- Social Security Disability
- Social Security Retirement
- State Specific Benefits
- Alternative Healthcare Options
- Survivors Benefits (Widows & Child)
- Premature Baby Birth
- ESRD (Dialysis)
- ALS (Lou Gehrig Disease)
- Terminal Illness
- Cancer
- SSI (Supplemental Security Income)
- Veteran's Benefits
- Tribal Benefits
- Catastrophic Claims

Have questions or want to learn more? Call 877-837-4196 or email services@fedlogicgroup.com for a consultation.

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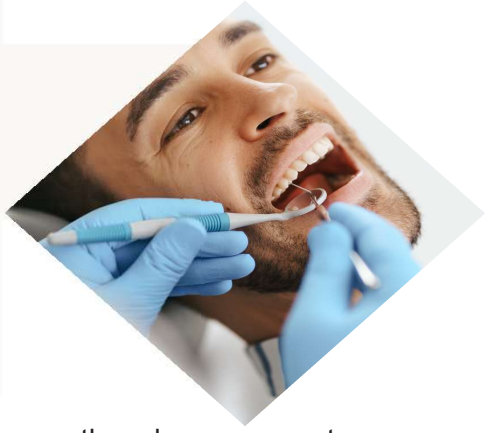
Dental Benefits



TAKING CARE OF YOUR ORAL HEALTH IS NOT A LUXURY —IT'S A NECESSITY TO LONG-TERM OPTIMAL HEALTH.

With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative, and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will only pay a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

GUARDIAN	DENTAL PLAN	
	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
Individual	$50	$50
Family (3 per family)	$150	$150
CALENDAR YEAR PLAN MAXIMUM		
Per Individual	$1,000	
	YOU PAY	
PREVENTIVE CARE		
Exams, Cleanings, X-rays, Fluoride Treatments	$0	$0
BASIC SERVICES		
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	90%	90%
MAJOR PROCEDURES		
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	60%	50%
ORTHODONTIA SERVICES		
Orthodontia	50%*	50%*
Lifetime Orthodontia Maximum	$1,000	

DENTAL (SEMI-MONTHLY RATES)	
Employee	$15.47
Employee + Spouse	$34.46
Employee + Child(ren)	$45.72
Employee + Family	$60.47

Rollover of Benefit Year Payment Limit for Group I, II, III Non-Othrodontic Services: A covered person submits at least one claim for covered charges during a benefit year and, that benefit year, receives benefits that are in excess of any deductible or co-pay fees, and in total do no exceed the Rollover Threshold. The amounts of this plan's Rollover Threshold, Reward, and Bank Maximum are:

Rollover Threshold	$500.00
Reward (if all benefits are for services provided by a preferred provider)	$350.00
Reward (if any benefits are for services provided by a non-preferred provider)	$250.00
Bank Maximum	$1,000.00

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Vision Benefits

HEALTHY EYES AND CLEAR VISION ARE AN IMPORTANT PART OF YOUR OVERALL HEALTH AND QUALITY OF LIFE

The table below summarizes the key features of the vision plan.
Please refer to the official plan documents for additional information on coverage and exclusions.

GUARDIAN	VISION PLAN	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
COST	**YOU PAY**	
Exam	$10	Up to $39
Materials	$10	
COVERED SERVICES - LENSES		
Single Lenses	$10	Up to $23
Bifocals	$10	Up to $37
Trifocals	$10	Up to $49
Frames	$130 max benefit; 20% of balance over $130	Up to $46
COVERED SERVICES – CONTACTS IN LIEU OF FRAMES/LENSES		
Contacts - Medically Necessary	$10	$210
Contacts - Elective	$130 max benefit	$100
BENEFIT FREQUENCY		
Exams	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months
Contacts	Once every 12 months	Once every 12 months

VISION (SEMI-MONTHLY RATES)	VISION PLAN
Employee	$4.53
Employee + Spouse	$7.62
Employee + Child(ren)	$7.78
Employee + Family	$12.30

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Life and Accidental Death & Dismemberment (AD&D) Insurance

Life insurance provides a lump-sum payment to your designated beneficiary or beneficiaries to help cover expenses in the event of your death. Accidental Death & Dismemberment (AD&D) insurance offers additional financial protection by paying a benefit if you die or sustain specific serious injuries due to a covered accident. For covered accidental injuries—such as the loss of sight or a limb—you'll receive a percentage of your elected AD&D coverage, determined by the severity of the injury.

LIFE / AD&D INSURANCE – FOR YOU - GUARDIAN		
	LIFE AND AD&D	**VOLUNTARY LIFE AND AD&D**
Coverage Amount	2x your basic annual earnings to a maximum of $100,000	Increments of $10,000; $20,000 minimum not to exceed $500,000
Evidence of Insurability / Proof of Good Health	None	Required if electing coverage equal to or greater than $150,000
Age Reduction Schedule-Benefit Reduces	35% @ age 65 50% @ age 70	35% @ age 65 50% @ age 70

DEPENDENT VOLUNTARY LIFE

Voluntary Life insurance for your dependents can help protect your family during difficult times.

LIFE / AD&D INSURANCE – FOR YOUR DEPENDENTS – GUARDIAN		
	SPOUSE	**CHILD(REN)**
Coverage Amount	Increments of $5,000; $10,000 minimum up to 50% of employee elected amount not to exceed maximum of $250,000	Increments of $1,000; 10% of employee elected amount to a maximum of $10,000 (ages 14 days-23 years)
Evidence of Insurability / Proof of Good Health	Required for amounts equal to or greater than $10,000	None
Age Reduction Schedule-Benefit Reduces	35% @ age 65 50% @ age 70	None

GUARANTEED ISSUE (GI) AND EVIDENCE OF INSURABILITY (EOI)

Employees and spouses who elect coverage when first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

IMPUTED INCOME

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds $50,000 and is subject to federal income, Social Security, and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

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Disability Insurance

Disability insurance can keep you financially stable should you become disabled and unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income.

SHORT-TERM DISABILITY BENEFITS AT A GLANCE - GUARDIAN	
Coverage	60% of your weekly earnings to a $600 maximum for 13 weeks.
When Benefits Begin	Benefit begins on the 15th day of disability
Election Required	Yes

LONG-TERM DISABILITY BENEFITS AT A GLANCE - GUARDIAN	
Coverage	60% of your pre-disability earnings, up to a maximum benefit of $5,000 per month until you recover or reach your Social Security Normal Retirement Age, whichever is sooner.
When Benefits Begin	Benefit begins on the 91st day of disability
Election Required	No

HOW STD AND LTD WORKS TOGETHER

Available PTO pays 100% of your pay until STD begins. → After 15 days of sickness or injury, approved STD pays a portion of your income. → After 13 weeks LTD begins if approved.

A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

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Voluntary Worksite Benefits

Just like it sounds, Supplemental Medical Plans — Accident, and Critical Illness — are designed to help cover costs that may arise from an injury, illness, or hospitalization. These plans are completely voluntary and offer a one-time, fixed benefit that you can use however you see fit. The funds can help cover out-of-pocket expenses not paid by your primary health insurance, such as deductibles or copays, as well as other costs like lost income, childcare, travel to and from treatment, home health care, or everyday household expenses.

Accident Insurance

SAMPLE ELIGIBLE EXPENSE

» Emergency Room Visits

» Medical Exams Including major diagnostic exams

» Fractures and Dislocations

» Hospital Stays

» Physical Therapy

» Transportation and Lodging – if you are away from home when the accident happens

HOW THE PLAN WORKS

» On his way to work, John was in a car accident.

» He was transported by ground ambulance to the emergency room and admitted to the hospital.

» He had a dislocated hip and spent five days in the hospital.

» He had several physical therapy sessions before returning to work.

» John submitted his accident claim and received $5,850 from his accident insurance coverage.

» He used it toward his deductible, copay and supplemental income for his missed work days.

SAMPLE REIMBURSEMENT	
Ground Ambulance	$300
Emergency Room	$150
X-ray	$50
MRI	$150
Hospital Stay – Admission + 5 days	$2,000
Dislocated Hip	$3,000
Appliances	$100
Physical Therapy (4 sessions)	$100
TOTAL BENEFIT PAID	**$5,850**

ACCIDENT INSURANCE (SEMI-MONTHLY RATES)	
Employee	$5.95
Employee + Spouse	$9.42
Employee + Child(ren)	$9.90
Employee + Family	$13.37

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Critical Illness Insurance

SAMPLE COVERED CONDITIONS

» Heart Attack

» Multiple Sclerosis

» Alzheimer's Disease

» Parkinson's Disease

» Stroke

» Major Organ Failure

HOW THE PLAN WORKS

» Tom suffered a relatively small stroke.

» He was hospitalized for five days.

» He began rehab to get back to where he was physically before the stroke.

» Tom submitted his claim and received a lump-sum payment of $10,000.

BENEFIT AMOUNTS	
Employee and Spouse	$5,000 to $30,000 in $5,000 increments
Children	50% of Employee Benefit

Please refer to your Paylocity enrollment platform for pricing.

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Additional Benefits

Through Guardian you will have access to ComPsych, a comprehensive employee assistance program, care giving support, and travel assistance.

COMSYCH

Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych Guidance Resources program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small. Contact us at (855)-239-0743 or at guidanceresources.com.

WELLTHY CAREGIVING

Many people juggle caregiving responsibilities outside of work. That's why we've partnered with Wellthy to help provide caregiving support services as part of our group disability insurance offerings. Tailored to meet a broad range of needs, you'll have access to the support you need to help tackle any caregiving challenge, while also being able to stay on top of your own physical, mental, and emotional wellness. How to access: Visit join.wellthy.com/guardian-members

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Health Benefit Glossary

Coinsurance. A percentage of a health care cost — such as 20 percent — that the covered employee pays after meeting the deductible.

Copayment. The fixed dollar amount — such as $30 for each doctor visit — that the covered employee pays for medical services.

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 per person and per family.

Formulary. A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Out-of-pocket limit. 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 co-payments and co-insurance.

Premium. The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

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Required Notices

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Notices

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that addresses the privacy and security of certain individually identifiable health information, called protected health information (or PHI). You have certain rights with respect to your PHI, including a right to see or get a copy of your health and claims records and other health information maintained by a health plan or carrier. For a copy of the Notice of Privacy Practices, describing how your PHI may be used and disclosed and how you get access to the information, contact Human Resources.

Women's Health and Cancer Rights Act Enrollment Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copays, and coinsurance applicable to other medical and surgical benefits provided under your medical plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act Disclosure
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier
than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

60-DAY SPECIAL ENROLLMENT PERIOD
In addition to the qualifying events listed in this enrollment guide, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP

HIPAA Special Enrollment Notice
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the medical plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program {CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your plan administrator.

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or You become divorced or legally separated from your spouse.

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Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
  The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days (or enter longer period permitted under the terms of the Plan) after the qualifying event occurs. You must provide this notice to your Plan Administrator.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or Bis effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.govlagencieslebsa.** (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov.**

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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MEDICARE PART D

Important Notice About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. We have determined that the prescription drug coverage offered by our Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage with our Medical Plan will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage with our Medical Plan, be aware that you and your dependents may not be able to get this coverage back.

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MEDICARE PART D

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

You should also know that if you drop or lose your current coverage with our Medical Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through our Medical Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (H300-633-4227) TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Remember, keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employement-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income..12

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Southern Eagle Distributing
Human Resources
5300 Glades Cut Off Road
Fort Pierce, FL. 34981

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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Notices

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

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MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

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TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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Notes:

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SOUTHERN EAGLE
DISTRIBUTING

2026 Benefits Overview

Disclaimer: This brochure highlights the main features of the Southern Eagle Distributing Employee Benefits Program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Southern Eagle Distributing reserves the right to change or discontinue its employee benefits plans at any time.

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