2025-2026
EMPLOYEE BENEFITS GUIDE

December 1, 2025 - November 30, 2026

Brown & Brown

WELCOME!

At Lottsa Cheese, we believe that taking care of our employees means more than just a paycheck. It means supporting your health, well-being, and peace of mind. That's why we're committed to providing access to quality health insurance in a way that puts you first.

To assist with your Open Enrollment decisions, this Enrollment Guide provides a high-level overview of the benefits offered and the associated costs. You MUST review and complete your enrollment form to ensure coverage. Any changes you make during this time will take effect on December 1, 2025.

For detailed information about each plan included in this guide, please contact Human Resources to request a Summary Plan Description (SPD). The SPD outlines additional benefits, exclusions, and limitations that apply. In the event of any discrepancies between this guide and the SPD, the SPD will take precedence. Lottsa Cheese reserves the right to modify the employee benefits package at any time.

Eligibility

To enroll in benefits, you must be full-time, working at least 30 hours per week over a 52-week period. Coverage will begin on the first day of the month following your eligibility date. Enrolled dependents will also be covered once you have met the required waiting period.

Eligible Dependents:

- Legal spouse
- Children under age 26
- Children who are disabled, live with you, and legally depend on you for support

DISCLAIMER: Please read this booklet carefully. Understanding the benefits available can help you choose the right benefit options for you and your family. This Benefits Guide Booklet is designed to provide basic information about the benefit plans and programs available at your employer. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract, the Summary of Benefits and Coverage (SBC), or the Summary Plan Description (SPD). This booklet does not constitute a SPD, SBC, benefit summary, or Plan Document as defined by the Employee Retirement Income Security Act (ERISA). You can obtain the referenced documents through your insurance carrier, HR, or Brown & Brown.

QUALIFYING LIFE EVENTS

The elections you make during open enrollment are locked in for the policy year.

It is very important to remember that you may only make changes to these benefit plans at open enrollment or within 30 days of a Life Event. Examples of life events:

- Getting married or divorced
- Having a baby or adopting a child
- Losing or gaining other health coverage
- A spouse or dependent passing away
- A change in your or your spouse's job status (like starting or losing a job)
- Turning 26

PRE-TAX BENEFITS

The following coverages are taken from your paycheck on a **pre-tax basis** and are governed by the IRS through a Section 125 Cafeteria Plan:

Medical
Dental
Vision

COBRA

COBRA is a benefit that provides workers and their families the option to continue group health benefits (medical, dental, and vision) under certain circumstances such as job loss, reduction in hours, or death. The length of COBRA continuation depends on the qualifying event, as follows:

18 Months:
- Termination of employment
- Leave of absence
- Loss of full-time status

36 Months:
- Death
- Loss of dependent eligibility
- Divorce

It is your responsibility to notify HR within 30 days of any listed occurrence. Once you give notification, information on how to enroll is sent to you, and you have 60 days to elect coverage. You are responsible for the total cost of the benefit premium plus a 2% administration fee.

Your COBRA administrator is **TASC.**

KEY CONTACTS

Brown & Brown INSURANCE®

Brown & Brown is your benefits broker. They can work with your insurance carriers on your behalf. Please contact them for assistance with claims, billing issues, network issues, coverage questions and any other benefit-related questions that come up.

Customer Service
Service Inbox *Fast responses for day-to-day service needs* 285.service@bbrown.com 843-266-4588

CARRIER CONTACTS

Plan	Carrier	Phone	Website
Medical	**Allstate/Allied Benefit System**	**888-306-0905**	**www.allstatebenefits.com**
Pharmacy Benefits	**Cigna**	**888-306-0905**	**www.mycigna.com**
Dental **Voluntary Life Claims** **Short Term Disability** **Accident** **Critical Illness**	**Unum**	**800-786-5433**	**www.unum.com**
Vision	**UNUM** **EyeMed Insight Network**	**866-939-3633**	**www.eyemed.com**
Telemedicine	**Recuro Health**	**855-637-3669**	**www.recurohealth.com/connect**

This guide is only intended to offer an outline of benefits. All details and contract obligations of plans are stated in the group contract/insurance documents, including any disclosures (whether regarding “grandfathering” of plans or others) required by the new health reform law, the Patient Protection and Affordable Care Act (PPACA). In the event of conflict between this guide and the group contract/ insurance documents, the group contract/insurance documents will prevail. Please contact your Human Resource Department for further information.

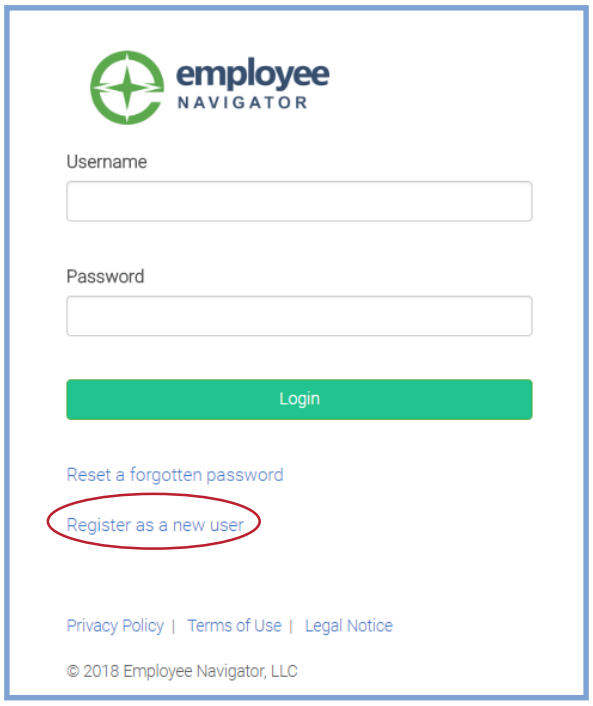
HOW TO ENROLL:

EMPLOYEE NAVIGATOR

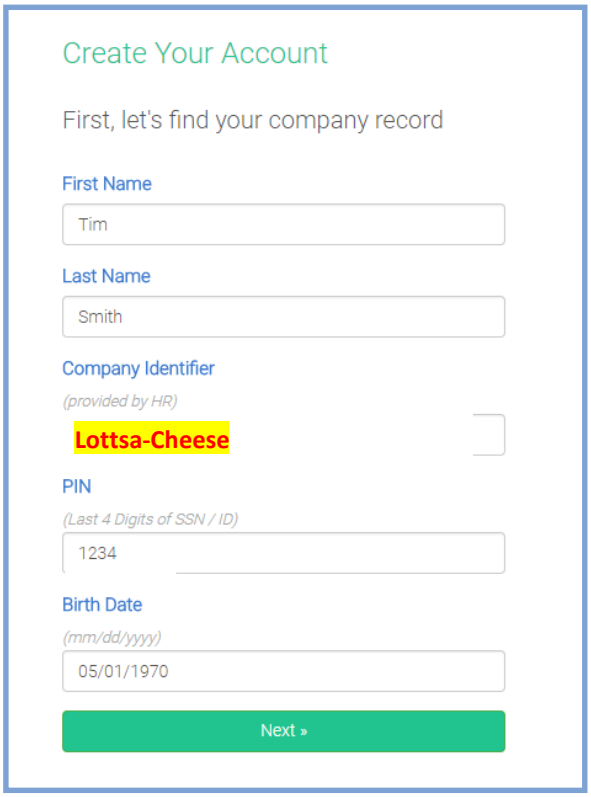
You will enroll in your benefits online on the Employee Navigator system. You must login to Employee Navigator to make your benefit selections or to waive coverage. You can also meet with your Brown & Brown contacts to enroll.

1. To login, please go to:

www.employeenavigator.com



2. Click on "Register as a new user" and input your: First Name, Last Name, Company Identifier which is **Lottsa-Cheese,** the last four of your SSN as your pin, and your birth date and click "Next".



3. Create a username and password and then click "Next"

4. Once logged in, please select the "Start Benefits" button

5. Ensure your information and address are correct, then click "Next"

6. Enter any dependents you would like to cover on any of your employee benefits, then click "Next"

7. Select the dependents you want on each plan, and which plan you'd like. If you would like to waive a particular benefit, please select "Don't want this benefit" at the bottom of the page

8. Once all benefits have been elected, confirm your selections and click "Done" on the Enrollment Summary page to complete your enrollment

9. Write down Username and Password:

Employee Navigator Login Information
Username: _____
Password:_____

KNOW WHERE TO GO

With so many options for receiving care, it can be hard to know where to go. This chart helps you understand the best choices for getting appropriate medical treatment and how to save money while still getting the care you need.

	Description	Type of Care	Cost
Virtual Visits 	A virtual visit lets you see a doctor via your smartphone, tablet, or computer.	• Allergies • Seasonal Flu • Sinus problems • Sore Throats • Stomach aches • Rashes • Bronchitis • Cough/Cold • Fever • Pink Eye	$
Convenience Care Clinics 	Visit a convenience care clinic when you can't see your doctor and your health issue isn't urgent. These clinics are often in stores.	• Strep Throat • Minor skin conditions • Vaccinations • Pregnancy tests • Earaches	$$
Primary Care Physician 	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Check-ups • Preventative services • Vaccinations • General Health Management	$$
Urgent Care 	Urgent care is ideal for when you need care quickly, but it is not an emergency. Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Small cuts that may need stitches • Minor Burns	$$$
Emergency Room 	The ER is for life threatening or very serious conditions that require immediate care. This is also when to call 911.	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain	$$$$

CHEAT SHEET:
KEY TERMS FOR OPEN ENROLLMENT

Open Enrollment is the annual period when employees can review, update, or renew their benefits elections, including health care coverage for the upcoming calendar year. Understanding employee benefits can be challenging, especially when the terminology is unfamiliar.

Healthcare Terms

Coinsurance is the portion of health care costs that you will share with the insurance company. For example: the member's co-insurance is 40%, and the insurer's co-insurance is 60%. For most services, the deductible must be paid before co-insurance applies.

Copayment (copay) is the set amount you will pay when receiving a medical service or a prescribed medication.

Covered charges are health care expenses that are covered under your health plan.

Deductibles are a specific dollar amount you pay out of pocket before benefits are available through a health plan.

Dependents are individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

I**n-network** refers to health care received from your primary care physician or a specialist within an outlined list of health care practitioners.

Inpatient refers to a person who is treated as a registered patient in a hospital or other health care facility.

Medicare is an insurance program administered by the federal government to provide health coverage to individuals aged 65 and older or who have specific disabilities or illnesses.

Out-of-network refers to health care you receive without a physician referral or services received from a nonnetwork service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket maximum (OOPM) is the maximum amount/risk you would be responsible for paying in health care expenses annually. OOPM includes deductible + the member's portion of coinsurance and co-pay. The out-of-pocket maximum does not include premiums, costs for non-essential health benefits, balance billing amounts for non-network providers, or expenditures for non-covered services.

Premium is the amount you pay for a health plan in exchange for coverage; health plans with higher deductibles typically have lower premiums.

Primary care physicians (PCPs) are doctors who are selected to coordinate treatment under your health plan, generally including family practice physicians, general practitioners, internists, and pediatricians.

Prescription Terms

Prior authorization requires approval in advance. The authorization form must be submitted by your doctor.

Step therapy is a type of prior authorization that requires you to try a less expensive drug that's used to treat the same condition before you can move up a "step" to a more expensive drug.

Quantity limits define the restricted amount or quantity of medication that's covered by your plan during a specific period.

Medical Plan
Option 1

Your health is important, and having the right medical coverage helps protect you and your family from high healthcare costs. Lottsa Cheese offers an **Allied Base major medical plan** designed to provide comprehensive coverage for a wide range of healthcare needs, including doctor visits, hospital care, and prescription medications.

Coverage Level	Pay Period Deduction
Employee Only	$32.47
Employee + Spouse	$192.34
Employee + Child(ren)	$130.45
Employee + Family	$269.69

Benefits	In-Network
Annual Deductible	Individual: $7,150 Family: $14,300
Coinsurance	Plan Pays: 100% You Pay: 0%
Annual Out-of-Pocket Max	Individual: $7,150 Family: $14,300
Primary Care Physician	$20
Specialist	$35
Virtual Doctor (Recuro Health)	$0
Urgent Care	$75
Emergency Room	Deductible
Labs *(Outpatient & Professional Services)*	Deductible
X-Rays & Diagnostic Imaging	Deductible
Imaging *(CT/PET Scans, MRIs)*	Deductible
Preventive Care	100%
Pharmacy *Generic* *Preferred (Brand Tier 2)* *Non-Preferred (Brand Tier 3)*	 $20 $50 $75
Mail Order (90 Day Supply) *Generic* *Preferred (Brand Tier 2)* *Non-Preferred (Brand Tier 3)*	 $60 $150 $225

Medical Plan

Option 2

Your health is important, and having the right medical coverage helps protect you and your family from high healthcare costs. Lottsa Cheese offers an **Allied Buy-Up major medical plan** designed to provide comprehensive coverage for a wide range of healthcare needs, including doctor visits, hospital care, and prescription medications.

Coverage Level	Pay Period Deduction
Employee Only	$61.63
Employee + Spouse	$257.63
Employee + Child(ren)	$181.76
Employee + Family	$352.47

Benefits	In-Network
Annual Deductible	Individual: $1,000 Family: $2,000
Coinsurance	Plan Pays: 80% You Pay: 20%
Annual Out-of-Pocket Max	Individual: $4,500 Family: $9,000
Primary Care Physician	$20
Specialist	$35
Virtual Doctor (Recuro Health)	$0
Urgent Care	$75
Emergency Room	Deductible, Coinsurance
Labs *(Outpatient & Professional Services)*	Deductible, Coinsurance
X-Rays & Diagnostic Imaging	Deductible, Coinsurance
Imaging *(CT/PET Scans, MRIs)*	Deductible, Coinsurance
Preventive Care	100%
Pharmacy *Generic* *Preferred (Brand Tier 2)* *Non-Preferred (Brand Tier 3)*	 $20 $50 $75
Mail Order (90 Day Supply) *Generic* *Preferred (Brand Tier 2)* *Non-Preferred (Brand Tier 3)*	 $60 $150 $225

Employee Benefit Announcement

Your employer-established health benefit plan is provided by Allstate Benefits and administered by Allied Benefit Systems, LLC (Allied).

Your plan works a little differently than the traditional PPO plans you might be accustomed to. With this plan, there is no network; you are free to use any doctor or hospital you choose (except for transplants and outpatient prescription drugs). The plan pays the same benefits regardless of where you go. The Member Advocacy Program described below is an important component of your plan, and team members are available to assist with billing and covered charge inquiries.

Members in the health benefit plan will only receive new Medical ID Card(s) if at least one of the following occurred at renewal: new members or an enrollment change. Otherwise, members can continue to use their current Medical ID Card(s). With the online tools outlined below, you can access temporary ID cards immediately, as well as all your plan documents.

Member Advocacy Program: An Important Part of Your Coverage

Health care and health care benefits can be complicated, and we know it's important to you to make the right health care choices for your family. Allstate Benefits and Allied have teamed up to provide you with a dedicated Member Advocacy Team. The team is available to help you:

- Understand your benefits and how to use your plan
- Understand your Explanation of Benefits (EOB)
- Find providers
- Answer questions about billing

Remember, this plan is different and does not pay benefits like a traditional PPO plan. It's important to know the amount you are responsible for on the provider bill. When you receive medical care, if you have a copay, you are required to pay that at time of service. After you receive care:

- You will receive an Explanation of Benefits (EOB) – EOBs are also available to you on the member portal at www.alliedbenefit.com
- The EOB will show what the plan paid and what is the Patient Responsibility
- You receive a bill from the provider
- Make sure your bill from the provider matches the Patient Responsibility portion on the EOB
- If you are billed for amounts that exceed the Patient Responsibility, call the Member Advocacy Team at 888-306-0905 before you pay any excess amounts. The team will help you understand what is your responsibility and what is not*
    - If you pay the provider for those excess amounts, they are not eligible for dispute under the Program

*Not all provider billing is eligible for the Member Advocacy Program. Excluded charges include, but are not limited to: Any amounts paid for by the member, charges for non-covered services or charges in excess of a benefit limit; charges for penalties under the plan (such as the 30% penalty for non-emergency use of an Emergency Room); non-emergency medical transportation when an authorized provider is not used, charges that should be bundled with another service charge (such as for the second and subsequent surgeries in the same surgical session and assistant surgeon and surgical assistant charges that should be billed as part of the surgical event). This list is subject to change without notice. Call the Member Advocacy Team to verify if charges are eligible.

To speak with a dedicated Team Member, please call 888-306-0905

Allied Member Advocacy Team hours (Central time)	
Monday–Thursday	7:30 a.m. to 7:00 p.m.
Friday	8:00 a.m. to 5:00 p.m.
Saturday	9:00 a.m. to 12:00 p.m.

Your plan also includes a Maternity Program – a valuable benefit that provides one-to-one support from a registered nurse for the health of you and your baby. Call the Member Advocacy Team to enroll.

For more details and other plan benefit information, we encourage you to visit your online member portal.

Your online member portal

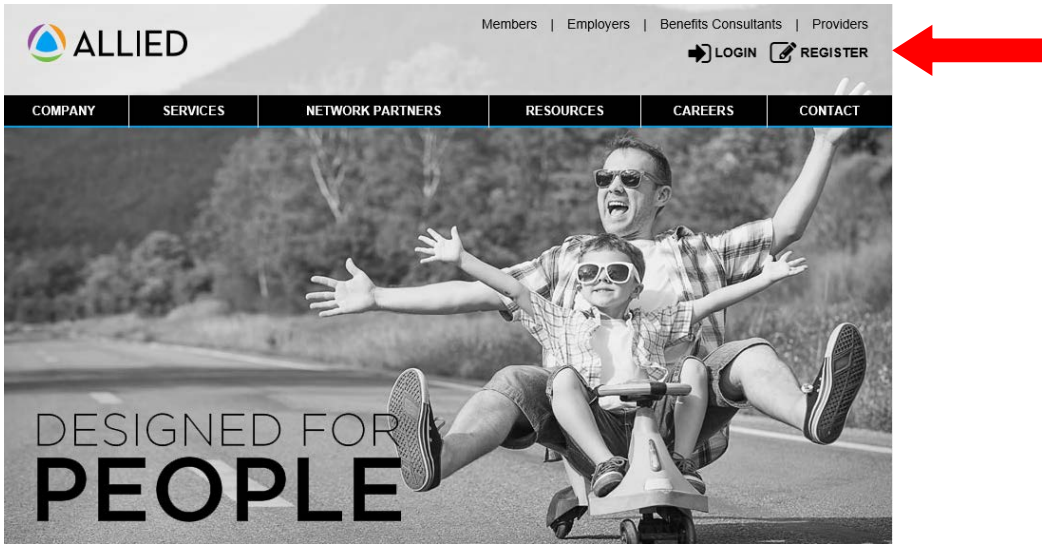
Refer to the following instructions for creating your member web account at www.alliedbenefit.com. This is where you go to access:

- Your plan documents
  - Summary Plan Description (SPD)
  - Summary of Benefits and Coverage (SBC)
  - Temporary ID cards
- View your own Personal Health Record for a complete record of all your health care activity under this plan
- Reports to help you understand how your claims have been processed and you can check claim status
- Allied's knowledge database, where you can get answers to medical questions, procedures & conditions
- Wellness reminders for tests and annual exams

Accessing Your Member Web Account

To access your Allied member web account. Here's how:

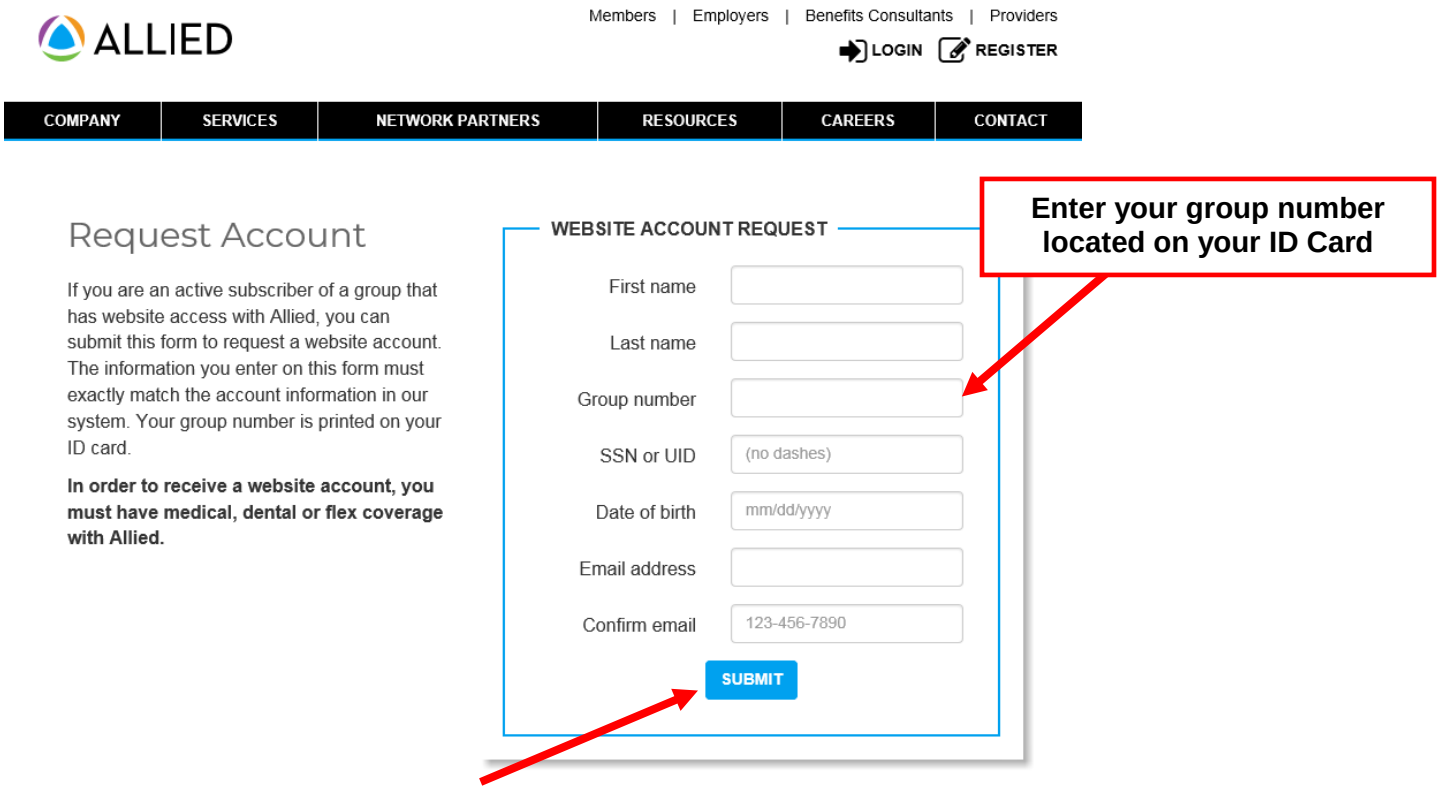
1) Go to **www.alliedbenefit.com**, you will be directed to Allied's home page.
   - Select "**LOGIN**", if you have your Allied member web account number and password; **or**
   - Select "**REGISTER**", if you never accessed your account. See instructions on next page.



Setting-Up Your Allied Member Web Account, for the first time

It only takes a few minutes to set up your Allied member web account, at: **www.alliedbenefit.com**, select "**REGISTER**" and proceed as follows:

1) Enter the required information into "**WEBSITE ACCOUNT REQUEST**" with your personal information. Your "**Group number**" begins with an L followed by 6 numbers and can be found on your ID Card or obtained from your employer.



2) Then select "**Submit**" button and you will receive your account information to the E-mail address you provided.
3) Once you have your login information, you can access your Allied member web account 24 hours a day at:

www.alliedbenefit.com

If you need help registering or logging in to the member portal, please call **888-306-0905** for assistance.

get to know your Core Value Plan

Allstate BENEFITS

How it works!

Your plan pays providers based on a multiple of the Medicare reimbursement rate[1] for each service you receive. There is no network[2], so you can go to any provider you want. Here's how it works:

1. Seek Care

You can go to any doctor or hospital[2]; simply show your Medical ID card to the provider.

If they have any questions, they can call the Customer Service number on the back of your card.

2. Receive Your EOB

You will receive an Explanation of Benefits (EOB) showing your Patient Responsibility. This includes copays, coinsurance, charges for non-covered services, and deductible amounts.

3. Review Your Bill

Your provider will send you a bill for any amounts due to them. This bill should not exceed the Patient Responsibility as shown on your EOB.

4. When to Call

If your bill shows an amount that exceeds the Patient Responsibility on your EOB, call the MAP Team immediately.

888-306-0905

5. The Team Gets to Work

MAP will work with your provider to resolve any inconsistencies on your bill. Afterward, you'll receive a letter explaining the resolution.

The Member Advocacy Program[3] (MAP) is here to:

- Answer questions about billing.
- Clarify your EOB.
- Find providers.
- Help you understand your benefits and how to use your plan.

Call at 888-306-0905

[1] Or a derived equivalent of the Medicare reimbursement rate. | [2] Pharmacy benefits and transplants still rely on the use of network providers.
[3] Non-covered services and certain other charges are not eligible for the program.

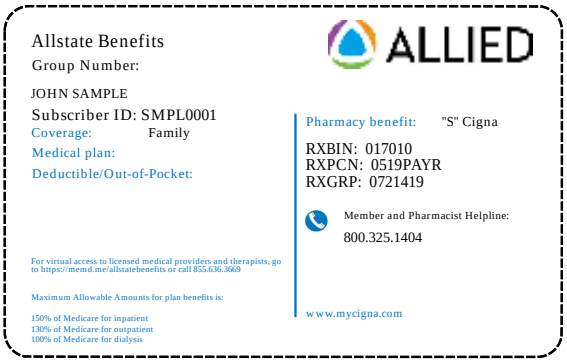
The Allstate Benefits Self-Funded Program provides tools for employers owning small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. Allstate Benefits is a marketing name for: Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in CO, WA and all other states where offered. For employers in the Allstate Benefits Self-Funded Program, stop loss insurance is underwritten by these insurance companies in the noted states.

ALLIED MEMBER PORTAL

Allstate BENEFITS

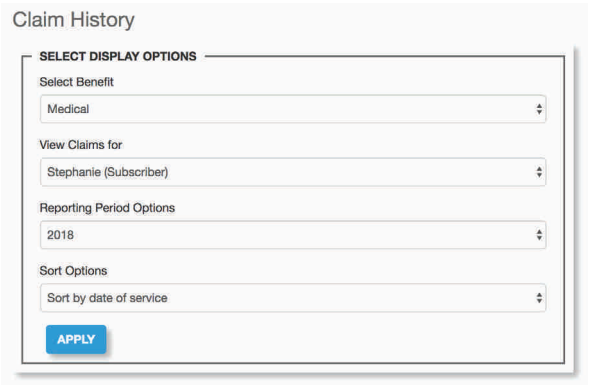
Use your secure member account to manage your benefits and take control of your healthcare. Log in to your account to experience these features and more.

ACCESS YOUR ID CARD

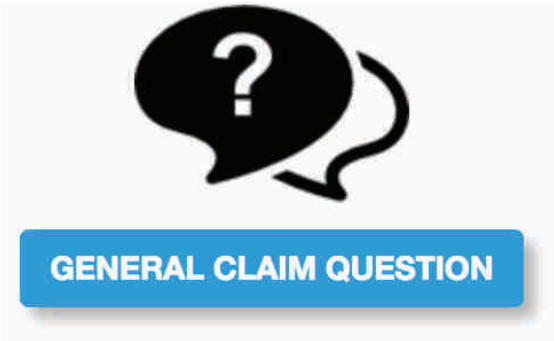

Allstate Benefits
Group Number:
JOHN SAMPLE
Subscriber ID: SMPL0001
Coverage: Family
Medical plan:
Deductible/Out-of-Pocket:
For virtual access to licensed medical providers and therapists, go to https://memd.me/allstatebenefits or call 855.636.3669
Maximum Allowable Amounts for plan benefits is:
150% of Medicare for inpatient
130% of Medicare for outpatient
100% of Medicare for dialysis
ALLIED
Pharmacy benefit: "S" Cigna
RXBIN: 017010
RXPCN: 0519PAYR
RXGRP: 0721419
Member and Pharmacist Helpline:
800.325.1404
www.mycigna.com

VIEW YOUR PERSONAL HEALTH RECORD

VIEW YOUR CLAIMS



GET ANSWERS TO YOUR BENEFITS QUESTIONS



HOW TO ACCESS PORTAL

NEW MEMBERS

1. Click **"REGISTER"** on top right corner of AlliedBenefit.com
2. Enter information in **"WEBSITE ACCOUNT REQUEST"**
3. Click **"SUBMIT"**

EXISTING MEMBERS

1. Click **"LOGIN"** on top right corner of AlliedBenefit.com
2. Enter account number and password
3. Click **"LOGIN"**

AlliedBenefit.com

Cigna Payer Solutions

YOUR PHARMACY BENEFITS

Five ways to get the most out of your pharmacy benefit plan

1. Use myCigna.com

Use the website or app for quick access to:

- See your pharmacy claim history
- Read your benefit details
- See medication prices based on your plan
- Ask a pharmacist a question
- Manage your Cigna Home Delivery Pharmacy℠ orders and request refills[1]

2. Learn what medications are covered

Save money by checking out the list of medications covered under your plan on **myCigna.com**. The amount you pay depends on whether your medication is listed as a generic, preferred brand, non-preferred brand or specialty medication.

3. Use the Drug Cost tool[2]

View medication costs based on your pharmacy plan, see if there are lower cost alternatives and compare prices between retail pharmacies and Cigna Home Delivery Pharmacy.[1] When discussing medicines with your doctor, use the tool on the myCigna® app.

Questions? Call the toll-free number on the back of your ID card.

4. Fill your medications in a 90-day supply

Cigna 90 Now℠ makes it easier to fill the medications you take every day.

- Choose where you want to fill your 90-day prescriptions – at a 90-day retail pharmacy in your plan's network, or through Cigna Home Delivery Pharmacy[1]
- Make life easier by taking fewer trips to the pharmacy to refill, and help stay healthy – with a 90-day supply on hand, you're less likely to miss a dose[3]
- Go to **Cigna.com/Rx90network** to learn more about the benefits of a 90-day supply and the pharmacies in your plan's network.

5. Get help with specialty medications

We can help you understand, manage and treat your condition. Our therapy management teams, made up of health advocates with nursing backgrounds and pharmacists, are specially trained to help deliver the best experience possible. We offer:

- Personalized, 24/7 support
- Condition-specific education on medication therapy and side effects
- Help with medication approval process
- Financial assistance programs if needed

Together, all the way.®

Cigna®

1. Plans vary, so some plans may not include Cigna Home Delivery Pharmacy or 90-day retail pharmacy. Please check your plan materials for more information on what pharmacies are covered under your plan.
2. Prices are not guaranteed, nor is the display of a price a guarantee of coverage. Your costs and coverage may vary at the time you fill your prescription at the pharmacy, and pricing at individual pharmacies may vary. Coverage and pricing terms are subject to change. Your pharmacy may offer a special sale price on a specific medication which may be less than the price displayed here. Please consult your pharmacy.
3. Internal Cigna analysis performed March 2016, utilizing 2015 Cigna national book of business average medication adherence (customer adherent > 80% PDC), 90-day supply vs. those who received a 30-day supply taking antidiabetics, RAS antagonist and statins.

NextGen Care

Urgent Care

24/7 Acute Care Access

24/7 access to board-certified doctors for treatment of common medical concerns with ongoing communication with your doctor. Accessible virtually through phone, web, and desktop computer.

Product Highlights

Coordinated

If needed, urgent care can seamlessly transition to Recuro's ongoing virtual primary care to improve patient health and preempt future issues.

Convenient

Patients can see a board-certified physician wherever they are, whenever they need it.

Personalized

Patients receive treatment plans based on their unique needs and can ask follow-up questions to their doctors after the visit, free of charge.

- 24/7 Access
- Multi-Channel Options
- Electronic Prescription Ordering
- Consult Transcriptions

RECURO HEALTH

info@recurohealth.com | 844.979.0313 | www.recurohealth.com | Scan QR Code

11 Minutes

Did you know?

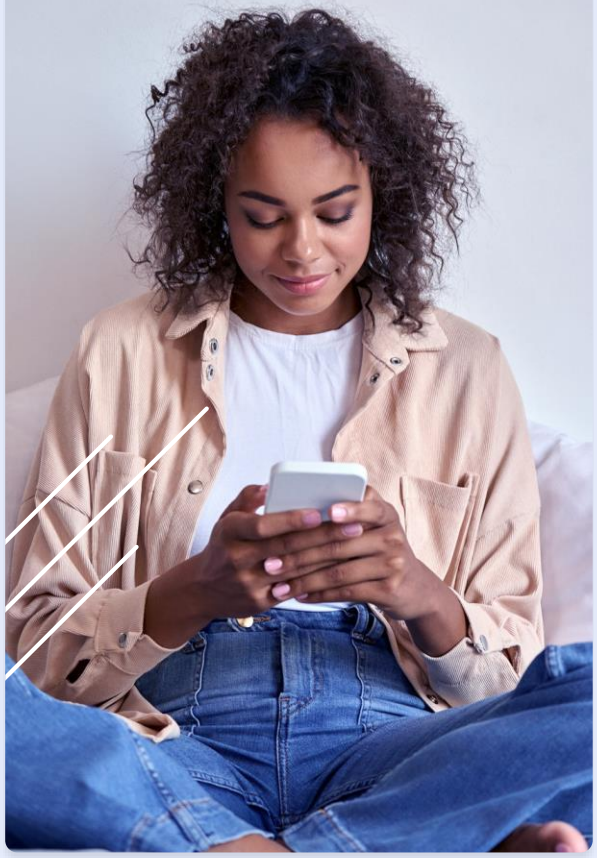
The average wait time for an urgent care consult is only 11* minutes.

*Subject to provider listed availability

Virtual Care Platform

NEXTGEN CARE

BENEFITS



Product Details

24/7 Access
Recuro physicians are available whenever our patients need them, day or night.

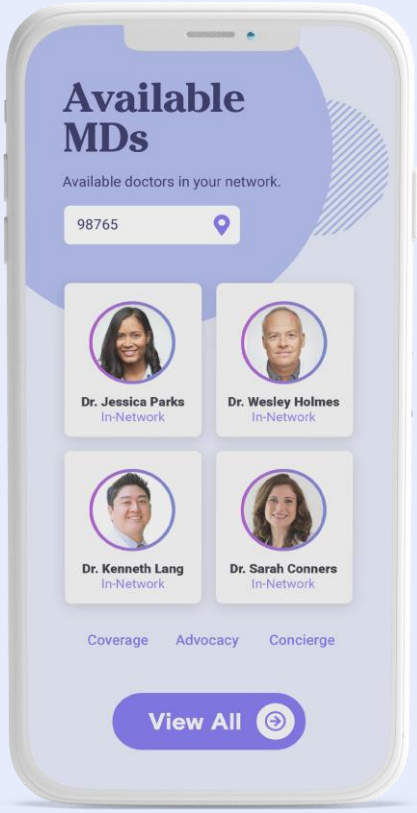
Multi-Channel Options
Live video, phone, and messaging options let each patient receive care the way they like.

Consult Transcription
Consults can be recorded and transcribed, allowing patients continuous access to information.

Electronic Prescription Ordering
Prescriptions are immediately sent to the patient's preferred pharmacy for easy pickup.

Conditions Treated

- Acne / Rashes
- Allergies
- Cold / Flu / Cough
- GI Issues
- Ear Problems
- Fever / Headache
- Insect Bites
- Nausea / Vomiting
- Pink Eye
- Respiratory Issues
- UTI's / Vaginitis
- And More



Dental Benefits

Your Dental Insurance is administered by **UNUM**. Dental insurance helps pay for dental care that includes checkups, cleanings, and X-rays. Many studies suggest that oral diseases, such as periodontitis, can affect other areas of your body – including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Coverage Level	Pay Period Deduction
Employee Only	$9.35
Employee + Spouse	$18.43
Employee + Child(ren)	$22.12
Employee + Family	$33.56

Coverage	In-Network Benefits
Annual Deductible (Calendar Year)	$25 Individual (Maximum 3 per Family) Waived for Preventive
Carrier Annual Maximum	$2,000
Preventative • *Cleanings* • *Oral Exams* • *Sealants* • *X-Rays*	Covered at 100% (deductible waived)
Basic Services • *Simple Extractions* • *Periodontics*	Covered at 80%
Major Services • *Dentures* • *Crowns* • *Implants* • *Endodontics*	Covered at 50%
Out-of-Network Reimbursement	90% Usual and Customary Charges
Rollover Benefit	You may rollover a portion of your unused annual maximum each year.

Employees are not sent hard copy Dental ID cards, instead, you will need to log onto the plan member site to register and access your card electronically at www.myunum.com. You can also download the Mobile App.

Vision Benefits

Your vision plan is administered by **UNUM** and utilizes the **EyeMed Insight Network.**

Find providers at www.eyemed.com.

Coverage Level	Pay Period Deduction
Employee Only	$1.16
Employee + Spouse	$2.33
Employee + Child(ren)	$2.54
Employee + Family	$3.99

Benefits	EyeMed Insight Network
	In-Network
Eye Exams	$10 Copay
Eyeglasses	
Single Standard Lenses	$10 Copay *(Additional cost may apply to specialized lenses. Please refer to your plan document.)*
Bifocal Standard Lenses	
Trifocal Standard Lenses	
Lenticular Lenses	
Frames	$130 allowance
Contact Lenses	
Non-Elective	Covered in Full
Elective: Conventional / Disposable	$130 allowance *(allowance includes materials only)*
Frequency	
Eye Exam	Once every 12 months
Lenses—Eyeglass or Contact	Once every 12 months
Frames	Once every 24 months
Out-of-Network	
Out of Network Benefits	A claim will need to be submitted for reimbursement at the rates listed on the plan documents.

Employees are not sent hard copy Vision ID cards, instead, you will need to log onto the plan member site to register and access your card electronically at www.eyemedvisioncare.com/unum. You can also download the Mobile App.

Life Insurance

Voluntary Life and AD&D Insurance

Some employees may want to purchase additional coverage. With **voluntary** Life and AD&D Insurance, you are responsible for the full cost of coverage. Employee and Spouse rates are calculated based on the individual's current age as of the effective date of the plan**. Benefits begin to reduce at age 65.** This coverage is offered through **UNUM.**

Evidence of Insurability (EOI) forms are required for any amount that exceeds the guaranteed issue amount or if elected outside of the new hire window.

Coverage	Benefit Amounts	Guarantee Issue
Employee	Increments of **$10,000** up to a maximum of **$500,000**	$70,000
Spouse	Increments of $**5,000** up to a maximum of **$250,000**	$25,000
Child(ren)	**$2,000 to a max of $10,000** A full benefit is payable from 14 days up to 26 years. Infants 14 days to 6 months receive $1,000	$10,000

You can update your beneficiaries on Employee Navigator at any time, but it is always a good idea to update them every open enrollment.

Disability Insurance

Voluntary Short-Term Disability

Often referred to as paycheck insurance, this coverage provides income in the event you are unable to work due to an illness, injury, or other qualifying condition. In the event you become disabled, a cash payment is made directly to you. The benefits from this policy will be reduced by any additional income you receive during the period of disability. **This is a voluntary benefit** and offered through **UNUM.**

Benefit Specifications	
Benefits Begin (Elimination Period)	If you become disabled, there is an elimination period before benefits are payable. Benefits begin being paid on the **8th day** due to an injury and on the **1st day** due to a sickness.
Weekly Benefit	Weekly benefit payout will be equal to **60%** of your pre-disability base salary up to a maximum of **$1,000 per week.**
Benefits Period	If your claim is approved, benefits will be paid up to **13 weeks**, dependent on the condition.
Pre-Existing Conditions Clause	3-month look back / 12-month exclusion

Voluntary Long-Term Disability

Often referred to as paycheck insurance, this coverage provides income in the event you are unable to work due to an illness, injury, or other qualifying condition. In the event you become disabled, a cash payment is made directly to you. The benefits from this policy will be reduced by any additional income you receive during the period of disability and is a taxable benefit. **This is a voluntary benefit** offered through **UNUM.**

Benefit Specifications	
Benefits Begin (Elimination Period)	Benefits begin after **90th day** of disability.
Monthly Benefit	Monthly benefit payout will be equal to **60%** of your pre-disability base salary up to a maximum of **$6,000** per month.
Benefits Period	If you are disabled, benefits can be paid through Social Security Natural retirement age (SSNRA)
Pre-Existing Conditions Clause	3-month look back / 12-month exclusion.

Individual disability insurance, social security income, and unemployment insurance, will reduce the Short-Term and Long-Term Disability benefits. This plan does not pay if incident is due to a Workers Compensation claim."

Accident Insurance

Your Accident plan is administered by **UNUM**. Accidents can occur at anytime. Medical expenses associated with an accident can be costly. Accident insurance is a cash benefit which pays you directly for medical procedures preformed as a result of an accident. It is your decision as to what to do with the money you receive in the event of a claim from this plan. Please see below for a brief overview of plan benefits/ cash pay outs. A detailed plan summary can be viewed by logging into the online enrollment system. This plan is not a replacement for major medical insurance.

Coverage Level	Pay Period Deduction
Employee Only	$3.24
Employee + Spouse	$5.73
Employee + Child(ren)	$7.40
Employee + Family	$9.89

Benefit	
Ambulance Air/Ground	$1,500/$400
Appliance	$100
Burns	Up to $10,000
Coma	$10,000
Concussion	$150
Dental Injury	Up to $300
Dislocation	Up to $6,000
Emergency Room	$150
Eye Injury with surgical repair	$300
Fracture	Up to $7,500
Hospitalization	Up to $1,500
Medical Imaging	$200
Physician/Urgent Care	$75
Tendon/ligament/rotator cuff injury with surgical repair	Up to $1,200
Accidental Death and Dismemberment	$50,000 (employee) $20,000 (spouse) $10,000 (child)
****Additional benefits are payable. Please refer to the plan document.****	
Annual Wellness Benefit	$50 per covered person

Supplemental products require a claim process. You must file a claim for reimbursement to receive a benefit pay-out. You must also attach a doctor's bill and your Explanation of Benefit from your Health Insurance Carrier along with your Claim. Please see Brown & Brown or your online benefits portal for the proper claim forms.

Critical Illness Insurance

Your Critical Illness plan is administered by **UNUM**. Medical expenses associated with the diagnosis of a critical illness can be costly. This plan pays you a lump sum cash payment if you are diagnosed with a serious illness. It is your decision as to what to do with the money you receive in the event of a claim from this plan.

Please see below for a brief overview of plan benefits/cash pay outs**. This plan is not a replacement for major medical insurance.**

Coverage Amounts	Benefit
Employee	$10,000 or $20,000
Spouse	$5,000 or $10,000
Child	Children are automatically covered at 50% of the employee's benefit
Conditions	First Occurrence
Invasive Cancer	100%
Coma	100%
Benign Brain Tumor	100%
Coronary Artery Disease	50%
Heart Attack	100%
Stroke	100%
Major Organ Failure	100%
Kidney Failure	100%
Childhood conditions – Child only (see plan document for conditions)	100%
Annual Wellness Benefit	$50 per covered person per year

The rates for this plan are based on your age and level of coverage. Please refer to the online enrollment system for your specific coverage options and rates.

Supplemental products require a claim process. You must file a claim for reimbursement to receive a benefit pay-out. You must also attach a doctor's bill and your Explanation of Benefit from your Health Insurance Carrier along with your Claim.
Please see Brown & Brown or your online benefits portal for the proper claim forms.

UNDERSTANDING MEDICARE

Even if you have health insurance through an Employer, it is important to be informed about all of your insurance options.

When it comes to Medicare, making uninformed decisions can lead to costly financial penalties.

Benefits of Medicare:

- ✓ The potential to lower your medical expenses
- ✓ In many regions, Medicare provides better coverage than some employer-sponsored plans
- ✓ It is likely that your current doctors accept Medicare
- ✓ Some plans also provide additional benefits such as dental care, transportation to healthcare facilities, and other services

How Does Medicare Work?

Original Medicare Options:

Medicare Part A – known as "hospital insurance"

What's Covered?

- Inpatient care in a hospital
- Skilled nursing facility care
- Hospice care
- Home health care

Medicare Part B – known as "medical insurance"

What's Covered?

- Doctor visits
- Medically necessary services
- Hospice care
- Home health care

Do I need to enroll?

When you are nearing eligibility, it's important to understand your options so you can make informed decisions. Individual circumstances will ultimately determine when you should enroll in Medicare.

When considering your options, keep the following in mind:

- Most individuals should enroll in Part A upon becoming eligible
- Certain people may choose to wait to enroll in Part B, depending on individualized circumstance
- If you do not qualify for premium-free Part A, you cannot enroll in Part A without first enrolling in Part B

If you are eligible for Medicare or approaching the age of 65, a *free consultation* with one of our agents can help you determine important next steps.

Follow this link to schedule an appointment: Medicare Consultation

**Please make sure to schedule appointment with Simon Coats or Susan Brown*

IMPORTANT NOTICES

CONTACT INFORMATION	
Mailing Address	1991 Glenns Bay Rd, Unit 102 Surfside Beach, SC 29575
Contact Name	Darlene Keck
Contact Title	Office Manager
Contact Phone:	842-828-0669

Your Medicare Part D Notice is the first section of this packet. Some other key notices include CHIPRA, HIPAA Privacy, and Notice of Coverage Options (Marketplace Notice). If you have any questions, please reach out to the contact listed above.

MEDICARE PART D
NOTICE OF CREDITABLE COVERAGE

An Important Notice from your Employer 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 your employer 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. Your employer has determined that the prescription drug coverage offered by the Welfare Benefit 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 employer coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current your employer coverage, be aware that you and your dependents will be able to get this coverage back at the next annual enrollment opportunity or qualified life event.

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 your employer 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.

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).

Note: You'll get this notice each year. You may also request a copy.

For more information about your option under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will be mailed a copy from Medicare each year. For more information about Medicare prescription drug coverage:
Visit www.medicare.gov. Call your State Health Insurance Assistance Program (or see "Medicare & You" Guide)
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Effective Date:	December 1, 2025
Name of Entity/Sender:	Lottsa Cheese, Inc.
Contact--Position/Office:	Darlene Keck - Human Resources

IMPORTANT NOTICES

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your employer.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your employer.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices is available for medical from Human Resources.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets

An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema. Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your employer.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 this 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

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.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

ADDITIONAL NOTICES

Patient Protection Rights Under Health Care Reform – Plans that require or allow for the designation of primary care providers by participants or beneficiaries

Some health plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your health plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your health plan using the contact information provided in the Benefit Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your health plan using the contact information provided in the Benefit Guide.

Health Insurance Marketplace Coverage Options and Your Health Coverage

•Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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.

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 on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-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..[1][2]

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.

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.**

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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?

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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer name Lottsa Cheese, Inc		Employer Identification Number (EIN) 57-0972940
Employer address 1991 Glenns Bay Rd, Unit 102		Employer phone number 842-828-0669
City Surfside Beach	State SC	ZIP code 29575
Who can we contact at this job? Human Resources		
Phone number (if different from above)	Email address Darlene@lottsacheese.com	

If you are not eligible for health insurance coverage through this employer, you and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

HEALTHCARE REFORM
Notice of Health Care Reform Changes

As a reminder, the following changes to your employer's Medical Plans and are still valid for this plan year.

- The lifetime benefit limit will be unlimited on essential services.
  - There will be no annual limit on essential benefits. Essential benefits may include:
  - Ambulatory Patient Services
  - Emergency Services
  - Hospitalization
  - Maternity and Newborn Care
  - Mental Health and Substance Abuse Disorders
  - Prescription Drugs
  - Rehabilitative and Facilitative Services and Devices (including durable medical equipment)
  - Laboratory Services
  - Prevention and Wellness Services
  - Chronic Disease Management
  - Pediatric Services, including oral and vision care
- Certain Preventive services are now covered 100% at no charge when you use the medical carrier's network providers. These include:
  - Routine adult physical
  - Routine Well child Exams
  - Routine Gynecological exams (includes pap and related fees)
  - Colorectal Cancer Screening
  - Routine mammograms
- Most Generic Oral Contraceptive Medications & Products for $0 cost-share. (FDA Approved Contraceptive Methods for women). Items available without a prescription are not covered under the Health Care Reform law.
- Pre-existing Condition exclusions do not apply
- Dependents may be covered until age 26. Dependents under the age of 26 may enroll within 30 days of renewal for coverage effective the start of the plan year.
- Primary care physicians: a participating physician specializing in pediatrics may be selected as the primary care physician for a covered dependent child.
- Gynecological and obstetric services: Authorization or referral for gynecologic or obstetric care will not be required.
- Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

FAMILY MEDICAL LEAVE ACT

Employee Rights & Responsibilities

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
for incapacity due to pregnancy, prenatal medical care or child birth;
to care for the employee's child after birth, or placement for adoption or foster care;
to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service- member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule
leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:
interfere with, restrain, or deny the exercise of any right provided under FMLA; and
discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor Wage and Hour Division

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under your employers group health 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.

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 after the qualifying event occurs. You must provide this notice to your Plan Administrator.

COBRA NOTICE CONTINUED

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.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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 B is 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.gov/ebsa. (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.

OMB Control Number 1210-0123 (expires 1/31/2026)

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, 2025. 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
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

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

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
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

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

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, 2025, 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)

Benefit Guide /Open Enrollment Presentation Disclaimer

This document is designed to provide basic information regarding benefit plans and programs available to eligible employees. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the “plan documentation”) for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual’s rights under any employee benefit plan or program. Your employer reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

Brown & Brown is your benefits broker and will work with the insurance carriers on your behalf. For assistance with claims, billing issues, network issues, coverage questions and any other benefit-related questions, please contact:

Service Inbox
Fast responses for day-to-day service needs
285.service@bbrown.com
843-266-4588

Office Hours: Monday through Friday, 8:00 am to 5:00 pm EST

Brown & Brown INSURANCE®

SOUTH CAROLINA

This guide is only intended to offer an outline of benefits. All details and contract obligations of plans are stated in the group contract/insurance documents, including any disclosures (whether regarding "grandfathering" of plans or others) required by the new health reform law, the Patient Protection and Affordable Care Act (PPACA). In the event of conflict between this guide and the group contract/ insurance documents, the group contract/insurance documents will prevail. Please contact your Human Resource Department for further information.