THE WINE GROUP

# 2025 Benefit Information Guide

# Welcome

The Wine Group (TWG) is truly proud of our employees' dedication and valuable contributions to our company's success. We strive to provide you and your family with tools and resources that help you live your healthiest life. The benefits you'll find here are carefully chosen to support your life outside of work, whatever it looks like for you. Whether you're checking it out for the first time or stopping by for a visit, this guide is crafted to help you choose the right benefits. We'll talk about medical, dental, vision, spending accounts, retirement, and more.

## PLAN SUMMARY

Does this guide contain everything I need to know about my health plan?

While there are many brief benefit summaries listed throughout this guide, they're just that: summaries. When you're trying to figure out whether a medical service or a medical supply will be paid for by your health plan, it's best to take a look at the Evidence of Coverage or Summary Plan Description as well. These documents have more details about your coverage. You can find them in your benefit administration portal, or by contacting HR. They're the final place you'll need to look if you have questions about your coverage because they're the binding agreement between you and the plan. If you notice differences between benefits in this guide and the Evidence of Coverage or Summary Plan Description, you should go by what's written in those documents, not this guide.



The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 33 for more details.

# Contents

# *Eligibility & Enrollment*

Quick answers to your questions

## WHO CAN SIGN UP?

All employees who regularly work at least 30 hours per week are eligible to enroll in our medical plan and 40 hours per week for all other benefits. More good news: you can also cover your spouse or domestic partner, eligible child(ren), and any other individual described in an eligible class for that benefit. Just keep in mind, you will be taxed on imputed income if covering a domestic partner or their child(ren).

### SPOUSAL SURCHARGE

When you enroll, you'll be asked to choose an option about adding a spouse/domestic partner to our medical plan:

- Domestic partner is eligible for employer medical and declines (monthly $200 surcharge will apply - see pg. 10)
- Not adding a spouse/domestic partner to medical coverage or waiving medical (no surcharge)
- Spouse is eligible for employer medical and declines (monthly $200 surcharge will apply – see page 10)
- Spouse/domestic partner is not employed or ineligible for employer medical (no surcharge)
    - You may also choose this option if your spouse/domestic partner IS enrolled in employer medical.

## WHEN DOES MY COVERAGE START?

**Enrollment in TWG's benefits plan is done annually.**
**Our plan year runs from January 1, 2025 through December 31, 2025**

### PROOF OF DEPENDENT ELIGIBILITY

You will be required to provide proof of eligibility for any new dependents added during open enrollment. Attempting to enroll an ineligible dependent could lead to discipline up to termination of employment. If your dependent becomes ineligible for coverage during the year, you must notify Dana Welker at 209.599.0379 or hrsupport@thewinegroup.com within 31 days.

If you miss the deadline to sign up, you can't enroll later unless you experience what's called a Qualifying Life Event (QLE). It's always a good idea to check with your plan administrator and your applicable plan document to see if you're allowed to make a mid-year change based on your situation.

## HOW DO I SIGN UP?

- Log in to Dayforce using single sign on from the TWG Connect page
- Follow this path: Dayforce > Choose Employee Role > Menu/Hamburger > Benefits > 2025 Open Enrollment > Start Enrollment
- Or by using the Dayforce mobile app: Log in to the Dayforce mobile app using your SSO > Click on the Benefits icon on the bottom menu bar and start your enrollment

Dayforce

## CAN I MAKE CHANGES AFTER I SIGN UP?

After you've signed up, you can only make changes to your benefits if you have what's called a qualifying life event (QLE). A QLE is something that happens to you or someone in your family. The list of QLEs is defined by the federal government. Some examples are:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of a dependent
- You or your spouse lose or gain coverage through our organization or another employer
- Medicare or Medicaid enrollment

You might be able to add or drop coverage if one or more of these things happen to your family after you sign up. Most Qualified Life Event changes, such as getting married or having a baby, are time sensitive and must be addressed within 30 days. Alternatively, if you lost eligibility or enrolled in Medicaid, Medicare, or state health insurance programs, you have to submit the request for change within 60 days. It's always a good idea to reach out to HR to find out if you can make changes.

## DO I HAVE TO SIGN UP?

No. You can "waive" some or all of the benefits offered. Keep in mind that if you waive coverage, you won't be able to enroll in our group benefits again until next year, unless you experience a qualifying life event.

If you don't sign up for any health insurance coverage at all, you might have to pay a penalty. Although the federal penalty requiring individuals to maintain health coverage was reduced to $0, some states have their own mandates.

To avoid paying these penalties in certain states, you can sign up for health insurance through our benefits program or purchase coverage from somewhere else, such as from a State or Federal Health Insurance Exchange.

Curious about Healthcare Reform and the Individual Mandate? Visit www.cciio.cms.gov. You can also visit www.coveredca.com for details on the Covered California State Health Insurance Exchange.

## BENEFITS SERVICE CENTER

You're good at what you do, but you aren't a benefits expert—and that's okay. Healthcare and benefits are complicated. That's why our broker, Marsh McLennan Agency, offers a dedicated Benefits Service Center line. You can talk to a real benefits expert who would love to answer your questions (in English *and* Spanish).

### HERE ARE EXAMPLES OF TOPICS THEY CAN COVER:

#### General Benefits Support

- How do I sign up?
- How do I find a provider?
- How do I get general answers to my benefits questions?

#### Qualified Life Events

- We had a baby. How do I add them to my benefits?
- My spouse lost their job, and now I need to add them to my benefits. Where do I start?

#### COBRA Support

- How do I continue coverage?
- How do I figure out my options?

#### Get support Monday through Friday, 7 am – 5 pm PT

- Toll-free: 855-208-4799 (PIN 1843)
- Email: thewinegroup@marshmma.com

# *Your Health*

# Medical & Prescription Plans

## PPO & HDHP

Your Preferred Provider Organization (PPO) plan and High Deductible Health Plan (HDHP) work very similarly, but there exist some notable differences. With both options, you have the flexibility to choose your providers whether they accept your insurance (In Network) or they do not (Out of Network). With either plan, you pay less when you choose a provider who is In Network. If you choose a provider who is Out of Network, you will often have to pay 100% up-front for services and file a claim for partial reimbursement from the Medical Plan. In contrast to the PPO Plan, the HDHP has a higher deductible with higher out-of-pocket costs overall. However, the HDHP is paired with a Health Savings Account (HSA) which can be used to pay your increased out-of-pocket costs. TWG will contribute money into your HSA each year to help with your healthcare expenses, and you may choose to contribute your own money into your HSA as well. There are many tax advantages to using an HSA with your HDHP. If you choose the PPO medical plan, the IRS does not allow you to have an HSA.

## OUT-OF-POCKET COSTS

- A flat fee called a “copay”
- A fee that’s a percentage of the total cost of the service, called “coinsurance”
- An amount that must be paid before your plan kicks in, called a “deductible”

## ADVANTAGES OF THE PPO

- Lower deductibles (Medical and Rx)
- Some services, such as a doctor’s office visit and some prescription medications, do not require the deductible to be met before the insurance will help pay

## ADVANTAGES OF AN HDHP

- Lower payroll deductions
- Allows participation in a Health Savings Account (HSA)

## TO FIND A PROVIDER IN YOUR PLAN’S NETWORK:

### CARRIER NAME PLAN TYPE

- Scan the QR Code or go to https://www.anthem.com/find-care/
- Select “Basic search as a guest,” select “Medical Plan,” choose your state. Select “Medical (Employer-Sponsored),” select “Prudent Buyer PPO/EPO” if you are a CA resident or select “National PPO (BlueCard PPO)” if you reside outside of CA
- Search by city, county, zip code, or by type of care

## SAVING MONEY ON YOUR MEDICATIONS

Your benefits cover a lot of prescription medications, but how much you pay for them, and how much your health plan covers, is determined by a system of "tiers." These tiers are more like a layer cake than a rating system: The quality is the same no matter where you are, but the higher you go on these tiers, the more expensive and/or hard to access the medication may be.

### HERE ARE SOME EXAMPLES OF THE TYPES OF MEDICATIONS IN EACH TIER:

**Tier 1 - Generic Formulary:**
These medications have the same active ingredients as brand-name medications, but they cost less.

**Tier 2 - Brand name:**
These are medications that a pharmaceutical company develops and sells under a specific name or trademark and cost more than their generic counterparts.

**Tier 3 - Non-formulary:**
Typically, brand medications with alternate brand or generic options that aren't on your health plan's preferred list, or Drug Formulary. Usually, this happens when there is a safe and effective alternative that is less expensive. If your doctor prescribes a non-formulary prescription, it's a good idea to speak with them or your pharmacist about generic alternatives.

**Tier 4 - Specialty:**
These medications treat chronic or complex conditions. They might require special storage or careful monitoring.

## WHY PAY MORE FOR YOUR MEDICATIONS?

**Use the mail**
You can save time and money by getting your medications shipped directly to you through a mail-order service. You can have a larger quantity, usually a 90-day supply, regularly shipped to your door. Go to www.optum.com to sign-up for delivery service.

**Shop around**
Some pharmacies offer less expensive medications. Try calling pharmacies inside warehouse clubs or discount stores to see if they offer a lower price. Shopping around could pay off.

**Try over-the-counter**
For colds, headaches, and other common conditions, over-the-counter medications can sometimes work just as well as prescription ones—and cost a lot less, too.

## NEED TO REACH A PROVIDER RIGHT AWAY?

**Telehealth services through Teladoc**

Teladoc is a 24/7 telehealth service that allows you to visit with providers from the comfort of your own home – or wherever you are! You can speak with licensed doctors by web, phone or mobile app.

Teladoc is a convenient option when you or your dependents have a minor medical issue (such as pink eye, rash, sore throat or allergies) and aren't up to seeing the doctor in person.

It's affordable, too. Through Teladoc, telehealth services will cost $20 per e-Visit for general medicine, behavioral health, and dermatology. If your provider recommends a prescription medication during your virtual visit, Teladoc will send it to a local pharmacy.

**Start your telehealth visit**

- By phone: 800-Teladoc (835-2362)
- Online: www.Teladoc.com
- Download Teladoc's mobile app

## PLAN HIGHLIGHTS

## PPO MEDICAL/RX PLAN

| | IN-NETWORK<br>CA - Anthem Prudent Buyer PPO/EPO<br>Outside of CA – National PPO (BlueCard PPO) | OUT-OF-NETWORK |
|---|---|---|
| **Annual Calendar Year Deductible** | | |
| Individual | $600 | $1,000 |
| Family | $1,200 | $2,000 |
| **Maximum Calendar Year Out-of-Pocket** (1) | | |
| Individual | $3,750 | None |
| Family | $7,500 | |
| **Professional Services** | | |
| Primary Care Physician (PCP), Specialist, Telehealth | $20 Copay, Deductible Waived | 40% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| Preventive Care Exam | No Charge, Deductible Waived | |
| Diagnostic X-ray and Lab | 20% Coinsurance | |
| Complex Diagnostics (MRI/CT Scan) | | |
| Chiropractic Services | 50% Coinsurance | 50% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| **Hospital Services** | | |
| Inpatient | 20% Coinsurance | 40% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| Outpatient Surgery | | |
| Urgent Care | $50 Copay, Deductible Waived | $50 Copay, Deductible Waived |
| Emergency Room | $250 Copay + 20% Coinsurance (Deductible and Copay May Be Waived If Admitted) | $250 Copay + 20% Coinsurance (Deductible and Copay May Be Waived If Admitted) |
| **Mental Health & Substance Abuse** | | |
| Inpatient | 20% Coinsurance | 40% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| Outpatient | | |
| **Prescription Drugs** | | |
| Deductible | $200 per Individual | Not Covered |
| Maximum Out of Pocket | $3,600 Individual / $7,200 Family | |
| Retail Prescription Drugs (30-day supply) | | |
| Tier 1 | $10 Copay, Deductible Waived | |
| Tier 2 | $25 Copay | |
| Tier 3 | $50 Copay | |
| Tier 4 (Specialty) | 20% up to $150 per prescription | |
| **Mail Order Prescription Drugs (90-day supply)** | | |
| Tier 1 | $20 Copay, Deductible Waived | Not Covered |
| Tier 2 | $50 Copay | |
| Tier 3 | $100 Copay | |
| Tier 4 (Specialty - up to 31 day supply) | 20% to $150 per prescription | |

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

## PLAN HIGHLIGHTS

## NEW! HDHP MEDICAL/RX PLAN

| | IN-NETWORK<br>CA - Anthem Prudent Buyer PPO/EPO<br>Outside of CA – National PPO (BlueCard PPO) | OUT-OF-NETWORK |
|---|---|---|
| **Annual Calendar Year Deductible** | | |
| Individual | $3,300 | $6,600 |
| Family | $5,000 | $13,200 |
| **Maximum Calendar Year Out-of-Pocket** (1) | | |
| Individual | $6,000 | None |
| Family | $10,000 | |
| **Professional Services** | | |
| Primary Care Physician (PCP), Specialist, Telehealth | 20% Coinsurance | 40% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| Preventive Care Exam | No Charge, Deductible Waived | |
| Diagnostic X-ray and Lab | 20% Coinsurance | |
| Complex Diagnostics (MRI/CT Scan) | | |
| Chiropractic Services | 50% Coinsurance | 50% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| **Hospital Services** | | |
| Inpatient | 20% Coinsurance | 40% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| Outpatient Surgery | | |
| Urgent Care | 20% Coinsurance | 40% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| Emergency Room | 20% Coinsurance | 20% Coinsurance, paid as in-network |
| **Mental Health & Substance Abuse** | | |
| Inpatient | 20% Coinsurance | 40% of Allowed Amount + 100% of Any Amount Greater Than Allowed Amount |
| Outpatient | | |
| **Prescription Drugs** | | |
| Deductible | Calendar Deductible Above Applies Before Copays Apply | Not Covered |
| Maximum Out of Pocket | Calendar Maximum Above Applies | |
| Retail Prescription Drugs (30-day supply) | | |
| Tier 1 | $10 Copay | |
| Tier 2 | $25 Copay | |
| Tier 3 | $50 Copay | |
| Tier 4 (Specialty) | 20% up to $150 per prescription | |
| **Mail Order Prescription Drugs (90-day supply)** | | |
| Tier 1 | $20 Copay | Not Covered |
| Tier 2 | $50 Copay | |
| Tier 3 | $100 Copay | |
| Tier 4 (Specialty - up to 31 day supply) | 20% to $150 per prescription | |

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

**The rates below are effective January 1 – December 31, 2025**

| COVERAGE LEVEL | MONTHLY PAYROLL DEDUCTION | |
|---|---|---|
| | PPO | HDHP |
| **Employees with Salary under $60k** | | |
| Employee Only | $120.00 | $110.00 |
| Employee and Spouse/Domestic Partner | $260.00 | $235.00 |
| Employee and Child(ren) | $215.00 | $195.00 |
| Employee and Family | $370.00 | $335.00 |
| **Employees with Salary $60k up to $120k** | | |
| Employee Only | $130.00 | $115.00 |
| Employee and Spouse/Domestic Partner | $280.00 | $250.00 |
| Employee and Child(ren) | $230.00 | $205.00 |
| Employee and Family | $395.00 | $355.00 |
| **Employees with Salary $120k up to $250k** | | |
| Employee Only | $140.00 | $120.00 |
| Employee and Spouse/Domestic Partner | $310.00 | $270.00 |
| Employee and Child(ren) | $255.00 | $220.00 |
| Employee and Family | $430.00 | $380.00 |
| **Employees with Salary $250k and above** | | |
| Employee Only | $200.00 | $175.00 |
| Employee and Spouse/Domestic Partner | $440.00 | $390.00 |
| Employee and Child(ren) | $360.00 | $320.00 |
| Employee and Family | $620.00 | $560.00 |
| **Spousal Surcharge** | $200.00 | $200.00 |

## NEED HELP DECIDING WHICH MEDICAL PLAN TO CHOOSE?

### MEET ALEX, YOUR ONLINE JELLYVISION BENEFITS COUNSELOR!

**Who is ALEX and what can ALEX help with?**

- Interactive, online tool
- Designed to help you learn about your health insurance options
- Recommends which plan may be best for you and your family based on your personalized responses
- Determine if the HSA plan is right for you!

alex® BY Jellyvision®

# *New Programs in 2025*

To Support Your Physical and Mental Health

## DIGITAL THERAPY FOR MUSCULOSKELETAL CONDITIONS

### HINGE HEALTH

- **Available at no cost to employees who elect TWG's PPO or HDHP Medical Plan**
- Evidence-based Digital Therapy can help with chronic back and joint pain by employing a program delivered via tablet and sensors with support from one-on-one health coaching.
- Coaches provide a seamless experience for members with a single point of contact, which helps to educate and guide members through dealing with pain. Your dedicated Physical Therapist and Health Coach will support you through the entire program via video visits, text, and phone calls.

## MEDICAL TRAVEL - LIFESTYLE SPENDING ACCOUNT (LSA)

The LSA is funded by TWG. The only qualified expense for this account is medical travel. Medical travel expenses are those incurred by a patient who requires medical attention that is not available where they live so they must travel in order to get the help they need.

## DETAILS

| | |
|---|---|
| **Medical Travel - LSA** | ▪ TWG-funded benefit affording employees, and their eligible dependents, up to $5,000 per incident or qualified medical travel.<br>▪ The LSA has a lifetime maximum of $10,000.<br>▪ Does not preclude you from contributing to an HSA.<br>▪ You and/or your dependent must be enrolled in TWG's medical plan in order to be eligible for this benefit. |

# COMPREHENSIVE MENTAL HEALTH BENEFIT

## LYRA HEALTH

Introducing Lyra Health, the mental health solution that goes beyond your average Employee Assistance Program.

## LIKE A TRADITIONAL EAP, LYRA PROVIDES:

- The first 8 visits with a Lyra provider are free (paid for by The Wine Group). Please note: Appointments involving Medication Management consultation are subject to cost-sharing. Lyra will provide a cost estimate when you book your appointment.

## KEY DIFFERENCES BETWEEN LYRA HEALTH VS. TRADITIONAL EAP:

- **Focus on Mental Health and Wellbeing**
  - Lyra Health: Focuses on mental health care by connecting employees with therapists, coaches, and other mental health professionals. It uses proven treatments and offers therapy, coaching, and self-guided programs.
  - Traditional EAP: Provides a wide range of services, including mental health support, financial counseling, legal help, and work-life balance assistance. Mental health care is just one part of what they offer.
- **Quality Care and Provider Network**
  - Lyra Health: Has a hand-picked network of top-quality providers and works to match employees with therapists trained for their specific issues. They also track progress to make sure the treatment is working.
  - Traditional EAP: May have a larger network of providers, but the quality and expertise of these providers can vary. There's often less focus on matching employees with the right specialist.
- **User Experience**
  - Lyra Health: Built to be easy to use, with a simple interface that makes getting care quick and easy. Employees can view provider profiles and choose the best match for their needs.
  - Traditional EAP: May require more steps to get started, like phone-based intake and referral processes, which can be less convenient.

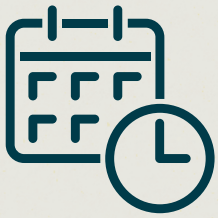
## IN ADDITION, LYRA PROVIDES COMPREHENSIVE MENTAL HEALTH BENEFITS FOR TWG EMPLOYEES AND THEIR ENTIRE FAMILY!

- Personalized care recommendations based on symptoms, severity, and preferences whether it be self-guided care or time with one of Lyra's top providers.
- Care is available in-person or virtually. Find a provider within minutes, and book appointments online or via the Lyra mobile app
- Lyra is integrated with The Wine Group's medical plans. This means, if you, and/or your dependents, are enrolled in either the PPO or the HDHP, after the first 8 free visits your Lyra provider will be able to bill your medical plan so you pay only your applicable copay or coinsurance for continued care.

Reach out by visiting Twg.lyrahealth.com or call 833-824-1859

Appointments are available quickly via online booking or by email so it's easy to get started.

Connect with licensed professionals matched to your specific situation and concerns.



Only 20% of therapies are proven to work. Our care options only use these eveidence-based methods.

# Dental Plans

Taking care of your smile

With the Dental PPO plan, you can pick any licensed dentist. Just keep in mind that your dental plan has settled on lower rates with a smaller group of providers—those in their network. If you choose a dentist outside that network for yourself or your dependents, you might have to pay more.

Register today for a Sun Life account at www.sunlife.com/account. A Sun Life account provides you with the ability to download your ID card, view benefit and claims information, and find a dentist.

Go Mobile! Scan the code on the right (or go to www.sunlife.com/mobileapps) to download our mobile app, Benefit Tools, to access many of the same resources as your Sun Life account.

## PLAN HIGHLIGHTS — SUN LIFE DENTAL PPO

| | IN-NETWORK Sun Life Dental Network | OUT-OF-NETWORK |
|---|---|---|
| **Calendar Year Deductible** | | |
| Individual | $50 | $50 |
| Family | $150 | $150 |
| **Annual Maximum** | | |
| Plan Pays | $1,750/Individual | |
| **Services** | | |
| Preventive | No Charge, Deductible Waived | Plan Pays 100% of Allowed Amount, You Pay Any Amount Over |
| Basic Services | 20% | Plan Pays 80% of Allowed Amount, You Pay Any Amount Over |
| Major Services | 50% | Plan Pays 50% of Allowed Amount, You Pay Any Amount Over |
| **Orthodontia Services** | | |
| Adult & Child up to age 26 (currently 23) | 50% up to $1,500 Plan Pay Max | Plan Pays 50% of Allowed Amount, You Pay Any Amount Over |

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

**The rates below are effective January 1 – December 31, 2025**

## COVERAGE LEVEL — PAYROLL DEDUCTION

| | EMPLOYEE MONTHLY |
|---|---|
| **Employees with > $250K Salary** | |
| Employee Only | $11.00 |
| Employee and Spouse/Domestic Partner | $24.00 |
| Employee and Child(ren) | $20.00 |
| Employee and Family | $34.00 |
| **Employees with < $250K Salary** | |
| Employee Only | $7.00 |
| Employee and Spouse/Domestic Partner | $15.00 |
| Employee and Child(ren) | $13.00 |
| Employee and Family | $22.00 |

# Vision Plans

Bringing your benefits into focus

VSP offers vision coverage as a Preferred Provider Organization (PPO) plan. With the vision plan, you can pick where to receive services. Just keep in mind that your vision plan has settled on lower rates with a smaller group of vision providers—those in their network. If you choose a vision provider outside that network for yourself or your dependents, you will have to pay for all the expenses yourself at the time of service. Then, you'll submit a claim, and VSP will reimburse you up to a certain "allowed" amount.

To find out if a vision provider is in your network, you can search on www.VSP.com or calling VSP.

| PLAN HIGHLIGHTS | VSP VISION PPO | |
|---|---|---|
| | **IN-NETWORK** VSP Signature Network | **OUT-OF-NETWORK** |
| **Exam – Every 12 months** | | |
| Individual | $20 Copay | Reimbursed Up to $50 |
| **Lenses – Every 12 months** | | |
| Single | $20 Copay | Reimbursed Up to $50 |
| Bifocal | | Reimbursed Up to $75 |
| Trifocal | | Reimbursed Up to $100 |
| Anti-Glare Coating | | Not Covered |
| Progressive | | Reimbursed Up to $75 |
| **Frames – Every 24 months** | | |
| Allowance | Up to $180 | Reimbursed Up to $70 |
| **Contacts – Every 12 months in lieu of lenses & frames** | | |
| Elective Allowance | Up to $150 | Reimbursed Up to $105 |
| Medically Necessary | $20 Copay | Reimbursed Up to $215 |

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

**The rates below are effective January 1 – December 31, 2025**

| COVERAGE LEVEL | PAYROLL DEDUCTION |
|---|---|
| | **EMPLOYEE MONTHLY** |
| **Employees with > $250K Salary** | |
| Employee Only | $2.00 |
| Employee and Spouse/Domestic Partner | $4.00 |
| Employee and Child(ren) | $3.00 |
| Employee and Family | $6.00 |
| **Employees with < $250K Salary** | |
| Employee Only | $1.00 |
| Employee and Spouse/Domestic Partner | $3.00 |
| Employee and Child(ren) | $2.00 |
| Employee and Family | $4.00 |

# *Your Finances*

# *Life & Disability*

## LIFE INSURANCE AND AD&D

The Wine Group provides eligible employees with income protection benefits. These financial benefits are intended to provide financial assistance for you and your beneficiaries in the event of disability, accident or death.

This benefit through Sun Life includes the following:

- Basic Life with AD&D Insurance of 3x annual earnings up to $600,000
- Benefits may reduce when you turn 70

## VOLUNTARY LIFE AND AD&D

You can choose to add more life insurance and AD&D coverage for you and/or your dependents. Here are details on the additional coverage amounts you can choose from:

**For Employees:**

- Increments of $10,000 up to a $500,000 maximum with a guarantee issue benefit of $240,000 if you enroll in the plan within 30 days of your initial eligibility.

**For your spouse:**

- Increments of $5,000 up to a $150,000 maximum with a guarantee issue benefit of $30,000 if you enroll in the plan within 30 days of your initial eligibility.

**For your child(ren):**

- Birth to 6 months, $1,000
- 6 months to age 26, $10,000.

**Optional AD&D:**

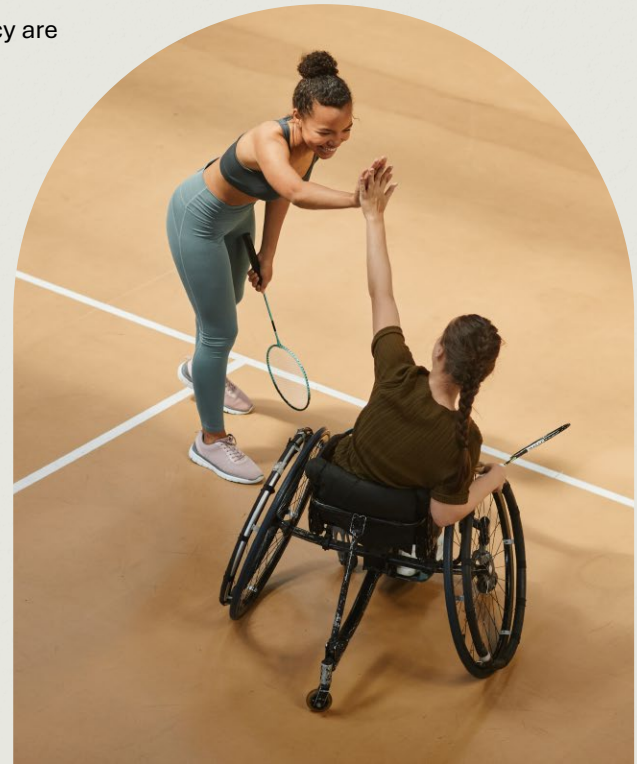
- Coverage is automatically included and equal to the life benefit.

Your coverage costs for this plan are dependent upon your age and the amount of coverage you are electing. Specific costs for coverage are listed in Dayforce for your review. If you choose to get additional coverage, the insurance company may want to make sure you're in good health. The insurance amounts here are subject to review and won't be effective until the insurance company approves. There's more info in the Summary Plan Description.

## DON'T FORGET TO UPDATE YOUR BENEFICIARIES!

The people or entities who you want to receive benefits from your policy are called beneficiaries. It's very important that they are up to date.

- You may change your beneficiaries at any time
- You may designate one person as your beneficiary or choose multiple beneficiaries, who will each get a percentage of the payout amount
- To select or change your beneficiary, log into Dayforce at https://sso.dayforcehcm.com/twg



Quick note on IRS Regulations: You can receive employer-paid life insurance coverage up to $50,000 on a tax-free basis and do not have to report the payment as income. However, coverage of more than $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

## DISABILITY INSURANCE

When you're too sick or injured to work, you need time to focus on healing—not worrying about your income. Enrolling in disability insurance offers you and your family peace of mind by helping to replace some of your income if you have a non-work related illness or injury. Your eligibility may be based on disability for your occupation or any occupation. The cost of your STD coverage will vary based on your age and salary. Please refer to Dayforce for your individual STD premium.

| YOUR PLANS | COVERAGE |
|---|---|
| **Voluntary Short Term Disability (STD) for employees who reside in California** | ▪ Administered by Voya, STD coverage provides a benefit equal to 20% of your earnings, up to $750 per week for a period up to 180 days.<br>▪ The plan begins paying these benefits at the time of disability/after you have been absent from work for 42 consecutive days. |
| **Voluntary Short Term Disability (STD) for employees who reside in all other states** | ▪ Administered by Voya, STD coverage provides a benefit equal to 60% of your earnings, up to $1,500 per week for a period up to 180 days.<br>▪ The plan begins paying these benefits at the time of disability/after you have been absent from work for 42 consecutive days. |
| **Long Term Disability Coverage (LTD)** | ▪ If your disability extends beyond 180 days, the LTD coverage through Sun Life can replace 60% of your earnings, up to maximum of $10,000 per month.<br>▪ Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability. |
| **State Disability Insurance** | ▪ The state you reside in may provide a partial wage-replacement disability insurance plan.<br>▪ For more information regarding statutory disability programs, contact Human Resources |

Note: Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.

# Supplemental Health Plans

Prepare for the unexpected twists and turns

## CRITICAL ILLNESS INSURANCE

If you choose to sign up for this coverage, Voya will pay you a lump sum of money if you're diagnosed with a specific critical illness.

**Some covered illnesses:**

- Cancer
- Heart Attack
- Stroke
- Alzheimer's
- Kidney Failure
- Organ Transplant

This type of coverage pays you directly in cash, so you can use the funds however you want. Here are a few examples:

- Medical expenses
- Lost income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to see specialists

**100% employee-paid**

Your employer doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your paycheck. Monthly post-tax rates are outlined below per $10,000 in coverage:

| Age | Employee/Spouse Non-Tabacco User | Employee/Spouse Tabacco User |
|---|---|---|
| Under 30 | $6.40 | $8.20 |
| 30-39 | $7.30 | $9.50 |
| 40-49 | $11.90 | $17.30 |
| 50-59 | $20.20 | $30.90 |
| 60-64 | $27.00 | $42.20 |
| 65-69 | $27.00 | $42.20 |
| 70+ | $36.80 | $58.10 |

| Election | Benefit Amounts & Guaranteed Issue |
|---|---|
| Employee | $10,000, $20,000, or $30,000 |
| Spouse | 50% of your benefit |
| Child(ren) | $3.10 per month for $5,000 in coverage up to $15,000 not to exceed 50% of your benefit |

### USING CRITICAL ILLNESS INSURANCE: AN EXAMPLE

Theo was diagnosed with cancer and needed a life-saving surgery right away, followed by chemotherapy. Theo's health plan required a $250 deductible and $2,500 in co-insurance after the hospital stay. Critical illness insurance provided a $20,000 cash payment after Theo's diagnosis. Theo used the funds to cover his deductible and co-insurance fees, plus the co-pay for each chemo session.

**Want to learn more?**

Visit www.voya.com.

# HOSPITAL INSURANCE

Hospital stays are difficult, especially if your health plan doesn't cover costs. To help ensure you can afford a hospital stay, you can sign up for hospital insurance through Voya. This benefit will pay cash to you or your family to offset medical and non-medical bills that you get after staying in the hospital.

## WHAT CAN HOSPITAL INSURANCE PAY FOR?

This type of coverage pays you directly in cash, so you can use the funds however you want. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Child care
- Lodging expenses for a companion
- Lost income

### 100% employee-paid

Your employer doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your paycheck. Monthly post-tax rates are outlined below:

| Election | Monthly Contribution |
|---|---|
| Employee Only | $13.38 |
| Employee + Spouse | $27.80 |
| Employee + Child(ren) | $24.18 |
| Family | $38.60 |

## USING HOSPITAL INSURANCE: AN EXAMPLE

Morgan needed gallbladder removal surgery, and due to some complications, had to stay in the hospital for four days. Morgan has health insurance, but it didn't cover the full cost of the stay. Morgan's health plan required a $500 deductible and $3,000 co-insurance. Hospital insurance helped make up the difference. It paid a $500 admission benefit plus $200 for each additional day. All told, Morgan owed $2,200 instead of $3,500.

| Out-of-Pocket Expenses | Benefit Amounts & Guaranteed Issue |
|---|---|
| $500 deductible | $500 admission benefit |
| $3,000 co-insurance | $200/day x 4 additional days = $800 |
| Total: $3,500 | Total benefits paid to Morgan: $1,300 |

### Want to learn more?

Visit www.voya.com.

# ACCIDENT INSURANCE

We all know they happen, but not everyone is prepared. Accident insurance is optional coverage that helps you pay for expenses if something unexpected occurs. The benefits are paid directly to you to help cover specific treatments, and the amount depends on the type of injury you have and what care you need.

## WHAT CAN ACCIDENT INSURANCE PAY FOR?

This type of coverage pays you directly in cash, so you can use the funds however you want. You could use the funds to pay for:

- Emergency room visits
- Ambulance transportation
- Doctor visits
- Hospital admission
- Surgery
- Medical equipment
- Outpatient therapy
- Diagnostic imaging

**100% employee-paid**

Your employer doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your paycheck. Monthly post-tax rates are outlined below:

| Election | Monthly Contribution |
|---|---|
| Employee Only | $4.74 |
| Employee + Spouse | $9.48 |
| Employee + Child(ren) | $10.20 |
| Family | $14.94 |

## USING ACCIDENT INSURANCE: AN EXAMPLE

Sam was involved in a car accident and needed to learn to walk again. The treatment was intense, so Sam couldn't work during recovery. Sam's accident insurance policy provided a $6,540 payment that Sam used to cover the out-of-pocket costs of treatment, monthly mortgage payments, and daycare fees. Accident insurance helped Sam focus on recovery instead of worrying about how to pay for it.

| Covered Event/Injury | Benefit Amount |
|---|---|
| Ambulance (ground) | $300 |
| Intensive Care x 15 days | $6,000 |
| Physician follow-up ($40 x 6) | $240 |
| Total benefit paid by Sam's Accident Plan | $6,540 |

**Want to learn more?**

Visit www.voya.com.

# Spending Accounts

## FLEXIBLE SPENDING ACCOUNT

With an FSA, you and your spouse, plus any eligible dependents, can use pre-tax dollars to cover health care/dependent care. There are different types of FSAs, but they all help reduce your taxable income.

| FSA TYPE | DETAILS |
|---|---|
| **Healthcare FSA** | ▪ Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance.<br>▪ **Does** preclude you from contributing to an HSA<br>▪ Maximum contribution for 2025 is $3,200.<br>▪ Use it or lose it! FSA funds don't roll over to the next year. Don't panic, though you can still use the funds during a grace period through March 15, 2026. Your claims submission deadline to use these funds is March 31, 2026.<br>▪ Please note that if you choose to enroll in the Anthem HDHP, you are unable to enroll in the Healthcare FSA. Instead, you have access to a Health Savings Account, please review the prior page for details. |
| **Dependent Care FSA** | ▪ Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves.<br>▪ Does **not** preclude you from contributing to an HSA.<br>▪ Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time.<br>▪ Maximum contribution for 2025 is $5,000.<br>▪ Maximum contribution for those earning $135,000 or more annually is $1,000.<br>▪ Use it or lose it! FSA funds don't roll over to the next year. Don't panic, though you can still use the funds during a grace period through March 15, 2026. Your claims submission deadline to use these funds is March 31, 2026. |

## HEALTH SAVINGS ACCOUNT

By enrolling in the High Deductible Health Plan (HDHP), you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified healthcare expenses, such as your deductible, copayments, and other out-of-pocket expenses.

Note: if you participated in a Medical FSA in 2024, and want to participate in the HSA in 2025, you must spend down your Medical FSA funds by year end.

## WHAT TO KNOW ABOUT YOUR HEALTH SAVINGS ACCOUNT

| | |
|---|---|
| **What are the benefits?** | ▪ HSA funds can grow on a tax-free basis, subject to state law. Please consult your tax advisor for applicable tax laws in your state.<br>▪ An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified healthcare expenses (tax regulations vary by state).<br>▪ **The Wine Group contributes $500 annually to your HSA for employees enrolled in Employee-Only HDHP coverage, and $1,000 annually for employees with dependents enrolled in HDHP coverage.** TWG will deposit the full annual employer contribution into your HSA when you enroll. Employees are required to inform an employer that they have opened an HSA in order to receive employer contributions. Employees may forfeit employer contributions if they fail to meet this condition. |
| **How do I become eligible to contribute to an HSA?** | ▪ You become eligible to contribute to an HSA if you are covered under the HDHP. |
| **You are not eligible to contribute to an HSA if...** | ▪ You are enrolled in a Non-Qualified health Insurance plan outside of The Wine Group's plan.<br>▪ You are enrolled in Medicare.<br>▪ You can be claimed as a dependent on someone else's tax return (excluding a spouse).<br>▪ You have not received any hospital care or medical services from the Veterans Administration (unless these services are related to a service-connected disability).<br>▪ You are enrolled in TWG's Healthcare Flexible Spending Account or a Health Reimbursement Arrangement outside of TWG. |
| **How do I get started?** | ▪ The most convenient way to pay for qualified expenses is to utilize the debit card. You can also use your own cash or a personal credit card and reimburse yourself through your online HSA. It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS. View the status of your claims and check your HSA balance at www.forma.com.<br>▪ Once the HSA is open, you can manage and access your account at any time by visiting www.forma.com. Consult your tax advisor for taxation information or advice. |
| **A few rules to keep in mind...** | ▪ **For 2025, the maximum contribution limit for employee and employer contributions in an employee's HSA is $4,300 if you enroll in the HDHP for Employee-Only coverage, and $8,550 for employees with dependent coverage.**<br>▪ It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.<br>▪ There is a 20% penalty for using HSA funds on non-qualified healthcare expenses if you are under age 65. For more details about what is considered a qualified healthcare expense, visit www.irs.gov Publication 502.<br>▪ Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon the maximum annual contribution limit for that calendar year, multiplied by the **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, if the employee becomes eligible to open their HSA on September 1st, they would be eligible to contribute 4/12 of the maximum annual limit in their first year of enrollment into the HSA plan. However, under the Full-Contribution Rule, the employee may be allowed to contribute the maximum annual contribution amount to their HSA, regardless of the number of months they were eligible to contribute to an HSA that year. Taking advantage of the Full-Contribution Rule would require you to reach out to Forma directly to deposit additional money into your account on a post-tax basis. Before depositing additional money into your account, please consult with a tax advisor to ensure that you understand the rules and potential penalties. |

## FREQUENTLY ASKED QUESTIONS ABOUT SPENDING ACCOUNTS

**Q: What does pre-tax dollars mean and why is this important?**
**A**: Pre-tax dollars are taken out of your salary before your taxes are withheld. Contributing pre-tax dollars reduces your adjusted gross income, which also reduces how much tax you pay on your income. In addition, if you use your spending accounts for eligible expenses, the money you use will be tax-free.

**Q: How do I know whether the HSA or Healthcare FSA accounts are right for me?**
**A**: This depends on your overall healthcare goals. If you do not have any immediate healthcare needs, the HSA allows for you to store and invest the funds you'd normally use on premiums in a bank account you own. If you have immediate medical needs, the contribution amount for a Flexible Spending Account acts similar to a cash advance and is available on the first day of your plan year. Plus, it works with any healthcare plan aside from the HDHP.

**Q: Where can I access my funds?**
**A**: You can access your funds directly through Forma.

**Q: What expenses are covered?**
**A**: You can view eligible expenses for HSAs at www.HSAstore.com and FSAs at www.FSAStore.com.

**Q: If I currently have a Healthcare FSA, but I decide to enroll in an HSA in 2025, can I still partake in the grace period on my Healthcare FSA?**
**A**: No, in this instance, you cannot partake in the grace period for your Healthcare FSA for 2024. If you enroll in an HSA in 2025, you must spend down your current Healthcare FSA funds to $0 by 12/31/2024.

**Q: Can both myself and my spouse open and contribute to FSA accounts separately?**
**A**: You and your spouse can open and contribute to FSA accounts separately. However, Dependent Care FSAs are family contribution accounts, meaning that your household cannot exceed the IRS maximum. If you and your spouse are enrolled separately in your own Dependent Care FSAs, you must both contribute no more than the maximum amount.

**Q: What happens to my spending account if I leave TWG?**
**A**: If you have an HSA, you are able to take the account and all the funds with you since it's your own. If you have a Healthcare FSA or Dependent Care FSA, you will only be able to submit claims with dates of service before your termination date for reimbursement. You can continue to contribute and use your Healthcare FSA through COBRA.

**Q: If I decline medical coverage, can I still enroll in an HSA or FSA plan through TWG?**
**A**: You can sign up for any FSA at TWG, regardless of whether you have medical coverage with TWG. You **cannot** enroll in an HSA unless you enroll to the HDHP medical coverage.

**Q: Can I change my contribution amounts in the middle of the plan year?**
**A**: You can change your HSA contributions throughout the year. You can only change your Healthcare FSA and Dependent Care FSA amounts if you have a qualified life event.

## MANAGING YOUR FORMA ACCOUNTS

The Wine Group utilizes Forma as the administrator for your FSA, Medical Travel - LSA, and HSA benefits. Through Forma, you are able to request a debit card to use for your FSA and HSA benefits. Of course, you can still submit manual claims for reimbursement if you wish, the debit card is not mandatory. The Medical Travel - LSA will require manual claim submission.

Please be on the lookout for an email prior to January 1 from Forma that will detail how to access your benefits and online account. If you already have a debit card from last year, and it has not expired, you can continue to use that debit card.

Questions? Reach out to Forma or Human Resources. Please refer to page 32 for contact information.

# Retirement

Planning for the future

## THE WINE GROUP RETIREMENT AND SAVINGS PLAN

This plan can help you take charge of your retirement goals with an effective combination of low-cost investments and the Schwab Retirement Planner®, a service that creates a personalized savings and investment strategy.

Your investment strategy is already built on factors such as your current retirement account balance, contribution rate, expected retirement age and estimated Social Security benefits. However, you may provide additional details to make the investment strategy even more personalized.

### ENROLLMENT

All you need to do is create a login ID and password using the Register Now link at workplace.schwab.com. Once registered, log in and follow the prompts to enroll or manage your account or by calling Participant Services at 800-724-7526.

### ELIGIBILITY

Once you meet your plan's eligibility requirements and you're at least 21 years of age, you may enroll on the next quarterly plan entry date (January 1, April 1, July 1 or October 1). You must complete the enrollment process within 31 days after your plan entry date. If you haven't completed the enrollment process within that time, you will be automatically enrolled in the plan at a pre-tax savings rate of 6% and placed into Schwab Retirement Planner.

To make things even easier, your plan offers an automatic annual savings increase to help you set aside extra money each year. Your savings rate will increase 1% until you reach a total of 10%.

### PRE-TAX CONTRIBUTIONS

You may contribute up to 75% of your eligible compensation before taxes each pay period. Federal law limits the amount you can contribute on a pre-tax basis in a given year. The limit is set annually and can be found at workplace.schwab.com or by calling Participant Services at 800-724-7526.

### ROTH CONTRIBUTIONS

For additional savings flexibility, you may make after-tax contributions to a Roth 401(k). Your contributions to the Roth 401(k) are made after income taxes are deducted. While you don't get an upfront tax deduction on Roth contributions, there are some important benefits to consider:

- You won't be charged taxes on any earnings, and no taxes will be due at withdrawal (as long as you're at least age 59½ and you've had the account for five years or more).
- There are no income limitations, unlike a Roth IRA.
- You'll have the ability to split contributions between the traditional 401(k) and Roth 401(k) accounts.

# THE WINE GROUP RETIREMENT AND SAVINGS PLAN CONTINUED

## COMPANY MATCHING CONTRIBUTIONS

TWG matches 50% on the first 6% of your contribution and funds the match each pay period. Both pre-tax and Roth 401(k) contributions are eligible for matching contributions.

## COMPANY PROFIT-SHARING CONTRIBUTIONS

TWG may make a discretionary profit-sharing contribution to your account if you're eligible under the terms of the plan. To receive a profit sharing contribution, you must be employed by TWG on the last day of the plan year and have worked a minimum of 1,000 hours in the plan year.

## VESTING

Vesting means ownership of your plan account. If you own 100% of your account, you are fully vested.

**Your Contributions**

- You're always 100% vested in your own contributions, including any rollovers you make to your plan account.

**Non-Elective and Matching Contributions**

- You're 100% vested in TWG's contributions and any earnings from those contributions.

**Profit Sharing Contributions**

- TWG's profit sharing contributions to your plan account vest according to the following schedule:
  - Year 1: 20% • Year 2: 40% • Year 3: 60% • Year 4: 80% • Year 5 and thereafter: 100%

NOTE: Roth contributions have the same limitations as a traditional 401(k) plan. The combined maximum amount of both pre-tax and Roth 401(k) contributions is set annually and can be found at workplace.schwab.com.

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

# *Your Work/Life*

# *Wellness Programs*

## LIVING THE GRAPE LIFE

The steps to choosing your benefits may be getting clearer, but when it comes to your overall well-being, it's all about the journey, not the destination. Be sure to bring along the right tools and an enthusiastic support system! Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. Your wellness benefits support this approach to total well-being for your mind and body. Plus, they're free.

### Simple Steps to a Healthier Life Program

By *Living the Grape Life*, you can improve your wellbeing in all areas of life that make you healthy, happy, and whole. Physical wellbeing? Check. Financial wellbeing? Check. Mental and social wellbeing? Check. Living the Grape Life has you covered!

### Learn and Grow

Enjoy resources like videos, articles, and other tools to support you in each area of wellbeing: Physical, financial, mental, and social.

### Enjoy Yourself

Who said taking care of yourself has to be a chore? Join the fun with personal and group challenges, create your own "snap challenges," and share your successes on the platform.

### Earn Rewards

Be well and earn rewards along the way! Use the tracking table on the platform's homepage to earn and submit your progress.

## JOIN NOW!

**From your computer, go to:**

- TWG Connect
- Or Microsoft Teams: Once in Teams, Click the Teams icon on left navigation bar>TWG Team>TWG Connect>TWG Connect link at top

**Click on the *Living the Grape Life* tile under the *Team Members Perks* section of TWG Connect:**

- Follow prompts to review and accept the EEOC agreement

**Start using *Living the Grape Life* on your computer or via the mobile app** (see below)

- **Mobile App** (optional): Download the "Navigate Wellbeing" app from your phone's app store. Log in using the username and password you creates via the above steps

**Team members without a computer?**

Share the instructions for the offline team members in the attached program flyer and overview documents.

**Access issues?**

Contact ITSupport@thewinegroup.com

## EMPLOYEE ASSISTANCE PROGRAM

Now offered to you through Curalinc: Your Employee Assistance Program (EAP) is a set of services that can support you through personal and professional challenges with resources, information, and counseling. Everything is confidential—what you talk about won't be shared with your employer—and free.

| PROGRAM COMPONENT | COVERAGE DETAILS |
|---|---|
| **Number of sessions** | 6 face-to-face sessions per year per member per incident |
| **How to access** | Phone or face-to-face sessions |
| **Topics may include** | **Mental Health Support:**<br>▪ Marital, relationship or family problems<br>▪ Bereavement or grief counseling<br>▪ Substance use disorder and recovery<br>**Community Support:**<br>▪ Child and eldercare<br>▪ Legal services and identity theft<br>▪ Financial support |
| **Who can utilize** | You, your dependents, and even other members of your household. |

GET IN TOUCH:

- By phone: 888-881-5462
- Online: https://www.supportlinc.com/
- Website password: thewinegroup

## PET INSURANCE

Nationwide's "My Pet Protection Plan" provides comprehensive pet insurance coverage for your furry family members from any licensed veterinarian of your choice. You can choose from two different plans for your cats and dogs that have been designed by veterinarians to ensure quality coverage with no waiting period once the policy is effective.

You will need to enroll directly through Nationwide. To get started, call 877.738.7874 (mention that you're an employee of The Wine Group) or visit benefits.petinsurance.com/thewinegroup.

- $250 annual deductible.
- Covers accidents, common illnesses, chronic conditions, procedures and testing.
- Choose from two levels of reimbursement to find the one that best fits your needs.
- 70% or 50% cash back on eligible vet bills and more.
- $7,500 maximum annual reimbursement.

## CALIFORNIA RATE EXAMPLE

| | My Pet Protection Monthly Premium | |
|---|---|---|
| Type of Animal | 70% Reimbursement | 50% Reimbursement |
| Cat | $21.84 | $16.38 |
| Dog | $36.40 | $27.30 |

## MILKSTORK

We are thrilled to announce a new addition to our employee benefits package that supports our commitment to diversity, inclusion, and family-friendly workplace policies. Starting today, The Wine Group is partnering with Milk Stork, the first and most trusted breast milk shipping service. This benefit is designed to support breastfeeding parents by providing a practical and supportive solution for managing breastfeeding responsibilities while traveling for work and being away from their baby.

### WHAT IS MILK STORK?

Milk Stork provides an easy-to-use service that delivers specially designed coolers to your location, enabling you to ship your breast milk home safely and efficiently when you are away on business. This service ensures that you can continue to nourish your baby without interruption, regardless of your work commitments.

To get started, visit www.milkstork.com/supermom. To access the portal, moms at The Wine Group will use their work email with the domain of @thewinegroup.com and create a login. Questions? Email Milk Stork at info@milkstork.com or Call 510.356.0221 Monday – Saturday 6am – 8pm Central Time

| Pump & Tote | Pump & Ship | International Pump & Check |
|---|---|---|
| ▪ Sizes: 34 oz. or 72 oz.<br>▪ Refrigeration: Max of 60 hours<br>▪ Shipped to mom's destination<br>▪ Includes breast milk storage bags and a tote bag for travel | ▪ Sizes: 34 oz. or 72 oz.<br>▪ Refrigeration: Minimum of 72 hours<br>▪ Shipped to mom's destination<br>▪ Includes breast milk storage bags and a pre-labeled box for overnight shipping | ▪ Sizes: 108 oz.<br>▪ Refrigeration: Minimum of 90 hours<br>▪ Shipped to mom's international destination<br>▪ Includes breast milk storage bags and a travel duffle and luggage tag |

# Directory & Resources

Below, please find important contact information and resources for The Wine Group.

| INFORMATION REGARDING | GROUP / POLICY # | CONTACT INFORMATION | |
|---|---|---|---|
| **Enrollment & Eligibility** | | | |
| Human Resources:<br>Dana Welker | | 209-599-0379 | hrsupport@thewinegroup.com |
| Online Enrollment Vendor:<br>Dayforce | | | https://sso.dayforcehcm.com/twg |
| **Medical Coverage** | | | |
| Personify (pka Health Comp)<br>RX Benefits - Optum<br>Teladoc<br>24/7 Nurse Health Line | L08876 | 855-469-1219<br>800-334-8134<br>800-835-2362<br>800-224-0336 | mycarehc.com<br><br>www.teladoc.com |
| **Dental Coverage** | | | |
| Sun Life<br>Dental PPO | 962312 | 800-442-7742 | www.sunlife.com/us |
| **Vision Coverage** | | | |
| VSP<br>Vision PPO | 12161255 | 800-877-7195 | www.vsp.com |
| **Life, AD&D and Disability** | | | |
| Sun Life<br>Life/AD&D, Vol. Life/AD&D<br>LTD | 956063 | 800-247-6875 | www.sunlife.com/account |
| **Flexible Spending Accounts** | | | |
| Forma | The Wine Group | support@joinforma.com | www.joinforma.com |
| **Voluntary Coverage** | | | |
| Voya<br>Critical Illness<br>Hospital Indemnity<br>Accident<br>Short Term Disability | 723185 | 877-236-7564 | https://presents.voya.com/EBRC/thewinegroup |
| Nationwide<br>Pet Insurance | 10314 | 877-738-7874 | Benefits.petinsurance.com/thewinegroup |
| **401(k) Retirement Plan Adviser** | | | |
| Schwab | | 800-724-7526 | workplace.schwab.com |
| **Employee Assistance Plan** | | | |
| Curalinc | group code: thewinegroup | 888-881-5462 | https://www.supportlinc.com |
| **Additional Benefits** | | | |
| Lyra | | 833-824-1859 | Twg.lyrahealth.com |
| Hinge | | 855-902-2777 | www.hinge.health/resources |
| Milk Stork | | info@milkstork.com | www.milkstork.com/supermom |
| **Benefits Broker** | | | |
| Marsh & McLennan Insurance Agency | | 855-208-4799<br>PIN: 1843 | www.MarshMMA.com<br>thewinegroup@marshmma.com |

# THE WINE GROUP, INC.'S HEALTH AND WELFARE BENEFITS ANNUAL NOTICE PACKET

For the 2025 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- Medicare Part D Creditable Coverage Notice
- HIPAA Special Enrollment Rights Notice
- HIPAA Notice of Privacy Practices
- Children's Health Insurance Program (CHIP) Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice
- Newborns' Mothers Health Protection Act (NMHPA) Notice
- General Notice of COBRA Continuation Rights
- HIPAA Privacy Notice of Availability
- HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice
- Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Should you have any questions regarding the content of the notices, please contact The Wine Group at 209-599-4111.

# MEDICARE PART D
# CREDITABLE COVERAGE NOTICE

**Important Notice from The Wine Group, Inc.**
**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 The Wine Group, Inc. 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. **The Wine Group, Inc. has determined that the prescription drug coverage offered by the Anthem Medical Plans 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.**

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## 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 while enrolled in The Wine Group, Inc. coverage as an active employee, please note that you're The Wine Group, Inc. coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in The Wine Group, Inc. coverage as a former employee.

You may also choose to drop you're The Wine Group, Inc. coverage. If you do decide to join a Medicare drug plan and drop your current The Wine Group, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

## 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 The Wine Group, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information or call 209-599-4111. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Wine Group, Inc. changes. You also may request a copy of this notice at any time.

## For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Name of Entity/Sender: The Wine Group, Inc.
Contact-Position/Office: Dana Welker – Benefit Analyst 3/Human Resources
Address: 17000 E. Hwy 120, Ripon, CA 95366
Phone Number: 209-599-0379

## HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment in The Wine Group, Inc. group health 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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact 209-599-4111.

# HIPAA NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Wine Group, Inc. (The Wine Group) sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of The Wine Group, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by The Wine Group, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

## Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the The Wine Group HIPAA Privacy Officer or Dana.Welker@thewinegroup.com:

The Wine Group, Inc.
Attention: HIPAA Privacy Officer
17000 E. Hwy 120 Ripon, CA 95366

## Effective Date

This Notice as revised is effective January 1, 2025.

## Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;

- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

## How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

### For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

### For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

### For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

### To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

### As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

### To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

### To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

## Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

### Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

### Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

### Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

### Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

### Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

### Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

### Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

### Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

### National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

### Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

### Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

## Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

### Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

### Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

### Notification of a Breach

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

## Other Disclosures

### Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or

(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

### Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

### Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

## Your Rights

You have the following rights with respect to your protected health information:

### Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

### Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or

- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

### Right to an Accounting of Disclosures

You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

### Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

### Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

### Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

### Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

## 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).**

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**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 January 31, 2024. Contact your State for more information on eligibility –**

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

| GEORGIA – Medicaid | INDIANA – Medicaid |
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| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: (678) 564-1162, Press 2 | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>Phone 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563<br>HIPP Website:<br>https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |

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| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>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<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremiumassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |

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| **MONTANA - Medicaid** | **NEBRASKA - Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |

| OKLAHOMA – Medicaid and CHIP | OREGON – Medicaid |
|---|---|
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website:<br>https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program\| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website:<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |

| WASHINGTON – Medicaid | WEST VIRGINIA – Medicaid and CHIP |
|---|---|
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone:304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

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

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

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

## WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at Dana.Welker@thewinegroup.com.

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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

# MODEL GENERAL NOTICE OF
# COBRA CONTINUATION COVERAGE RIGHTS
## ** Continuation Coverage Rights Under COBRA**

### *Introduction*

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

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

### You may have other options available to you when you lose group health coverage.

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

### *What is COBRA continuation coverage?*

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to The Wine Group, Inc., and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### *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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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: Peak One Administrators.**

### *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[1] 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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

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/agencies/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.

***Plan contact information***

The Wine Group, Inc.
17000 E. Hwy 120, Ripon, CA 95366
Dana.Welker@thewinegroup.com

## HIPAA NOTICE OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

The Wine Group, Inc. Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact The Wine Group Attn: Benefit Analyst 3, 17000 E. Hwy 120, Ripon, CA 95366. Dana.Welker@thewinegroup.com.

## HIPAA WELLNESS PROGRAM REASONABLE ALTERNATIVE STANDARDS NOTICE

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at The Wine Group Attn: Benefit Analyst 3, 17000 E. Hwy 120, Ripon, CA 95366 and we will work with you (and, if you wish, with your

doctor) to find a wellness program with the same reward that is right for you in light of your health status.

## YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

### What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

### You are protected from balance billing for:

*Emergency services*

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

*Certain services at an in-network hospital or ambulatory surgical center*

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.**

## When balance billing isn't allowed, you also have the following protections:

1. You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

2. Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills.


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