Important Legal Notices About Your Benefits

Health Care Reform

The new federal health reform law focuses on establishing new state-based mechanisms for obtaining coverage and for establishing federal standards to oversee benefit designs and costs of coverage. Most of the significant reforms, including Exchanges and guarantee issue requirements, became effective in 2014. Other less significant reforms have already been implemented with the 2011, 2012 and 2013 plan years. Some of the changes to health plan benefits include the elimination of pre-existing conditions, no life-time limits or annual limits on certain plan benefits. Recently, the government removed the requirement of the individual mandate. In other words, individuals are not required to purchase health insurance for 2019 and beyond and will not be subject to a potential penalty if health insurance is not purchased.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act ("HIPAA") deals primarily with how Samuel, Son & Co. can enforce eligibility and enrollment for health care benefits. Examples of some of the HIPAA requirements include:

- Special enrollment periods are available during the year to you and your eligible dependents (in certain circumstances) that lose other health care coverage if you enroll within 30 days after losing the other health care coverage.
- If you are not enrolled for health care coverage and add an eligible dependent (i.e. marriage), you can enroll yourself and your other eligible dependents within 30 days of the event. If you add an eligible dependent (i.e. birth, adoption or placement for adoption), you can enroll yourself and your newly acquired eligible dependents within 30 days of the event.

The Plan will not base eligibility rules or waiting periods on any of the following factors: health status, mental or physical medical condition, and genetic information, evidence of insurability or disability. Evidence of insurability will not be required when health care coverage is requested during a special enrollment period or during an annual enrollment. However, the Plan may continue to provide for the exclusion of specified health conditions and apply lifetime maximums on either specific benefits or all benefits provided under the Plan. These restrictions also do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

Changing Your Elections

In general, your annual pre-tax benefit elections are irrevocable for the plan year, January 1, 2027, through December 31, 2027. However, if you experience a Change in Status or special enrollment event that directly affects your eligibility for coverage; you may change your election within 30 days of the event. Under limited circumstances, an election change based solely on a Change in Status must be consistent with your Change in Status (i.e. if a child is born to you, you add coverage for that child).

In general:

Change in Status events provide more opportunities for you to make an election change than do special enrollment rights.

If your event could be considered both a Change in Status event and a special enrollment right, you may make any change allowed by either a Change in Status or special enrollment right.

Contact the Samuel, Son & Co. Benefits Department at 630-783-8900, for more information on the requirements for making an election change based on a Change in Status event or special enrollment right.

<u>Change in Status Events that Permit Election Changes for Health Benefits and Life Insurance Benefits:</u>

- Change in marital status: you may elect coverage for yourself and/or your newly acquired spouse or drop coverage for your spouse if you divorce, legally separate, have your marriage annulled or your spouse dies.
- Change in your number of dependents: you may elect coverage for your newborn, adopted child or a child placed with you for adoption. You may drop coverage if a dependent child dies.
- Change in employment status: you may add or drop coverage consistent with a change in employment status of you, your spouse or dependents that affect the benefit eligibility under this plan or under the employee benefit plan of your spouse or dependents. You, your spouse or dependent experience a change in employment status when any of the following occur and benefit eligibility is affected: begin or end employment, take part in a strike or lockout, begin or return from an approved leave of absence, switch from hourly to salaried, switch from union to non-union or vice versa, reduce or increase the number of hours you work or any similar change that affects your eligibility under the plan.
- Dependent eligibility: you may add or drop your child in the event he or she becomes or ceases to be eligible under the plan.
- Change in residence: you may change your coverage option if you move, and it significantly affects your benefit availability.

<u>Additional Change in Status Events that Permit Election Changes for Health Benefits Only:</u>

- Family and Medical Leave Act (FMLA) – certain election changes are permitted when you start an FMLA leave or when you return from an FMLA leave.
- Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a “qualified medical child support order” or QMCSO) that requires health coverage for an Associate’s child or foster child.
- You, your spouse, or your dependent become entitled to or lose eligibility for Medicare or Medicaid.
- You, your spouse or your dependent gain eligibility under another employer’s plan.
- A significant change in your cost for health coverage.

- A Change in Status that results in a “special enrollment right” under the Health Insurance Portability and Accountability Act (HIPAA). Please refer to the section below for more information.

You must complete a Change Form and return it to the Samuel, Son & Co. Benefits Department within 30 days of the Change in Status. If you miss this 30-day period, you will not be able to change your coverage until the following Annual Enrollment period, unless you have another Change in Status that affects your eligibility under the plan.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to enroll in a group health plan at times other than initial eligibility or the Annual Enrollment period. You have special enrollment rights if you and/or your eligible dependents lose other group health coverage, or you gain a new dependent. If either of these events occurs, you must enroll within the 30-day time limit explained here, or you will lose your special enrollment rights for that event.

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

Loss of eligibility does not include a loss of coverage that occurs because you fail to pay premiums on a timely basis, if your other coverage is terminated for cause or your voluntary termination of COBRA continuation 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 or your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

You must request enrollment in the medical and/or dental plan no later than 30 days after the event giving rise to your special enrollment right, by completing and returning a new Benefit Enrollment and Change Form. If you fail to request enrollment within the 30-day time period, you and your dependents will lose the special enrollment rights for that event.

If your special enrollment right occurs because you lost other coverage or married, your enrollment is effective on the first day of the month after your Benefits Department receives your properly completed Change Form. If your special enrollment right occurs because of a new dependent child, coverage is effective on the date of the birth, adoption, or placement for adoption.

If you or your dependent is eligible, but not enrolled, for health coverage under the Samuel, Son & Co. medical plan, you and/or your dependent may enroll in the plan if (i) your Medicaid or CHIP coverage is terminated as a result of loss of eligibility or (ii) you and/or your dependent become eligible for premium assistance under Medicaid or CHIP. However, to be eligible for this special enrollment opportunity, you must request coverage under the group health plan within 60 days after the date you and/or your dependent become eligible for premium assistance under Medicaid or CHIP or the date you or your dependent’s Medicaid or state-sponsored CHIP coverage ends. For more information on Medicaid and CHIP, please see the section below entitled Medicaid/CHIP.

To request enrollment due to a special enrollment right or obtain more information, contact the Samuel, Son & Co. Benefits Department at 630-783-8900.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	**ALASKA – Medicaid** The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	**CALIFORNIA – Medicaid** Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	**FLORIDA – Medicaid** Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	**ILLINOIS - Medicaid** Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	**IOWA – Medicaid and CHIP (Hawki)** Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid** Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	**MAINE – Medicaid** Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	**MINNESOTA – Medicaid** Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**MONTANA – Medicaid** Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	**NEVADA – Medicaid** Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	**NEW JERSEY – Medicaid and CHIP** Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	**NORTH CAROLINA – Medicaid** Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**

Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	**PENNSYLVANIA – Medicaid and CHIP** Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	**SOUTH CAROLINA – Medicaid** Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059	**TEXAS – Medicaid** Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	**VERMONT– Medicaid** Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	**WASHINGTON – Medicaid** Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	**WISCONSIN – Medicaid and CHIP** Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, 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

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act (FMLA), you may be eligible for up to 12 weeks of unpaid leave for certain family and medical reasons and continue your benefits at active employee rates. You are eligible for FMLA leave if you have been employed by Samuel, Son & Co. for at least one year and worked at least 1,250 hours over the previous 12 months.

You may be eligible to take FMLA leave:

- After the birth or adoption of your child or if a child is placed with you for adoption
- To care for your spouse, child or parent who has serious health condition (including medical conditions resulting from military service)
- If you have a serious health condition that makes you unable to perform your job

You may choose to either continue benefits on the same basis as if you continued working (were an active employee) or revoke your health benefit election (i.e. cancel your benefits) while you are on FMLA leave. If you revoke your benefit election while on FMLA leave, your election can be reinstated when you return to work. If you continue your benefits while on FMLA leave, you must pay your share of the cost for your benefits coverage during your period of FMLA leave. If your leave is unpaid (or paid and does not cover the entire cost), you are responsible for paying your portion of the premiums directly to the insurer. If you fail to make a premium payment, your coverage will be terminated. If your coverage terminates while you are on FMLA leave, your coverage can resume when you return from your FMLA leave of absence. For more information about FMLA leave and your benefit coverage while on FMLA leave, please contact Samuel, Son & Co. Benefits Department.

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA)

The Samuel, Son & Co. medical plan complies with the Mental Health Parity Act of 1996 (“MHPA”). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration, and scope of Mental Health Benefits.

MHPA and MHPAEA only apply to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees. Take it out if not applicable.

Transparency in Coverage (TiC) Machine-Readable Files (MRF) Notice

The Transparency in Coverage (TiC Regulations) and the Consolidated Appropriations Act of 2021 (CAA) (collectively “transparency requirements”) impose certain obligations on group health plans, health insurers, and health care providers.

Two of these requirements became effective July 1, 2022:

- Group health plans must make public a MRF with in-network provider rates for covered items and services (“In-network Rate Disclosures).
- Group health plans must make public a MRF with out-of-network allowed amounts and billed charges for certain covered items and services (“Out-of-network Rate Disclosures).

By clicking here, transparency-in-coverage.uhc.com you can find our health plan’s in-network and out-of-network rate disclosures as required under the TiC regulations.

Newborns' and Mothers' Health Protection Act (NMHPA)

The Samuel, Son & Co. medical plan will comply with all required provisions of the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA) with respect to health benefits provided under this plan. The plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. You only need to pre-certify maternity hospital stays if the hospital stay will be longer than the periods specified above. However, you must still pre-certify any hospital admission during your pregnancy that is not due to delivery or is in excess of the applicable timeframes outlined above. In addition, the plan will not require that a

provider obtain authorization from the plan and insurer for prescribing a length of stay not in excess of the above periods. However, the NMHPA generally does not prohibit the mother's or newborn's attending provider, after consulting with and obtaining consent from the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act (WHCRA)

The Samuel, Son & Co. medical plan complies with all required provisions of the Women's Health and Cancer Rights Act of 1998 (WHCRA) with respect to health benefits provided under this plan. The plan will cover certain breast reconstruction and other benefits in connection with a mastectomy. If you elect breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your physician for (1) all stages of reconstruction of the breast on which the mastectomy was performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, (3) prosthesis and (4) treatment of physical complications for all stages of mastectomy, including lymphedemas. Such coverage remains subject to the terms of the Plan, including normal deductible, copay, and coinsurance provisions.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Samuel, Son & Co. medical plan will comply with all required provisions of GINA with respect to health benefits and coverage under this plan. The plan will not discriminate on the basis of genetic information, including information about manifestation of a disease or disorder in a family, in addition to information about genetic tests. Furthermore, genetic information will not be requested or required for underwriting purposes or before enrollment, participants and covered dependents will not be required to undergo genetic testing and genetic information will not be used to adjust premiums or contributions for groups under the Samuel, Son & Co. medical plan. However, the plan and/or employer may use, in accordance with GINA, a minimum necessary amount of genetic testing results in order to make a determination about a claim payment where such information is necessary and/or required. For more information about GINA, please contact your Benefits Department.

Michelle's Law

Subject to future regulations and the Affordable Care Act, the Samuel, Son & Co. medical plan will comply with all required provisions of Michelle's Law with respect to health benefits provided under this plan to dependent children over the age of 18 who are enrolled in an institution of higher education on a full-time basis. If the dependent child is enrolled on a full-time basis and subsequently loses his/her full-time status at his/her institution of higher education as a result of taking a "medically necessary leave of absence" (as defined under Michelle's Law) due to a serious illness or injury, coverage for the dependent under the Samuel, Son & Co. medical plan will not terminate until the earlier of (i) the date that is one year after the first day of the medically necessary leave of absence or (ii) the date coverage would otherwise terminate under the plan. The student/dependent on leave is entitled to the same benefits as if he/she had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

Please note that under the Affordable Care Act, group health plans and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. Nonetheless, under some circumstances, such as a plan that provides dependent coverage beyond age 26, Michelle's Law provisions may apply. For more information about Michelle's Law and your dependent's benefit coverage under Michelle's Law, please contact the Samuel, Son & Co. Benefits Department.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't 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" means 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're 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 types of 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 these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible 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.
- 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 think you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
Important Information about Your Right to COBRA Continuation Coverage

This contains important information about your right to group health plan continuation coverage, which is a temporary extension of coverage under the Plan after you (and/or your qualified dependent) would otherwise lose group health coverage under the Plan. The right to this continuation coverage (COBRA continuation coverage) was created by Federal law under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you may elect to temporarily continue your group health coverage for yourself, and any eligible dependents covered by the Samuel, Son & Co. group health plans on the day your (or your qualified dependents) group health benefits ceased because of a qualifying event. You and your eligible dependents are eligible to elect COBRA continuation coverage even if you (or they) have health coverage under another group health plan. Please read this section carefully as it generally explains COBRA continuation coverage, when it may be available to you and your eligible dependents and what you (and they) need to do to protect the right to receive 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 Benefits Department.

Eligibility for COBRA Continuation Coverage

COBRA continuation coverage is continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each plan participant who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if group health coverage under the plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

Qualifying Events and COBRA Continuation Coverage

The qualifying events for COBRA continuation coverage and the maximum COBRA continuation coverage periods are shown in the charts that follow.

Employee COBRA Continuation Coverage

If you are an employee of Samuel, Son & Co. and are covered by Samuel, Son & Co.'s health plan you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
Termination of your employment (for reasons other than gross misconduct)	18 months
Reduction in your hours of employment with loss of eligibility for benefits	18 months

Spouse of an Employee COBRA Continuation Coverage

If you are the spouse of an employee of Samuel, Son & Co. and are covered by Samuel, Son & Co.'s health plan, you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with loss of eligibility for benefits	18 months
The death of the employee	36 months
Divorce or legal separation from the employee	36 months
The employee's entitlement to Medicare	36 months

Dependent Children of an Employee COBRA Continuation Coverage

Dependent children of an employee of Samuel, Son & Co. who are covered by Samuel, Son & Co.'s health plan have the right to COBRA continuation coverage (for the period stated) if they lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with loss of eligibility for benefits	18 months
The death of the employee	36 months
The employee's divorce or legal separation	36 months
The employee's entitlement to Medicare	36 months
Loss of eligible dependent status (i.e., reach maximum age, lose full-time student status)	36 months

The maximum period of COBRA continuation coverage is measured from the date of the loss of coverage due to the applicable qualifying event specified above.

The plan will offer COBRA continuation coverage to a qualified beneficiary only after the Samuel, Son & Co. Benefits Department has been properly notified that a qualifying event has occurred.

You must notify the Samuel, Son & Co. Benefits Department within sixty (60) days of the following qualifying events: divorce or legal separation of the employee; spouse or a dependent child losing eligibility for coverage as a dependent under the plan, or Medicare entitlement. You must provide this notice to the Samuel, Son & Co. Benefits Department within the sixty (60) day deadline or your right to COBRA continuation coverage will be lost and will not be reinstated. Notice requirements are detailed below.

A special rule applies if you drop coverage for your spouse and/or eligible dependent children because you are planning to divorce. In such a case, your spouse and/or dependent children who had previously been covered under the plan would be entitled to elect COBRA continuation coverage for up to thirty-six (36) months from the date the divorce is final, but only if the Samuel, Son & Co. Benefits Department is notified of the divorce within sixty (60) days from the date of final judgment. No retroactive coverage before the date of divorce is available.

If it is determined that an individual is not eligible for COBRA continuation coverage, the COBRA administrator, Benefit Resource (BRI) Inspira Financial, will notify such individual of his or her failure to qualify for COBRA continuation coverage. This notice will explain why the individual is not entitled to COBRA continuation coverage and will be sent within fourteen (14) days after the receipt of the individual's notice of a qualifying event.

Subsequent Qualifying Event

If a subsequent qualifying event that is not your termination of employment or reduction in work hours (such as your divorce, legal separation, your death or your dependent child ceasing to be eligible under the plan) occurs during an initial eighteen (18) month period of coverage, COBRA continuation coverage may be extended for your eligible dependents who are qualified beneficiaries for up to a maximum period of thirty-six (36) months measured from the date of the first qualifying event. An event shall not be a subsequent qualifying event unless that event would cause a loss of coverage under the Plan independent of the

initial qualifying event. The covered employee will not be eligible for an extension of your maximum 18-month period of COBRA continuation coverage for a subsequent qualifying event.

Notice of a subsequent qualifying event must be given to the COBRA administrator, Benefit Resource (BRI) Inspira Financial, within a maximum of sixty (60) days in order to extend COBRA continuation coverage. If you fail to inform the COBRA administrator, Benefit Resource (BRI) Inspira Financial, you will lose your right to extend your COBRA continuation coverage and this right will not be reinstated. Notice requirements are detailed below. Please see the special COBRA continuation coverage for Disabled Persons section of this guide for information on disability as a subsequent qualifying event.

Notice Requirements

In most cases, the COBRA administrator, Benefit Resource (BRI) Inspira Financial, will notify you of your right to elect COBRA continuation coverage. However, if your eligible dependent has a qualifying event as a result of your divorce, legal separation, Medicare entitlement or lose their status as a dependent, you or your covered dependent must properly notify the COBRA administrator, Benefit Resource (BRI) Inspira Financial, within a maximum of sixty (60) days of the qualifying event. In addition, if you have a child born, legally adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify the COBRA administrator, Benefit Resource (BRI) Inspira Financial, within sixty (60) days of the event in order to cover the child.

Notice must be submitted to the COBRA administrator, Benefit Resource (BRI) Inspira Financial, at PO Box 642 Willow Grove, PA 19090 on the written form approved by the Benefits Department. The form must be completed and submitted to the COBRA administrator, Benefit Resource (BRI) Inspira Financial, before the end of the applicable deadline. The forms, information and deadlines for certain events are outlined in the table below.

Event Requiring Notice	Deadline for Notice
Divorce or Legal Separation	Within 60 days from date of final court judgment
Dependent becomes ineligible under the plan	Within 60 days from date of ineligibility
Medicare entitlement	Within 60 days from date of entitlement
Determination of disability	Within 60 days of disability determination and before the end of the maximum 18-month COBRA continuation coverage period
Determination of non-disability status	Within 30 days of the Social Security Administration’s determination of non-disability
Marriage	Within 31 days from the date of marriage
Birth, Adoption or Placement for Adoption	Within 60 days from date of the event

Failure to properly provide the required notice may result in loss of any COBRA continuation right and, if lost, this right will not be reinstated.

The COBRA administrator, Benefit Resource (BRI) Inspira Financial, is the designated recipient for all COBRA continuation coverage notices. They may be reached at: 1-800-473-9595, PO Box 642 Willow Grove, PA 19090.

Electing COBRA Continuation Coverage

Once the COBRA administrator, Benefit Resource (BRI) Inspira Financial, receives notice that a qualifying event has occurred, COBRA continuation coverage will then be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, you may elect COBRA continuation coverage on behalf of your spouse and parents may elect COBRA continuation coverage on behalf of their children.

If you wish to elect COBRA continuation coverage, you must notify the COBRA administrator, Benefit Resource (BRI) Inspira Financial, within a maximum of sixty (60) days of the later of: (i) the date of the qualifying event or (ii) the date you received your COBRA notice. If you choose to continue benefits for yourself and your eligible dependent, before the maximum sixty (60) day election deadline, your coverage will continue uninterrupted. If you (or your eligible dependent) fail to elect COBRA continuation coverage within the maximum sixty (60) days after you are notified by the COBRA administrator, Benefit Resource (BRI) Inspira Financial, you will lose your right to COBRA continuation coverage and that right will not be reinstated.

You must also keep the COBRA administrator, Benefit Resource (BRI) Inspira Financial, informed of all the information needed to meet its obligation of both providing notice to you of your right to COBRA continuation coverage and providing the actual COBRA continuation coverage. Such information includes your current contact information and administrative information about yourself, your spouse, and/or dependents. You or your spouse's election to take COBRA continuation coverage can also be an election to cover all the other qualified beneficiaries in the family, unless the election is specific as to which qualified beneficiaries are to be covered.

You must notify the COBRA administrator, Benefit Resource (BRI) Inspira Financial, to request alternate coverage if you move outside the service area of the benefit network for your elected coverage. Alternate coverage will be made available (if available) to you not later than the date of the relocation or the first day of the month following the month in which the request is made.

Health Care Exchange - Notice

There may be other coverage options for you and your family. For example, you will be able to buy coverage through the Health Insurance Marketplace during the Marketplace's open enrollment period. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Special Enrollment Events and COBRA

If you have a child born to, adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify the COBRA administrator, Benefit Resource (BRI) Inspira Financial, and elect coverage within sixty (60) days of the child's birth, adoption or placement for adoption. If you get married during your COBRA continuation coverage, you may add your new spouse to your COBRA continuation coverage if you notify the COBRA administrator, Benefit Resource (BRI) Inspira Financial, within thirty-one (31) days of the date of the marriage. A new dependent may be a participant under this coverage for the remainder of your maximum COBRA continuation period (eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the applicable qualifying event).

Cost and Payment of COBRA Premiums

You must pay the full cost for COBRA continuation coverage (plus a two percent (2%) administrative fee). the COBRA administrator, Benefit Resource (BRI) Inspira Financial, will determine this cost, but it generally cannot exceed one hundred two percent (102%) of the plan's cost for providing coverage to similar situated covered active employees and their covered dependents. COBRA premiums are subject to change annually. If you and your covered dependents are receiving an additional eleven (11) months of COBRA continuation coverage due to disability as the qualifying event, the COBRA administrator, Benefit Resource (BRI) Inspira Financial, will determine COBRA premium which will not exceed one hundred fifty percent (150%) of the plan's cost for providing coverage, if the disabled qualified beneficiary is part of the COBRA continuation coverage group or one hundred two percent (102%) if the disabled qualified beneficiary is not receiving COBRA continuation coverage.

Once an election for COBRA continuation coverage is made, you (or your covered dependents) have a maximum of forty-five (45) days from the date of election to pay the premium for the current month and any retroactive COBRA premiums then due for the elected coverage. Although coverage is retroactive to the date of loss of coverage due to the initial qualifying event, no COBRA continuation coverage benefits will be paid until this first COBRA premium is received by the COBRA administrator, Benefit Resource (BRI) Inspira Financial. If payment is not received within the forty-five (45) day period, then coverage will either be revoked retroactively or not become effective. You will lose your right to COBRA continuation coverage and it will not be reinstated.

All subsequent COBRA premium payments are due on the first day of the month. The plan allows a thirty (30) day grace period for payment of required COBRA premiums (except the first payment previously discussed). Even if you do not receive a bill, you must still submit your COBRA premium payments within the required time period. ***The thirty (30) day grace period does not apply to the forty-five (45) day period for payment of the initial COBRA premium.*** If your COBRA premium payment is not postmarked by the last day of the grace period, your COBRA continuation coverage will end as of the last day of the last month for which a full COBRA premium payment was made.

If timely payment of the COBRA premium is made to the plan in an amount that is not more than fifty dollars ($50) or ten percent (10%) less than the required COBRA premium payment, then the amount paid is deemed to satisfy the plan's requirement for full COBRA premium payment, unless the COBRA administrator, Benefit Resource (BRI) Inspira Financial, notifies the qualified beneficiary of the amount of the deficiency and allows thirty (30) days for payment of the deficiency to be made.

COBRA premiums can be paid by you or by a third party on your behalf. Here are a few other details about COBRA premium payments you need to be aware of:

- No late or reminder notices will be sent for payments that have not been made.
- Once COBRA continuation coverage is terminated, it cannot be reinstated.
- All terms and conditions that apply to active participants in the plan are also applicable to COBRA continuation coverage participants.
- All rules and procedures for filing and determining benefit claims and appeals under the plan that apply to active employees also apply to COBRA continuation coverage.

Trade Act Credit

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PGBC) (eligible individuals) and pay for health coverage. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Responses to Information Regarding a Qualified Beneficiary's Right to Coverage

Upon request, the plan must inform health care providers regarding the qualified beneficiary's right to coverage during the applicable grace periods. In addition, the plan is required to respond to inquiries from health care providers regarding the qualified beneficiary's right to coverage during the election period and his or her right to retroactive coverage if COBRA continuation coverage is elected.

Changes in Benefits under COBRA

If you or any covered dependents elect COBRA continuation coverage, benefits will be the same as were in effect at the time of your qualifying event. You will be able to change your plan coverage option during annual enrollment to the same extent as similarly situated active employees. If the group health plan benefits of active employees change, benefits for qualified beneficiaries on COBRA continuation coverage will also change in the same manner.

Special COBRA Continuation Coverage for Disabled Persons

If you (and your covered dependents) are receiving eighteen (18) months of COBRA continuation coverage and your qualifying event is a termination of employment or a reduction of hours, your maximum COBRA continuation coverage period may be extended by eleven (11) months to up to a maximum of twenty-nine (29) months in total provided the following requirements are met:

- The Social Security Administration determines that you (or your dependent who is a qualified beneficiary) are disabled within the meaning of the Social Security Act;
- This disability exists as of the date of the qualifying event or at any time during the first sixty (60) days of COBRA continuation coverage following the qualifying event; and
- The disability lasts at least until the end of the eighteen (18) month period of COBRA continuation coverage.

Notice of the determination of disability under the Social Security Act must be provided to the COBRA administrator, Benefit Resource (BRI) Inspira Financial, within the initial eighteen (18) month coverage period and within sixty (60) days after the latest of: (1) the date of the Social Security Administration determination of disability; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the notice of disability. If you fail to properly notify the COBRA administrator, Benefit Resource (BRI) Inspira Financial, within the deadline above, you will lose your right to the extension of COBRA continuation coverage and this right will not be reinstated. Please refer to the Notice Requirements section above for information about proper notice to the plan.

If the Social Security Administration determines later that the qualified beneficiary is no longer disabled, the COBRA administrator, Benefit Resource (BRI) Inspira Financial, must be properly notified within thirty (30) days of the Social Security Administration’s determination. This notice will end the extended COBRA continuation coverage for all qualified beneficiaries within the coverage group. Failure to notify the COBRA administrator, Benefit Resource (BRI) Inspira Financial, that a qualified beneficiary is no longer disabled will result in termination of COBRA continuation coverage for all qualified beneficiaries within the coverage group effective on the date of the Social Security Administration determination and such coverage will not be reinstated. When the disabled qualified beneficiary becomes eligible for Medicare, the COBRA administrator, Benefit Resource (BRI) Inspira Financial, must be properly notified to end the extended coverage for the affected disabled qualified beneficiary. Please refer to the Notice section above for information about proper notice to the plan.

COBRA Continuation Coverage and Medicare

If your dependent is receiving COBRA continuation coverage and you become entitled to Medicare benefits, your coverage will end but COBRA continuation coverage for your qualified dependents may continue for up to thirty-six (36) months measured from the date of the initial qualifying event.

In addition, if you become entitled to Medicare and then later terminate employment (for reasons other than gross misconduct) or have a reduction in hours, your qualified dependents who are eligible for COBRA continuation coverage will be eligible for thirty-six (36) months of COBRA continuation coverage measured from the date you became entitled to Medicare. However, you will only be eligible for eighteen (18) months of COBRA continuation coverage measured from the qualifying event.

Termination of COBRA Continuation Coverage

COBRA continuation coverage shall not be provided beyond the earliest of the following dates:

- The date the maximum COBRA continuation coverage period expires based upon the qualifying event;
- The date the plan is terminated, and no other group health plan is provided to active employees;
- The last day of the month preceding the month for which the qualified beneficiary fails to pay the premium for COBRA continuation coverage by the last day of the grace period;
- The date the qualified beneficiary first becomes entitled to Medicare, including Medicare entitlement due to End Stage Renal Disease (ESRD), after the person elects COBRA continuation coverage;
- The date that initial payment is not received within a maximum of forty-five (45) days after the election of COBRA continuation coverage is made;
- The date the qualified beneficiary first becomes covered under another group health plan or policy after the date the person elects COBRA continuation coverage; or

- For a disabled qualified beneficiary receiving COBRA continuation coverage during the eleven (11) month disability extension period (and their covered family members), the date the disabled person receives a final determination by the Social Security Administration that he or she is no longer "disabled." This final determination shall end COBRA continuation coverage for all qualified beneficiaries as of the later of either: (a) the first day of the month following thirty (30) days from the final determination date; or (b) the end of the COBRA continuation coverage period based on the initial qualifying event without regard to a disability extension.

If your COBRA continuation coverage is terminated for any of the reasons noted above, your coverage will end and will not be reinstated.

In the event that your COBRA continuation coverage is terminated before the end of the maximum coverage period, the COBRA administrator, Benefit Resource (BRI) Inspira Financial, will notify you of the termination of your coverage as soon as administratively possible. This notice will explain why and when COBRA continuation coverage has ended.

Contact Information for COBRA Administrator

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

Keep the Plan Informed

In order to protect your family's rights, you should keep the COBRA administrator, Benefit Resource (BRI) Inspira Financial, informed of any changes in the address of family members. You should also keep a copy of all COBRA notices that you receive or send in your own records.

Plan Contact Information

Information about the plan may be obtained by contacting the COBRA administrator, Benefit Resource (BRI) Inspira Financial, at PO Box 642 Willow Grove, PA 19090.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- 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 www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and we will provide you with a copy.

If you have any questions about this Notice, please contact the Privacy Officer at Samuel, Son & Co.. The contact information for the Privacy Officer is as follows:

Privacy Officer

Samuel, Son & Co.
2200 Pratt Blvd
Elk Grove Village, IL 60007

Important Notice from Samuel, Son & Co. 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 Samuel, Son & Co. 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. Samuel, Son & Co. has determined that the prescription drug coverage offered by the Samuel, Son & Co. medical plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Samuel, Son & Co. coverage will not be affected.

The Prescription Drug Plan options that SAMUEL, SON & CO. offers are:

For Plan 1 HDHP plan, RX coverage: Covered 80% after medical deductible
Plan 2 PPO plan, Rx coverage: $5 / $30 / $60
Plan 3 PPO plan, Rx coverage: $5 / $30 / $60
Associated Tube: PPO plan, Rx coverage: $15 / $40 / $60
Retiree Branch 8: PPO plan, Rx coverage: $15 / $25 / $75

If you do decide to join a Medicare drug plan and drop your current Samuel, Son & Co. 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 Samuel, Son & Co. and do not 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 Samuel, Son & Co.'s Benefits Department at 630-783-8900 for further information. NOTE: You will 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 Samuel, Son & Co. changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC Updated April 1, 2011 - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have comments

concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 will 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).

Samuel, Son & Co.
Position/Office: Benefits Department
2200 Pratt Blvd
Elk Grove Village, IL 60007
630-783-8900

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 8.39% of your annual household income in 2024, 9.02% in 2025, 9.96% in 2026, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 8.39% in 2024, 9.02% in 2025, or 9.96% in 2026 of the employee’s household income. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from

income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Samuel, Son & Co.'s Benefits Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Samuel, Son & Co.	4. Employer Identification Number (EIN) Contact your Benefits Department

5. Employer address 2200 Pratt Blvd	6. Employer phone number 630-783-8900
7. City, 8. State, 9. Zip Code Elk Grove Village, IL 60007	
10. Who can we contact about employee health coverage at this job? Samuel, Son & Co.'s Benefits Department	
11. Phone number (if different from above)	12. Email address (optional) Benefits.usa@samuel.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☑Full time employees work 30 hours or more w

- With respect to dependents:

  ☑

  We do offer coverage. Eligible dependents are:

  - Your legal spouse or your domestic partner
  - Your children up to age 26, including your natural–born children, stepchildren, any children who are under your legal guardianship, who are in your custody under an interim court order of adoption, or who are placed with you for adoption
  - Your children, of any age, who are physically or mentally disabled and incapable of supporting themselves, and can be claimed as a dependent on your U.S. federal income tax return

☑If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Employee Eligibility—Look-Back Measurement Method

The Samuel, Son & Co. offers coverage under its Plan to full-time employees. A full-time employee is an employee who is employed, on average, for at least 30 hours of service per week or 130 hours of service in a calendar month. Full-time employees may also elect coverage for their dependent children up to age 26 and eligible spouse or domestic partner as defined by the Plan.

Effective January 1, 2026, Samuel, Son & Co. will use a look-back measurement method to determine whether an employee is a full-time employee for purposes of Plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Plan coverage determinations.

The look-back measurement method applies to all Samuel, Son & Co. employees working on an as needed basis. If you are a new non-seasonal employee who is expected to work full time, Samuel, Son & Co. will determine your status as a full-time employee who is eligible for Plan coverage based on your hours of service for each calendar month

The look-back measurement method involves three different periods:

- A **measurement period** for counting an employee's hours of service (also called a standard measurement period or an initial measurement period);
- A **stability period** when the employee is either treated as full-time or non-full time for Plan eligibility purposes; and
- An **administrative period** that allows time for Plan enrollment and disenrollment.

Samuel, Son & Co. establishes how long these periods will last, subject to specified IRS parameters.

The rules for the look-back measurement method are complex. They vary depending on whether an employee is an ongoing employee or a new employee, and whether a new employee is expected to work full time or is a variable, seasonal or part-time

employee. Samuel, Son & Co. intends to follow the IRS final regulations (including any subsequent guidance issued by the IRS on the look-back measurement method) when administering the look-back measurement method.

Ongoing Employees

For ongoing employees, Samuel, Son & Co. determines full-time status by looking at a **standard measurement period (SMP)** lasting an employee's hours of service during the SMP will determine his or her Plan eligibility for the stability period that follows the SMP.

An ongoing employee is one who has been employed by Samuel, Son & Co. for at least one complete SMP.

If an ongoing employee was employed, on average, for at least 30 hours of service per week (or 130 hours per month) during the SMP, the employee is treated as a full-time employee for a set period into the future, known as the **stability period**. This means that, generally, the employee is eligible for Plan coverage during the stability period, regardless of the employee's number of hours of service during the stability period, as long as he or she remains an employee.

The final IRS regulations include an exception for certain employees who have been continuously offered Plan coverage and who transfer to part-time positions during the stability period. If certain conditions are met, Plan eligibility for these transferred employees may end during a stability period. Samuel, Son & Co. intends to follow applicable IRS guidance, including the rules for changes in employment status, when administering the look-back measurement method.

If an ongoing employee was not employed, on average, for at least 30 hours of service per week (or 130 hours per month) during the SMP, the employee is not treated as a full-time employee during the stability period, regardless of the employee's number of hours of service during the stability period.

The stability period is the First day of the month following two months from the Measurement Period end date.

.Samuel, Son & Co. also uses an administrative period between the SMP and the stability period. The administrative period lasts 90 days. The administrative period overlaps with the prior stability period to prevent any gaps in coverage for employees enrolled in coverage because of their full-time status during a prior measurement period.

New Employees Expected to Work Full Time

For a new employee who is not a seasonal employee and who Samuel, Son & Co. reasonably expects at his or her start date to be a full-time employee, Samuel, Son & Co. will determine the employee's status as a full-time employee based on the employee's hours of service for each calendar month.

If the employee's hours of service for the calendar month equal or exceed an average of 30 hours of service per week (or 130 hours per month), the employee is a full-time employee for that calendar month. Once the new employee becomes an ongoing employee (that is, he or she is employed for at least one complete SMP), the measurement rules for ongoing employees will apply.

New Variable Hour, Seasonal or Part-time Employees

Under the look-back measurement method, Samuel, Son & Co. determines whether new variable hour employees, new seasonal employees and new part-time employees are full-time employees by measuring their hours of service during an **initial measurement period (or IMP).**

- An employee is a **variable hour employee** if, at the employee's start date, Samuel, Son & Co. cannot determine whether the employee is reasonably expected to be employed, on average, at least 30 hours per week because the employee's hours are variable or otherwise uncertain.
- A **seasonal employee** is generally an employee who is hired into a position for which the customary annual employment is six months or less. Also, the period of employment for a seasonal employee should begin each calendar year in approximately the same part of the year, such as summer or winter.
- A **part-time employee** is a new employee who Samuel, Son & Co. reasonably expects to be employed, on average, less than 30 hours per week during the IMP,

Like the method for ongoing employees, the look-back measurement method for new variable hours, seasonal and part-time employees utilize a stability period for when coverage may need to be provided, depending on the employee's hours of service during the IMP. An administrative period is also used to make eligibility determinations and notify and enroll employees.

The IMP lasts 12 consecutive months. It begins on the employee's start date.

If a new variable hour, seasonal or part-time employee was employed, on average, at least 30 hours of service per week (or 130 hours per month) during the IMP, the employee is treated as a full-time employee for a set period into the future, known as the stability period. This means that the employee is eligible for Plan coverage during the **stability period**, regardless of the employee's number of hours of service during the stability period, if he or she remains an employee.

If a new variable hour, seasonal or part-time employee was not employed, on average, at least 30 hours of service per week (or 130 hours per month) during the IMP, the employee is not treated as a full-time employee during the stability period, regardless of the employee's number of hours of service during the stability period.

The final IRS regulations contain special rules for a new variable hour, seasonal or part-time employee who, before the end of the IMP, changes employment to a position or status where if the employee had started employment in the new position or status, he or she would have reasonably been expected to be employed full time as a non-seasonal employee. Samuel, Son & Co. intends to follow applicable IRS guidance, including the special rules for changes in employment status when administering the look-back measurement method.

The stability period is the first day of the month following two months from the Measurement Period end date.

Samuel, Son & Co. also uses an administrative period between the IMP and the stability period. The administrative period lasts 90 days. The administrative period overlaps with the prior stability period to prevent any gaps in coverage for employees enrolled in coverage because of their full-time status during a prior measurement period.

Once a new variable hour, seasonal or part-time employee has been employed for an entire standard measurement period, the employee will be tested for full-time status, beginning with that standard measurement period, at the same time and under the same conditions as other ongoing employees.

Rehired Employees and Employees Returning from Unpaid Leave

The following rules apply to rehired employees and employees returning from unpaid leave:

- If an employee goes at least 13 consecutive weeks without an hour of service and then earns an hour of service, he or she is treated as a new employee for purposes of determining the employee's full-time status under the look-back measurement method. Samuel, Son & Co. will apply a rule of parity for periods of less than 13 weeks. Under the rule of parity, an employee is treated as a new employee if the period with no credited hours of service is at least four weeks long and is longer than the employee's period of employment immediately before the period with no credited hours of service.
- For an employee who is treated as a continuing employee, the measurement and stability periods that would have applied to the employee had he or she did not experience the break in service will continue to apply upon the employee's resumption of service.

In addition, a special averaging method applies when measurement periods include special unpaid leave (that is, leave under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) or jury duty leave). This method only applies to an employee who is treated as a continuing employee upon resuming services for the employer, and not to an employee who is treated as terminated and rehired. Under the averaging method, Samuel, Son & Co. will either:

- Determine the average hours of service per week for the employee during the measurement period, excluding the special unpaid leave period, and use that average as the average for the entire measurement period; or

Treat employees as credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave.

SUMMARY ANNUAL REPORT
For Samuel, Son & CO. (USA), Inc. Employee Welfare Benefits Plan

This is a summary of the annual report of the Samuel, Son & CO. (USA), Inc. Employee Welfare Benefits Plan, EIN 06-1251791, Plan No. 516, for period 01/01/2025 through 12/31/2025. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Samuel, Son & CO. (USA), Inc has committed itself to pay certain self-insured Medical, Vision, and Telehealth claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with Metropolitan Life Insurance Company, ComPsych, Lincoln National Life Insurance Company, and The Lincoln National Life Insurance Company to pay Dental, Life Insurance, Short-term Disability, Long-term Disability, Accidental Death and Dismemberment, Employee Assistance Program, Critical Illness, Accident, and Hospital Indemnity claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2025 were $4,728,149.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Samuel, Son & CO. (USA), Inc at 2200 Pratt Boulevard, Elk Grove Village, IL, 60007 or by telephone at 331-238-0654.

You also have the legally protected right to examine the annual report at the main office of the plan (Samuel, Son & CO. (USA), Inc, 2200 Pratt Boulevard, Elk Grove Village, IL, 60007) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site www.efast.dol.gov.

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)