



Employee **Benefit Guide**



October 1, 2026 – September 30, 2027

Table of Contents

Important Items to Remember _____	1
myuhc.com Registration _____	2
UnitedHealthcare 2ndMD _____	3
Medical Insurance _____	4
Surest - Steps to Register _____	5
Surest - How to Search _____	6
Optum Health Savings Account (HSA) _____	7
Flexible Spending Account (FSA) _____	8
Dental Insurance _____	9
Vision Insurance _____	10
Employer Paid Basic Life and AD&D _____	11
Voluntary Term Life _____	12
Employer Paid Short-Term Disability _____	13
Voluntary Long-Term Disability _____	14
UHC Benefit Assist _____	15
Accident Protection Plan _____	16
Critical Illness Protection _____	17
Hospital Indemnity Plan _____	18
LegalShield _____	19
Employee Assistance Program (EAP) _____	20
401K Plan Summary _____	21
401K Principal Account Access _____	22
CHIP Notice _____	24
Health Insurance Marketplace Notice _____	27
Combined Legal Notices _____	29
Cobra Notice _____	30
Michelle's Law _____	32
HIPAA Notice _____	33
USERRA Notice _____	37
Medicare Part D Notice of Creditable Coverage _____	38
Medicare Part D Non-Creditable Coverage _____	40
Contact Sheet _____	42

Important Items to Remember

NEW HIRE WAITING PERIOD

New employees are eligible for company insurance benefits: *1st of the Month following 30 Days of continuous full time employment*

TERMINATION OF BENEFITS

When your employment with the company is terminated, your benefits will stop: *At the end of that month*

ELIGIBLE EMPLOYEES

To be eligible for company benefits, you must be a full time employee working an average of *30 hours* per week during the year.

DEPENDENT CHILDREN

Children under the age of 26 are eligible to be covered under the benefits. They will be taken off of the plan at the *End of the Calendar Year* in which they turn 26.

OPEN ENROLLMENT

You can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc..) during this time period each year. Open enrollment usually occurs 30 days prior to your plan renewal. All changes made during this time period will take effect on the renewal date.

MAKING PLAN CHANGES DURING THE YEAR

If you've had a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc...) during the year, you're able to make coverage changes to your plan even though it's outside of the Open Enrollment window. Please turn in all paperwork within 30 days of your Qualifying Event to ensure it will be processed timely and any claims incurred will be paid. PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it once it's available.

STAY IN NETWORK

To obtain the best benefits, it's important to stay in the insurance carrier's network. Always check online or verify over the phone that a doctor or hospital is in network BEFORE your visit. Also, when having a procedure done in a hospital/facility, ask the hospital staff to make sure EVERY doctor/nurse/radiologist/anesthesiologist/etc... is in your network.

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

NEED A NEW ID CARD OR ANOTHER ID CARD FOR A DEPENDENT?

Access your ID card anytime by downloading the insurance carrier app. You can also contact your Employee Benefits Advocate at Patriot Growth: wpb.benefits@patriotgrowth.com or call 877-446-0424

MEDICARE PART D DISCLOSURE NOTICES

If you (and/ or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 39-42 for more details.

myuhc.com

Get answers about your benefits, claims and more.

Registration is quick and simple:

- 1 Go to [myuhc.com](#)®.
- 2 Click the “Register Now” button.
- 3 Enter your name, date of birth and the account numbers from your health plan ID card. Or, enter your Social Security number and date of birth.
- 4 Create a username and password.
- 5 Enter your email address and optional phone numbers, and choose security questions.
- 6 Review and agree to the website policies, and be sure to keep the email opt-in checked so you get relevant news and wellness information.

Upon registering, you will receive Explanations of Benefits, claim letters, regulatory notices and other important information by email. You may choose to get paper communications at any time by changing your Mailing Preferences.

On myuhc.com, you can:

- Check past and current statements and claim status.
- Review eligibility and look up benefits.
- Find a hospital or doctor, including UnitedHealth Premium® designated physicians.
- Print a temporary health plan ID card or request a replacement card.
- Take a health assessment and participate in online programs designed to help you set goals toward your health objectives.
- Learn about health conditions, symptoms and the latest treatment options.
- Use the **Individual** Health Record to organize and store your health data in one convenient, confidential place.
- Access UHC rewards



2nd.MD

Access to doctors for a second opinion



Facing a new diagnosis or managing a chronic condition? Looking at possible surgery? A change in your medication? Get a virtual second opinion from a doctor with 2nd.MD. They'll provide you with evidence-based information to help you understand your options. Within days, you and your family will be connected with a doctor to receive personalized information and education by video or phone. And it's all coordinated with your health plan resources. This service can help with all adult and pediatric subspecialties.

Connect with 2nd.MD specialists for a second opinion, and then 2nd.MD will provide a summary for you to share with your treating provider.



Get in touch with a doctor now

Request a
second opinion
online 24/7 at
uhc.care/programs
or by calling
1-866-269-3534.

United Healthcare®

2nd.MD

2nd.MD provides information and support as part of your health plan. It does not provide medical advice or other health services and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Members are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. 2nd.MD is not an insurance program and may be discontinued at any time. This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for your information only. It is provided as part of your health plan. Program nurses and other representatives cannot diagnose problems or suggest treatment. This program is not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. This is not an insurance program and may be discontinued at any time.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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Medical Insurance

- **Choice+ HSA** plan is a High Deductible Health Plan (HDHP) that pairs with a Health Savings Account (HSA). This is often referred to as "first-dollar responsibility," meaning you pay the contracted UHC Choice+ network rate for covered services until your deductible is met. Coinsurance will then apply until you reach your out-of-pocket maximum for the plan year. Preventive services and virtual visits through UHC Designated Virtual Network are covered at 100%.
- **Choice EPO 3000** plan is a traditional medical plan that provides in-network coverage through the UHC Choice network that includes a mix of copays, deductible and coinsurance.
- **Choice+ Surest** plan is a variable copay-based medical plan that puts you in control of your costs! Unlike traditional health plans, the Surest plan has no deductible or coinsurance, and covered services are assigned clear, bundled copays that you can view before receiving care. Note: Copays are based on Care Ratings so members are encouraged to shop and compare options before receiving care. <https://benefits.surest.com>

	UnitedHealthcare Choice+ HSA	UnitedHealthcare Choice EPO 3000	United Healthcare Choice+ Surest
Deductible	In-Network	In-Network	In-Network
Single	\$3,000	\$3,000	Does Not Apply
Family	\$6,000 (\$3,400 per person)	\$6,000	Does Not Apply
Coinsurance			
Member %	20%	20%	Does Not Apply
Out-of-Pocket Maximum			
Single	\$6,500	\$5,500	\$5,500
Family	\$13,000	\$11,000	\$11,000
Commonly Used Services			
Primary Care Physician Office Visit	Deductible + Coinsurance	\$30	\$25 to \$130
Specialist Office Visit	Deductible + Coinsurance	\$55	\$25 to \$130
Urgent Care	Deductible + Coinsurance	\$75	\$80
Emergency Room	Deductible + Coinsurance	\$400	\$350
Preventive Care			
Preventive Services	No Charge	No Charge	No Charge
Major Medical Expenses			
Outpatient Surgery	Deductible + Coinsurance	Deductible + Coinsurance	\$40 to \$3,500
Inpatient Hospitalization / Surgery	Deductible + Coinsurance	Deductible + Coinsurance	\$400 to \$3,500
CT scan, PT scan, MRI	Deductible + Coinsurance	\$300	\$150 to \$1,900
Diagnostic, X-ray and Lab	Deductible + Coinsurance	Deductible + Coinsurance	No Charge (*Not at a hospital)
Prescription Drug Coverage			
Generic (Tier 1)	Deductible then \$10	\$10	\$10
Brand Name (Tier 2)	Deductible then \$50	\$40	\$40
Non-Preferred (Tier 3)	Deductible then \$100	\$85	\$85
Specialty (Tier 4)	Deductible then 25%	25% coinsurance	\$400
Plan Information			
Plan Year	10/01/2026 – 09/30/2027	10/01/2026 – 09/30/2027	10/01/2026 - 09/30/2027
Deductible Period	Plan Year	Plan Year	Plan Year
Network Type	PPO (Out-of-Network available at a different benefit schedule)	In-Network Only EPO	PPO (Out-of-Network coverage available at a different benefit level)
Network Name	Choice Plus	Choice	Choice Plus
Member Website	www.myuhc.com	www.myuhc.com	https://benefits.surest.com
Customer Service Phone Number	1-855-619-6713	1-855-619-6713	1-855-619-6713

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck (26)

Employee Only	\$0.00	\$45.92	\$90.29
Employee + Spouse	\$198.12	\$280.51	\$331.80
Employee + Child(ren)	\$162.26	\$230.00	\$274.47
Family	\$295.14	\$425.77	\$501.09

Get the app. Register your account.

With a Surest account, your benefits are available when you are. Simply download the Surest app and register your account to see cost and care options, resources, and claims from (almost) anywhere, anytime. It's as easy as 1, 2, 3.

1

First things first:

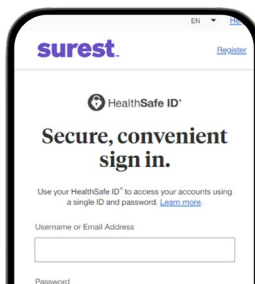
Download the free Surest app below or go to Benefits.Surest.com.



2

Next, register your Surest account using HealthSafe ID® (HSID). If you already have an HSID you don't need to create a new one.

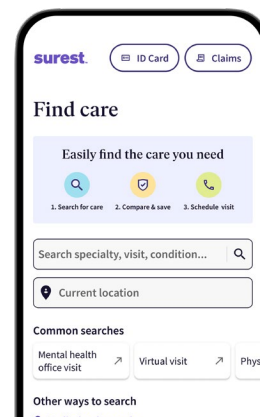
1. Provide your first and last name, date of birth, Surest member ID number, or Social Security number.
2. Create sign-in credentials.
3. Set up a recovery device.



3

Finally, the fun part:

Log in to your Surest account using your HSID credentials to shop and compare health care options—and find ways to save.

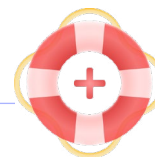


Pro tip: Once your account is created, you'll be prompted to set up communication preferences to get timely updates and information about your health plan and claims.

Get to know HealthSafe ID.

HealthSafe ID® (HSID) adds another layer of security to your account by using dual-factor authentication.

For added convenience and simplicity, **your HSID username and password are the same across UnitedHealthcare, Surest, and Optum benefits.** If you already have an HSID through any of these benefits, you don't need to create a new one. If you forgot your password—we can help you with that. Just reach out.



Questions?

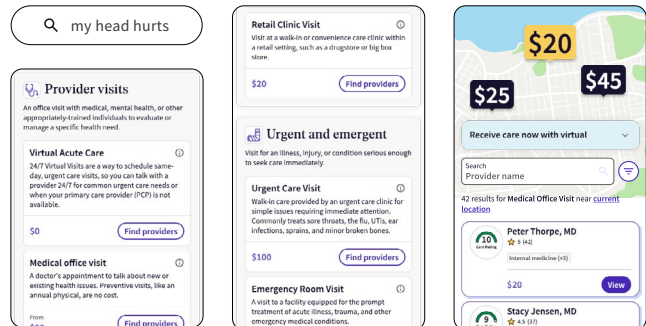
Member Services is available online via chat and email or by calling the number on the back of your Surest member ID card.

Search: So much more than “Is my doctor in-network?”

Download the **Surest app** or visit **Benefits.Surest.com** to search for care and supplies—and see the price before you get them.

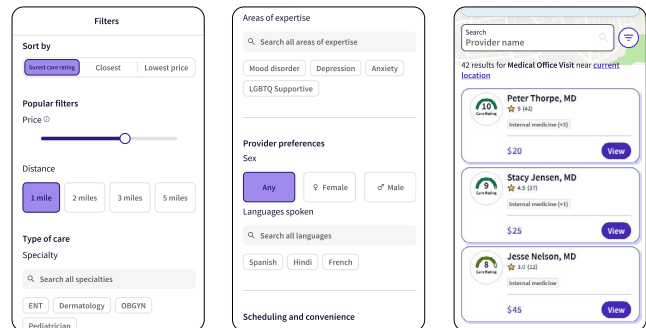
1 Search

- From the search bar, type in your condition, or symptoms like “my head hurts”
- Results will show care options for you to consider
- Select a doctor or location to see the copay
- You can also search by provider name to see prices and if they’re in-network



2 Compare

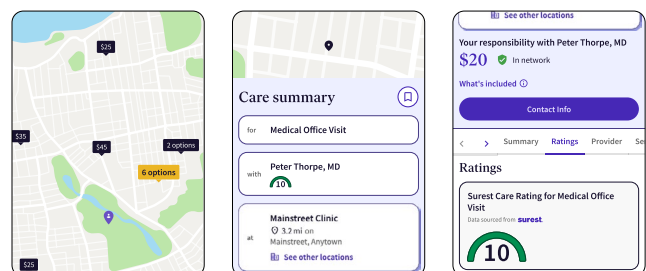
Turn on filters like specialty, gender, and distance to find care that suits you. With Surest Care Ratings, we evaluate providers based on their past performance and give them a higher rating—and lower copay—to help you find high-value care.



3 Decide

By seeing providers, locations, and costs in advance, you can make more informed decisions about care that fits your lifestyle and budget.

- View a map of provider listings to see upfront prices and nearby locations.
- Select the provider you want and see scheduling info.



Illustrative example only. Costs and coverage may vary.



Questions about how to search?

Scan the QR code to watch this video, or contact Member Services via chat and mail, or by calling the number on the back of your Surest member ID card.

OPTUMBANK Health Savings Account (HSA)

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

A Health Savings Account (HSA) is a personal savings account that you can use to pay for qualified medical, dental or vision expenses on a tax-free basis. Employees and their dependents that are enrolled in a Qualified High Deductible health plan are eligible to participate in an HSA.

Sonny's will contribute an annual amount of \$500 for Individual coverage/ \$1,000 for Employee and Dependent(s) coverage to your H.S.A. account.

WHAT ARE HSA ELIGIBLE EXPENSES?

Eligible Expenses under the HSA are called Qualified Medical Expenses (QME). These are defined in IRS Publication 502. Examples of qualified medical expenses are Deductibles, Office Visits, Prescription Drugs, Hospital bills, Dental and Vision expenses etc... Please note: There are penalties if you use the HSA for Non-QME's.

HOW DO I USE IT?

OPTUMBANK will provide you with a debit card. Use this to be for any prescriptions or doctor visits at the time of service or you can use it to pay for any bills you receive in the mail.

DO I HAVE TO USE ALL FUNDS BEFORE THE END OF THE YEAR?

No - all unused funds remain in your account - just like a regular savings account.

HOW DO I CONTRIBUTE?

Sonny's will allow you to contribute through pre-tax payroll deductions. You can also contribute outside of payroll - be sure to talk to your tax consultant about these contributions to make sure you receive all the tax benefits available.

WHAT TAX BENEFITS ARE THERE?

The goal of the HSA is to allow you to pay for medical expenses tax free. If you choose to contribute via payroll deductions, the money is taken out pre-tax. If you make contributions on your own, you will be able to deduct these amounts from your taxes for that year.

MEMBER WEBSITE / CUSTOMER SERVICE

<https://www.optumbank.com> / 866-234-8913, option 0. Customer Care is available 24-hours/day.

ARE THERE ANY CONTRIBUTION LIMITS?

For 2026, if you are enrolled in employee only coverage, you can contribute up to \$4,400 during the year. For family coverage, this limit is \$8,750. If you are between ages 55 and 64, you can contribute an extra \$1,000 per year.

For 2027, if you are enrolled in employee only coverage, you can contribute up to \$4,500 during the year. For family coverage, this limit is \$9,000. If you are between ages 55 and 64, you can contribute an extra \$1,000 per year.

Annual contribution limits will include those funds deposited by your employer.

WHO IS ELIGIBLE FOR AN HSA?

Employees and their dependents that are enrolled in a Qualified High Deductible health plan. *You cannot be enrolled in any other health plan that is not an HSA-eligible plan (like a spouse's plan). You also cannot be enrolled in Medicare or TriCare.

WHEN CAN I ENROLL IN AN HSA?

Typically, you'll enroll in an HSA during your open enrollment period when you make your annual benefit elections. Adjustments can be made to your personal contribution amount anytime throughout the year.

HOW CAN I ACCESS THE FUNDS?

Through a debit card or checks provided by Optum Bank.

CAN I CONTRIBUTE AFTER I TURN 65?

Generally, no. You cannot contribute after you turn 65, but you can use any funds you have left in your account.

IS THE HSA PORTABLE?

Yes. The HSA is your personal savings account. The money in this account does not expire and is yours no matter where you are employed.

CUSTOMER IDENTIFICATION PROGRAM (CIP)

In accordance with the US Patriot Act, Optum performs a CIP (Customer Identification Program) screening on all HSA applicants. The US Patriot Act sets forth minimum requirements that a bank must adhere to when a customer opens a new account or obtains a product of service. The information on each application is cross-referenced against public records, and in certain situations OPTUM is required to obtain additional documentation to open the employee's account. Something such as an address change, name change, social security number change, or little to no public record could trigger the application to go into pending status until additional documentation is obtained.

There is a fast and efficient way to submit vetting documents to OPTUM:
<https://memberforms.optum.com/HSA-Enrollment-Vetting-Form.html>

Flexible Savings Account

WHAT IS A FLEXIBLE SAVINGS ACCOUNT (FSA)?

A **Healthcare FSA** is a spending account that allows employees to set aside pretax earnings to pay for eligible health care expenses for you or any of your eligible dependents. Healthcare FSA funds can be used for eligible expenses such as **deductibles, copays, prescriptions, dental care, vision services, and certain over-the-counter items**. Employees choose an annual contribution amount during enrollment, and the full amount is available to use immediately. Be sure to plan carefully, as unused funds may be forfeited at the end of the plan year, subject to your employer's rollover provisions.

A **Dependent Care FSA** provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. It's a great option for employees who have **dependent children under the age of 13 who attend day care, after-school care or summer day camp, and/or provide care for a person of any age who is claimed as a dependent** on the federal income tax return and who is mentally or physically incapable of caring for himself or herself. Employees choose an annual contribution amount during enrollment, and those funds are available to use once they are contributed. Be sure to plan carefully, as unused funds are forfeited at the end of the plan year.

Use-It-Or-Lose-It Rule will apply.

WHAT ARE HEALTHCARE FSA ELIGIBLE EXPENSES?

Eligible Expenses under the Healthcare FSA are called Qualified Medical Expenses (QME). These are defined in IRS Publication 502. Examples of qualified medical expenses are Deductibles, Office Visits, Prescription Drugs, Hospital bills, Dental charges, Lenses & Frames, etc...

WHO IS ELIGIBLE FOR AN FSA?

Full time employees are eligible to participate and contribute to the FSAs. If you are enrolled in the Choice+ HSA medical plan you will only be able to participate in the Dependent Care FSA.

DO I HAVE TO USE ALL FUNDS BEFORE THE END OF THE YEAR?

In most cases, you must use all or the bulk of your funds before the end of the year. You may have the option to rollover up to \$680 from year to year back into your Healthcare FSA. The Dependent Care FSA will not rollover and claims must be incurred prior to the end of the plan year and be submitted within a 90-day period after the end of the plan year to be eligible for reimbursement.

IS THE FSA PORTABLE?

No - this is an employer owned account and it is not portable, however you are able to COBRA the Healthcare FSA for a limited time. Visit www.FSAstore.com to spend down any extra amount in your Healthcare FSA.

CUSTOMER SERVICE PHONE NUMBER

1-800-300-3838

ARE THERE ANY CONTRIBUTION LIMITS?

Before you enroll, you must first decide how much you want to contribute to your account(s). You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the calendar year.

The U.S. Treasury Department modified its Healthcare Flexible Spending Account (FSA) Use-or-Lose rule to allow up to a specified carryover of Healthcare FSA funds. The carryover "rollover" is applicable only to Healthcare FSAs (not to Dependent Care FSAs). Any unused amount above the carryover limit is subject to forfeiture and cannot be cashed out or transferred to other taxable or nontaxable benefits (e.g., HSAs).

In 2026, you can contribute up to **\$3,400** into your Healthcare FSA tax free.

In 2026, you can contribute up to **\$7,500** into your Dependent Care FSA tax free.

HOW DO I USE IT?

iSolved Benefit Services will provide you with a debit card that you can swipe, or you may have to submit claim forms or receipts along with itemized bills from your provider to obtain reimbursement.

WHEN CAN I ENROLL FOR AN FSA?

You may only enroll when you are first eligible, during the annual Open Enrollment period, or if you experience a qualifying life event (such as marriage, divorce, birth of a child, or loss of other coverage). Once enrolled, your election generally remains in effect for the entire plan year unless a qualifying life event occurs. Please note that the FSA operates on a **calendar year (January 1 through December 31)** and follows a separate enrollment period from your medical, dental, and other employee benefits.

HOW DO I CONTRIBUTE?

You contribute to the FSA through pre-tax payroll deductions. Because contributions are made before taxes, an FSA can help lower your taxable income.

MEMBER WEBSITE

www.isolvedbenefitservices.com

Dental Insurance

The **UHC DHMO** plan provides affordable, in-network only dental coverage through the National Exclusive Network. Members select a participating dentist and pay predetermined copays based on a schedule of benefits. There is no annual benefit maximum, helping employees budget for dental care with predictable out-of-pocket costs. Services received outside of the DHMO network are not covered.

The **UHC DPPO** plan offers the flexibility to receive care from both in-network and out-of-network providers. Members generally receive the highest level of benefits when using the UHC National Options PPO 30 Network. Out-of-network reimbursements are based on the plan's Maximum Allowable Charge (MAC) schedule, which may result in additional out-of-pocket costs if a provider's fees exceed the allowable amount.

UnitedHealthcare DHMO		UnitedHealthcare DPPO	
Deductible	In-Network	In-Network	Out-of-Network
Single	No Deductible	\$50	\$50
Family	No Deductible	\$150	\$150
Maximum the carrier will pay			
Annual Maximum	No Maximum	\$2,500	Combined with In-Network
Frequencies			
Cleaning	2 per 12 months	2 per 12 months	
Exam	2 per 12 months	2 per 12 months	
Dental Coverage			
PREVENTIVE SERVICES			
Exams / Cleaning	No charge	100%	100%
Bitewing X-Rays	No charge	100%	100%
BASIC SERVICES			
Fillings	No charge	100%	100%
Simple Extractions	\$10	100%	100%
MAJOR SERVICES			
Periodontal Gum Disease	\$36	60%	60%
Crowns	\$195+	60%	60%
Dentures	\$210+	60%	60%
Bridges	\$210+	60%	60%
Orthodontia	Child \$1,850+ / Adult \$1,950+	50%	50%
Orthodontia Lifetime Maximum	No Maximum	\$1,000	
Orthodontia Maximum Age	Adult and Child(ren)	Child Only (Up to Age 19)	
Out-of-Network Explanation			
	Services received outside of the DHMO network are not covered. You will be responsible for the full cost.	Your insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist, which may result in a balance bill.	
Plan Information			
Plan Year	10/1/2026 - 9/30/2027	10/1/2026 - 9/30/2027	
Network Name	National Exclusive Network	National Options PPO 30	
Member Website	www.myuhc.com	www.myuhc.com	
Customer Service Phone Number	1-855-619-6713	1-855-619-6713	

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck (26)

Employee Only	\$6.28	\$15.06
Employee + Spouse	\$10.99	\$30.12
Employee + Child(ren)	\$13.61	\$42.64
Family	\$17.27	\$58.55

Vision Insurance

UnitedHealthcare

Vision PPO

The UnitedHealthcare Vision PPO plan provides coverage for routine eye exams, prescription eyeglasses, and contact lenses through a nationwide network of both private practice and retail vision providers. Members have the flexibility to choose eyeglasses or contact lenses to meet their vision needs and can often receive additional discounts on eyewear purchases from participating providers.

In addition to your standard vision benefits, members may receive a 30% discount on additional pairs of glasses purchased through participating in-network providers (some exclusions may apply). The plan also offers savings on laser vision correction through UnitedHealthcare's partnership with QualSight LASIK, one of the largest LASIK program managers in the United States. Members can receive significant discounts on LASIK procedures, including Traditional, Custom, and Bladeless LASIK options.

Vision Coverage	In-Network	Out-of-Network
Eye Exam	\$10	Up to a \$40 reimbursement
Single Vision Lens	\$10	Up to a \$40 reimbursement
Lined Bi-Focal Lens	\$10	Up to a \$60 reimbursement
Lined Tri-Focal Lens	\$10	Up to a \$80 reimbursement
Lenticular Lens	\$10	Up to a \$80 reimbursement
Contact Lens Allowance	\$160 allowance	Up to a \$135 reimbursement
Frame Allowance	\$150 allowance + 30% off	Up to a \$45 reimbursement
Frequencies		
Exam Frequency	Once every 12 months	
Lens Frequency	Once every 12 months	
Frame Frequency	Once every 24 months	
Out of Network Explanation		
	Copays do not apply to out-of-network benefits. Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Receipts for payments should be submitted within 90 days after the date of service.	
Plan Information		
Plan Year	10/1/2026 - 9/30/2027	
Network Name	UnitedHealthcare Vision Network	
Member Website	www.myuhcvision.com	
Customer Service Phone Number	1-800-638-3120	

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck (26)

Employee Only	\$3.79
Employee + Spouse	\$6.38
Employee + Child(ren)	\$6.51
Family	\$10.29

Employer-Paid Life Insurance

Mutual of Omaha

Basic Life and AD&D Insurance

As a full-time employee, you are provided with Employer-Paid Basic Life and Accidental Death & Dismemberment (AD&D) Insurance through Mutual of Omaha at no cost to you. This coverage provides a \$50,000 benefit to your designated beneficiary(ies) in the event of your death. The AD&D benefit may provide an additional benefit if death or certain serious injuries result from a covered accident.

It is important to **keep your beneficiary information up to date in ADP**. Beneficiary designations determine who will receive your life insurance benefit, so be sure to review and update your information whenever you experience a major life event such as marriage, divorce, birth of a child, or death of a beneficiary.

Included at no additional cost: Mutual of Omaha's Will Preparation Service, which allows you to create a simple will online. To get started, visit www.willprepservices.com and use registration code **MUTUALWILLS**.

Life Insurance Benefits	
Life Insurance Coverage	\$50,000
Accidental Death & Dismemberment	Equal to the amount of your life insurance benefit
Age Reduction Schedule	At age 65, amounts reduce to 65%; At age 70, amounts reduce to 45%; At age 75, amounts reduce to 30%; At age 80, amounts reduce to 20%; At age 85, amounts reduce to 15%; At age 90, amounts reduce to 10%
Beneficiary	Person, people, trust, or organization that receives the life insurance proceeds (death benefit) when the insured person dies. Primary Beneficiary: First in line to receive the benefit. Contingent (Secondary) Beneficiary: Receives the benefit if the primary beneficiary dies before the insured or cannot accept the benefit.
Plan Information	
Plan Year	10/1/2026 - 9/30/2027
Member Website	www.mutualofomaha.com
Customer Service Phone Number	1-800-316-2796

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Voluntary Term Life Insurance

Mutual of Omaha

Term Life and AD&D Insurance

Eligible full-time employees may purchase additional Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance for themselves and their eligible dependents. This coverage provides added financial protection beyond the employer-paid life insurance benefit.

Employees must elect coverage for themselves in order to enroll a spouse and/or child(ren) in dependent life insurance coverage.

If you currently have Voluntary Life Insurance, you may increase your coverage by one unit (\$10,000) during each Open Enrollment, up to the plan's Guaranteed Issue amount, without completing Evidence of Insurability (EOI). Requests above the Guaranteed Issue amount may require EOI approval from the insurance carrier.

It is important to keep your beneficiary information up to date in ADP. Beneficiary designations determine who will receive your life insurance benefit, so be sure to review and update your information following major life events such as marriage, divorce, or the birth of a child.

Life Insurance Benefits	
Employee Life Insurance Coverage	\$10,000 - \$500,000 in increments of \$10,000; Guarantee Issue up to \$150,000 (Not to exceed 5 times annual salary)
Spouse Life Insurance Coverage	\$5,000 - \$250,000 in increments of \$5,000; Guarantee Issue up to \$25,000 (Not to exceed 100% of employee's Life Insurance benefit)
Child(ren) Life Insurance Coverage	\$10,000
Accidental Death & Dismemberment	Equal to the amount of the life insurance benefit.
Age Reduction Schedule	Reductions start at age 70 (Reduced to 45%), age 75 (Reduced to 30%), age 80 (Reduced to 20%), age 85 (Reduced to 15%), and age 90 (Reduced to 10%). Spouse coverage terminates at age 70.
Guaranteed Insurability	Guarantee Issue is available to new employees. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.
Beneficiary	Person, people, trust, or organization that receives the life insurance proceeds (death benefit) when the insured person dies. Primary Beneficiary: First in line to receive the benefit. Contingent (Secondary) Beneficiary: Receives the benefit if the primary beneficiary dies before the insured or cannot accept the benefit.
Plan Information	
Plan Year	10/1/2026 - 9/30/2027
Member Website	www.mutualofomaha.com
Customer Service Phone Number	1-888-534-1747

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Employer Paid Short-Term Disability Insurance

Mutual of Omaha

Short-Term Disability

Sonny's provides Short-Term Disability (STD) coverage at no cost to all eligible full-time employees.

STD benefits help replace a portion of your income if you are unable to work due to a covered illness, injury, or pregnancy. Short-Term Disability coverage is designed to provide financial support during a temporary disability, giving you peace of mind, and helping you focus on your recovery.

STD Insurance Benefits	
How does my insurance carrier define Disability?	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job.
Weekly Benefit	60% of your before-tax weekly earnings, not to exceed \$1,000
When do benefits start? (Elimination period)	Accident: Day 8 / Illness: Day 8
How long do my benefits pay out?	Up to 26 weeks
Are there any limitations on coverage for Pre-Existing conditions?	A pre-existing condition limitation does not apply.
Is Maternity Covered?	Yes
Guaranteed Insurability	Yes
Plan Information	
Plan Year	10/1/2026 - 9/30/2027
Member Website	www.mutualofomaha.com
Customer Service Phone Number	1-888-534-1747

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Voluntary Long-Term Disability Insurance

Mutual of Omaha

Long-Term Disability

A long-term disability can have a significant impact on your financial well-being and future security. Long-Term Disability (LTD) insurance provides valuable income protection if you become unable to work due to a covered illness or injury after your short-term disability benefits end.

LTD benefits help replace a portion of your income, providing financial support while you focus on your recovery and helping you maintain financial stability during an extended period of disability.

Survivor Benefit: If you pass away while receiving Long-Term Disability benefits, a lump-sum survivor benefit equal to three (3) times your monthly disability benefit will be paid to your eligible survivor.

LTD Insurance Benefits	
How does my insurance carrier define Disability?	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings.
Monthly Benefit	60% of before-tax monthly earnings, not to exceed \$6,000
When do benefits start? (Elimination period)	180 calendar days after the onset of your disabling injury or illness or the date your short-term disability ends.
How long do my benefits pay out?	Up to age 65, Social Security Normal Retirement Age, or 3.5 years, whichever is longest (prior to age 62); reduced duration schedule at age 62 and older.
Are there any limitations on coverage for Pre-Existing conditions?	12/12 (Any condition treated in the 12 months prior to coverage that results in disability within the first 12 months of coverage is excluded.)
Own Occupation Limitation	2 Years
Guaranteed Insurability	Yes, subject to the Pre-Existing Conditions Clause.
Plan Information	
Plan Year	10/1/2026 - 9/30/2027
Member Website	www.mutualofomaha.com
Customer Service Phone Number	1-888-534-1747

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

BENEFIT ASSIST



Supplemental Health | Benefit Assist



**Actively working to get your
benefit payout to you**

With UnitedHealthcare Benefit Assist in your corner, the claims process is easier

If you're a health plan member with a supplemental health plan—like Accident, Critical Illness or Hospital Indemnity—it's good to know you've got Benefit Assist looking out for you. The service, included at no additional cost, is designed to help make sure you get the benefits you're eligible for—and get them easier.

Here's how Benefit Assist does the heavy lifting for you:



Review

Benefit Assist will review your eligible medical claims



Support

If any of your medical claims appear to qualify for a supplemental health plan benefit payout, you will either be paid automatically or contacted directly*



Connect

When an eligible event is not paid automatically, a claims specialist may help you submit your supplemental health plan claim and get your eligible benefit payout

*Calls may appear on caller ID as WellTok, Unknown or an 888 number.

**United
Healthcare**

Accident Insurance

UnitedHealthcare Financial Protection

Accident Protection Plan

Unexpected accidents can happen at any time, and the resulting medical expenses can add up quickly. The Accident Protection Plan provides an extra layer of financial protection by paying cash benefits directly to the insured when a covered accident occurs. These benefits can help offset costs such as deductibles, copays, transportation, household expenses, or any other financial needs during recovery.

Benefits are paid directly to you, allowing you to use the funds however you choose.

The examples shown in this benefit guide are intended to highlight some of the benefits available under the Accident Protection Plan. They are not a complete list of covered benefits. For full plan details, including benefit amounts, limitations, and exclusions, please click the plan name on this page to view the complete summary of benefits provided by UHC Financial Protection.

Injury	Scheduled Benefit (Spouse Benefit is 100% of EE; Child benefit 50% of EE)
Burn - 2nd Degree	\$1,000
Burn - 3rd degree	\$3,000
Coma	\$30,000
Concussion	\$300
Dental Injury	\$400 (Crowns), \$200 (Extractions)
Dislocation - Hip	\$12,000 / \$6,000
Dislocation - Knee	\$6,000 / \$3,000
Dislocation - Shoulder	\$2,000 / \$1,000
Fracture - Hip	\$10,000 / \$5,000
Fracture - Skull	\$12,000 / \$6,000
Fracture - Arm	\$2,400 / \$1,200
Fracture - Hand	\$2,000 / \$1,000
Follow-Up Visits	\$100 up to 5 per accident
Appliance Benefit	\$250 - \$750
Emergency Room Treatment	\$500
Hospital Admission	\$3,000
Hospital Confinement	\$1,000 per day
Accidental Death & Dismemberment	\$100,000 (Life), \$400,000 (Common Carrier)
Plan Information	
Plan Year	10/01/2026 - 9/30/2027
Member Website	www.myuhcfp.com

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck (26)

Employee Only	\$7.76
Employee + Spouse	\$12.29
Employee + Child(ren)	\$16.53
Family	\$25.04

Critical Illness Insurance

UnitedHealthcare

Critical Illness Protection Plan

A serious illness can create unexpected financial challenges, even when you have medical coverage. The Critical Illness Protection Plan helps provide financial support by paying a lump-sum cash benefit directly to the insured upon diagnosis of a covered critical illness. These benefits can be used however you choose, including for medical bills, travel expenses, household expenses, childcare, or lost income.

The Critical Illness Protection Plan helps protect employees from the potentially high costs associated with the diagnosis of a serious illness by providing financial assistance when it is needed most.

The conditions listed in this benefit guide represent only a brief summary of covered conditions and are not a complete list. In addition to covered adult conditions, the plan includes benefits for a wide range of covered childhood conditions, including: Cerebral Palsy, Childhood Diabetes, Congenital Heart Disease, Cystic Fibrosis, Down Syndrome, Muscular Dystrophy, and more.

For complete details regarding covered conditions, benefit amounts, limitations, exclusions, and plan provisions, please click the plan name at the top of this page to view the full plan summary provided by UHC Financial Protection. Rates will be listed in ADP and are based on based on the employee's age and tobacco status. Spouse age and tobacco status are also based on Employee age and tobacco status.

Critical Illness Benefit	
Employee Scheduled Benefit	\$10,000 (Option A), \$20,000 (Option B)
Spouse Scheduled Benefit	\$5,000 (Option A), \$10,000 (Option B)
Child Scheduled Benefit	\$5,000 (Option A), \$10,000 (Option B)
Pre-Existing Condition Clause	No benefits for events occurring before the effective date of coverage.
Wellness Benefit	\$100 payable once per calendar year per insured
Illness	% of Schedule Benefit
Cancer	100% for invasive cancer, 25% for non-invasive cancer, \$250 for skin cancer
Heart Attack / Stroke	100%
Advanced Alzheimer's Disease	100%
Major Organ Failure	100%
Parkinson's Disease / ALS	50%
Plan Information	
Plan Year	10/01/2026 - 9/30/2026
Member Website	www.myuhcfp.com

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Hospital Indemnity Insurance

UnitedHealthcare

Hospital Indemnity Protection Plan

The Hospital Indemnity Protection Plan helps provide financial protection from unexpected hospital-related expenses by paying cash benefits directly to you for covered services, such as hospital admissions, confinement, and ICU stays. Benefits can be used for any expense, including medical bills, deductibles, transportation, household expenses, or lost income.

The plan also includes a Wellness Benefit, which pays a benefit for completing eligible preventive care services, such as blood test for triglycerides, breast ultrasound, fasting blood glucose test, colonoscopy, mammography, Pap smear, PSA (blood test for prostate cancer) and other qualifying wellness activities.

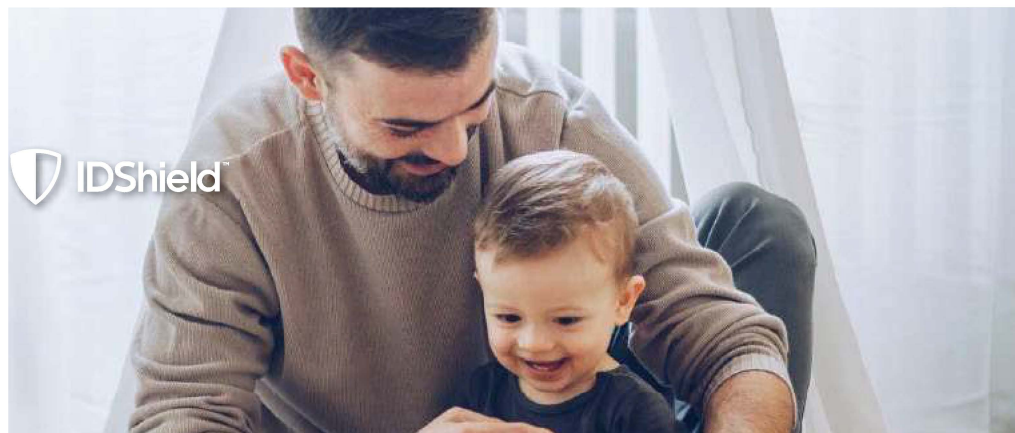
Hospital Indemnity Benefit	
Hospital Admission	\$1,500 (Option A), \$2,500 (Option B) / Up to 3 Days per plan year
Hospital Confinement	\$150 (Option A), \$250 (Option B) / Up to 364 Days per plan year
ICU Confinement	\$150 (Option A), \$250 (Option B) / Up to 364 Days per plan year
ICU Admission	\$1,500 (Option A), \$2,500 (Option B) / Up to 3 Days per plan year
Wellness Rider	\$100 One covered test per calendar year per covered member. Children are excluded from Wellness.
Plan Information	
Plan Year	10/1/2026 - 9/30/2027
Member Website	www.myuhcfp.com

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck (26)

	Option A	Option B
Employee Only	\$9.95	\$13.70
Employee + Spouse	\$24.50	\$34.74
Employee + Child(ren)	\$15.34	\$24.58
Family	\$28.71	\$46.07

LEGALSHIELD



Have You Ever... To learn more about LegalShield and IDShield please visit: <https://shieldbenefits.com/sonnys/overview> or scan the QR code.

- ☐ Needed your Will prepared or updated?
- ☐ Signed a contract?
- ☐ Received a moving traffic violation?
- ☐ Worried about being a victim of identity theft?

- ☐ Been concerned about your child's identity?
- ☐ Had social media accounts? (Facebook, Instagram, Twitter, LinkedIn, Youtube)



The LegalShield membership includes:

- **Dedicated Law Firm** Direct access, no call center
- **Legal Advice/Consultation** On unlimited personal issues
- **Letters/Calls** Made on your behalf
- **Contracts/Documents Reviewed** Up to 15 pages
- **Residential Loan Document Assistance** For the purchase of your primary residence
- **Will Preparation** - Living Will, Health Care Power of Attorney
- **Speeding Ticket Assistance** Upload your speeding ticket from the mobile app directly to law firm
- **IRS Audit Assistance** (Begins with the tax return due April 15th of the year you enroll)
- **Trial Defense** (If named defendant/respondent in a covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (Available 90 days after enrollment)
- **25% Preferred Member Discount** (Bankruptcy, criminal charges, DUI, personal injury, etc.)
- **24/7 Emergency Access** For covered situations

The IDShield membership includes:

- **Credit Monitoring** Continuous credit monitoring through Experian
- **Online Privacy Management** IDShield provides consultation and guidance on ways participants can protect their privacy and personally identifiable information across the internet and on their smart devices.
- **Reputation Management & Score** Scans social media accounts for existing content that could be damaging to participants' online reputation. Ranks your online reputation risk by giving you a score based off the content found on your social media accounts.
- **Financial Account Monitoring** Accounts monitored include checking, savings, employer 401k accounts, loans and more.
- **\$3 Million Protection Policy** Coverage for lost wages, legal defense fees, stolen funds and more
- **Unlimited Service Guarantee** Ensures that we won't give up until your identity is restored!
- **Identity Restoration** Performed by Licensed Private Investigators to restore your identity to its pre-theft status.
- **24/7 Emergency Access** In the event of an identity theft emergency

Plan	Family Price	Individual Price
LegalShield	\$9.67 Bi-weekly	\$9.67 Bi-weekly
IDShield	\$7.36 Bi-weekly	\$3.90 Bi-weekly
Combined	\$15.65 Bi-weekly	\$13.57 Bi-weekly



Put your law firm and identity theft protection in the palm of your hand with the LegalShield and IDShield mobile apps!

Pre-Paid Legal Services, Inc. ("PPLSI") provides access to legal services offered by a network of provider law firms to LegalShield members through membership-based participation. Neither LegalShield nor its officers, employees or sales associates directly or indirectly provide legal services, representation, or advice. See a legal plan for complete terms, coverage, amounts and conditions. IDShield is a product of LegalShield. LegalShield provides access to identity theft protection and restoration services. For complete terms, coverage and conditions, please see an identity theft plan. All Licensed Private Investigators are licensed in the state of Oklahoma. An Identity Fraud Protection Plan ("Plan") is issued through a nationally recognized carrier. LegalShield/IDShield is not an insurance carrier. This covers certain identity fraud expenses and legal costs as a result of a covered identity fraud event. See a Plan for complete terms, coverage, conditions, limitations, and family members who are eligible under the Plan.

FOR MORE INFORMATION PLEASE CONTACT AN INDEPENDENT ASSOCIATE:

Associate Name Barry Olfern LegalShield Business Solutions
Phone Number 954-655-2446
Email: barryolfern@legalshieldassociate.com



EMPLOYEE ASSISTANCE PROGRAM (EAP)

MUTUAL OF OMAHA



We're Here
to Help

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

We're Here to Help

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

EAP Benefits

- Access to EAP professionals 24 hours a day, seven days a week
 - Provides information and referral resources
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)

*Face-to-face visits can also be used toward legal consultations

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period.

- Legal assistance and financial resources
 - Online will preparation
 - Legal library & online forms
 - Financial tools and resources
- Resources for:
 - Substance use and other addictions
 - Dependent and elder care resources
- Access to a library of educational articles, handouts and resources via mutualofomaha.com/eap

What to Expect

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. There is **no cost** to you for utilizing EAP services. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help

Visit mutualofomaha.com/eap or call **800-316-2796** for confidential consultation and resource services.



Mutual of Omaha

Insurance products and services are offered by Mutual of Omaha Insurance Company or one of its affiliates. Home office: 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Mutual of Omaha Insurance Company is licensed nationwide. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Companion Life Insurance Company, Hauppauge, NY 11788-2937, is licensed in New York. Each underwriting company is solely responsible for its own contractual and financial obligations. Some exclusions or limitations may apply.

Sonny's 401(k) Plan Summary

Sonny's offers a 401(k) plan administered by Principal.

Eligibility

You must be 18 years of age and have completed 30 days of service. Participation begins on the 1st day of the month following 30 days of employment.

Employee Contributions

New hires are automatically enrolled at a 5% pre-tax contribution rate invested in a Target Date Fund. **If you do not wish to participate, you must opt out directly through Principal.** Contributions may be changed at any time, and employees may choose Pre-Tax or Roth contributions.

Employer Match

Sonny's provides a discretionary match of 50% of the first 5% contributed, up to a maximum match of 2.5%.

Your Contribution	Sonny's Match
1%	0.50%
2%	1.00%
3%	1.50%
4%	2.00%
5%+	2.50%

Vesting

Employer contributions are 100% vested after 1 year of service and 1,000 hours worked.

Loan Options

Up to 2 active loans. Minimum loan amount: \$1,000. Borrow up to 50% of vested balance or \$50,000, whichever is less.

Questions?

Principal Financial Group • 800-986-3343 • principal.com

Helping you manage your retirement goals

24/7 ACCOUNT ACCESS

Planning for retirement doesn't have to be complicated. Set up your account to stay on track with your retirement savings goals. And since your life is busy enough, we've made getting to your information simple and convenient. Use these resources to access your account when and how you want.

Online

First-time users

Go to principal.com/welcome

- Select **Get started**
- Enter your first name, last name, date of birth, mobile phone number (this is the quickest way to verify your identity), and your ID number (this is either your Social Security number or a specific ID provided by your employer), or ZIP code.
- Agree to do business electronically and click **Continue**.
- A security code will be sent to your phone. You can choose to receive it by text or by call. Enter the code when you receive it.
- If Principal is unable to send a code to your phone, you will need to upload a photo of your ID and a selfie to confirm it's really you.
- Create a **unique username**, set a secure **password**, and add your **email address**.
- Select and answer **three security questions** to use if you need to call us.
- You now have access to your online account, and you'll get a confirmation email within a few minutes.
- Once you've created an account, future logins can be easier with a **passkey**. Set one up—you can choose facial recognition, a fingerprint, or a PIN for safe, quick logins.
- Keep your contact information up to date (especially your phone number and email address), and your account will automatically be covered by the Customer Protection Guarantee—which means Principal will reimburse your account if there's unauthorized activity.¹

Ongoing account access

Go to principal.com

- Select **Log in**.
- Enter your **username** and **password** (click **Forgot username** or **Forgot password** if you need to reset) and click **Verify**.
- If you're logging in from a new device, resetting your username or password, or you've opted to use verification codes every time you log in, you'll receive a security code via text message, voice call, or authentication app.
- Enter the security code and click **Verify**.



Questions?

Having trouble setting up your account?
Give us a call at **800-986-3343**.

Stay up to date!

Keeping your email address current helps you stay in the know with communications tailored to you.

- Click on the **retirement plan** link of the account you want to access. Use the tabs at the top of the page to navigate the website.

Your account

Education Hub

Available options include:

(Not all options are available for certain plans. Check with your human resources contact to find out what is available.)

- Plan info & forms
- Statements
- Contributions
- Investments
- Loans & withdrawals
- Rollovers
- Retirement Wellness Planner

- Overview
- Monthly webinars
- Retirement planning
- Managing money
- Life event planning
- Calculators & tools

Mobile

Check your account on the go.

- Principal® app — Available for iPhone[®] and Android[™]²

- principal.com/OnTheGo

Phone

First-time users

Call **800-547-7754**

- You may be asked to provide some personal information like your date of birth or Social Security number, to verify your identity.
- Listen to the menu and select an option.
- When prompted, establish your **personal identification number (PIN)** using your **Account/Contract Number**.

Ongoing account access

Call **800-547-7754**

- Listen to the menu and select an option
 - If prompted, enter your **(PIN)**
- (Note: Some options do not require you to enter your PIN.)

Follow the prompts to:

(Not all options are available for certain plans. Check with your human resources contact to find out what is available.)

- Check your account balance
- Check investment performance
- Request or review loan information
- Review investment options
- Manage your rollover funds
- Transfer retirement funds between available investment options
- Get information regarding an expected Form 1099-R
- Talk with a representative

¹ The Customer Protection Guarantee applies to employer-sponsored retirement plans record kept by Principal® including defined benefit, defined contribution, employee stock ownership plans, retirement accounts with pension payments made through Principal® Custody Solutions, and nonqualified deferred compensation plans with distributions made through Principal. It's effective for unauthorized activity that occurs after participants have registered their account online, provided their contact information, and kept it up to date in the event of changes. Guarantee details are subject to change. Exclusions to the policy may apply. www.principal.com/customer-protection-guarantee

² The mobile application offered by Principal® to view account information is currently supported on iPhone® (operating systems 12.0 or later) and Android™ (operating systems 5.0 or higher).

Principal® app is available for iPhone® and Android™.

Apple and iPhone are registered trademarks of Apple Inc.

Android is a trademark of Google LLC.

Insurance products and plan administrative services provided through Principal Life Insurance Company®, a member of the Principal Financial Group®, Des Moines, Iowa 50392.

Principal®, Principal Financial Group®, and Principal and the logomark design are registered trademarks of Principal Financial Services, Inc., a Principal Financial Group company, in the United States and are trademarks and service marks of Principal Financial Services, Inc., in various countries around the world.

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.flmedicaidtplecovery.com/flmedicaidtplecovery.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/dfcr/ 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 Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@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	MONTANA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov
NEBRASKA – Medicaid	NEVADA – Medicaid
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	NEW JERSEY – Medicaid and CHIP
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	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	NORTH CAROLINA – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	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	PENNSYLVANIA – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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	SOUTH CAROLINA – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	TEXAS – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	VERMONT– Medicaid
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/	Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – 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)	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
<https://www.dol.gov/agencies/ebsa>
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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

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

Yes If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% of the employee's household income.

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](https://www.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 your employer via the information provided below.

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

1. Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2024.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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 Sonny's Enterprises, LLC		4. Employer identification Number (EIN)
5. Employer Address 5870 Hiatus Rd		6. Employer Phone Number 800-327-8723
7. City Tamarac	8. State FL	9. Zip Code 33321
10. Who can we contact about employee health coverage at this job? Human Resources Department, HR, 800-327-8723, HRbenefits@sonnysdirect.com		
11. Phone number (If different from above) 800-327-8723		12. Email address HRbenefits@sonnysdirect.com

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

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

☐ All Employees, Eligible employees are:

☒ Some Employees, Eligible employees are:

Full-time employees working on average 30 hours or more a week

- With respect to dependents:

☒ We do offer coverage, Eligible dependents are:

Spouse, Legal Domestic Partner, and Dependent Children

☐ We do not offer coverage.

☒ 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.**

Special Enrollment Notice

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

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

To request special enrollment or obtain more information, contact Human Resources Department, HR, 800-327-8723, HRbenefits@sonnysdirect.com.

Patient Protection Model Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

UnitedHealthcare generally ALLOWS the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources Department, HR, 800-327-8723, HRbenefits@sonnysdirect.com.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add: You do not need prior authorization from UnitedHealthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources Department, HR, 800-327-8723, HRbenefits@sonnysdirect.com

Newborn's Act Disclosure

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

WHCRA Enrollment Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a Symmetrical appearance
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Please see full plan certificates..

If you would like more information on WHCRA benefits, call your plan administrator 855-619-6713

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 855-619-6713 for more information.

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

RETIREE COVERAGE ONLY:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Sonny's Enterprises, LLC (855-619-6713, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Retiree coverage only: Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 after the qualifying event occurs. You must provide this notice to: Sonny's Enterprises, LLC (855-619-6713. You will be receiving paperwork from Optum Financial COBRA. Please be on the lookout for these documents if you plan to continue your Medical, Dental, Vision or Healthcare FSA benefits.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

* <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Human Resources Department, HR, 800-327-8723, HRbenefits@sonnysdirect.com

Michelle's Law Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the Sonny's Enterprises, LLC group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

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

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The Sonny's Enterprises, LLC group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- the dependent child was covered under the plan as a student immediately prior to the leave of absence and would otherwise lose eligibility due to the loss of student status..

To obtain additional information, please contact: UnitedHealthcare 855-619-6713.

Sonny's Enterprises, LLC

5870 Hiatus Rd, Tamarac, FL, 33321
800-327-8723, HRbenefits@sonnysdirect.com

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

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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

Special Notes: We never sell or market your personal information

Greater limits on disclosures: We will never share any substance abuse treatment records without your written permission.

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

How We Handle Substance Use Disorder (SUD) Records

In addition to the general privacy protections described in this Notice, specific federal laws and regulations (42 CFR Part 2) apply to records regarding your identity, diagnosis, prognosis, or treatment for substance use disorders ("SUD Records") when received from a federally funded "Part 2" SUD program.

- **Use and Disclosure of SUD Records:** If we receive SUD Records from a Part 2 program, we will use and disclose those records only for purposes of treatment, payment, and health care operations, or as otherwise permitted by law. We may share this information within our health system to ensure you receive coordinated care, provided that the disclosure is consistent with your authorization or applicable federal regulations.
- **Legal and Administrative Protections:** We are strictly prohibited from using or disclosing your SUD Records for the purpose of initiating or substantiating any criminal charges against you or to conduct any investigation of you. Furthermore, your SUD Records will not be used or disclosed for legal, administrative, or legislative proceedings (such as civil, criminal, or administrative trials or hearings) without your express written consent or a specific court order that meets the requirements of 42 CFR Part 2.
- **Fundraising Communications:** We may use certain information to contact you for fundraising efforts to benefit our organization. However, if we intend to use any information derived from your SUD Records for these purposes, you have the absolute right to elect not to receive these communications. You may opt out of receiving fundraising materials at any time by contacting our Privacy Officer.

Global Consent for Future Use and Disclosure

You have the right to provide a single, "global" written consent that allows us to use and disclose your SUD Records for all future treatment, payment, and health care operations (TPO) purposes.

- **Efficiency of Care:** If you provide this global consent, we may share your SUD information with other health care providers, health plans, and business associates involved in your care without needing to obtain a new signature from you for each individual disclosure.
- **Your Right to Revoke:** You have the absolute right to revoke this consent at any time. Your revocation must be in writing. Please note that revoking your consent will not affect any actions we took or disclosures we made before we received your written request.
- **Redisclosure:** Information disclosed based on this global consent may be redisclosed by the recipient as permitted by HIPAA (for treatment, payment, or operations), but it generally cannot be used for legal or criminal proceedings against you without a separate, specific authorization.

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, on our web site, and we will mail a copy to you.

Effective Date of this notice: 10-01-2026

OHCA notice:

Privacy Official: Sonny's Enterprises, LLC, HRbenefits@sonnysdirect.com, 800-327-8723

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS	HEALTH INSURANCE PROTECTION
You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and: • you ensure that your employer receives advance written or verbal notice of your service; • you have five years or less of cumulative service in the uniformed services while with that particular employer; • you return to work or apply for reemployment in a timely manner after conclusion of service; and • you have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.	• If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. • Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.
RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION	ENFORCEMENT
If you: • are a past or present member of the uniformed service; • have applied for membership in the uniformed service; or • are obligated to serve in the uniformed service, then an employer may not deny you: • initial employment; • reemployment; • retention in employment; • promotion; or • any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.	• The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. • For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra • If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. • You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <https://www.dol.gov/agencies/vets/programs/userra/poster> Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

ESGR
1-800-336-4590

Important Notice: Medicare Part D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sonny's Enterprises, LLC 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. Sonny's Enterprises, LLC has determined that the prescription drug coverage offered by the **Choice Plus Surest** and **Choice EPO 3000**.

medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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 group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and the group plan will be your primary coverage and Medicare will be your secondary coverage.

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your reenrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be cancelled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

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 under the group plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher

Important Notice: Medicare Part D Creditable Coverage Disclosure

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 your Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if the group plan coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

Contact Human Resources for more information:

Sonny's Enterprises, LLC

Human Resources

HRBenefits@sonnysdirect.com

For questions about Medicare prescription drug coverage,
Grace Agency is here to help.

**GRACE**
agency

MEDICARE INSURANCE CONSULTANTS

PATRIOT
GROWTH INSURANCE SERVICES

Educating you about
Medicare insurance
options and resources
to meet your health
and wellness goals.



OURS IS A KINDER AND GENTLER APPROACH TO THE WORLD OF MEDICARE INSURANCE



800-791-4840 | info@graceagency.org

Important Notice:

Medicare Part D Non-Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Sonny's Enterprises 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are three 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. **Sonny's Enterprises** has determined that the prescription drug coverage offered by the **CHOICE+HSA** is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the group plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from the group plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

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 decide to drop your current coverage under the group plan, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the group plan. If you are losing creditable prescription drug coverage from a group plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Since the prescription drug coverage under the group plan, is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and the group plan will be your primary coverage and Medicare will be your secondary coverage.

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug

Important Notice: Medicare Part D Non-Creditable Coverage Disclosure

coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your reenrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be cancelled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

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

Contact your Human Resources Employee Benefits Administrator for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if the group plan coverage changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare

& You" handbook for their telephone number) for personalized help

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

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

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Sonny's Enterprises, LLC.

Human Resources

HRBenefits@sonnysdirect.com

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and wellness goals.



OURS IS A KINDER AND GENTLER APPROACH TO THE WORLD OF MEDICARE INSURANCE



800-791-4840 | info@graceagency.org

Important Contacts

Benefit Assistance	Company	Phone	Email / Website
Benefits Department	Sonny's	800-327-8723	HRBenefits@sonnysdirect.com
Employee Benefits Advocate	Patriot Growth	877-446-0424	wpb.benefits@patriotgrowth.com
Insurance Carrier Contacts			
Medical	UHC	855-619-6713	myuhc.com
Medical - Surest	UHC Surest	855-619-6713	benefits.surest.com
Dental	UHC	855-619-6713	myuhc.com
Vision	UHC	855-619-6713	myuhcvision.com
Life and AD&D	Mutual of Omaha	800-228-7104	mutualofomaha.com
Disability	Mutual of Omaha	800-228-7104	mutualofomaha.com
Supplemental Insurance	UHCFP	866-556-8298	myuhcfp.com
Vendor Contacts			
Health Savings Account (HSA)	Optum Bank	866-234-8913	optumbank.com
Flexible Spending Account (FSA)	iSolved Benefit Services	800-300-3838	isolvedbenefitservices.com
Employee Assistance Program (EAP)	Mutual of Omaha	800-316-2796	mutualofomaha.com/eap
401K	Principal	800-986-3343	principal.com
UHC Benefit Assist	UHCFP	866-556-8298	myuhcfp.com

Sonny's Enterprises, LLC

Employee Benefit Guide

October 1, 2026 – September 30, 2027



Wpb.benefits@patriotgrowth.com

877-446-0424