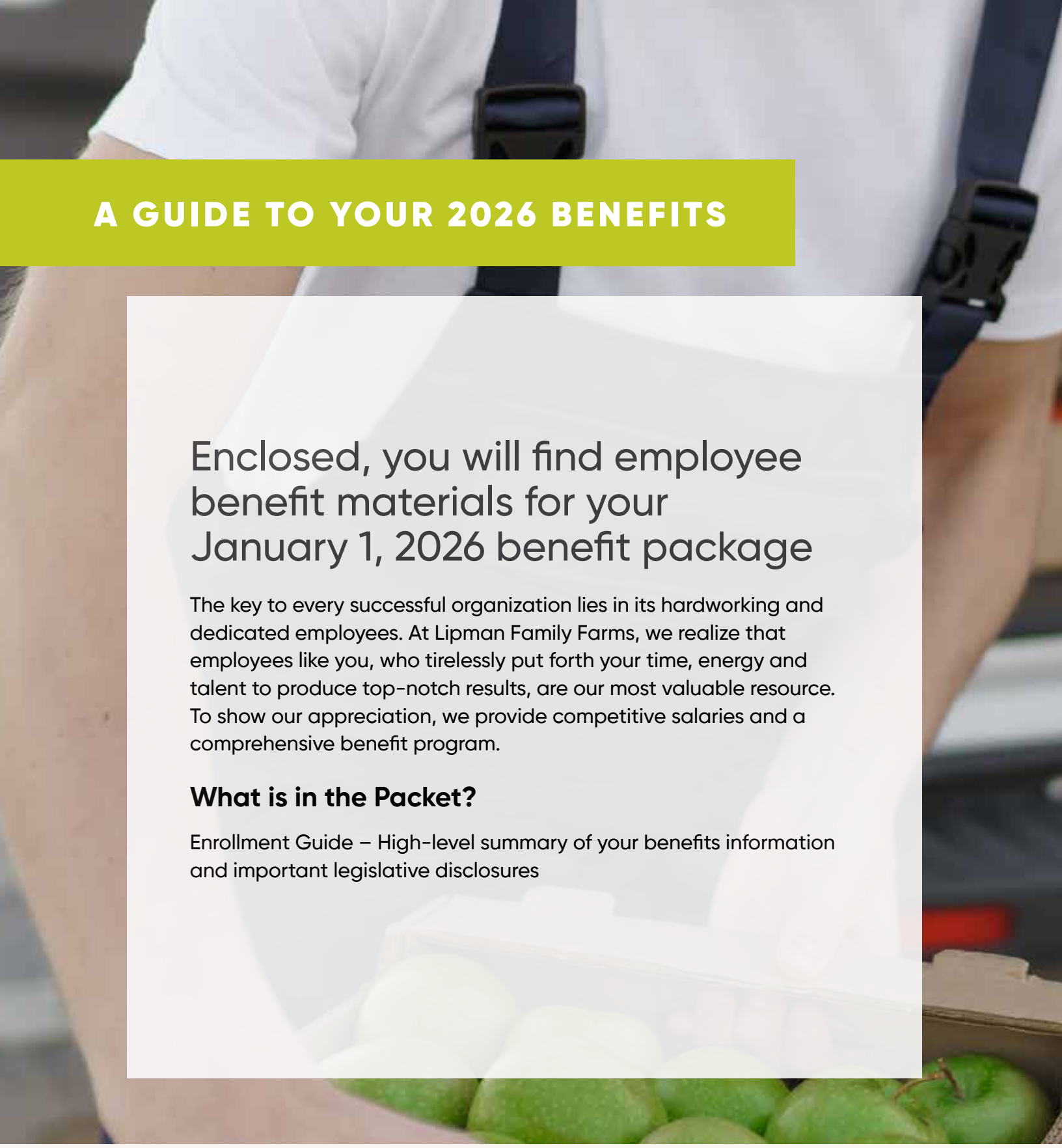
2026 BENEFIT GUIDE

LIPMAN
family farms®

JANUARY 1, 2026 – DECEMBER 31, 2026



A GUIDE TO YOUR 2026 BENEFITS

Enclosed, you will find employee benefit materials for your January 1, 2026 benefit package

The key to every successful organization lies in its hardworking and dedicated employees. At Lipman Family Farms, we realize that employees like you, who tirelessly put forth your time, energy and talent to produce top-notch results, are our most valuable resource. To show our appreciation, we provide competitive salaries and a comprehensive benefit program.

What is in the Packet?

Enrollment Guide – High-level summary of your benefits information and important legislative disclosures

Click or the scan the QR code to review your 2026 Summary of Benefits Coverage (SBC)

CONTENTS

IMPORTANT NOTICE TO EMPLOYEES:

This Benefit Guide provides a general description of the various benefits available to you through the Lipman Family Farms Employee Benefits program. The details of these plans and policies are contained in the official plan and policy documents.

This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

LIPMAN family farms

ELIGIBILITY

FOR YOU

All full-time employees working an average of 30 hours per week are eligible to enroll in benefits. For specific details, please refer to the plan documents.

New full-time employees' benefits for all lines of coverage will begin on the first of the month following their date of hire.

FOR YOUR FAMILY

Legislation regulates eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible Dependents includes:

- Legal Spouse
- Dependent children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

DEPENDENT COVERAGE

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

Spouse Verification Documentation:

Marriage Certificate

Child Verification Documentation:

Birth Certificate, court document awarding custody or requiring coverage

You can provide these documents to your Benefits Department.

ENROLLMENT

WHEN CAN I APPLY FOR MY BENEFITS?

- During your initial new hire eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event

MID-YEAR ENROLLMENT CHANGES – Section 125 Cafeteria Plan

Employees receive the tax benefits of a Section 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event.

Changes must be reported within 30 days of the actual event.

Some common qualifying events may include:

- Marriage, Divorce or Death of Spouse
- Birth, Adoption or change in Legal Custody
- Loss of other coverage
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

PLEASE NOTE:

The IRS does not consider financial hardship a qualifying event to drop coverage.

To determine if any of these apply to you, please check with your Human Resources representative.

employee NAVIGATOR

COMPANY ID:
lipmanff

ACTIVE ENROLLMENT

OPEN ENROLLMENT IS ACTIVE FOR ALL LINES OF COVERAGE.

ALL EMPLOYEES MUST COMPLETE ENROLLMENT BY DECEMBER 10, 2025 OR LOSE BENEFITS.

NEW USERS

1. You will receive a Registration Email
2. Use the link in the email to create your Employee Navigator profile
3. Confirm and update personal information
4. Elect OR waive each line of coverage
5. Review Enrollment Summary
6. Click the Agree button

RETURNING USERS

1. You will receive a Welcome Email
2. Login to ioa.employeenavigator.com
3. Confirm and update personal information
4. Elect OR waive each line of coverage
5. Review Enrollment Summary
6. Click the Agree button

MEDICAL INSURANCE

Healthgram - Cigna PPO Network

	HSA PLAN 1	PPO PLAN 2	PPO PLAN 3
MEDICAL BENEFITS	CHOICE PLUS NETWORK - MEMBER COST		
Deductible (Ded) - Individual / Family	$3,500/$7,000	$2,000 / $4,000	$0 / $0
Is Deductible Calendar Year or Policy Year?	Calendar Year	Calendar Year	Calendar Year
Is Deductible Embedded or Non Embedded	Non-Embedded	Embedded	Embedded Out of Pocket Max
Out of Pocket Maximum (Individual / Family)	$7,000/$14,000	$5,000 / $10,000	$2,500 / $5,000
Coinsurance (Coin)	20%	20%	None
Prescription Drugs	Deductible then $10 / $30 / $50	$10 / $30 / $50	$10 / $30 / $50
Mail Order Drugs (90 Day Supply)	Deductible then $25 / $75 / $125	$25 / $75 / $125	$25 / $75 / $125
PHYSICIAN OFFICE VISITS			
Primary Care Physician	Ded + Coin	$30 copay	$20 copay
Virtual Visits	Ded + Coin	$0	$0
Specialist	Ded + Coin	$60 copay	$45 copay
Referral Needed for Specialist?	No	No	No
PREVENTIVE CARE			
Routine Adult Physical Exams Well Woman Exams Routine Mammograms and Colonoscopy Well Child Exam & Immunizations	Covered 100%	Covered 100%	Covered 100%
DIAGNOSTIC / LABORATORY			
Independent Clinical Lab (Blood Work)	Ded + Coin	$0	$0
Independent Diagnostic Testing Facility (X-rays)	Ded + Coin	Coinsurance only	$0
Advanced Imaging (MRI, PET, CT Scan, Nuclear Medicine)	Ded + Coin	$450 copay	$200 copay
HOSPITALIZATION / OUTPATIENT SERVICES			
Inpatient Hospitalization (Facility)	Ded + Coin	Ded + Coin	$700 copay
Outpatient Surgical Care (Hospital Facility)	Ded + Coin	Ded + Coin	$300 copay
Physician Services at Hospital or ER	Ded + Coin	Ded + Coin	$0
Emergency Room	Ded + Coin	Ded + Coin	$200 copay
Urgent Care	Ded + Coin	$60 copay	$45 copay
OUT-OF-NETWORK BENEFITS			
Deductible (Individual / Family)	$4,800 / $13,500	$5,000 / $10,000	$5,000 / $10,000
Out of Pocket Maximum (Individual / Family)	$11,250 / $22,000	$30,000 / $90,000	$30,000 / $90,000
Coinsurance	50%	50%	50%

*This information summarizes the Lipman Family Farms Medical benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

Website: www.Members.HealthGram.com

Phone: 866-904-9081

MEDICAL DEDUCTIONS

The Weekly payroll deductions for the Medical Plans are outlined below. Please reference the Wellness Plan Overview included on page 9 for more information on how to earn the Wellness Credits.

WEEKLY PAYROLL DEDUCTIONS	Not Participating in Wellness		
	HSA PLAN 1	PPO PLAN 2	PPO PLAN 3
Employee Only	$35.52	$50.27	$74.89
Employee + Spouse	$71.95	$110.24	$177.06
Employee + Child(ren)	$58.42	$87.96	$139.11
Employee + Family	$97.97	$153.08	$250.04

WEEKLY PAYROLL DEDUCTIONS	Tobacco Free Credit Only		
	HSA PLAN 1	PPO PLAN 2	PPO PLAN 3
Employee Only	$30.52	$45.27	$69.89
Employee + Spouse	$66.95	$105.24	$172.06
Employee + Child(ren)	$53.42	$82.96	$134.11
Employee + Family	$92.97	$148.08	$245.04

WEEKLY PAYROLL DEDUCTIONS	PCP Visit		
	HSA PLAN 1	PPO PLAN 2	PPO PLAN 3
Employee Only	$25.52	$40.27	$64.89
Employee + Spouse	$61.95	$100.24	$167.06
Employee + Child(ren)	$48.42	$77.96	$129.11
Employee + Family	$87.97	$143.08	$240.04

WEEKLY PAYROLL DEDUCTIONS	Complete Participation		
	HSA PLAN 1	PPO PLAN 2	PPO PLAN 3
Employee Only	$20.52	$35.27	$59.89
Employee + Spouse	$56.95	$95.24	$162.06
Employee + Child(ren)	$43.42	$72.96	$124.11
Employee + Family	$82.97	$138.08	$235.04

NOTES:

- Earn $5 Weekly Credit to certify you are Tobacco Free or upon completion of a Tobacco cessation course
- Earn $10 Weekly Credit for visiting your Primary Care Physician (PCP) between 1/1/26 and 12/31/26.
- Wellness Incentives can be combined to a $15.00 Weekly Credit for participation as noted above

LIPMAN FAMILY FARMS WELLNESS PROGRAM

The Lipman Family Farms Wellness Program rewards you for taking an active role in your health. If you are enrolled in a Lipman Family Farms sponsored medical plan and complete the required wellness activities, you can earn an incentive of up to $15.00 medical premium credit each pay period (up to $780 for the full year).

Start earning your wellness incentives by completing the following activities:

PRIMARY CARE PHYSICIAN (PCP) VISIT

Visit your Cigna Primary Care Physician between January 1, 2026 and December 31, 2026. Annual routine wellness visits at your PCP are covered at 100% with no cost to you.

TOBACCO AFFIDAVIT

Confirmation that you are tobacco free or acknowledgment that you will complete a qualified tobacco cessation course or coaching.

WELLNESS INCENTIVES

Lipman Family Farms understands that knowing one's health numbers plays a key factor in early detection of chronic and life-threatening diseases. In recognition of the importance of adopting a healthier lifestyle, Lipman Family Farms will continue to provide incentives for participation. You are not required to participate or complete these activities.

Employees who do choose to participate in the Lipman Family Farms Wellness Program will receive a premium credit of $10.00 each weekly pay period for completing an annual wellness exam with a Primary Care Physician (PCP) visit and a premium credit of $5.00 each weekly pay period for completing the tobacco affidavit (those whose status is tobacco free or upon completion of a tobacco cessation course).

WHICH ACCOUNT IS RIGHT FOR ME? FSA OR HSA?

Administered by Employee Benefits Corporation (EBC)

Health Care FSA
(Flexible Spending Account):

General Purpose Health Care FSA reimburses you for health, prescription, dental, and vision expenses not covered or only partially covered by your medical, dental, and vision plans.

2026 limits:

» $3,400

Dependent Care FSA
(Flexible Spending Account):

A Dependent Care FSA reimburses you for dependent care expenses that you incur in order for you (and your spouse) to work, including childcare or care for dependents who are mentally or physically incapable of caring for themselves. The maximum contribution amount is $7,500 if you are married filing a joint return or if you are a single parent. If you are married but filing separately, the annual maximum contribution is $3,750.

Click or scan the QR code to watch the video

For a complete list of eligible expenses reimbursable with an FSA account, as well as a complete list of ineligible expenses, please visit the following IRS website: www.irs.gov/publications/p502/ar02.html#en_US_publink100017894

HSA
(Health Savings Account):

What is a Health Savings Account (HSA)?

An HSA allows an individual to set aside pre-tax dollars in a trust or custodial account to pay for qualified medical expenses.

2026 limits:

» $4,400 Single
» $8,750 Family
» $1,000 over 55+ catch-up contribution

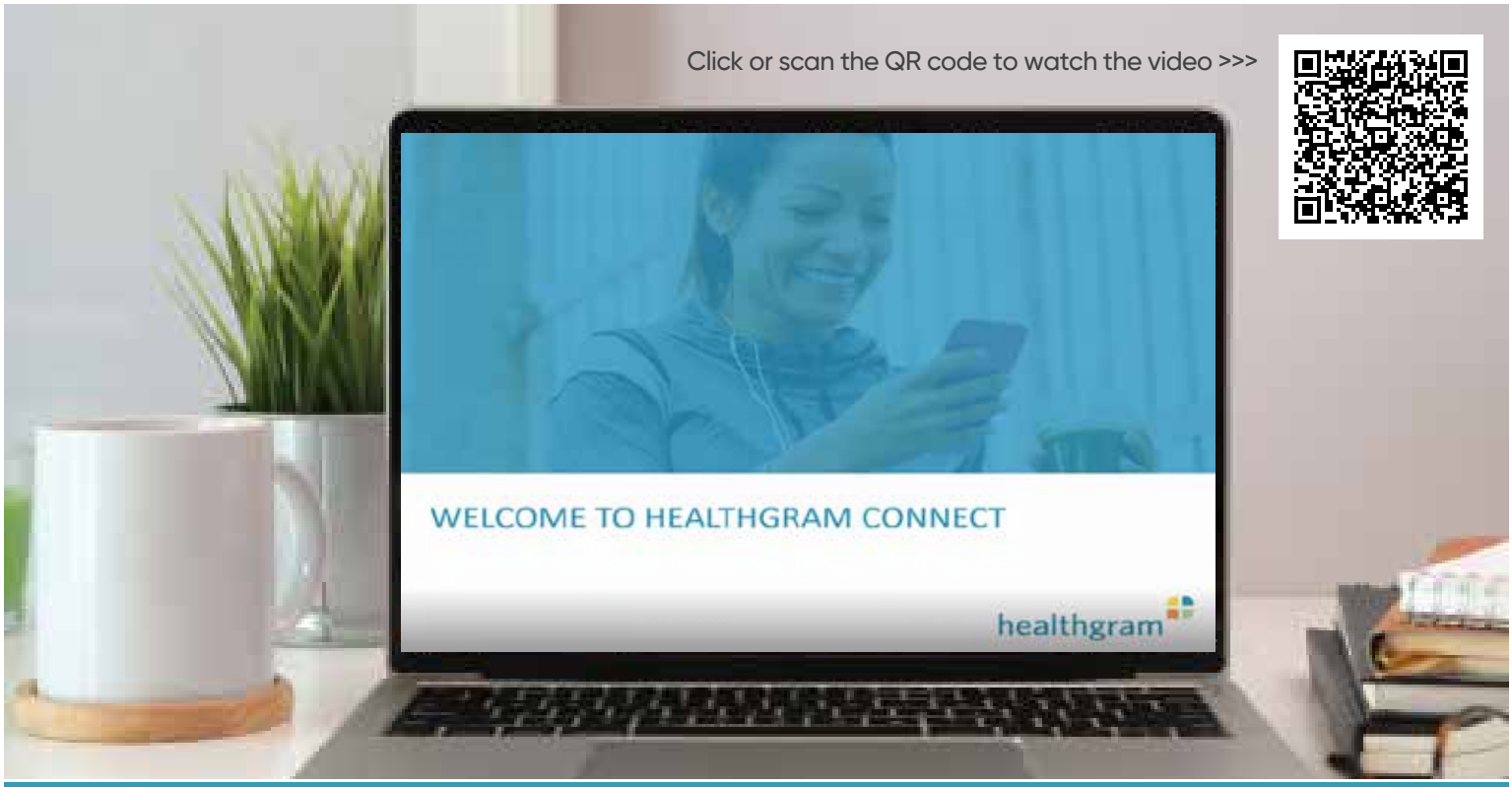
To qualify for an HSA, you must meet the following criteria:

- You must be enrolled in a High Deductible Health Plan (Plan 1);
- You cannot be enrolled in another health plan that is not an HDHP Plan

HSAs offer you the following advantages:

An HSA allows an individual to set aside pre-tax dollars in a trust or custodial account to pay for qualified medical expenses.

- Tax Savings. You contribute pre-tax dollars to the HSA. Interest accumulates tax-free and funds are tax-free to withdraw for healthcare expenses (including dental and vision)
- The funds are yours. Unused account dollars are yours to keep, even if you retire or leave the company.
- Funds are not use-it or lose-it, they carry over from year to year.



How to Access Your Healthcare Benefits Through Healthgram

Healthgram, in partnership with Lipman Family Farms, strives to offer the best network options to its employees. To do so, we allow Lipman Family Farms' employees to access the CIGNA medical network.

This means that the medical network is through CIGNA and the benefits are administered by Healthgram.

It's important for Members and Providers to note the following instructions for how to access care, eligibility and benefits coverage information.

Providers

- **For any questions regarding eligibility or benefits coverage, please visit the Healthgram Provider Portal at: providers.healthgram.com**
- If physicians still have eligibility or benefits questions after visiting the Provider Portal, please call Healthgram at: 1.800.550.6214
- Precertification Process: Please call Healthgram at 1.800.550.6214 to be routed to the correct precertification dept. for CIGNA.

Members:

- To find an in-network provider, login to your Member Portal at: members.healthgram.com
- Always take your Health Insurance ID Card with you to appointments and show it to the provider's office upon arrival.
- You may also share this document with your provider to give them guidance on who to contact if they have questions regarding your eligibility or benefits coverage.
- To view a digital copy of your ID card, log into your Member Portal at members.healthgram.com and click on the "ID Card" link on your dashboard.
- If you need to manually submit a claim to Healthgram for reimbursement, login into your Member Portal at members.healthgram.com and download the Claim Form within the "Documents" section.

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Healthgram Connect: Your One-Stop Resource

Your employer has teamed up with Healthgram to provide you and your family with access to a concierge support team called Connect.

The Healthgram Connect team is here to help you better manage your healthcare needs:

- Find the right doctor, hospital, and facility
- Ensure providers are in-network
- Estimate pricing for certain procedures
- Resolve claim and billing questions
- Understand benefits and coverage
- Find fair-cost facilities
- Earn monetary rewards
- Know the precertification process

Three ways to contact Healthgram Connect:

Call **866.904.9081**
Chat **members.healthgram.com**
Email **askConnect@healthgram.com**

We're here for you!

WELCOME TO HEALTHGRAM

Lipman Family Farms has partnered with Healthgram to bring you valuable benefits and a new way to think about healthcare. **Healthgram is your contact for benefits administration and customer service.**

Our goal is to help you choose the best benefit options for you and your family and become a trusted resource for your healthcare needs. We look forward to becoming your partner along the way.

IMPORTANT INFORMATION TO KNOW

FINDING A DOCTOR

Your network access will be through Cigna.

In-network healthcare providers have negotiated discounts so charges in-network should always be lower than those out-of-network. To help save on healthcare costs, select a doctor in your network.

Search for in-network healthcare providers at: members.healthgram.com.

For more detailed information, view the complete guide on page 9.

CONTACTING HEALTHGRAM

Member Support: 1-866-904-9081
8:00 am-6:00 pm EST Monday-Friday

Contact your Advisor :

- For answers about your plan and benefits
- Before any planned medical procedures
- For billing assistance
- To confirm precertification for an upcoming procedure, or a penalty may apply

Your member portal: Verify coverage, request a copy of your ID card, check claims status and more from your mobile-friendly online portal. Register at members.healthgram.com and view the complete guide on page 8.

YOUR MEDICAL ID CARD

Your ID card details the benefits offered to you through your employer. **It is being mailed to your home with accompanying instructions**. Provide your new ID card to ALL of your providers after 1/1/2023 and dispose of old cards.

YOUR PHARMACY BENEFITS

Your pharmacy provider is Elixir Soultions. Please note that although the 4-tiered co-pay (generic, formulary, and non-formulary, specialty) for prescription drugs has not changed, your preferred drug list has changed. The medication you currently take may be subjected to prior authorization. your pharmacy information is printed on your new medical ID Card.

Contacting Elixir Solutions:
1-800-771-4648
Please have your ID number ready.

Elixir Solutions for Pharmacy

What to know about your Elixir Rx benefit:

- You will be receiving a new medical ID card with the Elixir logo. Present this new ID card to your pharmacy.
- When seeking out a new pharmacy, remember that local pharmacies and discount stores such as Walmart and Costco, are typically less expensive.
- **Fill or refill existing prescriptions before the transition date to limit disruption**.

Your Mail Order Prescriptions:

- To continue your mail order prescription, you will need to set up an account with Elixir Solutions using one of the options below. When asked for an Identification Number, use your member ID found on your Healthgram ID card.
    - Option 1: Ask your doctor to send a new prescription to Elixir using this number: NCPDP 36-77361
    - Option 2: Visit elixirsolutions.com to manage your prescriptions online
    - Option 3: Call 866-909-5170 (TTY: 771) and Elixir will transfer your prescription
    - Option 4: Mail your new prescription to:

    7835 Freedom Ave. NW

    Norton Canton, OH 44720
- To discontinue your mail order prescription, ask your doctor's office to send your prescription to a low-cost retail pharmacy.

Your Specialty Prescriptions:

- If you are currently using a specialty medication that you receive through the mail, contact a Elixir Pharmacy Benefit Advisor. They will help you transition your prescription to another pharmacy without interruption.

Helpful resources

Healthgram:
866-904-9081

Elixir Solutions Pharmacy Benefit Advisor:
1-800-771-4648

Elixir Solutions Website:
elixirsolutions.com

Mail order resources

Elixir Solutions Customer Service:
866-909-5170

Elixir Solutions Website:
elixirsolutions.com

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Click or scan the QR code to access the Prior Authorization form

YOUR HEALTHGRAM MEMBER PORTAL

Tracking your health and wellness is easier than ever before. With helpful applications and a mobile-friendly layout, your Healthgram portal gives you everything you need to manage your care online.

1. **Health Plan:** View benefits plans and status.
2. **Portal Alerts:** Stay informed of compliance requirements, document due dates and health alerts from your dashboard. You'll also find your Health Risk Assessment here.
3. **Healthgram Trax:** Set personal wellness goals and track compliance with your company's Trax program.
4. **Find A Doctor:** Search for an in-network provider at the click of a button.
5. **Health Record:** View lab results, care action plans and health resources.
6. **Preventive Care:** Track and receive alerts regarding your recommended screenings.
7. **How Can We Help?:** Compare healthcare costs, view your Summary of Benefits, check on a claim status, get a copy of your ID card, or contact our Customer Service team
8. **Healthgram Connect:** Contact your Advisor
9. **Appointments:** View or schedule

Register for your Member Portal:

1 Visit the login page at **members.healthgram.com**

2 Click the "Need to Register?" link.

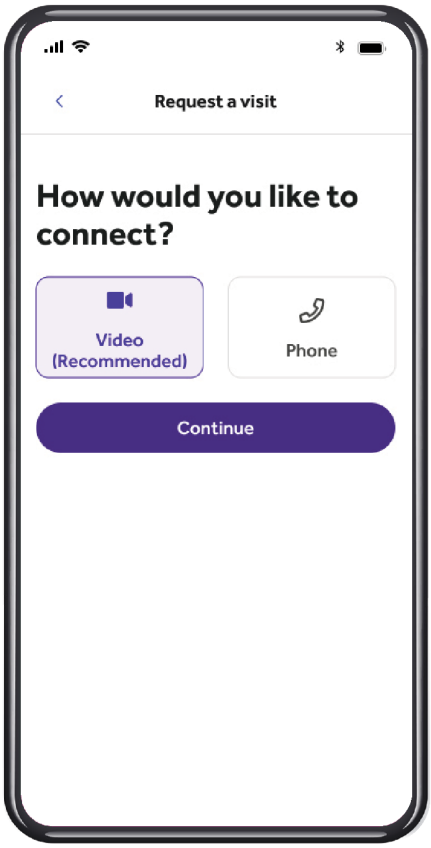
3 Enter the required information.

4 Enter your username and password to login!

TELADOC

The right care when you need it most

Here for you anytime, anywhere, by phone or video.



Your Teladoc Health service(s):

General Medical (24/7 Care)

Free/visit

Need care for non-urgent and common conditions? Get same-day virtual visits from anywhere. Teladoc Health's doctors, nurse practitioners and other healthcare providers can diagnose, treat and even prescribe medicine if needed.

- Allergies
- Bronchitis
- Flu
- COVID-19
- Pink eye
- Rashes
- Sinus infections
- Sore throats

Get started

Visit Teladoc.com

Call 1-800-TELADOC (800-835-2362) | Download the app

Teladoc Health is not available internationally.

Click or scan the QR code to access Teladoc Frequently Asked Questions

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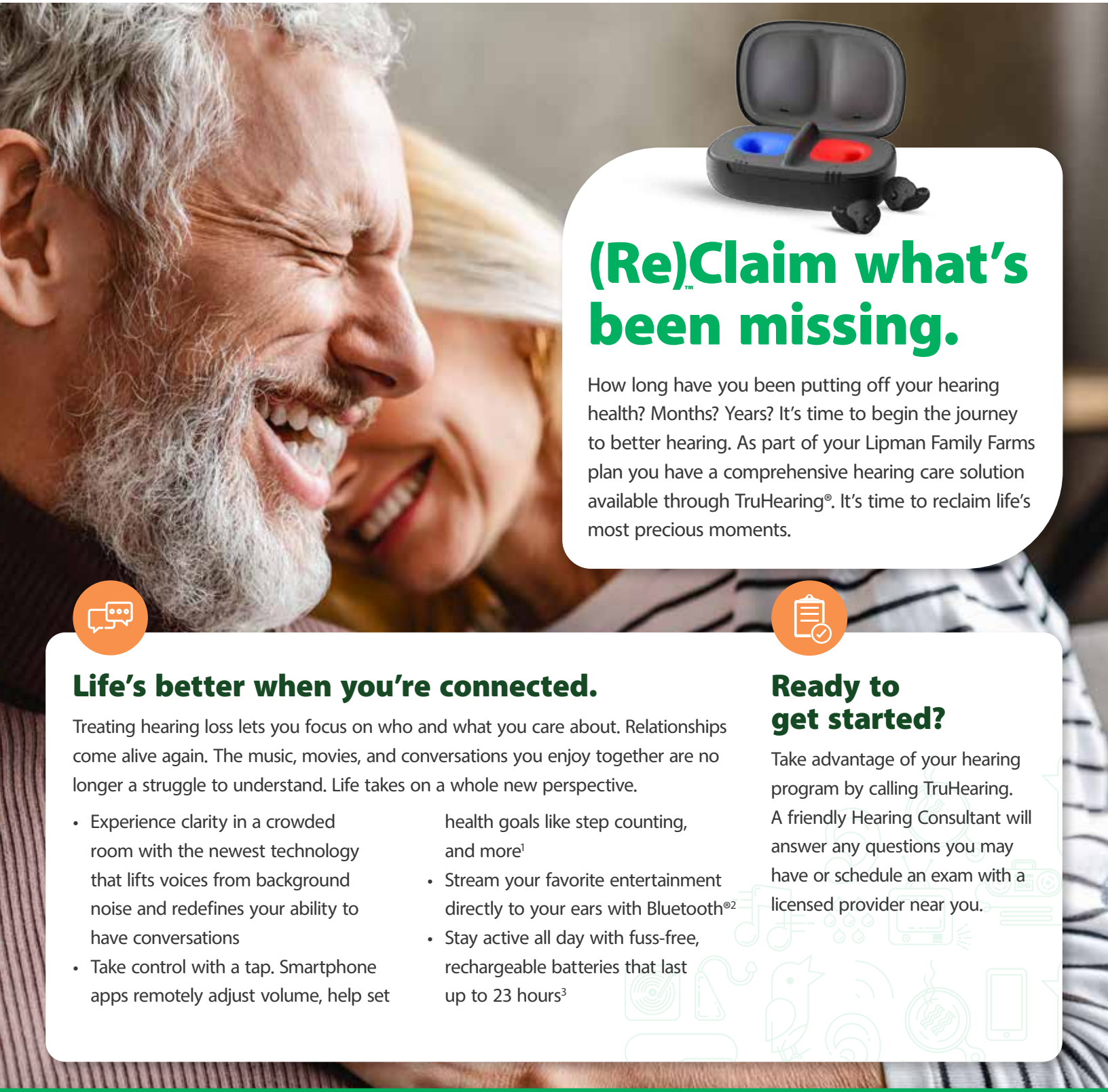
TruHearing®

1-833-312-3178 | TTY: 711



(Re)Claim™ what's been missing.

How long have you been putting off your hearing health? Months? Years? It's time to begin the journey to better hearing. As part of your Lipman Family Farms plan you have a comprehensive hearing care solution available through TruHearing®. It's time to reclaim life's most precious moments.

Life's better when you're connected.

Treating hearing loss lets you focus on who and what you care about. Relationships come alive again. The music, movies, and conversations you enjoy together are no longer a struggle to understand. Life takes on a whole new perspective.

- Experience clarity in a crowded room with the newest technology that lifts voices from background noise and redefines your ability to have conversations
- Take control with a tap. Smartphone apps remotely adjust volume, help set health goals like step counting, and more[1]
- Stream your favorite entertainment directly to your ears with Bluetooth®[2]
- Stay active all day with fuss-free, rechargeable batteries that last up to 23 hours[3]

Ready to get started?

Take advantage of your hearing program by calling TruHearing. A friendly Hearing Consultant will answer any questions you may have or schedule an exam with a licensed provider near you.

Give TruHearing a call today.

1-833-312-3178 | TTY: 711

Hours: 8am–8pm, Monday–Friday

DENTAL INSURANCE

Healthgram - Cigna DPPO Network

Scan or Click the QR code to access the carrier's website >>>

DENTAL SUMMARY OF BENEFITS	VOLUNTARY PPO LOW		VOLUNTARY PPO HIGH	
In-Network Deductible	$100 Individual/$300 Family		$50 Individual/$150 Family	
Out-of-Network Deductible	$100 Individual/$300 Family		$50 Individual/$150 Family	
Calendar Year Maximum	$1,000		$1,500	
Orthodontia Lifetime Maximum	Not Covered		$1,500	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Preventive Services	100% Deductible Waived	100% Deductible Waived	100% Deductible Waived	100% Deductible Waived
Basic Services	80%	80%	100%	80%
Major Services	50%	50%	50%	50%
Orthodontia Services *(children to age 19)*	Not Covered	Not Covered	50%	50%
Out-of-Network Reimbursement	-	MAC	-	90th% of UCR

WEEKLY PAYROLL DEDUCTIONS	VOLUNTARY PPO LOW	VOLUNTARY PPO HIGH
Employee Only	$6.02	$8.96
Employee + Spouse	$12.03	$18.82
Employee + Child(ren)	$11.43	$17.03
Employee + Family	$18.05	$26.89

*This information summarizes the Lipman Family Farms Dental benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

VISION INSURANCE

EyeMed

Scan or Click the QR code to access the carrier's website >>>

VISION SUMMARY OF BENEFITS	EXAM ONLY PLAN	BUY-UP	FREQUENCY
Comprehensive Eye Examination	$15	$0 at PLUS Providers / $10	12 months
Materials Copay	N/A	$25	
Eyeglass Frames	Discount	$150 at PLUS Providers; 10% of $100 retail allowance, 20% off balance	24 months
STANDARD EYEGLASS LENSES			
Single Vision Bifocal Trifocal	Discount	Covered 100% after materials copay	12 months
ELECTIVE CONTACT LENSES (IN LIEU OF EYEGLASS LENSES)			
Conventional/Disposable	Discount	$0; 15% off balance over $100 allowance / $0; 100% off balance over $100 allowance	12 months
Fit and Follow-up (Standard/Premium)		$40 allowance for contact lens fit & 2 follow-up visits / 10% off retail price	
MEDICALLY NECESSARY CONTACT LENSES			
Contact Lens	N/A	Covered 100% additional fitting fee applies based on type of lens	12 months

WEEKLY PAYROLL DEDUCTIONS	EXAM ONLY PLAN	BUY-UP
Employee Only	$0.00	$1.31
Employee + Spouse	$0.00	$2.63
Employee + Child(ren)	$0.00	$3.10
Employee + Family	$0.00	$4.75

****Employees enrolled in the Medical plan will be automatically enrolled in the same tier for the Exam Only Vision plan. Employees have the option to Buy-Up to the full coverage.**

*This information summarizes the Lipman Family Farms Vision benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

ENHANCED BENEFIT OPTION

Members get more, save more and are more satisfied with Eye360[1,2,3]

At EyeMed, we are always listening to our members. We hear what they want and what they need. Then, we connect the dots and create solutions that drive savings, convenience and transparency.

That's why we created Eye360[1] – an enhanced insurance benefit plan proven to help members save on eye exams and out-of-pocket costs[2] while increasing member satisfaction.[3]

HOW IT WORKS

With Eye360, members receive the following enhancements – on top of their base insurance benefit:

- $0 copay vision care exam
- $50 added to the frame allowance
- $100 additional glasses allowance[4] (applied after our industry-leading 40% off second pair of glasses discount)

MORE VALUE, MORE SAVINGS AT PLUS PROVIDERS

With Eye360, members save more than 89% versus retail.[2] Or up to 68% savings versus retail on an additional pair.[4,5] All of these extras are available when members visit a PLUS Provider – a select group of providers in the EyeMed network. With over 5,600 PLUS Providers nationwide, including independent, retail and online options, members will find plenty of locations nearby. Best of all, we keep saving simple with no paperwork or promo codes – it's built right into the plan.

With Eye360, unmatched savings and value are in sight– Contact your EyeMed rep or visit **eyemed.com**

SEEING DOUBLE

With Eye360's industry-leading additional glasses allowance, 2 is better than 1.[4] Especially when it comes with so much extra value – like 68% savings versus retail.[5] Members can now picture themselves with new glasses and new prescription sunglasses in the same year. Or perhaps it's a pair of contact lenses for nights out and a pair of glasses for work.[6] Eye360 helps members save.

PLUS PROVIDER

Find nearby PLUS Providers on our Provider Locator
Just look for the PLUS

[1]Member access to PLUS Providers is only available in conjunction with the Eye360 product and is not available in all states. [2]Based on EyeMed Book of Business 2022. [3]Eye360-PLUS Provider Survey-Wave 2, conducted by The Web Opinion, April 2022. [4]Additional glasses allowance is available to qualifying groups quoted after 7/1/23 with an effective date 1/1/24 and beyond. Additional glasses allowance can be used on frame and/or lenses, with or without options. Not available in all states. [5]Based on EyeMed Book of Business 2022. [6]Contact lens benefit must be used prior to the additional glasses allowance.

Fully insured plans are underwritten by Fidelity Security Life Insurance Company®, Kansas City, MO 64111

S-2303-CB-102

BASIC LIFE AND AD&D INSURANCE

VOLUNTARY LIFE AND AD&D INSURANCE

MUTUAL OF OMAHA

Basic Life Insurance and AD&D coverage provides important financial protection in the event of your death.

SUMMARY OF BENEFITS

Life Benefit Amount	$50,000
AD&D Benefit Amount	$50,000
Benefits will reduce	35% at age 65 50% at age 70
Additional Features	Living Benefits Option

Your Employer pays 100% of the premium for this coverage, it is at no cost to you, the employee

You can purchase supplemental life and AD&D insurance for yourself and/or your dependents. You must elect covreage on yourself in order to cover dependents.

SUMMARY OF BENEFITS

Benefit Increment	$10,000
Minimum Benefit	$10,000
Maximum Benefit	5x your salary up to $500,000
Guarantee Issue Amount	$150,000

SPOUSAL COVERAGE

Benefit Increment	$5,000
Minimum Benefit	$5,000
Maximum Benefit	100% of EE Election up to $100,000
Guarantee Issue Amount	$25,000

CHILD(REN) COVERAGE

Maximum Benefit	$10,000

If you are requesting coverage over the Guarantee Issue Amount, please submit an Evidence of Insurability form directly to Mutual of Omaha. The form can be completed online at www.mutualofomaha.com/eoi or you can request a paper form from Human Resources.

Scan or Click the QR code to access the carrier's website >>>

EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

EAP Benefits:

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Legal assistance and financial services
- Don't delay if you need help. Visit mututalofomaha.com/eap or call 1-800-316-2796 for confidential and resource services.

Lipman Family Farms provides eligible employees with a variety of plans to provide replacement income for you or your beneficiaries in the event of disability, accident, or death. The following information is a summary of coverage only. Refer to your summary plan description (SPD) or certificate of coverage for more details.

*This information summarizes the Lipman Family Farms Basic Life and AD&D and Voluntary Life and AD&D benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

SHORT-TERM DISABILITY INSURANCE (STD)

MUTUAL OF OMAHA

Scan or Click the QR code to access the carrier's website >>>

SUMMARY OF BENEFITS

Elimination Period for Accident	14 days
Elimination Period for Illness	14 days
Benefit Duration	13 weeks
Benefit Percent	60%
Benefit Maximum	$2,000 per week
Pre-Existing Limitationss	3 / 6

Employees living in California and New Jersey will have benefits offset by the State Disability plans.
Visit Employee Navigator for rate information

LONG-TERM DISABILITY INSURANCE (LTD)

MUTUAL OF OMAHA

Scan or Click the QR code to access the carrier's website >>>

SUMMARY OF BENEFITS

Elimination Period	90 days
Benefit Amount	up to 60% of monthly salary
Benefit Maximum	$10,000 per month
Duration of Benefits	Social Security Normal Retirement Age as long as you remain disabled
Own Occupation	24 Months
Pre-Existing Conditions	6 / 12

Visit Employee Navigator for rate information

*This information summarizes the Lipman Family Farms Disability benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

VOLUNTARY SUPPLEMENTAL INSURANCE

MUTUAL OF OMAHA

Group Critical Illness Insurance

An unexpected critical illness can have a lasting impact on you and your family - physically, emotionally and financially. You can give your family the extra security they need to lessen the financial impact of a serious illness by purchasing Critical Illness. A critical illness insurance policy provides a lump-sum cash benefit upon diagnosis of a critical illness like a heart attack, stroke, or cancer. The benefit can be used to pay out-of-pocket expenses or to supplement your daily cost of living.

BENEFIT CATEGORY	CONDITION	% of CI PRINCIPAL
Heart/Circulatory	Heart Attack, Heart Transplant, Stroke	100%
	Heart Valve Surgery, Coronary Artery Bypass, Aortic Surgery	25%
Organ Lacerations	Major Organ Transplant/Placement on UNOS list, End-Stage Renal Failure	100%
	Acute Respiratory Distress Syndrome (ARDS)	25%
Childhood/Developmental *benefits only available to children	Cerebal Palsy, Structural Congenital Defects, Genetic Disorders, Congenital Metabolic Disorders, Type 1 Diabetes	100%
Cancer	Cancer (Invasive)	100%
	Bone Marrow Transplant	50%
	Carcinoma in Situ, Benign Brain Tumor	25%

COVERAGE GUIDELINES	MINIMUM	GUARANTEE ISSUE	MAXIMUM
For You	$10,000	$10,000	$10,000
Spouse	$10,000	$10,000	$10,000
Child(ren) *benefit per child	$3,000	$3,000	$3,000

ADDITIONAL BENEFITS

*Health Screening Benefit — Pays a flat, annual benefit of $50 for a health screening test.

*Guaranteed Issue with no medical questions

Employee or Spouse Premium Rates (52 payroll deductions per year)	
Age	$10,000
0-29	$1.15
30-39	$2.10
40-49	$4.38
50-59	$9.44
60-69	$19.82
70-79	$36.46
80+	$46.15

*This information summarizes the Lipman Family Farms Voluntary Supplemental benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

VOLUNTARY SUPPLEMENTAL INSURANCE

MUTUAL OF OMAHA

Group Voluntary Accident Insurance

An accident insurance policy supplements your medical coverage and provides a cash benefit for injuries you or an insured family member sustain from an accident. This benefit can be used to pay out-of-pocket medical expenses, help supplement your daily living expenses and cover unpaid time off work.

BENEFIT (example, not a complete list)	CONDITION	AMOUNTS
Initial Care & Emergency - *Most Treatment/service required within 72 hours of accident; Once per accident per insured*	Emergency Room	$200
	Urgent Care Center	$125
	Initial Physician Office Visit	$100
Specified Injuries	Fractures Surgical Fractures Non-surgical	Up to $5,000/ Up to $2,500
	Lacerations	Up to $600
Hospital, Surgical & Diagnostic	Admission	$1,500
	Daily Confinement (Up to 365 days per accident)	$300 per day
	Diagnostic	Up to $150
Follow-Up Care - *Treatment/service required within 365 days of accident; Medical device is once per accident per insured*	Physician Follow-Up Office Visit	$75; Up to 2 per accident
	Therapy Services	$50; Up to 6 per accident

WEEKLY PAYROLL DEDUCTIONS	
Employee Only	$3.92
Employee + Spouse	$6.23
Employee + Child	$7.15
Family	$9.23

*This information summarizes the Lipman Family Farms Voluntary Supplemental benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

VOLUNTARY HOSPITAL INDEMNITY INSURANCE

MUTUAL OF OMAHA

Hospital stays can be stressful and having to worry about the high cost of hospitalization should not be a part of the recovery plan. Hospital Indemnity Insurance helps to ease your mind about handling hospitalization costs even if they are not hospital bills.

A hospital indemnity insurance policy supplements your medical coverage and provides a cash benefit for hospital related fees you or an insured family member sustain as a result of being hospitalized. This benefit can be used to pay out of pocket medical expenses, help supplement your daily living expenses, and cover unpaid time off work

As an active employee of Lipman family farms, you have hospital indemnity coverage for yourself and your family members, and premiums can be deducted from your paycheck. Hospital indemnity supplements your existing health insurance coverage by helping pay for out-of-pocket expenses incurred due to an injury or illness that may not be covered under other insurance plans.

Coverage guidelines and benefits are outlined below. This insurance offers financial protection by paying a cash benefit if you or an insured dependent are hospitalized. The benefit amount payable is the same for you and your insured dependent(s).

BENEFIT CATEGORY	AMOUNTS
HOSPITAL ADMISSION & CONFINEMENT	
Admission benefits are payable up to a combined total of two days per policy year and are not payable on the same day. Confinement benefits are payable up to a combined total of 30 days per policy unless otherwise noted and are not payable on the same day as hospital/ICU admission benefits	
Hospital Admission	$1,500 per day
Daily Hospital Confinement	$100 per day
ICU Admission	$2,500 per day
Daily ICU Confinement	$200 per day
Daily Newborn Nursery Care Confinement	$50 per day (up tp two days per policy year)
ADDITIONAL BENEFITS	
Health Screening Benefit	$50 (one time per insured per calendar year, up to six per family per calendar year)
Express Benefits	$100 (one benefit per hospital admission)
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family with discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.ampilfonusa.com/mutualofomaha to learn more
WEEKLY PAYROLL DEDUCTIONS	
Employee Only	$5.25
Employee + Spouse	$12.18
Employee + Child	$7.24
Family	$14.48

*This information summarizes the Lipman Family Farms Voluntary Hospital Indemnity benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

LegalShield℠

Affordable Legal and Identity Theft Protection

LegalShield provides the legal and identity theft protection you and your family need and deserve.

LEGAL BENEFITS*:

- Legal Consultation and Advice
- Court Representation
- Dedicated Provider Law Firm
- Legal Document Preparation and Review
- Letters and Phone Calls Made on Your Behalf
- Speeding Ticket Assistance
- Will Preparation
- 24/7 Emergency Legal Access

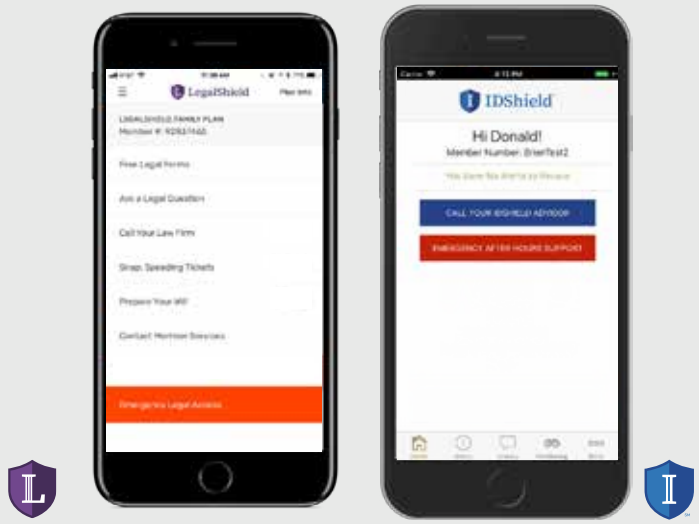
IDENTITY THEFT BENEFITS*:

- Identity Consultation and Advice
- Dedicated Licensed Private Investigators
- Identity Monitoring
- Credit Monitoring
- Child Monitoring
- Complete Identity Restoration
- Identity and Credit Threat Alerts
- 24/7 Emergency Access

Identity theft services are powered by IDShield.

We have an app for that!

With the LegalShield and IDShield mobile apps, you can easily begin your Will preparation track your identity and have on-the-go access, 24/7!



Download on the App Store

GET IT ON Google Play

Affordable legal and identity theft protection

$16.50

MONTHLY

For more information visit:

benefits.legalshield.com/lipman

*Restrictions may apply. See a plan contract for details. General Exclusions: The following items are excluded from any service: Legal Remedy - Any Stolen Identity Event where the Member is unwilling or unable to prosecute or otherwise bring a civil or criminal claim against any person culpable or reasonably believed to be culpable for the fraud or its consequences. Dishonest Acts - Any dishonest, criminal, malicious or fraudulent acts, if the Member(s) that suffered the fraud personally participated in, directed or had knowledge of such acts. Financial Loss - Any direct or indirect financial losses attributable to the Stolen Identity Event, including but not limited to, money stolen from a wallet, unauthorized purchases of retail goods or services online, by phone, mail or directly. Business - The theft or unauthorized or illegal use of any business name, DBA or any other method of identifying business (as distinguished from personal) activity. Third Parties not Subject to U.S. or Canadian Law - Restoration services do not remediate issues with third parties not subject to United States or Canadian law that have been impacted by an individual's Stolen Identity Event, such as financial institutions, government agencies, and other entities. Google Play and the Google Play logo are trademarks of Google Inc. Apple, the Apple logo, and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries.

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TERMS TO KNOW

SCAN OR CLICK THE QR CODE TO WATCH A SHORT VIDEO ON THE TERM YOU WOULD LIKE TO KNOW

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

AD&D: Accidental Death & Dismemberment

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using Out-of-Network providers.

ELIMINATION PERIOD: This is the time period between injury or illness and the receipt of benefit payments.

EMBEDDED DEDUCTIBLE: An embedded deductible is a system that combines individual and family deductibles in a family health insurance policy. When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible in order for after-deductible benefits to kick in, each individual only needs to meet the individual deductible in order for after-deductible benefits to kick in.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EVIDENCE OF INSURABILITY (EOI): This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

IN-NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAC: Maximum allowable charge

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

NON-EMBEDDED DEDUCTIBLE: A non-embedded deductible is also referred to as an aggregate deductible. Under an aggregate deductible, the total family deductible must be paid out-of-pocket before after-deductible benefits kick in for the health care services incurred by any family member.

OUT-OF-NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

OUT-OF-POCKET MAXIMUM: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available In-Network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

UCR: Usual, customary, reasonable

MANDATORY NOTICES

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

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 29-32 for more details.

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 **Lipman Family Farms** 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. **Lipman Family Farms** has determined that the prescription drug coverage offered by the **PPO Plan 2, PPO Plan 3,** and **PPO Plan 4** 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 premium (a penalty) to join a Medicare drug plan later.

Important Notice:
Medicare Part D Creditable Coverage Disclosure

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:

Valeria G. Hernandez
Human Resources Manager
7407 Southfront Road
Livermore, CA 94551
P (925) 454-8700 x8066
C (209) 666-7978

Alissia Trujillo
HR Benefits and 401k admin
315 New Market
Florida 34142
Manteca
C (239) 986 6598

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

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 **Client Name** 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. **Lipman Family Farms** has determined that the prescription drug coverage offered by the **HSA Plan 1** 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

Group plans with < 20 lives will not be affected. There is coordination of benefits and Medicare will be your primary coverage and the group plan will become your secondary coverage.

Important Notice:
Medicare Part D Non-Creditable Coverage Disclosure

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.

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).

Contact Human Resources for more information:

Valeria G. Hernandez
Human Resources Manager
7407 Southfront Road
Livermore, CA 94551
P (925) 454-8700 x8066
C (209) 666-7978

Alissia Trujillo
HR Benefits and 401k admin
315 New Market
Florida 34142
Manteca
C (239) 986 6598

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

800-791-4840 | info@graceagency.org

MANDATORY NOTICES

HIPAA Notice of Special Enrollment Rights

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 days after your or your dependents other coverage ends.

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

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact Human Resources.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Model General Notice of COBRA Continuation of Coverage Rights

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;

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- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child.".

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

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

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

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

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

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

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

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

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

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of

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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

Plan and COBRA continuation coverage can be obtained on request:

Valeria G. Hernandez	**Alissia Trujillo**
Human Resources Manager	**HR Benefits and 401k admin**
7407 Southfront Road	**315 New Market**
Livermore, CA 94551	**Florida 34142**
P (925) 454-8700 x8066	**Manteca**
C (209) 666-7978	**C (239) 986 6598**

www.medicare.gov/medicare-and-you

Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored 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.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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

Women's Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

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 (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 deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

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Newborns' and Mothers' Health Protection Act

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

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).

ALABAMA – Medicaid

Website: myalhipp.com | Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website:
myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program - dhcs.ca.gov/hipp
Phone: 916-445-8322 | Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: www.in.gov/medicaid
www.in.gov/fssa/dfr
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

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KANSAS – Medicaid

Website: 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: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
www.mymaineconnection.gov/benefits/s/?language=e n_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: mn.gov/dhs/health-care-coverage
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

Website: 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 5218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid and CHIP

Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK - Medicaid

Website: www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid & CHIP

Website: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website:
medicaid.utah.gov/upp
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: medicaid.utah.gov/expansion
Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program CHIP Website: chip.utah.gov

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VERMONT– Medicaid

Website: www.greenmountaincare.org
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: dhhr.wv.gov/bms/Pages/default.aspx
mywvhipp.com
Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid

Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2027)

CONTACTS

LINE OF COVERAGE	CARRIER	CUSTOMER SERVICE
Medical	Healthgram - Cigna PPO Network	800-480-5035 www.Members.HealthGram.com
Teladoc	Teladoc Health	1-800-TELADOC (835-2362) Teladoc.com
Health Spending Account (HSA) Flexible Spending Account (FSA)	Employee Benefits Corporation	608-829-8440 | 800-346-2126 x 165 www.ebcflex.com
Dental	Healthgram - Cigna DPPO Network	800-480-5035 www.Members.HealthGram.com
Vision	EyeMed	866-939-3633 www.eyemed.com
Employer Paid Basic Life & AD&D	Mutual of Omaha	800-775-8805 www.mutualofomaha.com
Voluntary Life & AD&D	Mutual of Omaha	800-775-8805 www.mutualofomaha.com
Employee Assistance Program	Mutual of Omaha	800-316-2796 www.mutualofomaha.com
Short Term Disability	Mutual of Omaha	800-877-5176 www.mutualofomaha.com
Long Term Disability	Mutual of Omaha	800-877-5176 www.mutualofomaha.com
Accident/Criticall Illness	Mutual of Omaha	800-775-8805 www.mutualofomaha.com
Legal & Identity Theft Protection	LegalShield	www.benefits.legalshield.com/lipman
TruHearing	TruHearing	1-833-312-3178 | TTY: 711
Connect Advisor	Healthgram - Cigna PPO Network	866-904-9081 askconnect@healthgram.com

Your Connect Advisor is ready to answer questions about your health plan, sort out billing problems, help you save money on healthcare costs and support you every step of the way!

The Healthgram Health Advisor can assist members with benefits questions, membership card issues, claims, billing inquiries, etc. All we do is send these emails to Healthgram. Healthgram should be the first line of defense and we can deal with anything escalated. Here is Healthgram's Health Advisor Contact information: 866-904-9081

CONTACT	PHONE	EMAIL
Benefits Support	866-379-3154	benefits@lipmanfamilyfarms.com

BENEPLACE is a best-in-class savings platform that's reliable, budget-friendly, and focused on one thing: rewarding you with discounts on products and services from the brands you love!

Visit ioausa.savings.beneplace.com to find out more.

2026 BENEFIT GUIDE

LIPMAN FAMILY FARMS

JANUARY 1, 2026 - DECEMBER 31, 2026

INSURANCE OFFICE OF AMERICA