

**Open Enrollment is open from
Monday, October 20 –
Friday, October 31, 2025**



2026 BENEFITS GUIDE





Inside the Guide

Welcome	3
Benefit Basics	4
Eligibility	5
How to Enroll in Your Benefits	6
Medical	7
Virtual Visits and Mobile App	10
TrueScripts Prescriptions	11
Get To Know Your Care Options	12
Dental.....	13
Vision.....	14
Health Savings Account (HSA)	15
Flexible Spending Account (FSA)	17
Company Paid Benefits	20
Voluntary Benefits.....	21
Voluntary Benefits (continued)	22
Employee Assistance Program (EAP)	27
Wellworks	28
Utopia WellCare	29
Level2 Diabetes Specialty Care	30
Important Contacts	31



Welcome

At BGDC, we understand that our Associates are the foundation of our success. Our goal is to provide comprehensive and competitive benefits to support the needs of our Associates and their family members. This benefit guide is designed to provide you with the information needed to select the benefits that best suit you.

We will be holding a passive enrollment this year, which means if you don't take any action your benefits will roll over into 2026. If you want to elect the FSA you will need to do that as it does not roll over. You must make these changes prior to **October 31, 2025** by calling the Enrollment Call Center. Open enrollment is your annual opportunity to make benefit elections. Outside of this period, you will only be able to make changes if you have a qualifying life event.

What's New for 2026?

- Telehealth services are now covered at 100% prior to deductible on the High-Deductible Health Plan
- Prescription drug coverage is now through TrueScripts
- Dental, Vision, Life and Disability benefits now with Guardian
- ID Theft coverage now with Norton LifeLock
- Legal coverage now with LegalEASE

Please review this benefit guide in its entirety and reach out to the Human Resources Team with any additional questions.

Thank you,
Human Resources Team

Benefit Basics

Your Benefit Choices

BGDC is pleased to give you the opportunity to select your benefits and enroll in the plans of your choice. We strive to offer you high quality benefits, flexibility, and freedom of choice at affordable costs. A primary strength of the program is the ability to customize a benefit plan to your personal and family needs.

Important Benefits Plan Information



Core Benefits: There are four medical plan options and two dental plan options available to provide you with choice in selecting a plan that best meets the needs of you and your family. Benefits are unbundled – you may enroll in just medical, just dental, or both programs. A BGDC-paid vision plan is available for your vision needs. All options provide out-of-network benefits, but you will best control your expenses by having services rendered with in-network providers. Please note: CBA Associates have a bundled package of either the Enhanced medical, Enhanced dental and vision plan or the High Deductible Health Plan (HDHP) medical, Enhanced dental and vision plan with the HSA employer contribution as described on pages 15-16.



Preventative care: This is your annual check-up. When seeing an in-network provider, this care is covered at 100% on all four medical plans. No deductible or copays.



Prescription drug plan: When you enroll in any of our medical options, you automatically have prescription coverage as well. When possible, and after discussing it with your healthcare provider, use generic medications that are subject to a fixed copay. Brand name medications are subject to coinsurance.



Maintenance prescription program: Optum Rx services help make it easier for you to save on medications and keep track of them. Order a 3-month supply through Optum Rx and you may pay less on medications. You will also receive standard shipping at no cost and save on trips to the pharmacy.

Some benefits in this booklet are provided automatically with no cost to you, while others require Associate contributions. Keep in mind that you are contributing towards your health care with pre-tax dollars. Pre-tax contributions provide additional savings by reducing your taxable income.

Additional information about your benefits package is available from your local Human Resources team.

Benefit	Who Pays	Tax Treatment
Medical and Prescription	BGDC and you	Pre-Tax
Dental	BGDC and you	Pre-Tax
Vision	BGDC	N/A
Basic Life and AD&D	BGDC	N/A
Supplemental Term Life and AD&D	You	After-Tax
Business Travel Accident Insurance	BGDC	N/A
Legal and Identity Theft Protection	You	After-Tax
Short-Term Disability (STD)	BGDC	N/A
Long-Term Disability (LTD)	BGDC	N/A
Health Savings Account (HSA)	BGDC and you	Pre-Tax
Flexible Spending Accounts (FSA)	You	Pre-Tax
Whole Life Insurance	You	After-Tax
Critical Illness Insurance	You	After-Tax
Accident Insurance	You	After-Tax
Hospital Indemnity Plan	You	After-Tax
Auto/Homeowners/Pet Insurance	You	After-Tax
401(k) Retirement Plan	BGDC and you	Tax Deferred
Employee Assistance Program (EAP)	BGDC	N/A
Utopia WellCare	BGDC	N/A
Level2 Specialty Care	BGDC	N/A
Wellworks	BGDC	N/A

Collective Bargaining Agreement (CBA) Associates:

This booklet outlines the benefits offered to all eligible BGDC Associates. If you are an eligible Associate who is covered by a Collective Bargaining Agreement, please review your CBA and the plan documents and summaries that pertain to your plan, which may include different features and provisions than what is identified and summarized above and in this document.

Eligibility

Eligible Associates

You may enroll in the BGDC Associate Benefits Program if you are a full-time Associate working at least 30 hours per week.

As a new hire, unless covered by a Union Collective Bargaining Agreement, benefits will be effective the first day of the month following 30 days of employment.

Eligible Dependents

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, domestic partner, and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children, and children obtained through court-appointed legal guardianship, as well as children of same sex domestic partners. Please be aware proof of dependent eligibility may be required.

Reminder: Please make sure your dependents enrolled on the plan are eligible. There will be a dependent eligibility audit this year.

Working Spouse Attestation

All Associates and their covered spouse/domestic partner in our medical plan are required to complete the Working Spouse Attestation form every year. If your spouse/domestic partner is employed and offered medical coverage by their employer, they should enroll in their employer's health plan. If medical coverage is offered through their employer but they would prefer to enroll in BGDC's medical insurance plan, they can do so but you will pay an assessment of \$125 per month, in addition to your contributions.

The spousal surcharge would not apply if your spouse/domestic partner is:

- Currently employed by BGDC
- Not employed
- Eligible for Medicare (but not another employer-sponsored medical plan)
- Not offered/eligible for medical coverage through their employer

Domestic Partner

If you are insuring a domestic partner, your costs will be on a Before and After-Tax basis under federal tax law. The portion of insurance premium that your employer pays for your coverage is not taxed as income. Federal law treats benefits for spouses, children, and certain dependents the same way. However, a domestic partner is not considered a spouse under federal law. As a result, if you elect to have your domestic partner covered under your plan, you will pay income tax and Social Security payroll tax on the portion of the insurance premium that your employer contributes to insure your domestic partner.

Qualified Life Events

A qualified life event is a change in your life that may impact your or dependents' eligibility for benefits. Generally, you may only change your benefits during the annual open enrollment period. However, you can change benefit elections during the year if you have a qualified life event. Examples include:

- Change of legal marital status
 - (i.e., marriage, divorce, death of spouse)
- Change in number of dependents
 - (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status
 - (i.e., spouse loses job, etc.)



If such a change occurs, you must make the changes to your benefits within 30 days of the event date.

Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

When Coverage Begins

The effective date for your benefits is January 1, 2026.

All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a qualified life event.



How to Enroll in Your Benefits

Making Your Elections Through a Benefits Counselor

To enroll in the programs offered by BGDC, or to make any changes, you can call the Enrollment Call Center Benefits Counselors at **888-260-8082** Monday through Friday from 9am-6pm ET between Monday, October 20th through Friday, October 31st. You do not need to make an appointment.

They will be able to walk you through all the benefit options you have and answer any questions relating to what the plans cover, what the costs are, and other important features you may need to know about.

If you want to learn more about the High Deductible Health Plan offering that can be paired with a Health Savings Account, which BGDC will contribute to, please call the Enrollment Call Center so they can help you understand the differences in this plan.

Household Needs Assessment

BGDC is committed to providing a comprehensive and affordable health plan for our associates, but also recognizes that some associates may have more affordable insurance options available to them based on their unique situations but may not fully understand what the best option is for them.

The Enrollment Call Center specializes in education-driven risk management through their proprietary Benefit Resource Genie™ and database to develop custom solutions at the associate household level to ensure the best possible outcome for their situation. Engaging the Enrollment Call Center is not only a valuable resource for our benefit-eligible associates, but it can also improve BGDC's overall medical spend, which will help keep the plan as affordable as possible going forward.

They will also ask you some questions regarding your household income and other health coverages you may have available. They will be doing this to see if you qualify for any other programs that might be more affordable for you or your family members, including options for alternative funding for expensive medications, based on who you're covering and what your healthcare needs are.



If you want to make any changes to your benefits for 2026, you must contact the Enrollment Call Center by Friday, October 31, 2025.

You can reach them at **888-260-8082** Monday through Friday from 9am-6pm ET from Monday, October 20th through Friday, October 31st. You do not need to make an appointment.

Medical

United
Healthcare

BGDC will be offering four medical plan options in 2026: the Basic PPO Plan, the Standard PPO Plan, the Enhanced PPO Plan, and a High Deductible Health Plan. The coverage will continue to be administered by United Healthcare and includes prescription drug coverage through OptumRx. The network of providers will be the United Healthcare Choice Plus national network.

All four plans give you the choice of going to see any physician or hospital you choose, but you receive the maximum level of benefits if you receive care from in-network providers. While the plans allow you to receive services in- and out-of-network, it remains your responsibility to make sure you are using in-network providers in order to receive the benefits of the plan's in-network benefit schedule. If your out-of-network provider charges more than the "Maximum Allowable Amount", as determined by United Healthcare, you may be subject to balance billing and higher deductibles and out of pocket maximums.

Please refer to the summary plan description for complete plan details. Find an in-network provider and review cost estimates at [myuhc](https://myuhc.com).

Basic PPO Plan

The Basic PPO Plan has the highest out-of-pocket costs, but the lowest Associate premium contribution of the three medical PPO plan options. The Basic Plan has a copay for Primary Care Provider (PCP) office visits, and your preventive care services are covered at 100% when you use an in-network provider. The plan pays 60% in-network and 40% out-of-network after your deductible is met.

Standard PPO Plan

The Standard PPO Plan is provided at a lower Associate premium contribution than the Enhanced Plan, but total out-of-pocket costs are higher, but lower compared to the Basic Plan. The Standard Plan has a copay for Primary Care Provider (PCP) office visits, and your preventive care services are covered at 100% when you use an in-network provider. The plan pays 70% in-network and 50% out-of-network after your deductible is met.

Enhanced PPO Plan

The Enhanced PPO Plan has the highest Associate premium contribution, but the lowest out-of-pocket costs compared to the Standard and Basic Plans. The Enhanced Plan has a copay for Primary Care Provider (PCP) office visits, and your preventive care services are covered at 100% when you use an in-network provider. The plan pays 80% in-network and 50% out-of-network after your deductible is met.



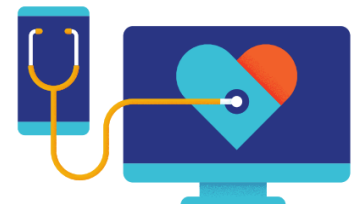
High Deductible Health (HDHP) Plan with HSA

The HDHP Plan has some of the highest deductible and out-of-pocket costs but has the lowest Associate premium contribution of all the medical plan options. On the HDHP Plan your preventive care services are covered at 100% when you use an in-network provider but due to IRS guidelines for having a Health Savings Account (HSA), all other services including prescription drugs will not be paid by the plan until the deductible is met. The plan will pay 80% in-network and 60% out-of-network after your deductible is met.

United Healthcare Online Resources

Once the plan year starts you can log on to your individual United Healthcare account at myuhc.com by clicking "Register Now" and following the step-by-step instructions. The UHC website offers many features and allows you to:

- Locate an in-network UHC provider
- Request a new ID card
- View and manage your benefits and health
- Review and print an Explanation of Benefits (EOB)



High Deductible Health Plan with Health Savings Account

Many BGDC associates pay a lot of money out of their paychecks to have their health insurance, but because they don't use many medical services during the year they don't really get much for it. A high deductible health plan (HDHP) is a plan specifically allowed by the IRS to be paired with a Health Savings Account, which offers triple tax advantages.

A high deductible plan is not allowed to have copays. You will have to meet the deductible before the plan will start paying for all services (including prescription drugs) other than preventive care. The benefit of having a high deductible health plan is that it can be paired with a Health Savings Account, which BGDC will contribute to on your behalf, and which you can contribute your own pre-tax dollars as well. If you don't spend your HSA dollars each year they roll over indefinitely, and there is no use it or lose it provision like the Flexible Spending Account has. You can even invest your HSA dollars so that they grow as quickly as possible. You own your HSA account and all funds in it, even if you leave BGDC. Please read more about the benefits of the HSA on pages 15-16 to determine if it may be a good fit for you.

	UHC High Deductible Health Plan	
	In-Network	Out-of-Network
Annual Deductible		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Maximum Out-of-Pocket (includes deductibles)		
Individual	\$7,500	\$15,000
Family	\$15,000	\$30,000
Coinsurance		
Coinsurance (Plan pays after deductible is met)	80%	60%
Preventive Care		
Well Adult and Well Child Visits	Covered in Full	40% after ded.
All Other Medical Services		
Primary Care / Specialty Care	20% after ded.	40% after ded.
Urgent Care / Emergency Room	20% after ded.	40% after ded.
X-ray and Lab Tests	20% after ded.	40% after ded.
Inpatient Facility	20% after ded.	40% after ded.
Outpatient Facility / Surgical	20% after ded.	40% after ded.
Retail Pharmacy (30 Day Supply)	Pharmacy Accumulates to Your Deductible & Medical Out-of-Pocket Maximum	
All Tiers of Prescriptions	20% after ded.	40% after ded.
Mail Order Pharmacy (90 Day Supply) (90 Day at Retail is available as well)		
All Tiers of Prescriptions	20% after ded.	40% after ded.

Prescription Drug Coverage

Regardless of the medical plan you select, you will receive prescription drug coverage administered by TrueScripts. The plan covers both generic and brand-name medications. TrueScripts offers a nationwide network of participating pharmacies and mail order services.

The prescription drug plan in the Enhanced and Standard options have a separate prescription out-of-pocket (OOP) maximum. Once you hit the maximum your remaining prescription drug expenses will be paid at 100%. The Basic Plan does not have a separate prescription out-of-pocket maximum. Your prescription expenses will accumulate towards the medical out-of-pocket maximum.



PPO Medical Plan Overview

	UHC Basic Plan		UHC Standard Plan		UHC Enhanced Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible						
Individual	\$5,850	\$17,550	\$2,500	\$6,900	\$1,500	\$3,675
Family	\$11,700	\$35,100	\$5,000	\$13,800	\$3,000	\$7,350
Maximum Out-of-Pocket* (includes deductibles and copays)						
Individual	\$7,350	\$22,050	\$5,000	\$13,800	\$2,500	\$7,350
Family	\$14,700	\$44,100	\$10,000	\$27,600	\$5,000	\$14,700
Coinsurance						
Coinsurance (Plan pays after deductible is met)	60%	40%	70%	50%	80%	50%
Preventive Care						
Well Adult and Well Child Visits	Covered in Full	40% after ded.	Covered in Full	50% after ded.	Covered in Full	50% after ded.
Physician Office Visits						
Primary Care	\$50 copay	40% after ded.	\$40 copay	50% after ded.	\$30 copay	50% after ded.
Specialty Care	\$65 copay	40% after ded.	\$50 copay	50% after ded.	\$40 copay	50% after ded.
Diagnostic Services						
X-ray and Lab Tests	40% after ded.	40% after ded.	30% after ded.	50% after ded.	20% after ded.	50% after ded.
Urgent Care	\$50 copay	40% after ded.	\$50 copay	50% after ded.	\$50 copay	50% after ded.
Emergency Room	40% after ded.	40% after ded.	30% after ded.	50% after ded.	20% after ded.	50% after ded.
Inpatient Facility	40% after ded.	40% after ded.	30% after ded.	50% after ded.	20% after ded.	50% after ded.
Outpatient Facility / Surgical	40% after ded.	40% after ded.	30% after ded.	50% after ded.	20% after ded.	50% after ded.
Mental Health						
Inpatient	40% after ded.	40% after ded.	30% after ded.	50% after ded.	20% after ded.	50% after ded.
Outpatient	Office: \$50/visit Other: 40% after ded.	40% after ded.	Office: \$40/visit Other: 30% after ded.	50% after ded.	Office: \$30/visit Other: 20% after ded	50% after ded.
Retail Pharmacy (30 Day Supply)						
Annual Pharmacy Out of Pocket Maximum (Single / Family)	None – included with your Medical OOP Maximum		Individual: \$2,500 Family: \$5,000		Individual: \$2,500 Family: \$5,000	
Generic (Tier 1)	\$15 copay	Not covered	\$10 copay	Not covered	\$10 copay	Not covered
Preferred (Tier 2)	40%, \$250 max	Not covered	30%, \$150 max	Not covered	30%, \$150 max	Not covered
Non-Preferred (Tier 3)	50%, \$400 max	Not covered	40%, \$200 max	Not covered	40%, \$200 max	Not covered
Preferred Specialty (Tier 4)	30%	Not covered	30%	Not covered	30%	Not covered
Mail Order Pharmacy (90 Day Supply) (90 Day at Retail is available as well)						
Generic (Tier 1)	\$37.50 copay	Not covered	\$25 copay	Not covered	\$25 copay	Not covered
Preferred (Tier 2)	40%, \$500 max	Not covered	30%, \$275 max	Not covered	30%, \$275 max	Not covered
Non-Preferred (Tier 3)	50%, \$800 max	Not covered	40%, \$500 max	Not covered	40%, \$500 max	Not covered
Preferred Specialty (Tier 4)	30%	Not covered	30%	Not covered	30%	Not covered

Virtual Visits and Mobile App

United
Healthcare

With 24/7 Virtual Visits, associates can conveniently connect to a doctor by phone or video for free through **myuhc.com** or the UnitedHealthcare app.



Connecting associates with 24/7 care, from virtually anywhere

Doctors can treat a wide range of health conditions, from flu and pinkeye to migraines and more, and can even prescribe medication as needed. 24/7 Virtual Visits may treat many of the same conditions as in-person urgent care, so it may be a good alternative option for associates – particularly in times when their primary care provider isn't available. No appointments are necessary, and 98% of needs are resolved. **Virtual visits are \$0 on the PPO medical plans!**



Activate your Myuhc.com account



Get the most out of your benefits

Your personalized website, myuhc.com, features tools designed to help you:

- **Find, price and save on care** – you can save with Virtual Visits and other tools. You can save an average of 36% when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7.
- **Understand your benefits** and the financial impact of care decisions.
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status.
- **Access claim details**, plan balances and your health plan ID quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills**, get estimates and compare medication pricing
- **Check your plan balances**, access financial accounts and more

Activation is quick



- 1 Go to **myuhc.com > Register Now**
- 2 Fill out the required fields and create your username/password
- 3 Enter your contact information and security questions
- 4 Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates.

TrueScripts Prescriptions

TrueScripts™
Amazing Care

KEEPING YOU CONNECTED

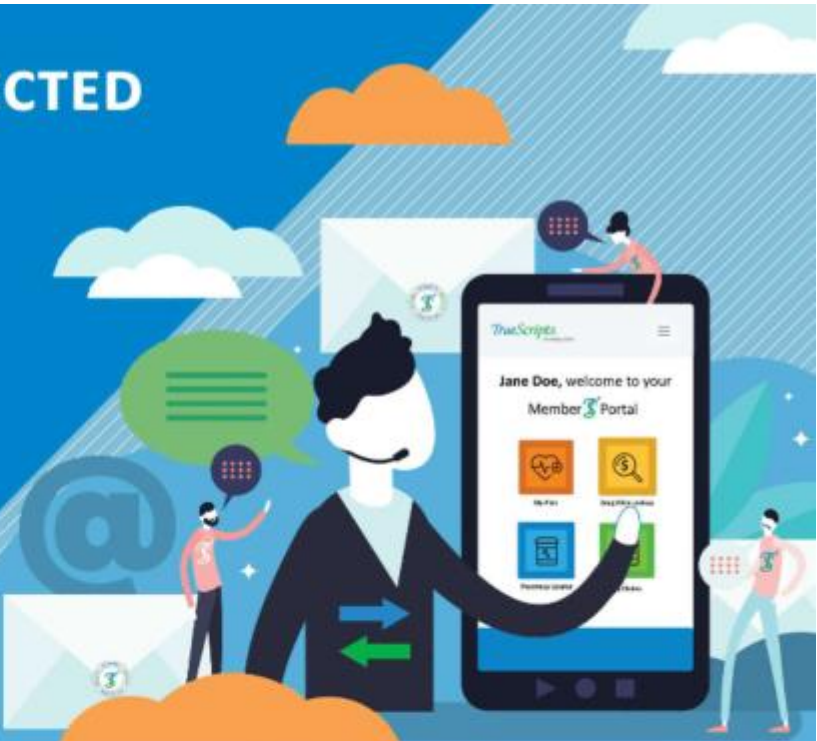
Member Portal

- Real-Time Drug Price Lookup
- Live Chat
- Pharmacy Locator
- Personal Plan Information & Claims History
- Additional Member Forms & Resources



Scan above
or
Enter below

memberportal.truescripts.com [Get Started!](#)



TrueScripts Members, follow these instructions to register:

- Enter the URL above into your web browser or click “Get Started” if viewing this document electronically. You can also scan the QR code from your mobile device to begin the registration process.
Note: You will not be able to register until on or after your effective date with TrueScripts.
- On the Member Portal landing page, choose ‘Register’ from the top navigation bar.



- Enter your personal information to complete the registration process.
**Note that you will need to have your Member ID card readily available*
- Check your email to verify and complete your account set-up.
- Once inside the portal, quickly access important information and helpful resources from your Member Dashboard. **Pro Tip:** The Drug Price Lookup tool will help you find the best price for your medications!



My Plan



My ID Card



My Claims



Drug Price Lookup



Pharmacy Locator

Get To Know Your Care Options

United
Healthcare

How much you pay for care can depend on where you get it. For serious or life-threatening conditions, call 911 or go to an emergency room. For everything else, it may be best to contact your PCP first. If seeing your PCP isn't possible, it's important to know your other care options, especially before heading to the emergency room.

START HERE

Care options to consider and approximate costs



PCP

Care from the doctor who may know you best



24/7 Virtual Visits

See a doctor whenever, wherever



Convenience Care

Basic conditions that aren't generally life-threatening



Urgent Care

Serious conditions that aren't generally life-threatening



Emergency Room

Life- and limb-threatening emergencies

Average cost

\$165

FREE

\$100

\$185

\$2,500

Hours

Varies by location

24/7

Varies by location

Varies by location – may be open nights/weekends

24/7

How to connect

Contact your PCP

myuhc.com/virtualvisits

myuhc.com

myuhc.com

myuhc.com

✓ Indicates the recommended place for care for the following common conditions

	PCP	24/7 Virtual Visits	Convenience Care	Urgent Care	Emergency Room
Broken bone				✓	✓
Chest pain					✓
Cough	✓	✓	✓		
Fever	✓	✓	✓		
Muscle Strain	✓		✓		
Pinkeye	✓	✓	✓		
Shortness of breath					✓
Sinus problems	✓	✓	✓		
Sore throat	✓	✓	✓		
Sprain	✓		✓	✓	
Urinary tract infection	✓	✓	✓		

Need to find a network provider or PCP?

Visiting an out-of-network provider could end up costing you more for care. To find PCPs, urgent care centers, and emergency rooms in your network, go to www.myuhc.com.

Not sure where to go for care? Call the number on your health plan ID card.

*Source 2020: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated \$2,315 difference between the average emergency room visit, \$2,500 and the average urgent care visit \$185.) This information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

**The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

Check your official health plan documents to see what services and providers are covered by your plan.

Dental



BGDC offers two dental plans through Guardian. With their PPO plans, benefits provided are a variety of covered services/procedures that allow you the flexibility to choose any licensed provider, in or out of network. Our plan uses their DentalGuard Preferred network.

Many people think they do not need dental coverage because their teeth are fine. However, if you want to keep your teeth healthy, getting regular check-ups is the way to go. The BGDC dental plans through Guardian provide coverage options for four main types of expenses:

1. Preventative and Diagnostic: Routine exams and cleanings, fluoride treatments, sealants, and x-rays.
2. Basic: fillings and extractions
3. Major: treatment such as crowns and dentures
4. Orthodontia (Enhanced Plan only)



All plans allow you to:

- Save on out-of-pocket expenses when you visit an in-network dental office
- Visit any dentist of your choice – select a different dentist for each member of your family
- Go to dental specialist of your choice

The plans provide the maximum benefit when you visit an in-network dentist. Guardian provides an extensive provider network with flexibility to see any dentist, in or out of network.

Dental Comparison

	Guardian Standard Dental Plan	Guardian Enhanced Dental Plan
	In and Out-of-Network Benefits*	In and Out-of-Network Benefits*
Annual Deductible		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum		
Annual Max Per Person	\$1,500	\$2,000
Services		
Preventive	Covered in Full	Covered in Full
Basic	20% after deductible	20% after deductible
Major	50% after deductible	50% after deductible
Orthodontia (adults and children up to age 26)		
Benefit Percentage	Not covered	50% up to \$2,000 Lifetime Max

*Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. Benefits are paid on "Reasonable and Customary" (R&C) rates for a given area, and providers can balance bill you for amounts over the R&C rate. R&C charges are based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by Guardian.

Download the mobile app or login online



Want to find a dentist near you? Go to www.guardianlife.com/find-a-provider and select the PPO: DentalGuard Preferred plan.

Vision



BGDC offers a vision plan through Guardian using Davis Vision's network. This network provides access to one of the largest networks of eye care professionals. You will enjoy low out-of-pocket costs, and access to top retailers including Costco Optical, Walmart, Sam's Club and Visionworks. Plans include the option to buy glasses using in-network benefits through online stores and a discount on LASIK, and additional savings on lens enhancements and certain other vision purchases.



Vision Comparison

	Guardian Vision (Davis Vision Network)	
	In-Network Benefits	Out-of-Network Benefits
Exams		
Routine Exams (once per 12 months)	\$20 copay	Up to \$50 allowance
Retinal Imaging	Up to \$39 copay	Applied to the exam allowance
Vision Materials		
Lenses (once per 12 months) • Single Vision • Bifocal • Trifocal • Lenticular	\$20 copay	Up to \$48 allowance Up to \$67 allowance Up to \$86 allowance Up to \$126 allowance
Lens Enhancements Add below enhancements at no cost when obtaining covered eyewear Transition Lenses Standard Polycarbonate Factory Scratch Coating	Allowances vary depending on options	Applied to the allowance
Contacts (in lieu of glasses benefit) (once per 12 months) Elective Conventional Lenses	\$120 allowance, then 15% off balance	Up to \$105 allowance
Elective Disposable Lenses Medically Necessary Lenses	\$120 allowance then 15% off balance Covered in full	Up to \$105 allowance Up to \$210 allowance
Frames (once per 12 months)	\$120 allowance, 20% off balance	\$48 allowance

Download the mobile app or login online



Want to find a vision provider near you? Go to www.guardiananytime.com/fpapp/vision and select the Davis Vision network.

Health Savings Account (HSA)



Health Savings Account Overview

A Health Savings Account (HSA) is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses with pre-tax dollars. The Health Savings Account (HSA) and any funds in it are yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” rule; while there is an annual maximum contribution limit as noted below, there is no overall balance limit. If you don’t spend your dollars in a particular year your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free
- You don’t pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse’s PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person’s tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse’s FSA. (Enrollment in a limited purpose health care FSA is allowed).



2026 HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions for the 2026 tax year:

- \$4,400 Individual / \$8,750 Family
- If you are age 55 and over, you may contribute an extra \$1,000 catch up contribution
- **BGDC will make the below annual contributions for 2026 to your HSA:**
 - **\$1,000 for Employee Only**
 - **\$2,000 for Employee and Spouse**
 - **\$2,000 for Employee and Child(ren)**
 - **\$2,000 for Family**
- Employer contributions will be deposited on the following timeline: 50% on January 1 and 50% as a dollar-for-dollar match per pay based on your contributions
- **The combination of employee and employer contributions cannot exceed the annual IRS maximum amounts listed above**



How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense (see link below). Or you can pay your physician or yourself back through the online portal or mobile app. There's no need to turn in receipts (but keep them for your records). You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. For additional assistance, please go online or call Chard Snyder directly.

Keep Your Money

Unlike an FSA, the money in your HSA is always yours to keep and can be rolled over from year to year. You can take your unused balance with you when you retire or leave BGDC Distribution.

Invest In Your HSA Savings

Investing your HSA now allows you to be better prepared for future healthcare and retirement expenses. Your invested HSA funds grow tax free and remain tax free when you use them to pay for eligible healthcare expenses. You can also use your HSA as a long-term retirement investment option. After the age of 65, your HSA funds can be used for any non-healthcare expenses.

Your HSA Advantage account offers self-directed mutual fund investments to help you grow your healthcare savings for future needs. Easily manage your account from the Chard Snyder Mobile App or your online account.



Health Savings Brokerage Account

Along with your Chard Snyder HSA account, there is an opportunity for more targeted, strategic investment of your HSA dollars for retirement savings with Charles Schwab.

- Easy online enrollment into a Charles Schwab individual brokerage account through partnership with Healthcare Bank through Chard Snyder
- Investment choices from HSA-eligible mutual funds stocks, bonds, exchange-traded funds, fixed-income investments and money market funds
- Integrated online portal for 24/7 account management
- Ability to view balance and transaction details and personally manage HSA investments, including transfers, trading, and portfolio allocation monitoring
- Monthly account statements, trade confirmations, and regulatory materials sent via email or online paperless option
- Learn more about the investment options at the [Chard Snyder Health Savings Account Brokerage page](#)

Never pay taxes

Contributions are made on a before-tax basis, and your withdrawals will never be subject to federal income taxes when used for eligible expenses. Any interest or earnings on your HSA balance build tax-free, too.*

You can learn more at Chard Snyder's [HSA page](#).

*Money in an HSA grows tax-free and can be withdrawn tax-free if it is used to pay for qualified healthcare expenses (for a list of eligible expenses, see IRS Publication 502, available at www.irs.gov). If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn plus a 20% penalty tax if you withdraw the money for ineligible expenses before age 65. After age 65, withdrawals for ineligible expenses are only subject to ordinary income tax. Please review your state regulations as you may have to pay state taxes depending on your residency.



Looking for more information?

Click on the video icon to watch the attached educational video or go to:
<https://fast.wistia.net/embed/iframe/narmv3kr4s?seo=false>

Flexible Spending Account (FSA)



A Flexible Spending Account is a special type of account you and your employer put money into to pay for certain out-of-pocket health care expenses. Your contributions to this account are not taxed so you will save the amount that would have been paid in taxes on this money.

BGDC provides both a Healthcare and Dependent Daycare FSA through Chard Snyder, a division of Ascensus. Chard Snyder offers you several ways to use the money in your FSA. For both healthcare and dependent care expenses, you can pay your provider directly online using the Chard Snyder Mobile App or your online account. For healthcare expenses, you can use the debit card to pay providers at the point of service.

Am I eligible?

Full-time associates are eligible for the flexible spending accounts. Associates enrolled in the HDHP plan who are contributing to the Health Savings Account are eligible for the limited purpose healthcare FSA as outlined below.

What Are Flexible Spending Accounts?

Flexible spending accounts, or FSAs, allow you to set aside pre-tax money and use it to reimburse yourself for certain types of expenses. Since the money you set aside in an FSA reduces the income tax you pay each year, it's like getting a discount on those expenses. There are three types of FSAs:

1. The **Healthcare FSA** lets you set aside up to \$3,400 per year for eligible medical, prescription, dental and vision expenses not paid by your insurance plans, like copayments, coinsurance and deductibles.
2. The **Dependent Care FSA** lets you set aside up to \$7,500* per year (on a pre-tax basis) for reimbursement of eligible dependent care expenses. (If you are married and file a separate income tax return, the limit you can contribute is \$3,750 per year).
3. The **Limited Purpose Healthcare FSA** only reimburses you for **eligible dental and vision expenses**. You may contribute up to \$3,400 per year to this account.

You may want to consult your tax advisor to see if these accounts make sense for your situation.

How Do I Use the Healthcare FSA?

Below are examples of eligible medical expenses you can pay with the health care FSA:

- Copayments or deductibles under the medical plan (or similar expenses from your spouse's medical plan if you are covered under your spouse's plan)
- Non-covered vision plan expenses (co-pays and other out-of-pocket expenses)
- Non-covered dental plan expenses (co-pays, deductibles and other out-of-pocket expenses)
- Out-of-pocket costs for prescription drugs
- Other expenses which would qualify as a medical deduction on your tax return
- Certain over-the-counter medicines with a prescription from your doctor

Eligible Expenses

Healthcare FSA	Dependent Daycare FSA
• Most out-of-pocket medical expenses • Prescription/over-the-counter medications • Dental/vision expenses • Fertility treatment • Maternity Charges • And more	• Day care • After-school Programs • Elder Care • Nanny/babysitter expenses • Preschool/nursery school • And more

To see a complete list of eligible expenses, please visit the Chard Snyder [resource library](#).



The account cannot be used to reimburse some types of expenses, such as:

- Non-medically supervised programs to help you lose weight
- Non-medically necessary cosmetic surgery
- Non-prescription sunglasses
- Teeth bleaching
- Funeral expenses
- Any expense not considered "medically necessary" by the IRS



What if I Don't Use All the Money in my FSA?

You should plan carefully before deciding how much money to put into an FSA so that you don't lose any unused funds at the end of the calendar year.

- You can roll over up to \$680 in unused money from either the health care FSA or the limited purpose FSA from one calendar year to the next.
- Any additional unused money is forfeited.
- **You cannot roll over any unused money from the dependent care FSA at the end of the calendar year. It's strictly a "use it or lose it" account.**

Chard Snyder Benefit Card

If you enroll in the Healthcare or Limited Purpose Healthcare FSA, you will receive a debit card to use when paying for services you receive, if you choose. It works just like a typical debit card, except that it should only be used for qualifying expenses such as those listed above.

The Chard Snyder Benefit Card provides an easy, convenient way to use your FSA funds to pay for eligible items and services. You will receive a debit card to use when paying for services you receive. It works just like a typical debit card, except that it should only be used for qualifying expenses such as those listed above. **The Chard Snyder Benefit Card is only to be used for your Healthcare FSA not your Dependent Care FSA.**



The Chard Snyder Benefit Card

- Convenient way to pay for eligible expenses directly from your FSA
- Works like a debit card
- Connect with your mobile wallet for contactless payments
- Your card is valid for 5 years
- Save your receipts

You may use your card until the expiration date shown on the front. You will receive new cards just before your current card expires.

If you select the full or limited Healthcare FSA for the first time, you will receive a new debit card good for 5 years.

If you enroll in the HSA for 2026 and have funds left in your Healthcare FSA as of December 31, 2025, that money will automatically be rolled over into the Limited Purpose FSA (dental and vision expenses only) according to IRS rules.

Not Sure How to Spend Your FSA Money?

Visit the Chard Snyder FSA Store for the largest selection of FSA-eligible products

Visit **FSAstore.com/FlyerCHARD**
for the largest selection of guaranteed FSA-eligible
products with zero guesswork.

Get \$5 off with code, FCCHARD5.
One use per customer.



Chard Snyder Mobile App and Web Portal

You can log on to the Chard Snyder participant portal to access a variety of features related to your FSA accounts.

Participant Portal

- Sign up for direct deposit
- Monitor balances
- And many others



chard.lh1ondemand.com/Login

You can also download the Chard Snyder mobile app and access most of the same features.

Mobile App Features:

- Submit claims with receipt images using your phone's camera
- View account balances and transaction details
- Enable Face ID or Touch ID for easy, secure access
- Catalog past and current receipts using your phone's camera
- Scan any product for eligibility using your phone's camera

Things to Remember

- While the Healthcare FSA allows you to roll over up to \$680 for the next plan year, the Dependent Daycare FSA is a use it or lose it benefit, therefore, no rollover is permitted.
- While calculating how much to contribute, estimate carefully and conservatively.
- You must re-enroll every year during open enrollment
- The IRS allows for various tax credits for healthcare and dependent care expenses.
- You may not participate in an FSA if you are taking medical expense deductions on your annual tax return.



The Chard Snyder Mobile App



Manage
your FSA
on the go,
anywhere,
anytime



You must enroll in your FSA each year if you want those dollars available. Your election in 2025 does not copy over into 2026!



Looking to contact Chard Snyder?
Visit www.chard-snyder.com or call 513-459-9997

Company Paid Benefits



BGDC provides the below benefits to eligible Associates through Guardian. These benefits are provided at no cost to you.

Basic Term Life and AD&D

We know life insurance is an important part of your financial well-being and security, especially if you have others that depend on you. Even if you are single, your beneficiary can use your life insurance to pay off any outstanding debts and other expenses you may leave behind. AD&D insurance provides you and or your beneficiary with coverage in the event of accidental death or dismemberment.

Age reductions apply for the Associate (35% reduction at age 65, 60% reduction at age 70, and 75% at age 75).

Coverage	Full Time Benefit
Basic Life and AD&D	1 times base pay up to \$1,000,000

Coverage	Full Time Union Benefit
Basic Life	Flat \$15,000
Basic AD&D	Flat \$20,000

Short-Term (STD) and Long Term (LTD) Disability

BGDC wants to protect you and your family against unexpected risks like a loss of income due to disability. That is why we will automatically enroll you in Short and Long-Term Disability coverage to help replace your paycheck if you are unable to work.

Coverage	Benefit
Short-Term Disability	Covers 60% of weekly base pay up to \$1,000 per week for 90 days, beginning on the 8 th day of injury or sickness
Long-Term Disability	Covers 50% of monthly base pay up to \$10,000 max benefit, beginning after 90 days of disability



Voluntary Benefits



In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional Supplemental Life insurance and other benefits to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc.

Supplemental Term Life and AD&D Insurance

You may purchase additional life insurance with Guardian if you want more coverage. You may purchase coverage for yourself, your spouse, and any dependents. You must purchase coverage for yourself if you are going to purchase coverage for your spouse or dependents. Your contributions will depend on your age and the amount of coverage you elect. Age reductions apply for the Associate but not for the spouse.

The Supplemental AD&D benefit pays you benefits if you suffer a covered accident that results in paralysis or the loss of a limb, speech, hearing or sight, third degree burn, brain damage or coma. If you suffer a covered fatal accident, benefits will be paid to your beneficiary. Your Supplemental AD&D amount will be equal to the Supplemental Term Life amount you elect.

There will be a true open enrollment on the Supplemental Life and AD&D for 2026, allowing associates and spouses to enroll up to the Guarantee Issue without answering health questions for 2026. If you or your spouse have a chronic or acute health condition that may typically cause a life insurance denial, this is an important opportunity for you to elect up to the Guarantee Issue amounts.

Coverage	Benefit
Associate	From \$20,000 to \$1,000,000 in \$10,000 increments (not to exceed 5x base pay) \$300,000 guaranteed issue when first eligible as a new hire
Spouse (based on Associate age)	From \$5,000 to \$250,000 in \$5,000 increments (up to 100% of the Associate amount) \$50,000 guarantee issue when first eligible as a new hire
Dependent children	From \$2,000 to \$10,000 in \$2,000 increments (election and rate covers all family children from 14 days to 26 years) \$10,000 guarantee issue when first eligible as a new hire



Voluntary Benefits (continued)

CHUBB®

BGDC has partnered with Chubb Insurance for the Critical Illness, Accident and Hospital Indemnity plans. If you currently have these coverages, they will move over automatically unless you communicate to the Enrollment Call Center team that you wish to terminate or change them.

Hospital Indemnity Plan

An unexpected hospital stay can be expensive as you meet your deductible and out-of-pocket obligations under the medical plan. That is why we are offering a Hospital Indemnity Plan that works in conjunction with your medical plan to provide financial protection by paying you a direct benefit due to a hospitalization. This plan includes:



Coverage	Benefit
Admission Benefit	\$1,500 for up to 4 admissions per calendar year \$1,500 additional ICU Supplemental Admission (paid concurrently with the Admission benefit when a covered person is admitted to the ICU)
Confinement Benefit	\$100 per day for up to 30 days per calendar year \$200 per day additional ICU Supplemental Confinement (paid concurrently with the Admission benefit when a covered person is admitted to the ICU)
Confinement Benefit for Newborn Nursery Care	\$75 per day for up to 2 days per routine delivery and 4 days for caesarean delivery for Newborn Nursery Care
Maternity Follow-up Benefit	\$50 for up to 3 maternity follow-up visits per childbirth

- Children are eligible for coverage up to age 26.
- There are no pre-existing condition limitations on this plan.
- Childbirth is considered a covered sickness.

Accident Insurance

As you are aware, accidents happen. Even though our medical plan provides coverage when you seek medical assistance due to an accident, there will likely be some out-of-pocket expenses. This benefit provides coverage option for you, your spouse, and your dependent children that is designed to help you pay for high, out-of-pocket costs that can accumulate as a result of an accident that occurs off the job. Coverage provides a direct cash benefit that supplements your medical insurance. Below is a partial list of reimbursements for specific accident-related expenses.



Coverage	Benefit
Fracture Benefit	Up to \$10,000 depending on the fracture and type of repair
Concussion Benefit	\$500
Coma Benefit	\$10,000
Broken Tooth Benefit	Crown: \$300 / Extraction: \$150 / Dentures: \$300 / Implants: \$300
Ambulance Benefit	Ground: \$400 / Air: \$1,250
Emergency Care Benefit	\$100 to \$200 depending on location of care
Emergency Physician Follow-up Visit Benefit	\$100 (3 per year)
Surgical Repair Benefit	\$200 to \$2,000 depending on the type of surgery
Therapy Benefit	\$50 per visit up to 10 visits per accident
Hospital Admission Benefit	\$1,500 for the day of admission / \$3,000 for ICU admission
Accidental Death Benefit	\$50,000 for Associate, \$25,000 for spouse and \$10,000 for children
Sporting Activity Injuries Benefit	This rider increases the amount payable by 25% for injuries resulting from an accident that occurs while participating as a player in an organized sports activity. \$1,000 per person per year limit. Please review the rider language for terms, conditions and limitations.

- Children are eligible for coverage up to age 26.
- There are no pre-existing condition limitations on this plan.

Voluntary Benefits (continued)

CHUBB®

Group Critical Illness Insurance

The Critical Illness plan pays a lump sum benefit based on the amount of coverage in effect on the date of diagnosis or treatment if you or someone in your family develops a serious illness. While the medical plan covers many of the immediate costs you may encounter, this plan helps with additional expenses not covered by the plan. Children are covered automatically at 25% of the associate benefit. Some diagnoses include an additional benefit for Recurrence. Rates are age-banded based on the Associate age and depend on Tobacco Use status of the Associate.



Coverage	Initial Benefit
Benefit Amounts	Associate: \$5,000 up to \$30,000 Spouse/Domestic Partner: 50% of Associate amount Children: 25% of Associate benefit amount
Cancer	Cancer except skin cancer – 100% Benign Brain Tumor – 100% Breast Cancer Carcinoma In Situ – 100% Carcinoma In Situ – 25% Skin Cancer – \$250 (once per covered member per year)
Cardiovascular Disease	Coronary Artery Bypass (CAB) – 50%
Childhood Disease	Autism Spectrum Disorder – 100% of dependent amount Cerebral Palsy – 100% of dependent amount Cleft Lip or Cleft Palate – 100% of dependent amount Congenital Birth Defects - 100% of dependent amount Cystic Fibrosis – 100% of dependent amount Diabetes (Type 1) – 100% of dependent amount Down Syndrome – 100% of dependent amount
Functional Loss	Coma – 100% Loss of ability to speak, hearing, or sight – 100% Paralysis of 2 or more limbs
Heart Attack	Full Heart Attack – 100% Sudden Cardiac Arrest – 50%
Infectious Disease	Bacterial Cerebrospinal Meningitis – 25% Diphtheria – 25% Legionnaire's Disease – 25% Malaria – 25% Necrotizing Fasciitis – 25% Osteomyelitis – 25% Rabies – 25% Tetanus – 25% Tuberculosis – 25%
Kidney Failure	Kidney Failure – 100%
Major Organ Transplant	100%
Progressive Disease	ALS – 100% Alzheimer's Disease – 100% Multiple Sclerosis – 100% Parkinson's Disease – 100% Systemic Lupus Erythematosus (SLE) – 100%
Severe Burn	Severe Burns – 100%
Stroke	Strokes – 100%
Health Screening Benefit	\$75 one time per calendar year for each covered member (30 day waiting period)

- Children are eligible for coverage up to age 26.
- There are no pre-existing condition limitations on this plan.

Voluntary Benefits (continued)



Legal Protection Program

The LegalEASE program offers a variety of services to address multiple legal and personal needs like elder care issues, divorce and custody issues, estate planning needs, civil lawsuits and financial matters assistance.

The plan covers the Associate and all family members at one monthly rate of \$20.45. Telephone and office consultations are available for an unlimited number of personal legal matters with an attorney of their choice. For non-covered matters that are not otherwise excluded, this benefit provides four (4) hours of network attorney time and services per year.



The LegalEASE legal network includes over 21,500 attorneys in all 50 states. The highest level of services are provided when you see an in-network attorney. Out of network attorney services are reimbursed according to a set fee reimbursement schedule.

Coverage	Partial List of Covered Services/Situations		
Family	• Child Custody • Child Support • Conservatorship • Contested Divorce	• Name Change • Post Divorce Proceedings • Domestic Violence • Immigration Assistance	• Juvenile Court & Scholl Admin. Proceedings • Prenuptial Agreements • Adoption
Home & Real Estate	• Purchase/Sale of Primary Residence • Home Equity Loan	• Tenant Dispute • Neighbor Dispute • Property Tax	• Zoning Application • Boundary or Title Dispute • Landlord Dispute
Estate Planning	• Simple Will • Complex Will	• Living Will • Living Trust	• Healthcare Power of Attorney • Probate of Small Estate
Financial Benefits	• Debt Collection Defense • Bankruptcy • Foreclosure	• Garnishment Defense • Tax Audit • Tax Defense	• Student Loan Refinancing • Student Loan Collection Defense • Repossession Defense
Civil Lawsuits	• Civil Litigation Defense	• Discounted Contingency Fees	• Incompetency Defense
Elder-Care Issues	• Elder Law Matters • Will Preparation	• Living Will or Advance Directive • Financial Power of Attorney	• Medical Power of Attorney
Traffic & Other Matters	• Traffic Ticket • Vehicle Repair & lemon Law	• Serious Traffic Matters Administration Proceedings	• DUI Defense

Voluntary Benefits (continued)



ID Theft Protection Program

We do more online than ever – from banking, shopping and even socializing – making personal information more vulnerable to cyber threats. Norton LifeLock helps protect your identity, finances, and privacy with powerful tools and support.

Whether you choose Essential, Premier, or Premier Plus, you'll gain peace of mind knowing your personal information is being monitored and protected. Norton LifeLock helps ensure your personal information is not anywhere it shouldn't be by protecting the things you care about most: identity, money and assets, family, and privacy.

Associates have three pricing options to select from:

Essential	Includes 1 Bureau monitoring, up to 3 protected devices, and 10 GB of PC Cloud backup		 Take Back Control of Your Identity Your personal data is everywhere— from doctor's offices to mobile apps. Norton LifeLock Benefit Plans help prevent fraud, block scams, monitor activity, and strengthen your financial wellbeing. Get Protection Now  Protect Your Well-Being from Every Angle  Fraud Detection Monitor identity and finances to detect identity fraud early.  Identity Restoration Get peace of mind with expert help if your identity is compromised.  Threat Prevention Block scams and cyberthreats to protect your data and devices.  Enhanced Privacy Remove your personal details from data broker sites and enjoy a safer, more private internet experience.  Financial Insights Gain financial insights into your credit, spending, and income. Available this Winter  Scam Detection Built-in AI assistant helps you navigate suspicious websites and SMS messages, and offers advice if you think you're being scammed.	
	Individual Coverage	\$7.49/month		
Premier	Includes 3 bureau monitoring, up to 5 protected devices, and 50 GB of PC Cloud backup			
	Individual Coverage	\$9.99/month		
Premier Plus	Family Coverage	\$14.98/month		
	Includes 3 bureau monitoring, up to 10 protected devices, and 500 GB of PC Cloud backup			
	Individual Coverage	\$12.99/month		
	Family Coverage	\$21.98/month		

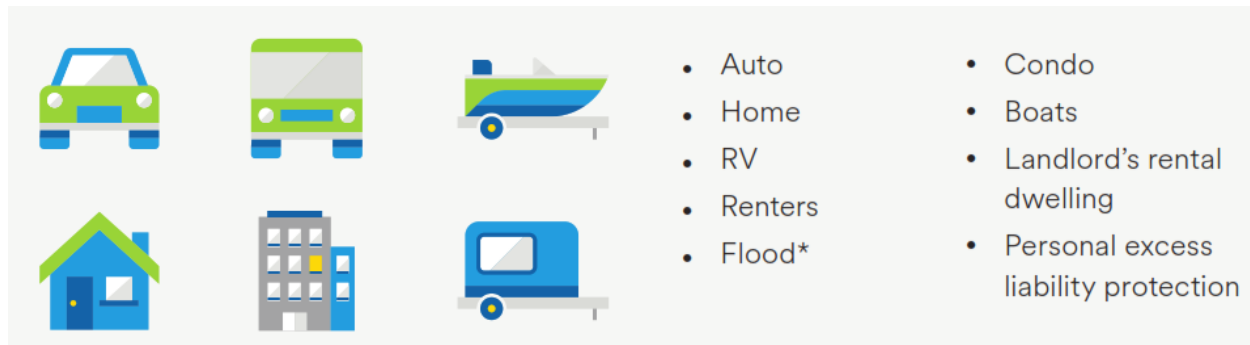
Voluntary Benefits (continued)



Auto/Homeowners

Just like medical, premiums and out-of-pocket expenses for auto and home insurance are going up. From auto accidents to natural disasters, there has been an increase in the severity and frequency of incidents. And without the right coverage, an accident or storm can be devastating to your financial wellbeing. With Farmers GroupSelectSM Auto & Home, you can have access to the protection you need to stay prepared for the unexpected. And the support you need to get back on track. You can request a quote and enroll at 800-438-6381 or visit myautohome.farmers.com.

Associates save an average of \$562 on auto insurance when you switch to Farmers Insurance because when you purchase your Auto/Homeowners coverages through this employer-sponsored program, you get access to valuable group discounts.



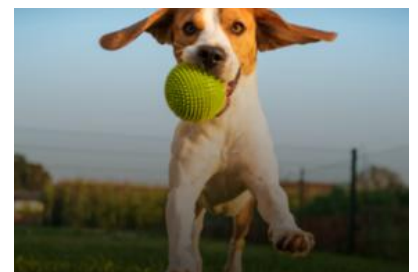
Pet Insurance



HealthyPaws Pet insurance helps to reimburse you for covered unexpected veterinary expenses for your furry family members. This will help to give you confidence that you can pay for treatment for your pets if they become sick or have an accidental injury. With HealthyPaws, you have the power of choice, and coverage can be customized to best meet your and your pets' needs. Once the policy is effective, accident coverage begins at midnight and illness coverage begins after 14 days. Every pet and pet parent is unique, so each pet's premium will be unique based on the species, breed, age, and ZIP code, as well as the coverage amount you select. You can call 844-260-7911 or visit the HealthyPaws website [here](http://healthy.paws.com) at any time during the year to request a quote and enroll in Pet Insurance.

Flexible features

- Pet parents can select from a range of annual limits, deductibles and coinsurance levels.
- Various levels of coverage from \$100 – \$1,000. Also includes optional wellness coverage (preventive care).
- Straightforward pricing and options with customizable limits, no dog or cat breed exclusions, discounts and healthy pet incentive, and no upper age limits.
- New and innovative benefits, such as grief counseling for the loss of your furry family member, loss or theft coverage, automatic coverage limit increases annually and virtual vet concierge services.



CHUBB®

Chubb Lifetime Benefit Term Insurance

BGDC is partnering with Chubb to give you the option to buy Permanent Term Life Insurance at an affordable fixed premium. This product has premiums that are guaranteed to never increase, and a level death benefit to provide money to your family upon death, and while you are living too. It also provides money if you need home health care, assisted living, or nursing care, through a unique Long Term Care rider. This coverage is offered to all Associates ages 18-70 and is portable if you ever leave BGDC.

If you want to enroll in the Chubb Whole Life with Long Term Care product please call the Enrollment Call Center during open enrollment.

Employee Assistance Program (EAP)



Guardian's EAP is available to you in addition to the benefits provided with your Guardian insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life – at no additional cost.

The program offers counseling, legal and financial consultation, work-life assistance and crisis intervention services to you and your household family members. They can talk to you about anything going on in your life including:

- Family – going through a divorce, caring for an elderly family member, returning to work after having a baby
- Work – job relocation, building relationships with coworkers and managers, navigating through reorganization
- Money – budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- Legal Services – issues relating to civil, personal and family law, financial matters, real estate and estate planning
- Identity Theft Recovery – ID theft prevention tips and help from a financial counselor if you are victimized
- Health – coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- Everyday Life – moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet



What happens when I call?

When you call, you will speak with a GuidanceConsultantSM, a master's- or PhD-level counselor who will collect some general information about you and will talk with you about your needs. The GuidanceConsultantSM will provide the name of a counselor who can assist you. You can then set up an appointment to speak with the counselor over the phone or schedule a face-to-face visit.

What counseling services does the EAP provide?

3 face-to-face or virtual sessions per person, per issue, per year

The EAP provides free short-term counseling with counselors in your area who can help you with your emotional concerns.

If the counselor determines that your issues can be resolved with short-term counseling, you will receive counseling through the EAP. However, if it is determined that the problem cannot be resolved in short-term counseling in the EAP and you will need longer-term treatment, you will be referred to a specialist early on and your insurance coverage will be activated.

Can my children use the EAP?

Yes. The EAP is a confidential benefit for employees and their household family members.

This program includes up to three (3) in person, phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. You can call 855-239-0743 to speak with a counselor or schedule an appointment 24/7/365. When you call, a Guidance Consultant will collect general information about you and your needs. Then they will connect you with a counselor who can assist you.

If you do not need to speak to a counselor, and are just looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a counselor to guide you to the information you are looking for or help you schedule an appointment.

Any personal information provided to a Guidance Consultant or counselor stays completely confidential based on HIPAA privacy laws.

Log on to guidanceresources.com or search "GuidanceNow" on iTunes Store or Google Play. Use the Web ID below to register for an account.

Web ID: Guardian

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward.

Guidance Resources can help you and your family get professional support and guidance to make life a little easier. The EAP program provides you with easy-to-use services to help with the everyday challenges of life – at no additional cost to you.

Wellworks



EARN UP TO \$600 IN REWARDS!

You will need to complete the Wellness Program activities to be eligible to redeem Wellness Dollars in the Wellworks For You Rewards Mall.

Log in to your portal today to learn more!

In the Rewards Mall, you may choose from a variety of reward cards including your favorite restaurant and retail stores! You may also choose to redeem your Wellness Dollars to make a donation to a designated charity of your choice.

ACTIVITY	INCENTIVE
Biometrics + the Know Your Number Assessment	\$200
Annual Physical w/Doctor Signature	\$200
Preventive Age/Gender Exam (1 per year)	\$100
Dental Exam (1 per year)	\$50
Vision Exam (1 per year)	\$50

PORTAL LOGIN INSTRUCTIONS

Your Account Has Been Created for You!

1. Go to www.wellworksforyoulogin.com
2. Your username will be:
BGDC + Employee ID
Example: BGDC123456
3. Password: Your DOB in MMDDYYYY
4. Accept the terms of the Consent Form
5. Fill in the required information

Forgot Your Username or Password?

1. Go to www.wellworksforyoulogin.com
2. Click the link **Forgot Username** or **Forgot Password**
3. Follow the instructions to retrieve your username or reset your password
4. If issues persist, please contact Wellworks For You at **800.425.4657**



FOR ADDITIONAL SUPPORT, CHAT WITH US LIVE ON THE WELLNESS PORTAL

(not available on the mobile app)

Our "Chat Live" feature will give you access to chat with one of our helpful representatives during our regular business hours (Monday to Friday 8:00am EST to 7:00pm EST) to answer any questions and guide you on a path towards wellness.

Utopia WellCare



Utopia WellCare is a program that allows you to access nutrition counseling services with Registered Dietitians. Through your health plan, this program offers you 6 free sessions to learn more about your health and nutrition.

The program applies a functional nutrition approach to help with any health issue, such as diabetes, high cholesterol, high blood pressure, weight control, and pain management.

You can schedule an appointment at www.utopiawellcare.com.

Some conditions they address are:

- Mood regulation
- Stress and anxiety
- Body composition
- Cardiovascular issues
- Endocrine imbalances
- Kidney imbalances & cancer
- Autoimmunity
- Allergies and environmental exposures
- Gastrointestinal disorders



While the 1 on 1 consultations are only available to associates and dependents on the insurance plan, Utopia WellCare also offers resources to all associates at BGDC. Utopia WellCare sends monthly education emails that offer tips and tricks on nutrition and wellness. They have group programs and challenges on a variety of different wellness topics to encourage community, motivation, fun, and high-quality results. The Utopia WellCare App is available to you to help drive continuous engagement and patient support.

Improving employee wellness through a registered dietitian telehealth network



It's Free for Employees

Step 1

Schedule

Patients schedule their visits online

Step 2

Consult

Patients connect virtually to a qualified registered dietitian

Step 3

Thrive

Patients achieve goals and improve health outcomes

Level2 Diabetes Specialty Care

level2

Work to improve type 2

Here's the Level2 experience:



Insights

Learn about glucose starting with a continuous glucose monitor at no extra cost and find out what works.



Care Team

Made up of providers, coaches, dietitians and other experts as guides through Level2.



Level2 Method

A defined process to understand and work to improve glucose control in a series of phases.

Diabetic health plan members can receive a **free continuous glucose monitor (CGM)** when they engage with the Level2 program!

It's already included in the health plan at no extra cost.

Learn more and join at

mylevel2.com/care

Or call

1-844-302-2821 (TTY 711)



Your participation in Level2 Specialty Care is not a guarantee that you will improve your type 2 diabetes, and Level2 does not guarantee any individual any specific results. Please discuss with your doctor whether Level2 is right for you. You have received this information because you may be eligible to participate in Level2 through your current health plan based on the information we have. Participation in Level2 Specialty Care and getting a continuous glucose monitor (CGM) are subject to certain health plan and clinical eligibility criteria. Level2 is available to eligible members of select UnitedHealthcare plans at no additional charge outside of payment of their plan premium. Qualified members are prescribed a CGM when they join Level2 Specialty Care. See program details at mylevel2.com. Health coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. The company does not discriminate on the basis of race, color, national origin, sex, age or disability in health program activities. To contact your health plan administrator, please call the number on the back of your health plan member ID card.

Important Contacts

Have Questions? Need Help?

During open enrollment, the Benefit Counselors will be able to help answer all questions related to coverage options and pricing. You will need to contact Farmers Insurance directly for proposals on the Home & Auto, and you will need to call HealthyPaws directly for proposals for Pet Insurance.

Please note that if you are enrolling in any benefits for the first time, you will not be able to register for the carrier portals and mobile apps and view your individual information until January 1st. Until then the carriers will only be able to answer generic questions regarding providers and coverage.

	CARRIER	PHONE NUMBER	WEBSITE
Benefit Resource Center (BRC) for benefits questions	USI	855-874-0829	BRCMidwest@usi.com
Medical	UHC	Call number on back of ID card or 866-414-1959	myuhc.com
Dental	Guardian	800-541-7846	guardianlife.com
Vision	Guardian	877-393-7363	Davisvision.com
Basic Life and AD&D	Guardian	800-525-4542	guardianlife.com
Voluntary Life and AD&D	Guardian	800-525-4542	guardianlife.com
Short-Term Disability (STD)	Guardian	800-268-2525	guardianlife.com
Long-Term Disability (LTD)	Guardian	800-538-4583	guardianlife.com
Critical Illness	Chubb	833-896-2968	chubb.com/workplacebenefitsclaims
Hospital Indemnity	Chubb	833-896-2968	chubb.com/workplacebenefitsclaims
Accident	Chubb	833-896-2968	chubb.com/workplacebenefitsclaims
Flexible Spending Account (FSA)	Chard Snyder	800-982-7715	chard-snyder.com
Health Savings Account (HSA)	Chard Snyder	800-982-7715	chard-snyder.com
Auto/Homeowners	Farmers Insurance	Quotes: 800-438-6381 Service: 800-422-4272 24/7 Claims: 800-854-6011	Quotes: myautohome.farmers.com Service: farmers.com/autohomelogin
Pet Insurance	HealthyPaws	844-260-7911	www.healthypawspetinsurance.com/quote/step1
Legal Plan	LegalEase	1-800-248-9000	Legaleaseplan.com/lpgd
Identity Theft Protection	Norton LifeLock	800-607-9174	My.norton.com
Whole Life with Long Term Care	Chubb	855-241-9891	chubb.com
Employee Assistance Program (EAP)	Guardian	855-239-0743	guidanceresources.com
Wellworks	UHC	800-425-4657	wellworksforyou.com
Utopia WellCare	UHC	724-407-1500	utopiawellcare.com
Level2 Specialty Care	UHC	844-302-2821	mylevel2.com/our-approach/
Enrollment Support			
Enrollment Call Center		888-260-8082 Monday – Friday 9am-6pm ET	If you want to make any benefit changes for 2026 please call the Enrollment Call Center by October 31, 2025.

BGDC Distribution, LLC.

Important Legal 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 page 10 for more details.

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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:

HDHP Plan: Deductible (Individual/Family) - \$5,000/\$10,000; Out of Pocket Maximum - \$7,500/\$15,000

Basic Plan: Deductible (Individual/Family) - \$5,850/\$11,700; Out of Pocket Maximum - \$7,350/\$14,700

Standard Plan: Deductible (Individual/Family) - \$2,500/\$5,000; Out of Pocket Maximum - \$5,000/\$10,000

Enhanced Plan: Deductible (Individual/Family) - \$1,500/\$3,000; Out of Pocket Maximum - \$2,500/\$5,000

NEWBORNS ACT DISCLOSURE – FEDERAL

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).

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 (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 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

ADA NOTICE REGARDING WELLNESS PROGRAMS

Wellworks is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of wellness dollars for completing activities such as a physical and preventive visit. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive wellness dollars.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and BGDC Distribution may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellworks will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a registered nurse, doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Wellworks.

HIPAA WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Wellworks and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Lindsay Myers
3800 Garman Road, Salem, VA 24153
540-529-8342
lindsay.myers@bgdcdistribution.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.***

Contact information for questions or complaints is available at the end of the notice.

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, usually 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.

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 up to 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 at the end of this notice.
- 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/hipaa/filing-a-complaint/index.html.
- 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.

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.

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.

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/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

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

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date: 1/1/2026
- Privacy Official: Lindsay Myers, Director of Human Resources

Important Notice from BGDC Distribution, LLC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BGDC Distribution 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. BGDC Distribution has determined that the prescription drug coverage offered by the UHC Medical Plans for the plan year 2026 are, 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.

UHC High Deductible Health Plan		
	In-Network	Out-of-Network
Retail Pharmacy (30 Day Supply)	Pharmacy Accumulates to Your Deductible & Medical Out-of-Pocket Maximum	
All Tiers of Prescriptions	20% after ded.	40% after ded.
Mail Order Pharmacy (90 Day Supply) (90 Day at Retail is available as well)		
All Tiers of Prescriptions	20% after ded.	40% after ded.

	UHC Basic Plan		UHC Standard Plan		UHC Enhanced Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail Pharmacy (30 Day Supply)						
Annual Pharmacy Out of Pocket Maximum (Single / Family)	None – included with your Medical OOP Maximum		Individual: \$2,500 Family: \$5,000		Individual: \$2,500 Family: \$5,000	
Generic (Tier 1)	\$15 copay	Not covered	\$10 copay	Not covered	\$10 copay	Not covered
Preferred (Tier 2)	40%, \$250 max	Not covered	30%, \$150 max	Not covered	30%, \$150 max	Not covered
Non-Preferred (Tier 3)	50%, \$400 max	Not covered	40%, \$200 max	Not covered	40%, \$200 max	Not covered
Preferred Specialty (Tier 4)	30%	Not covered	30%	Not covered	30%	Not covered
Mail Order Pharmacy (90 Day Supply) (90 Day at Retail is available as well)						
Generic (Tier 1)	\$37.50 copay	Not covered	\$25 copay	Not covered	\$25 copay	Not covered
Preferred (Tier 2)	40%, \$500 max	Not covered	30%, \$275 max	Not covered	30%, \$275 max	Not covered
Non-Preferred (Tier 3)	50%, \$800 max	Not covered	40%, \$500 max	Not covered	40%, \$500 max	Not covered
Preferred Specialty (Tier 4)	30%	Not covered	30%	Not covered	30%	Not covered

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, the following options may apply:

- You may stay in the BGDC Distribution Medical Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose BGDC Medical Plan creditable coverage.
- You may stay in the BGDC Medical Plan and also enroll in a Medicare prescription drug plan. The BGDC Medical Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the BGDC Medical Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the BGDC Medical Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with BGDC Distribution and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through BGDC Distribution changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/15/2025
Name/Entity of Sender: BGDC Distribution, LLC
Contact Position/Office: Lindsay Myers, Director of Human Resources
Address: 3800 Garman Road, Salem, VA 24153
Phone Number: 540-529-8342

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhpp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)



Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace 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 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.²

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all 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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	BGDC Distribution, LLC
Contact--Position/Office:	Lindsay Myers
Address:	3800 Garman Road, Salem, VA 24153
Phone Number:	540-529-8342

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name BGDC Distribution, LLC		4. Employer Identification Number (EIN) 88-0739972	
5. Employer address 3800 Garman Road		6. Employer phone number 540-529-8342	
7. City Salem	8. State VA	9. ZIP code 24153	
10. Who can we contact about employee health coverage at this job? Lindsay Myers			
11. Phone number (if different from above)		12. Email address Lindsay.myers@BGDCDistribution.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 associates working at least 30 hours or more per week.

- With respect to dependents:
☒ We do offer coverage. Eligible dependents are:
Legal spouse, domestic partner, and children up to age 26.

- ☐ 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.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly