2024 Ben E. Keith Company Annual Notices

The Ben E. Keith Company Welfare Benefit Plan 502 and Retirement Plan 001 provides coverage and benefits that comply with applicable federal and state laws. Several of those laws require that we provide you with a summary of your rights each year.

These Notices are included in the following pages:

We're also reminding you of other important Notices you have already received or that are contained in this document, including:

Please review this information and keep it with your other important benefits communications. This information is always available on the Ben E. Keith Company benefits portal at bek.family in **Resources** > **Plan documents & policies**.

For more information, contact the Corporate Benefits Team at 1-817-877-5700.

IMPORTANT INFORMATION ABOUT YOUR BEN E. KEITH PRESCRIPTION DRUG COVERAGE AND MEDICARE

2024 NOTICE OF CREDITABLE COVERAGE: BEK PPO MEDICAL PLAN

Please read this Notice carefully, as this Notice has information about prescription drug coverage under the Ben E. Keith PPO Medical Plan (the "BEK PPO Medical Plan") 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 BEK PPO Medical Plan 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 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. Ben E. Keith has determined that the prescription drug coverage offered by the BEK PPO Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the BEK PPO Medical Plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your BEK PPO Medical Plan creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your Company coverage will not be affected. For most persons covered under the BEK PPO Medical Plan, the BEK PPO Medical Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about which plan pays first and which plan pays second, see the Ben E. Keith Company Summary Plan Description (SPD) or contact Medicare.

If you decide to join a Medicare drug plan and drop your current PPO coverage, you may be able to re-enroll in a Ben E. Keith medical plan during a future Annual Enrollment or within 31 calendar days following a qualified life 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 BEK PPO Medical Plan coverage and don't join a Medicare drug plan within 63 continuous days after your 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 19 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…
See the Ben E. Keith Company Summary Plan Description (SPD) or call the Corporate Benefits Team at 1-817-877-5700. **Note:** You'll receive this Notice each year and if your medical coverage changes. You can find a copy of this Notice any time in the **Resources** section of bek.family.

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 medicare.gov.
- Call your State Health Insurance Assistance Program for personalized help. Find your state's number on the inside back cover of your copy of the "Medicare & You" handbook.
- 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 at socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

IMPORTANT! Keep this **2024 Notice of Creditable Coverage**. 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 you maintained creditable coverage and, therefore, whether or not you must pay a higher premium (a penalty).

Date of this Notice: October 1, 2023
Name of Entity: Ben E. Keith Company
Corporate Benefits Team: 1-817-877-5700

2024 NOTICE OF CREDITABLE COVERAGE: BEK HSA MEDICAL PLAN

Please read this Notice carefully, as this Notice has information about prescription drug coverage under the Ben E. Keith Health Savings Account Medical Plan (the "BEK HSA Medical Plan") 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 BEK HSA Medical Plan 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 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. Ben E. Keith has determined that the prescription drug coverage offered by the BEK HSA Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the BEK HSA Medical Plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your BEK HSA Medical Plan creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your Company coverage will not be affected. For most persons covered under the BEK HSA Medical Plan, the BEK HSA Medical Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about which plan pays first and which plan pays second, see the Ben E. Keith Company Summary Plan Description (SPD) or contact Medicare.

If you decide to join a Medicare drug plan and drop your current HSA coverage, you may be able to re-enroll in a Ben E. Keith medical plan during a future Annual Enrollment or within 31 calendar days following a qualified life 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 BEK HSA Medical Plan coverage and don't join a Medicare drug plan within 63 continuous days after your 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 19 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…
See the Ben E. Keith Company Summary Plan Description (SPD) or call the Corporate Benefits Team at 1-817-877-5700. **Note:** You'll receive this Notice each year and if your medical coverage changes. You can find a copy of this Notice any time in the **Resources** section of bek.family.

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 medicare.gov.
- Call your State Health Insurance Assistance Program for personalized help. Find your state's number on the inside back cover of your copy of the "Medicare & You" handbook.
- 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 at socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

IMPORTANT! Keep this **2024 Notice of Creditable Coverage**. 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 you maintained creditable coverage and, therefore, whether or not you must pay a higher premium (a penalty).

Date of this Notice: October 1, 2023
Name of Entity: Ben E. Keith Company
Corporate Benefits Team: 1-817-877-5700

WOMEN'S HEALTH AND CANCER RIGHTS

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.

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.

This coverage will be subject to the provisions, limitations, exclusions, deductibles and coinsurance that apply to other medical and surgical benefits provided under the Ben E. Keith medical option in which you're enrolled. For more information, refer to your Summary Plan Description (SPD) in the **Resources** > **Plan documents & policies** section of bek.family or call UnitedHealthcare at 1-844-587-8503.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans 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 addition, plans may not require that a provider obtain prior authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

For more information, refer to your Summary Plan Description (SPD) in the **Resources** > **Plan documents & policies** section of bek.family or call UnitedHealthcare at 1-844-587-8503.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you're declining enrollment in a Ben E. Keith medical plan for yourself or your eligible family members (your spouse and children) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical plan if you or your family member(s) lose eligibility for that other coverage (or if the employer stops contributing toward your or your family members' other coverage). However, **you must request enrollment within 31 calendar days** after your or your family members' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new family member as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical option, provided you are eligible. However, **you must request enrollment within 31 calendar days** after the marriage, birth, adoption or placement for adoption.

If coverage is lost under your State Medicaid or a Children's Health Insurance Program (CHIP) plan, or you become eligible for premium assistance under your State Medicaid or CHIP plan, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical plan. **You must request enrollment within 60 calendar** days of the date of the event. (See the "Children's Health Insurance Program (CHIP)" Notice for more information.)

To request special enrollment, see your HR Manager or Office Manager or contact the Corporate Benefits Team at 1-817-877-5700.

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 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 visit 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 the Ben E. Keith medical plan, we must allow you to enroll if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 calendar days of being determined eligible for premium assistance.

If you have questions about enrolling in a Ben E. Keith medical plan, see your HR Manager or Office Manager, or contact the Corporate Benefits Team at 1-817-877-5700. You can also contact the Department of Labor at 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, 2023. Contact your state for more information on eligibility.

Alabama – Medicaid
http://myalhipp.com/
1-855-692-5447

Arkansas – Medicaid
http://myarhipp.com/
1-855-MyARHIPP (855-692-7447)

Colorado – Medicaid and CHP+
http://www.healthfirstcolorado.com/
1-800-221-3943/State Relay 711
CHP+: http://www.colorado.gov/pacific/hcpf/child-health-plan-plus
1-800-359-1991/State Relay 711
Health Insurance Buy-In: https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
1-855-692-6442

Florida – Medicaid
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
1-877-357-3268

Georgia – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
1-678-564-1162, Press 1
1-678-564-1162, Press 2

Kansas – Medicaid
http://www.kancare.ks.gov
1-800-792-4884
HIPP phone: 1-800-967-4660

Louisiana – Medicaid
http://www.medicaid.la.gov or http://www.ldh.la.gov/lahipp
1-888-342-6207 (Medicaid)
1-855-618-5488 (LaHIPP)

Missouri – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
1-573-751-2005

North Carolina – Medicaid
https://medicaid.ncdhhs.gov/
1-919-855-4100

Oklahoma – Medicaid and CHIP
http://www.insureoklahoma.org
1-888-365-3742

South Carolina – Medicaid
https://www.scdhhs.gov
1-888-549-0820

Texas – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
1-800-440-0493

Washington – Medicaid
https://www.hca.wa.gov/
1-800-562-3022

To see if any other states have added a premium assistance program since July 31, 2023, 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)

or

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

IMPORTANT REMINDER: REVIEW NOTICES YOU MAY HAVE ALREADY RECEIVED

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For more information about your rights and obligations under the Plan and under federal law, review the COBRA Rights Notice that was provided to you when you first became eligible. You can also find information in the Plan's Summary Plan Description (SPD) in the **Resources** > **Plan documents & policies** section of bek.family or by contacting your HR Manager or Office Manager.

HIPAA PRIVACY AND SECURITY

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own health care information.

The Ben E. Keith Company HIPAA Notice of Privacy Practices explains how the Ben E. Keith Company Welfare Benefit Plan may and may not use and share your protected health information and how you can exercise your health privacy rights. It also explains our obligation to notify you following a breach of unsecured protected health information. We're required to notify you of the availability of this Notice every three years.

For a copy of the most recent Notice, go to the **Resources** > **Plan documents & policies** section of bek.family or contact the Corporate Benefits Team at 1-817-877-5700.

SOCIAL SECURITY NUMBERS OF FAMILY MEMBERS

Ben E. Keith is required by law to collect the Social Security number (or other taxpayer identification number) of each family member who enrolls in a Ben E. Keith medical plan and report that information to the Internal Revenue Service each year.

If a family member does not yet have a Social Security number (for example, a newborn child), you can request one from the Social Security Administration by visiting https://www.ssa.gov/forms/ss-5.pdf**.** Applying for a Social Security number is free.

If you have not yet provided the Social Security number (or other taxpayer identification number) for each of your enrolled family members, please add it to your information when enrolling during Annual Enrollment or when requesting coverage for a family member following a qualified status change. If there are delays in getting a Social Security number, please see your HR Manager or Office Manager or contact the Corporate Benefits Team at 1-817-877-5700.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Ben E. Keith is required to provide you with an SBC for each medical plan option each year during Annual Enrollment. The SBCs describe the benefits available to you, in a prescribed format, so you can easily compare your Ben E. Keith medical options to other plans that may be available to you.

The 2024 SBCs for the Ben E. Keith PPO Medical Plan and the BEK HSA Medical Plan are included on pages 13 – 24 of this document. If you have questions about these summaries, or want an additional copy, go to the **Resources** > **Plan documents & policies** section of bek.family or contact the Corporate Benefits Team at 1-817-877-5700.

2022 SUMMARY ANNUAL REPORT
FOR BEN E. KEITH COMPANY WELFARE BENEFIT PLAN

This is a summary of the annual report of the Ben E. Keith Company Welfare Benefit Plan, EIN 75-0372230, Plan No. 502, for the period January 1, 2022 through December 31, 2022. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Ben E. Keith Company has committed itself to pay certain self-insured medical, stop loss and short-term disability claims incurred under the terms of the Plan.

Insurance Information

The Plan has contracts with Cigna Health and Life Insurance Company and Affiliates (dental); National Guardian Life Insurance Company (vision); Blue Cross and Blue Shield of Alabama (BCBS medical); and Lincoln National Life Insurance Company (employee, spouse and child life/AD&D) to pay medical, dental, vision and life/AD&D claims incurred under the terms of the Plan. The total premiums paid for the plan year ending December 31, 2022 were $10,451,055.

Because they are so called “experience-rated” contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2022, the premiums paid under such “experience-rated” contracts were $3,547,394 and the total of all benefit claims paid under these contracts during the plan year was $2,454,314.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The report includes insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write Ben E. Keith Company at 601 East 7th Street, Fort Worth, TX 76102, or contact the Corporate Benefits Team at 1-817-877-5700**.**

You also have the legally protected right to examine the annual report at the main office of the plan (Ben E. Keith Company, 601 East 7th Street, Fort Worth, TX 76102) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room N1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

2022 ANNUAL FUNDING NOTICE

RETIREMENT PLAN FOR EMPLOYEES OF BEN E. KEITH COMPANY AND ITS AFFILIATES

This Notice includes important information about the funding status of your single employer pension plan ("the Plan"). It also includes general information about the benefit payments guaranteed by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. All traditional pension plans (called "defined benefit pension plans") must provide this Notice every year regardless of their funding status. This Notice does not mean that the Plan is terminating. It is provided for informational purposes and you are not required to respond in any way. This Notice is required by federal law. This Notice is for the plan year beginning July 1, 2022, and ending June 30, 2023 ("Plan Year").

How Well Funded Is Your Plan?

The law requires the administrator of the Plan to tell you how well the Plan is funded, using a measure called the "funding target attainment percentage." The Plan divides its Net Plan Assets by Plan Liabilities to get this percentage. In general, the higher the percentage, the better funded the plan. The Plan's Funding Target Attainment Percentage for the Plan Year and each of the two preceding plan years is shown in the below chart as well as how the percentage was calculated.

Funding Target Attainment Percentage			
	2022	**2021**	**2020**
1. Valuation Date	7/1/2022	7/1/2021	7/1/2020
2. Plan Assets			
a. Total Plan Assets	$497,077,097	$581,617,175	$560,538,562
b. Funding Standard Carryover Balance	$0	$0	$0
c. Prefunding Balance	$58,286,143	$75,433,112	$70,564,183
d. Net Plan Assets (a) – (b) – (c) = (d)	$438,790,954	$506,184,063	$489,974,379
3. Plan Liabilities	$380,129,547	$355,475,056	$340,405,107
4. Funding Target Attainment Percentage (2d)/(3)	115.43%	142.39%	143.93%

Plan Assets and Credit Liabilities

The above chart shows certain "credit balances" called the Funding Standard Carryover Balance and Prefunding Balance. A plan might have a credit balance, for example, if in a prior year an employer contributed money to the plan above the minimum level required by law. Generally, an employer may credit the excess money toward the minimum level of contributions required by law that it must make in future years. Plans must subtract these credit balances from Total Plan Assets to calculate their Funding Target Attainment Percentage.

Plan Liabilities

Plan Liabilities in line 3 of the chart above are estimates of the amount of assets the Plan needs on the Valuation Date to pay for promised benefits under the plan.

Year-End Assets and Liabilities

The asset values in the above chart are measured as of the first day of the Plan Year. As of June 30, 2023, the fair market value of the Plan's assets was $438,453,629. On this same date, the Plan's liabilities, determined using market rates, were $417,532,993.

Supplemental Information

The Moving Ahead for Progress in the 21st Century Act, the Highway and Transportation Funding Act of 2014 and the Bipartisan Budget Act of 2015 require us to provide the below supplemental information. These federal laws changed how pension plans calculate their liabilities. Prior to 2012, pension plans determined their liabilities using a two-year average of interest rates. Now pension plans also must take into account a 25-year average of interest rates. This means that interest rates likely will be higher and plan liabilities lower than they were under prior law. As a result, your employer may contribute less money to the plan at a time when market interest rates are at or near historical lows.

The below chart compares the effect of using interest rates based on the 25-year average (the "adjusted interest rates") and interest rates based on a two-year average of the Plan's: (1) Funding Target Attainment Percentage; (2) Funding Shortfall; and (3) Minimum Required Contribution. The funding target attainment percentage of a plan is a measure of how well the plan is funded on a particular date. The funding shortfall is the amount by which liabilities exceed net plan assets. The minimum required contribution is the amount of money an employer is required by law to contribute to a plan for a given year.

The following table shows this information determined with and without the adjusted interest rates. The information is provided for the Plan Year and for each of the two preceding plan years, if applicable.

	2022		2021		2020	
	With Adjusted Interest Rates	**Without Adjusted Interest Rates**	**With Adjusted Interest Rates**	**Without Adjusted Interest Rates**	**With Adjusted Interest Rates**	**Without Adjusted Interest Rates**
Funding Target Attainment Percentage	115.43%	80.02%	142.39%	94.01%	143.93%	108.31%
Funding Shortfall	$0	$109,560,129	$0	$32,209,235	$0	$0
Minimum Required Contribution	$0	$22,316,429	$0	$15,478,982	$0	$0

Participant Information

The total number of participants and beneficiaries covered by the Plan on the Valuation Date was 5,446. Of this number, 2,787 were current employees, 989 were retired and receiving benefits, and 1,670 were no longer working for the employer and have a right to future benefits.

Funding & Investment Policies

Every pension plan must have a procedure to establish a funding policy for plan objectives. A funding policy relates to how much money is needed to pay promised benefits. Our policy is to fund our qualified defined benefit plan on an actuarial basis to accumulate assets sufficient to meet the benefits to be paid in accordance with ERISA requirements.

Pension plans also have investment policies. These generally are written guidelines or general instructions for making investment management decisions. We seek to maintain the funded status with a focus on asset growth being in line with the liability growth. This approach employs a blended mix of fixed income investments, including bonds, and return-seeking investments including equity securities, multi-asset credit, and real estate. Given the primary objective of maintaining the Plan's funded status, there is a significant commitment to bonds and other interest-bearing instruments, which provide a reasonable level of income and have a moderating effect on the volatility of the funded status. The bond portion of the portfolio emphasizes long-duration, high quality credit and government bonds that will tend to perform similar to the Plan's liabilities. Typically, we aim to invest approximately 70% of the Plan's assets in fixed income. The remainder is invested in equities and other return-seeking asset classes, with a liquidity (cash) range of 1%-5%.

Under the Plan's investment policy, the Plan's assets were allocated among the following categories of investments, as of the end of the Plan Year. These allocations are percentages of total assets:

Asset Allocations as of June 30, 2023	**Percentage**
Stocks	21.3%
Investment grade debt instruments	67.6%
Real Estate	7.0%
Other	4.1%

Right to Request a Copy of the Annual Report

Pension plans must file annual reports with the US Department of Labor. The report is called the "Form 5500." These reports contain financial and other information. You may obtain an electronic copy of your Plan's annual report at www.efast.dol.gov by using the search tool. Annual reports also are available from the US Department of Labor, Employee Benefits Security Administration's Public Disclosure Room at 200 Constitution Avenue, NW, Room N-1513, Washington, DC 20210, or by calling 1-202-693-8673. Or you may obtain a copy of the Plan's annual report by making a written request to the plan administrator. Annual reports do not contain personal information, such as the amount of your accrued benefits. You may contact your plan administrator if you want information about your accrued benefits. Your plan administrator is Ben E. Keith Company.

Summary of Rules Governing Termination of Single-Employer Plans

If a plan terminates, there are specific termination rules that must be followed under federal law.

There are two ways an employer can terminate its pension plan. First, the employer can end a plan in a "standard termination" but only after showing the PBGC that such plan has enough money to pay all benefits owed to participants. Under a standard termination, a plan must either purchase an annuity from an insurance company (which will provide you with periodic retirement benefits, such as monthly for life or, if you elect, for a set period of time when you retire) or, if the plan allows and you elect, issue one lump-sum payment that covers your entire benefit. Your plan administrator must give you advance notice that identifies the insurance company (or companies) selected to provide the annuity. The PBGC's guarantee ends upon the purchase of an annuity or payment of the lump-sum. If the plan purchases an annuity for you from an insurance company and that company becomes unable to pay, the applicable state guaranty association guarantees the annuity to the extent authorized by that state's law.

Second, if the plan is not fully-funded, the employer may apply for a distress termination. To do so, however, the employer must be in financial distress and prove to a bankruptcy court or to the PBGC that the employer cannot remain in business unless the plan is terminated. If the application is granted, the PBGC will take over the plan as trustee and pay plan benefits, up to the legal limits, using plan assets and PBGC guarantee funds.

Under certain circumstances, the PBGC may take action on its own to end a pension plan. Most terminations initiated by the PBGC occur when the PBGC determines that plan termination is needed to protect the interests of plan participants or of the PBGC insurance program. The PBGC can do so if, for example, a plan does not have enough money to pay benefits currently due.

Benefit Payments Guaranteed by the PBGC

When the PBGC takes over a plan, it pays pension benefits through its insurance program. Only benefits that you have earned a right to receive and that cannot be forfeited (called vested benefits) are guaranteed. Most participants and beneficiaries receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits that are not guaranteed. The amount of benefits that PBGC guarantees is determined as of the plan termination date. However, if a plan terminates during a plan sponsor's bankruptcy, then the amount guaranteed is determined as of the date the sponsor entered bankruptcy.

The PBGC maximum benefit guarantee is set by law and is updated each calendar year. For a plan with a termination date or sponsor bankruptcy date, as applicable, in 2023 the maximum guarantee is $6,750 per month, or $81,000 per year, for a benefit paid to a 65-year-old retiree with no survivor benefit. If a plan terminates during a plan sponsor's bankruptcy, the maximum guarantee is fixed as of the calendar year in which the sponsor entered bankruptcy. The maximum guarantee is lower for an individual who begins receiving benefits from PBGC before age 65 reflecting the fact that younger retirees are expected to receive more monthly pension checks over their lifetimes. Similarly, the maximum guarantee is higher for an individual who starts receiving benefits from PBGC after age 65. The maximum guarantee by age can be found on PBGC's website, www.pbgc.gov. The guaranteed amount is also reduced if a benefit will be provided to a survivor of the plan participant.

The PBGC guarantees "basic benefits" earned before a plan is terminated, which include:

- Pension benefits at normal retirement age;
- Most early retirement benefits;
- Annuity benefits for survivors of plan participants; and
- Disability benefits for a disability that occurred before the date the plan terminated or the date the sponsor entered bankruptcy, as applicable.

The PBGC does not guarantee certain types of benefits:

- The PBGC does not guarantee benefits for which you do not have a vested right, usually because you have not worked enough years for the company.
- The PBGC does not guarantee benefits for which you have not met all age, service, or other requirements.
- Benefit increases and new benefits that have been in place for less than one year are not guaranteed. Those that have been in place for less than five years are only partly guaranteed.
- Early retirement payments that are greater than payments at normal retirement age may not be guaranteed. For example, a supplemental benefit that stops when you become eligible for Social Security may not be guaranteed.
- Benefits other than pension benefits, such as health insurance, life insurance, death benefits, vacation pay, or severance pay, are not guaranteed.
- The PBGC generally does not pay lump sums exceeding $5,000.

In some circumstances, participants and beneficiaries still may receive some benefits that are not guaranteed. This depends on how much money the terminated plan has and how much the PBGC recovers from employers for plan underfunding.

For additional general information about the PBGC and the pension insurance program guarantees, go to the “General FAQs about PBGC” on PBGC’s website at www.pbgc.gov/generalfaqs. Please contact your employer or plan administrator for specific information about your pension plan or pension benefit. PBGC does not have that information.

Where to Get More Information

For more information about this Notice, you may contact the Corporate Benefits Team at 1-817-877-5700.

For identification purposes, the plan number is 001, the plan sponsor’s name is Ben E. Keith Company, and the employer identification number or “EIN” is 75-0372230.

2022 SUMMARY ANNUAL REPORT
BEN E. KEITH RETIREMENT SAVINGS PLAN

This is a summary of the annual report for the Ben E. Keith Retirement Savings Plan (Employer Identification Number 75-0372230, Plan Number 002) for the plan year July 1, 2021 through June 30, 2022. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the Plan are provided by a trust fund. Plan expenses were $15,037,798. These expenses included $539,473 in administrative expenses and $14,303,272 in benefits paid to participants and beneficiaries, $195,053 in certain deemed and/or corrective distributions, and $0 in other expenses. A total of 6,588 persons were participants in or beneficiaries of the Plan at the end of the Plan year, although not all of these persons had yet earned the right to receive benefits.

The value of Plan assets, after subtracting liabilities of the Plan, was $242,449,495 as of the end of the plan year, compared to $240,538,233 as of the beginning of the Plan year. During the Plan year, the Plan experienced a change in its net assets of $1,911,262. This change includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The Plan had total income of $16,949,060, including employer contributions of $26,858,026, employee contributions of $23,648,991, other contributions/other income of $13,984,042, and earnings from investments of -$37,541,999.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, any part thereof, on request. The report includes an accountant's report, financial information and information on payments to service providers, assets held for investment, and information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the Plan participates.

To obtain a copy of the full annual report, or any part thereof, write Ben E. Keith Company at 601 East 7th Street, Fort Worth, TX 76102, or call 1-817-877-5700.

You also have the right to receive from the Plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the Plan: 601 East 7th Street, Fort Worth, TX 76102, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room N-1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

UnitedHealthcare

Ben E. Keith Company PPO Plan

Coverage for: Family | **Plan Type:** PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-734-7670 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,000** Individual / **$3,000** Family Non-Network: **$2,000** Individual / **$6,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, Prescription drugs - **$75** per person. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: **$3,000** Individual / **$6,000** Family Non-Network: **$6,000** Individual / **$12,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-844-587-8503** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit, deductible does not apply.	50% coinsurance	$20 Copay per visit by a Designated Virtual Network Provider. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$50 copay per visit, deductible does not apply.	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: $15 copay Mail-Order: $30 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. CVS pharmacies are not covered. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: $35 copay Mail-Order: $70 copay	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: $75 copay Mail-Order: $150 copay	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay per visit, then 30% coinsurance	$200 copay per visit, then 30% coinsurance	None
	Emergency medical transportation	30% coinsurance	*30% coinsurance	*Network deductible applies
	Urgent care	$75 copay per visit, deductible does not apply.	50% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	$300 inpatient confinement deductible applies out-of-network prior to the overall deductible. Preauthorization is required out-of-network or a $500 penalty applies.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	PCP: $35 copay per visit, deductible does not apply	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	$300 inpatient confinement deductible applies out-of-network prior to the overall deductible.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or a $500 penalty applies.
	Rehabilitation services	30% coinsurance	50% coinsurance	Outpatient rehabilitation services are unlimited per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Habilitative services	30% coinsurance	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: Unlimited.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or a $500 penalty applies.
	Durable medical equipment	30% coinsurance	50% coinsurance	None
	Hospice services	No Charge	No Charge	Limited to 180 days per calendar year. Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or a $500 penalty applies.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Routine eye care
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic (Manipulative care) – 20 visits per calendar year
- Infertility treatment
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copay	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$35
Coinsurance	$3,841
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,516**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist coinsurance	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,075
Copayments	$700
Coinsurance	$1,142
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,937**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist coinsurance	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$400
Coinsurance	$420
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,820**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-844-4864.or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$3,200** Individual / **$6,400** Family Non-Network: **$5,600** Individual / **$11,200** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$6,400** Individual / **$12,900** Family Non-Network: **$12,900** Individual / **$25,800** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-844-587-8503** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	Virtual visits - 30% coinsurance by a Designated Virtual Network Provider. No virtual coverage out-of-network.
	Specialist visit	30% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	30% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: 30% coinsurance Mail-Order: 30% coinsurance	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. CVS pharmacies are not covered. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Prescription drug costs are subject to the annual deductible.
	Tier 2 – Your Mid-Range Cost Option	Retail: 30% coinsurance Mail-Order: 30% coinsurance	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: 30% coinsurance Mail-Order: 30% coinsurance	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	*30% coinsurance	*Network deductible applies
	Emergency medical transportation	30% coinsurance	*30% coinsurance	*Network deductible applies
	Urgent care	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
If you are pregnant	Office visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	30% coinsurance	50% coinsurance	Outpatient rehabilitation services are unlimited per calendar year.
	Habilitative services	30% coinsurance	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: Unlimited.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	30% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or no coverage.
	Hospice services	0% coinsurance	0% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Routine eye care
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic (Manipulative care) –20 visits per calendar year
- Infertility treatment
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,200
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,200
Copayments	$0
Coinsurance	$2,832
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,092**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,200
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,200
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,200
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Notice of Nondiscrimination

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-734-7670 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 11-866-734-7670 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意:如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-734-7670 (TTY:711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-734-7670 (TTY: 711).

Arabic : .)انتباه :إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك .اتصل بـ 1-866-734-7670 (الهاتف النصي :711

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-734-7670 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-734-7670 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-734-7670 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગજુ રાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે િનઃશુલ્ક ઉપલબ્ધ છે. 1-866-734-7670 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-734-7670 (TTY: 711).

Hindi: □ान द□: अगर आपकी भाषा िहंदी है, तो आपके िलए भाषा सहायता सेवाएँ िनःशु□ उपल□ ह□। 1-866-734-7670 (TTY: 711) पर कॉल कर□।

Laotian: ໂປດຊາບ:ຖ້າວ່າທ່ານເວົ້າພາສາລາວ,ການບໍລິການຊ່ວຍເຫືຼອດ້ານພາສາ,ໂດຍບໍ່ເສັຽຄ່າ,ແມ່ນມີພ້ອມໃຫ້ທ່ານ.ໂທຣ 1-866-734-7670 (TTY:711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-734-7670 (телетайп: .)711

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveiss erviços linguísticos, grátis. Ligue para 1-866-734-7670 (TTY:711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-734-7670 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-866-734-7670 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-734-7670 (TTY: 711).

Japanese: 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-866-734-7670 (TTY: 711)まで、お電話にてご 連絡ください。