STRIVE to THRIVE

BENEFITS GUIDE

2025/2026

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DEAR ASSOCIATES,

As I mark my second year as Chief Human Resources Officer (CHRO) of the Ashford Group of Companies, I want to take a moment to thank you for your continued commitment to our organization. It has been a privilege to get to know our teams, hear your stories, and better understand the benefits that matter most to you.

As part of our ongoing commitment to support your health and well-being, we're making these changes to our benefits for 2025/2026:

- Lower out-of-pocket maximums across all medical plans.
- Premium contributions will increase by 2% for most associates. This is significantly below the national medical inflation trend of 6-8%.
- Introduction of Generation**You™**, a new concierge service to help you navigate your medical coverage and select the plan that best fits your needs.

Annual Enrollment is your opportunity to take a look at your benefits and choose the coverage that best fits your needs. Carefully review the changes and take advantage of the resources available to help you make informed decisions.

If you have questions or need assistance during Annual Enrollment, reach out to our Benefits Team at **Benefits@RemingtonHotels.com**. We're here to support you every step of the way.

Thank you again for all that you do. I look forward to continuing this journey together as we build a workplace where every associate can thrive.

Rick Badgley
Chief Human Resources Officer

GETTING STARTED

ANNUAL ENROLLMENT

When is 2025-2026 Annual Enrollment?

Benefits Annual Enrollment will be held August 18 through August 29, 2025.

You only have a limited time to make your elections, so don't wait, enroll early! Your elections will remain in effect from October 1, 2025, through September 30, 2026, unless you experience a family status change due to a qualifying life event.

All current benefits will continue into the following plan year if you do not make any changes.

What's New This Year?

PASSIVE ENROLLMENT

- **No changes?** No actions needed. Your current benefits will continue into the following plan year.
- Annual deductibles and maximum out-of-pocket will reset on October 1.
- **Benefit changes wanted?** Visit your Benefit Enrollment Platform. To learn more about your Benefit Enrollment Platform, visit **page 4**.

MEDICAL PLANS

- **Annual Out-of-Pocket Maximum** lower for all medical plans: $7,000 Individual | $14,000 Family.
- Launch of Generation**You™**, a personalized concierge service designed to guide you through your medical coverage options and assist with plan selection.
- In early October, all medical plan participants will receive a new ID card from Gen**You**.

Contact the Benefits Team
You can contact the Benefits Team at **benefits@remingtonhotels.com** or your HR Team anytime you have questions about your benefits.

To get the benefit coverage that's best for you and your family, you need to enroll on time. If you have a qualifying event during the year, you need to meet specific deadlines to make changes.

Your elections will remain in effect through the end of the benefit year (September 30, 2026), unless you have a qualifying life status change. The deadline to enroll is 30 days from your eligibility date or the date of the qualifying event.

ENROLL ON YOUR COMPANY'S BENEFITS ENROLLMENT PLATFORM

Company	Enrollment Platform
Ashford, Remington, and Premier	myadp.com
INSPIRE	workforcenow.adp.com
RED Hospitality, Sebago, and Island Time Watersports	paycomonline.net/v4/ee/web.php/app/login

You can access many things from the enrollment platform!

- View benefit plan information
- Track and print your pay statements and W2s right from your phone or tablet

MAKING CHANGES DURING THE YEAR

While you are generally only allowed to change your benefits elections during the annual enrollment period, certain life events provide an exception. Life events allow you to change your benefits elections in the middle of the plan year.

Important! If you have a life event status change, or you are a new hire, you cannot enroll until the date the event occurs.

Qualified life status events include:

- Marriage or divorce
- Birth, death, or legal adoption
- Associate gains or has a loss of coverage
- Family member gains or has a loss of coverage

Qualified Life Event Status Changes must be reported within 31 calendar days of the event to change benefits. You can report changes on the Benefit Enrollment Platform or the mobile app.

- **Ashford, Remington, and Premier:** After you confirm your elections, click Submit to review the list of required documents. You will also be notified by mail from ADP Dependent Verification Services with specific instructions.
- **Inspire:** Upload proper documentation of the event to ADP. HR will be notified of the pending request and will approve/deny after reviewing.
- **RED:** Upload proper documentation of the event to Paycom. HR will be notified of the pending request and will approve/deny after reviewing.

Provide your documentation within 45 calendar days. Your changes will be pended until the documentation is approved by the Benefits Department.

HOW TO ENROLL

ELIGIBILITY

ASSOCIATES

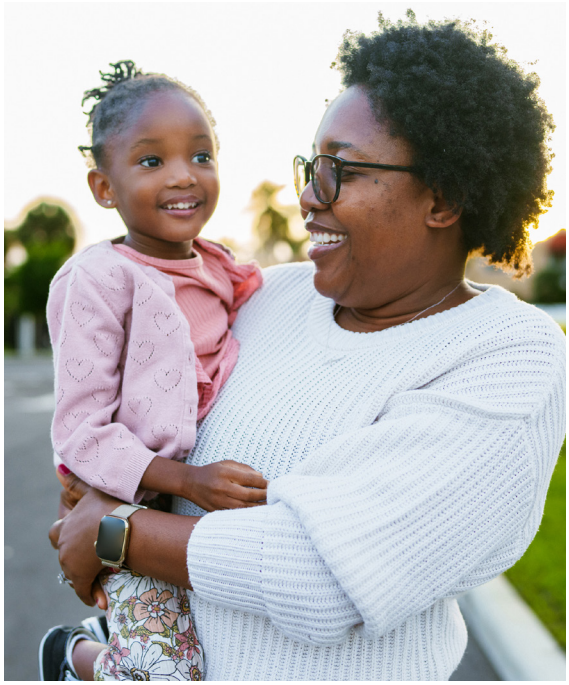
Eligibility for benefits is determined by your status as Full-Time or Part-Time in the Company's HR/Payroll system.

- **Full-Time:** Associates who are working 30 or more hours per week are eligible to participate in all benefit programs offered by the company.
- **Part-Time:** Associates who are classified as part-time are expected to work less than 30 hours per week and are eligible to participate in the Retirement Savings Plans and the Employee Assistance Program (EAP).

FAMILY MEMBERS

If you are an eligible associate and elect coverage, you can also elect the following coverage for your eligible family members:

- Medical
- Dental
- Vision
- Dependent Life and AD&D
- Group Accident
- Critical Illness



You must have coverage for yourself to enroll your eligible family members.

Your eligible family members include:

- Your legal spouse
- Your dependent children up to age 26 – including biological children, adopted children, stepchildren, or those for whom you have legal guardianship.
- A dependent child currently covered on your policy who is disabled mentally or physically, as defined by the Social Security Administration, may continue on your policy.

Note: Dependent Verification may be requested.

ACA MEASUREMENT PERIOD

The ACA (Affordable Cares Act) Measurement Period for benefits eligibility is a 12-month look-back period. Associates must work an average of 30 hours per week during the measurement period to be benefits eligible.

Global Measurement Period	Effective Date for Status Change
July 3 – July 2	October 1

Associates that average more than 30 hours per week will keep their benefits eligibility or become eligible to elect benefits.

Note: *Eligibility for benefits may vary by location or union affiliation. Refer to the SPD, your collective bargaining agreement, or your local HR representative with questions.*

STRIVE TO THRIVE

STRIVE to HEALTH

Strive to Health is represented by the orange logo and is focused on the health benefits, wellness, ways to get active, nutrition, self-care, and activity challenges.

STRIVE to WELLBEING

Strive to Wellbeing is represented by the blue logo and is focused on mental health, mindfulness, giving back to the community, resiliency, and assistance programs.

STRIVE to WEALTH

Strive to Wealth is represented by the green logo and is focused on income protection, discount programs, financial planning, and retirement.

BENEFITS WEBSITE

You have convenient access to your benefits and more through your smartphone, tablet, or desktop computer … whenever, wherever, and however you want!

Get started at **strivetothrivebenefits.com**, and save a shortcut to your smartphone's home screen. Whether you're in need of a doctor or simply need to know what your plan pays, it's all right there in the palm of your hand.

The benefits website is designed to give you 24/7 access to your benefits.

Know Your Benefits

The website gives a detailed breakdown of benefits anytime you need it. Check them before scheduling your appointment.

ID Cards

A generic ID card is available within the website. Download a copy to your mobile device so you can easily share it at the doctor's office.

Contact Information

Quickly find service contact information and online resources.

Explore the Benefits Website today! Scan or click the QR code to get started.

GenerationYou™ (GenYou) is concierge service offered by UMR that is tailored to you and your family's unique medical care needs. When you call UMR, you will speak with a member of the GenYou team to help you with understanding your benefits, comparing providers, accessing cost estimates, scheduling appointments, and referring you to more in-depth support if you need it.

YOUR GENYOU GUIDE

When you call, the first person you will speak with is a GenYou Guide. They can help with:

- Understanding your benefits
- Finding the best quality care
- Comparing providers
- Scheduling appointments for you
- Gathering cost estimates
- Locating resources

CARE GUIDES AND CARE SUPPORT

Depending on your situation, you may be referred to a CARE Guide registered nurse or social worker who can help with:

- Answers to your medical questions
- Assistance in navigating available programs
- Locating a specialist
- Help with appeals
- Accessing behavioral health and substance use resources
- Finding community resources such as counseling, food banks, and housing shelters
- Outreach if you are at risk of serious health conditions like diabetes, cancer, heart conditions, etc.

If you need long-term treatment coordination, your GenYou Guide may refer you to CARE Support, who are nurse managers that offer enhanced case management.

How to contact GenYou

844-600-0919

Download the UMR App Today

On the app, you can:

- Access the *Story of You*
- Find care providers
- Access your digital ID card
- View claims information
- Find out if there is a copay for your upcoming appointment
- See how much you've paid toward your deductible, and more

Download on the App Store

GET IT ON Google Play

STORY OF YOU

When you log in to **UMR.com**, you will be prompted to complete the GenYou *Story of You*.

The 5-minute questionnaire includes general questions about your health.

- Providing this information will help the GenYou team to better support you in the future.
- After completing *Story of You*, you'll get personalized recommendations for UMR resources.
- Once completed, you can view your recommendations by clicking *Point of You* in the GenYou menu.

GENERATIONYOU™

Our medical benefits through UMR help you maintain your well-being through preventive care, affordable prescriptions, and access to an extensive network of providers. To find an in-network UMR provider, visit **umr.com**.

MEDICAL BENEFITS

CONSIDER YOUR COVERAGE

The three Medical plans—Gold EPO, Silver EPO, and Bronze EPO—have different levels of coverage and different price points, allowing you to choose based on your financial and health needs. Review the chart on the next page to see how the plans compare to each other.

HOW YOU PAY FOR CARE

When you enroll in the plan, you pay a medical plan contribution out of each paycheck. To help with this cost, the Company shares this cost with you — in fact, the Company pays the majority of this cost on your behalf. Below illustrates how you pay for in-network coverage.

October 1: (start of the plan year)

With the Bronze EPO plan, you pay all costs until the deductible is met. With the Silver and Gold EPO plans, you pay copays for most services, even if you haven't met the deductible. Deductibles vary by plan.

A **copay** is a fixed amount that you pay out-of-pocket for covered services, such as Primary Care Office Visits, Specialist Office Visits, Urgent Care, and prescription drugs.

A **deductible** is the total amount you pay for covered services before the plan starts covering the costs. The deductible applies to MRIs, Inpatient and Outpatient Care, Emergency Room, etc.

Coinsurance is your share of the cost of a covered health care service after you've met your deductible.

You pay coinsurance until you meet the out-of-pocket maximum: $7,000 Individual / $14,000 Family.

Deductibles and coinsurance apply **only** to select major medical services. The out-of-pocket maximum is the total amount you will pay out of pocket for covered services during the plan year. Copays, deductibles, and coinsurance add up to annual out-of-pocket maximum.

You don't pay anything for the rest of the year if you meet the out-of-pocket maximum.

The **out-of-pocket maximum** is the total amount you will pay out of pocket for covered services during the plan year. Copays, deductibles, and coinsurance add up to annual out-of-pocket maximum. If you reach your out-of-pocket maximum, you are covered at 100% for the remainder of the year.

September 30: (end of the plan year)

Medical Plans At A Glance

	Gold EPO	Silver EPO	Bronze EPO
Annual Deductible	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family	$5,000 Individual $10,000 Family
Coinsurance	80%	70%	70%
Annual Out-of-Pocket	$7,000 Individual $14,000 Family	$7,000 Individual $14,000 Family	$7,000 Individual $14,000 Family
Preventive Care Services	100%	100%	100%
GenerationYou™ (Virtual Care)	$0 copay	$0 copay	$0 copay
Airrosti	$30 copay	$40 copay	70% after ded.
Office Visit: PCP	$10 copay	$20 copay	70% after ded.
Office Visit: Specialist	$30 copay	$40 copay	70% after ded.
Hospital Services Inpatient / Outpatient	80% after ded.	70% after ded.	70% after ded.
Urgent Care	$40 copay	$40 copay	70% after ded.
Emergency Room	$500 Copay per visit; 20% Coinsurance	$500 Copay per visit; 30% Coinsurance	70% after ded.
Prescription Services Rx: Retail (30 days)			
Tier 1	$5 copay	$5 copay	70% after ded.
Tier 2	$50 copay	$50 copay	
Tier 3	$100 copay	$100 copay	
Specialty	$250 copay	$250 copay	

HAVE QUESTIONS?

Call GenerationYou™ at 844-600-0919 for help with:

- Medical and prescription questions
- Personal, family, and marriage counseling
- Scheduling an appointment with an in-network doctor
- Understanding your medical bills
- And more!

The plans are EPOs, which stands for Exclusive Provider Organization and only cover costs when you visit an in-network provider and/or facility. **If you go out-of-network, you pay 100% of the cost except in the case of a medical emergency.**

TELEHEALTH

CARE ANYTIME, FROM ANYWHERE WITH TELADOC

Save time and money on non-emergency medical or mental health care with telehealth services provided through Teladoc. When you enroll in one of our medical plans, you and your covered dependents can connect 24/7 with board-certified doctors and licensed mental health professionals by phone, video, or app.

With Teladoc, you pay **$0 for care**, avoid long waits for appointments, and can access care from anywhere. Telehealth-trained doctors can even get prescriptions sent to your pharmacy, if medically necessary. Providers can diagnose and treat many common issues, including:

- Cold and flu
- Sinus infections
- Sore throat
- Allergies, and more

MENTAL HEALTH SUPPORT

Teladoc also provides confidential help from licensed therapists or psychiatrists for:

- Stress, anxiety, depression
- Grief or relationship issues
- Work-life balance
- Medication management

Appointments are available seven days a week, including evenings.

GET STARTED

1. Visit **www.teladoc.com** or download the Teladoc app.
2. Create your account and complete your medical history.
3. Request care anytime you need it.

Scan this QR code to download the Teladoc app today!

Where you go for care matters. Your choice may be able to save you time and money. If you need help deciding where to go for care, contact GenerationYou™!

Virtual Care	When you're not feeling well or need care fast, have a visit in just minutes with a board-certified doctor or therapist. **Good for:** • Cold & Flu • Ear Pain • Pink Eye • Sinus Problems • UTI Infections (Female, 18+)	$$$$$
Primary Care Physician	The go-to place for managing your health care. Your primary care provider knows your medical history best. **Good for:** • Annual physicals • Routine screenings • Vaccines • Sprains and strains • Chronic conditions • Medicine refills • Anxiety and depression	$$$$$$
Urgent Care Center	Immediate care for conditions that are not life-threatening. Shorter average wait times than the emergency room. **Good for:** • Asthma • Cuts requiring stitches • Broken bones • Concussions • Vomiting and diarrhea	$$$$$$
Emergency Room	Immediate care for life-threatening conditions, including heart attack and stroke. **Good for:** • Fever in a child less than 3 months old • Chest pain • Shortness of breath • Sudden numbness, weakness, or speech difficulty • Severe belly pain • Coughing or vomiting blood • Uncontrolled bleeding • Mental health crisis	$$$$$$
Freestanding Emergency Room	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher. **Good for:** • Most major injuries except trauma • Severe pain	$$$$$$

KNOW WHERE TO GO

PRESCRIPTIONS

SMITHRX – YOUR PHARMACY BENEFITS MANAGER

What is a Pharmacy Benefits Manager?

Pharmacy benefits managers (or PBMs) coordinate the interaction between your employer, physician, health plan, and pharmacy. Your PBM powers your pharmacy experience by:

- Making sure you're charged the correct copay at the pharmacy
- Setting up your medications to be covered according to your plan design
- Managing clinical requirements related to your prescriptions

Since your PBM benefits are closely related to your health coverage, you're automatically covered when you enroll in your health plan.

What pharmacy can I go to?

SmithRx has over 83,000 pharmacies in its network, including retail pharmacies like CVS, Walgreens, RiteAid, Walmart, Costco, and more. Additionally, SmithRx gives you access to mail order pharmacies like Amazon Pharmacy and Walmart Mail Order, and specialty pharmacies like Senderra and Kroger.

What if I need assistance?

The SmithRx Member Services team is available Monday to Friday, 7 am to 7 pm (CST):

- Phone: 844-454-5201
- Email: **help@smithrx.com**
- Chat: On the SmithRx website at **smithrx.com**

In addition, SmithRx has on-site clinical staff and after-hours answering to ensure you can always get the assistance you need. You can also create an account on our member portal at **member.mysmithrx.com** and your ID card.

HAVE QUESTIONS?

Explore the links below to find answers to your questions about SmithRx.

SmithRx's **"Find My Meds"** tool makes it easy to find a pharmacy location to fill your prescription, while showing you the costs associated with your prescription plan.

Need **mail-order pharmacy information**? SmithRx gives you access to 3 mail-order pharmacy options.

Want to know **how to transition your medication** to SmithRx's Specialty Pharmacy Programs?

Explore the SmithRx **Connect 360** Programs!

ONE PASS SELECT™ FITNESS AND WELL-BEING SUBSCRIPTION

One Pass Select™ is a fitness and well-being subscription service. One Pass Select provides access to over 20,000 gyms and fitness studios. For one discounted monthly fee, you can access multiple gyms. Some of the facilities include, but are not limited to: Planet Fitness, CrossFit, RetroFitness, Blink, LA Fitness, Crunch, OrangeTheory, Pure Barre and Row House.

One Pass Select™ offers five membership tiers to choose from, with the option to change tiers monthly. When you enroll, you will choose the tier that meets your fitness goals: Digital, Classic, Standard, Premium, or Elite, which cost from $10 to $250 per month. Note that monthly fees are not prorated for partial months.

Classic and above tiers also include free membership with Walmart+ and Shipt grocery delivery services. You can cancel at any time with a 30-day notice.

For more information, or to enroll, visit **OnePassSelect.com**.

PAIN MANAGEMENT

Fix Pain Fast! Airrosti providers are experts at diagnosing and rapidly resolving the source of your injury. Each patient receives one full hour of assessment, diagnosis, treatment, and education designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to activity — usually within 3 visits (based on patient-reported outcomes).

COMMON CONDITIONS TREATED BY AIRROSTI

- Neck Pain
- Mild Back Pain
- Hip Pain
- Achilles Tendinitis
- Headaches
- Rotator Cuff Pain
- Knee Pain
- Carpal Tunnel
- Shin Splints
- And more!

SCHEDULE YOUR APPOINTMENT TODAY!

- Call 800-404-6050
- Go online to **airrosti.com**

Scan or click this QR code to visit Airrosti's website.

Airrosti is currently only available in these states:

- Ohio
- Virginia
- Texas
- Washington

Associates and dependents must be currently enrolled in one of the Company's medical plans to have access to this program.

DENTAL

The PPO dental plans are designed to help you maintain a healthy smile through regular preventive dental care and to fix any problems as soon as they occur. Because preventive care is so important, the plans cover these services in full with no deductible or copay. The plans allow you to see any provider, but you will receive the highest level of benefits when you utilize in-network providers through MetLife (**PDP Plus Network**).

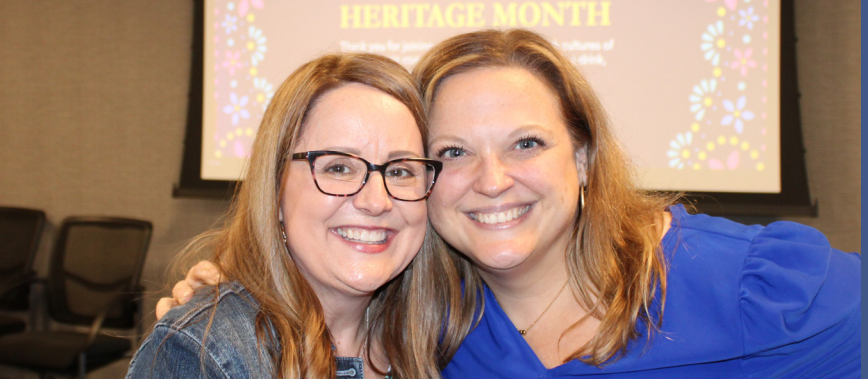
		High Plan	Low Plan
Annual Deductible	Individual Family	$50 $150	$75 $225
Maximums	Individual Annual Maximum Individual Lifetime Orthodontic	$1,500 $1,500	$750 N/A
Diagnostic and Preventive Services	Routine exams, X-rays, fluoride, and cleanings	No charge	No charge
Dental Cleanings	4 cleanings per year	No charge	No charge
Basic Restorative Services	Fillings, extractions, emergency treatment	80% coinsurance*	60% coinsurance*
Major Restorative Services	Crowns, inlays and onlays, dentures, and bridges	50% coinsurance*	40% coinsurance*
Orthodontics	Orthodontia for you, and your covered spouse and dependent children, up to age 26	50% coinsurance*	N/A

ORTHODONTIC COVERED SERVICES

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

- The benefit payable for the initial placement will not exceed 25% of the amount charged by the Dentist
- The benefit payable for the periodic follow-up visits will be payable on a monthly basis during the course of the orthodontic treatment if:
  - » Dental Insurance is in effect for the person receiving the orthodontic treatment; and
  - » Proof is given to MetLife that the orthodontic treatment is continuing

Scan or click this QR code to find an in-network MetLife Dental Provider. The name of our network is PDP Plus Network.



VISION

Vision insurance helps pay the cost of periodic vision examinations and necessary lenses and frames. The vision plan covers an annual eye exam, eyeglass lenses or contacts, and frames every 12 months. The plan allows you to see any provider, but you will receive the highest level of benefit when you utilize in-network providers through MetLife (**VSP Network**).

	Frequency	In-Network Costs	Out-of-Network Reimbursement
Eye health exam, dilation, prescription, and refraction for glasses	Once every 12 months	Covered in full after $10 copay	Up to $45
Retinal Imaging	Once every 12 months	Up to a $39 copay on routine retinal screening when performed by a private practice	n/a
Materials and Eyewear	Once every 12 months	$10 copay for materials and eyewear	n/a
Single / Lined Bifocal / Lined Trifocal / Lenticular	Once every 12 months	Covered after $10 eyewear copay	Up to $30 / $50 / $65 / $100
Basic Progressive Lens	Once every 12 months	Covered in full after $55 copay	Up to $50
Allowance*	Once every 12 months	$130 allowance after $10 eyewear copay	Up to $55
Costco, Walmart & Sam's Club	Once every 12 months	$70 allowance after $10 eyewear copay	n/a
Contacts (Necessary)	Once every 12 months	$130 allowance after $10 eyewear copay	Up to $210
Contacts (Elective)	Once every 12 months	Up to $130 allowance	Up to $105
Second Pair of Glasses	Additional: A second set of glasses or contacts is available in the same plan year. Applicable copays apply. Two pairs of prescription eyeglasses; or One pair of prescription eyeglasses and an allowance toward contact lenses; or Double your contact lens allowance		
Laser Vision Correction	Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK, and Custom LASIK. This offer is only available at MetLife participating locations.		

*You will receive an additional 20% savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco.

Note: Contacts are in lieu of glasses.

Scan or click this QR code to find an in-network MetLife Vision Provider.

MENTAL HEALTH RESOURCES

THE FOLLOWING MENTAL HEALTH RESOURCES ARE FREE TO ALL ASSOCIATES.

Mental health is integral to living a healthy, balanced life. One in five Americans experience mental health issues. Our mental health encompasses our psychological, emotional, and social well-being. This means it impacts how we feel, think, and behave every day. Our mental health also contributes to our decision-making process, how we cope with stress and how we relate to others in our lives.

EMPLOYEE ASSISTANCE PROGRAM

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. Our Employee Assistance Program (EAP) is available to you in addition to the benefits of your MetLife insurance coverage. This program provides easy-to-use services to help with life's everyday challenges — at no additional cost to you.

Expert advice for work, life, and your wellbeing

The program's experienced counselors provided through LifeWorks — one of the nation's premier providers of Employee Assistance Program services — can talk to you about anything going on in your life. The program includes up to 5 in person, phone, or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year.

Get Started with the EAP

To utilize the resources provided by the EAP, call 888-319-7819 or visit **metlifeeap.lifeworks.com**.

Username: metlifeeap

Password: eap

LIFEWORKS SUPPORT & RESOURCES

The Company EAP can help support your mental, emotional, relational, and even physical goals.

Explore resources through your EAP program designed to help you achieve your physical health goals, including:

- Weight Loss Tools
- Building Conscious Eating Habits
- Diet and Nutrition Resources
- Self-guided CareNow Programs
- And more!

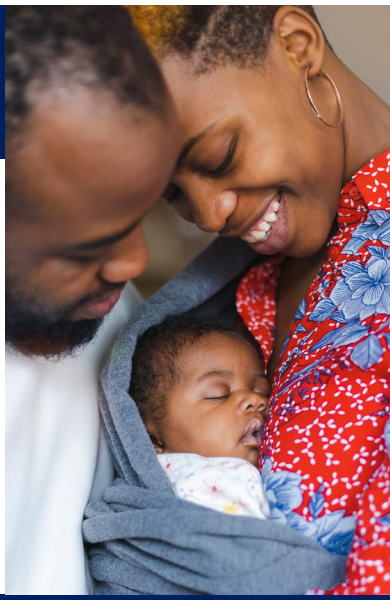
MARKETPLACE CHAPLAINS

Marketplace Chaplains provide a personalized service through the use of Chaplain Care Teams, which are voluntary, neutral from company operations, and strictly confidential. Chaplains are male and female as well as ethnically diverse.

- Download the MyChap app to your mobile device
  - » Click here to download for **Android** | **Apple**
- Enter code: 1573

PAID PARENTAL LEAVE

To support our new parents, associates who give birth or adopt a child will receive up to four weeks of paid parental leave (for hourly associates, average hours worked are used).



ELIGIBILITY

To be eligible for paid parental leave, you must be a full-time regular associate with a minimum of 6 months of employment, and you must meet one of the following criteria.

- The parent who gave birth
- A biological parent or the spouse of the biological parent of the newborn, or
- A parent who has adopted a child or been placed with a foster child, (in either case, the child must be age 17 or younger).

BASIC LIFE AND AD&D

The Company provides you with Basic Life and Accidental Death and Dismemberment (AD&D) at no cost, through MetLife. This coverage helps ensure that loved ones, such as a spouse or other designated survivors, will be financially secure after your death.

Your Basic Life and AD&D coverage amount can be viewed in your Benefits Enrollment Platform.

SUPPLEMENTAL LIFE AND AD&D

In addition to Company-provided Life and A&D coverage, you may also purchase Supplemental Life and AD&D through MetLife. New hires can enroll in the maximum coverage amount for themselves with no questions asked. If you waive Life coverage when first eligible and decide to enroll later, you will have to provide a statement of good health called Evidence of Insurability (EOI), which can be approved or denied at the carrier's discretion at that time.

To enroll in Supplemental Spouse or Child Life and AD&D, you have to enroll in coverage for yourself first.

Spouse coverage for new entrants is guaranteed in the amount of $50,000. If waived when first eligible, coverage in any amount is subject to EOI approval.

Supplemental Life and AD&D Coverage

Associate	You may purchase coverage of $50,000, $100,000, and $200,000
Spouse	You may purchase coverage of $50,000, $100,000*, and $150,000*
Children	You may purchase coverage of $10,000. Coverage up to age 26 (live birth to 6 months $1,000)

*Subject to Evidence of Insurability for new entrants

Beneficiary Designation

Your beneficiary is the person(s) or entity (e.g., trust or charity) you name to receive your life insurance benefits in the event of your death. You may update your beneficiary information any time by going to your Benefits Enrollment Platform.

If you do not designate a beneficiary, the insurance company may take longer to pay out the benefit and will have to use their internal policy to determine who gets the proceeds (e.g., your surviving spouse, your estate, etc.).

Benefits for a dependent's death are payable to you (i.e., no beneficiary designation is needed).

INCOME PROTECTION

DISABILITY

SHORT-TERM DISABILITY*

Voluntary Short–Term Disability (STD) through MetLife protects a portion of your income if you become disabled because of a non-work related illness or injury for up to 13 weeks. STD benefits may be reduced by any state-paid disability benefits you receive.

Note: If you waive STD coverage when first eligible and decide to enroll later, you will have to provide a statement of good health called Evidence of Insurability (EOI), which can be approved or denied at the carrier's discretion at that time. If you do not complete the EOI within 60 days of enrollment, your STD election will be changed to "Waived."

Eligibility	1st of the month following hire
Benefit Begins	After 15 days
Benefit Amount	60% of weekly earnings
Maximum Benefit	$2,500/week; Up to 13 week duration

Disability Forms

You can find disability forms on your benefits enrollment platform.

LONG-TERM DISABILITY

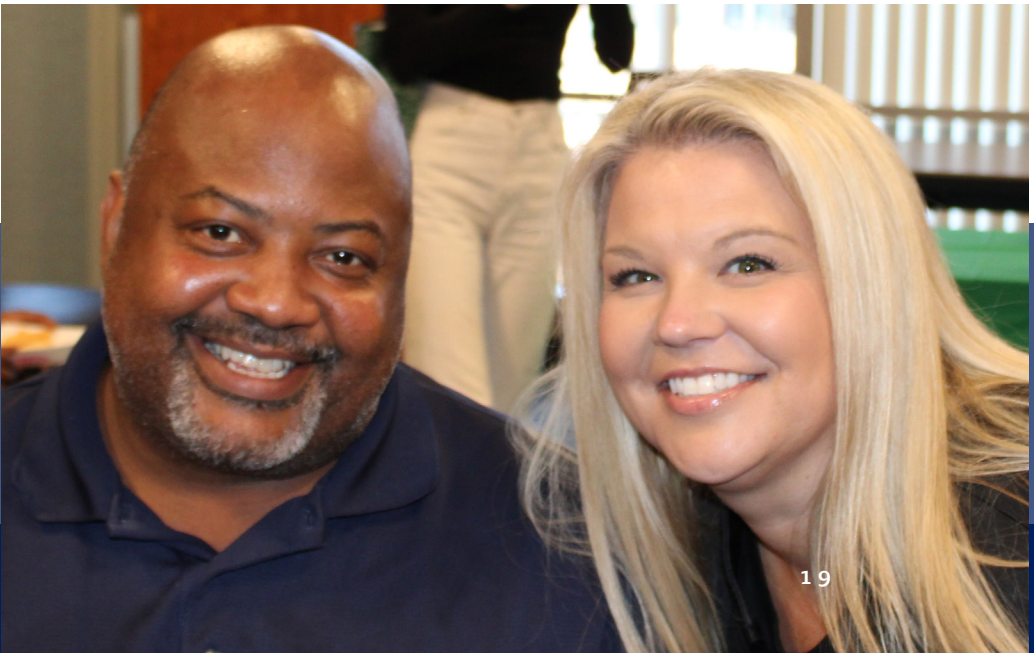
Voluntary Long-Term Disability (LTD) through MetLife protects a portion of your income if you become disabled because of a non work-related illness or injury for longer than 90 days. Certain exclusions as well as pre-existing condition limitations may apply.

Note: If you waive LTD coverage when first eligible and decide to enroll later, you will have to provide a statement of good health called Evidence of Insurability (EOI), which can be approved or denied at the carrier's discretion at that time. If you do not complete the EOI within 60 days of enrollment, your LTD election will be changed to "Waived."

Benefit Begins	After 90 days of disability
Benefit Amount	60% of monthly earnings
Maximum Monthly Benefit	Class 1: $10,000 Class 2: $6,000
Pre-Existing Conditions	Prior to effective date

Note: The company provides Corporate associates with Employer-paid Long-Term Disability (LTD) benefits.

Scan this QR code to save MetLife's contact information to your phone.



*Residents of CA, NJ, NY, and PR may be eligible for state disability benefits that will be offset from the VSTD. It is your responsibility to determine eligibility for your respective state/territory.

VOLUNTARY BENEFITS

ACCIDENT INSURANCE

Accident insurance provides a financial cushion for life's unexpected events by providing you with a lump-sum payment when your family needs it most. It pays various cash amounts if, as the result of an accident, you or your covered dependents receive medical care for one of more than 150 covered events as defined in your group certificate, including accidental death or dismemberment. Accident insurance pays regardless of what your medical plan may cover. The payment you receive is yours to spend however you like.

The plan provides a lump-sum payment for over 150 covered events such as:

- Fractures
- Dislocations
- Second and third degree burns
- Cuts or lacerations
- Eye injuries
- Coma
- Torn knee cartilage
- Ruptured disc
- Concussions

You'll receive a lump-sum payment when you have these covered medical services/treatments:

- Ambulance
- Emergency care
- Inpatient/Outpatient surgery
- Physician follow-up visits
- Transportation
- Medical Testing Benefits (includes X-rays, MRIs and CT Scans)
- Therapy services (including physical and occupational therapy)

This plan provides protection for covered events experienced while off the job only.

	Low Plan	High Plan
Fractures & Dislocations	$50 – $3,000	$100 – $6,000
Second & Third Degree Burns	$50 – $5,000	$100 – $10,000
Concussions	$200	$400
Eye Injuries	$200	$300
Ambulance	$200 – $750	$300 – $1,000
Emergency Care	$25 – $50	$50 – $100
Physician Follow-Up	$50	$75
Medical Appliances	$50 – $500	$100 – $1,000
Inpatient Surgery	$100 – $1,000	$200 – $2,000

Scan this QR code to save MetLife's contact information to your phone.

CRITICAL ILLNESS

Critical illness insurance through MetLife works to complement your medical coverage and pays in addition to what your medical plan may or may not cover. It's coverage that provides financial support when you or a dependent becomes seriously ill.

Upon diagnosis, it provides you with a lump-sum payment of $15,000 or $30,000 in initial benefits. If you or a covered dependent experience more than one covered condition, the maximum total benefit amount is 3 times that of the initial benefit amount, which is $45,000 or $90,000.

The following medical conditions are covered:

- Cancer
- Heart Attack
- Stroke
- Coronary Artery Bypass Graft
- Kidney Failure
- Alzheimer's Disease
- Major Organ Transplant
- And many other conditions

Please note: Benefits will not be payable for covered conditions that are caused by or result from a pre-existing condition if the covered condition occurs during the first 6 months of coverage.

$50 WELLNESS SCREENING BENEFIT

Health screenings are an important part of managing your health. That's why your Critical Illness insurance coverage from MetLife provides an additional Health Screening Benefit for covered screenings and tests. Now, everyone who's enrolled—you, your spouse, and dependent children—can earn an extra benefit just for taking care of their health.

How to claim your $50 Health Screening Benefit

You can submit multiple claims for your spouse or dependent children, all on one call.

1. Call **800-438-6388**.
2. Provide a few details, including: the healthcare provider's name, address, and phone number, the screening/test and the date it was completed, and the address where the test/screening was performed.
3. Receive your Health Screening Benefit payment. (Checks are typically issued within a few business days once your claim has been processed.)

LEGAL INSURANCE

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. For a monthly fee, you can have a team of top attorneys ready to help you take care of life's planned and unplanned legal events.

MetLife Legal Plans gives you access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft, or caring for aging parents.

MetLaw could save you hundreds of dollars in attorney fees for common legal services like these:

- Estate planning documents, including Wills and Trusts
- Identity theft defense
- Traffic offenses
- Family Law, including adoption and name change
- Real estate matters
- Financial matters, such as debt-collection defense document review
- Advice and consultation on personal legal matters

Scan or click this QR code to access MetLife Legal Plans.

SAVINGS

401(K) SAVINGS PLAN

The 401(k) Retirement Plan is designed to help you save for your future. Through before-tax or after-tax contributions to your account, you build income for retirement. You can choose from a variety of investment options to help meet your goals.

To enroll or to make changes, log on to **netbenefits.fidelity.com** or call 800-835-5097.

Eligibility

You are eligible to participate in the 401(k) contribution portion of the Plan if:

- You complete 4 months of service
- You are at least 21 years old

Once you satisfy the 401(k) contribution requirements, you will become eligible to participate in the 401(k) contribution portion of the Plan on the first day of the following month.

Contributing to the Plan

You can decide how much of your salary you want to contribute directly from your paycheck.

Through automatic payroll deduction, you may contribute between 1% and 100% of your eligible pay, up to the annual IRS dollar limit (2025 = $23,500). You may change your deferral percentage at any time (please allow 1-2 pay periods for changes to take effect).

In addition, you can automatically increase your retirement savings plan contributions each year through the Annual Increase Program. To sign up, access the Contributions section within Fidelity NetBenefits®, or call the plan's toll-free number.

If you are age 50 or over by the end of the taxable year and have reached the annual IRS limit or Plan's maximum contribution limit for the year, you may make additional salary deferral contributions to the Plan up to the IRS Catch Up Provision Limit (2025 = $7,500).

The Roth 401(k) contribution option is also available to you. A Roth 401(k) contribution to your retirement plan allows you to make after-tax contributions and take any associated earnings tax-free at retirement.

Company Contributions

The company will match your 401(k) contributions with Safe Harbor contributions. Here's how it works:

- **Dollar for dollar** on the first **3%** of your eligible pay that you contribute.
- **50 cents per dollar** on the next **2%** you contribute.

That means if you contribute **5% of your pay**, you get a **4% company match**!

The plan will match on the combined total of your before-tax deferral contributions, Roth 401(k) after-tax deferral contributions, and the catch-up contribution amounts up to the matching limit.

Scan or click this QR code to enroll in the 401(k) Savings Plan through Fidelity.

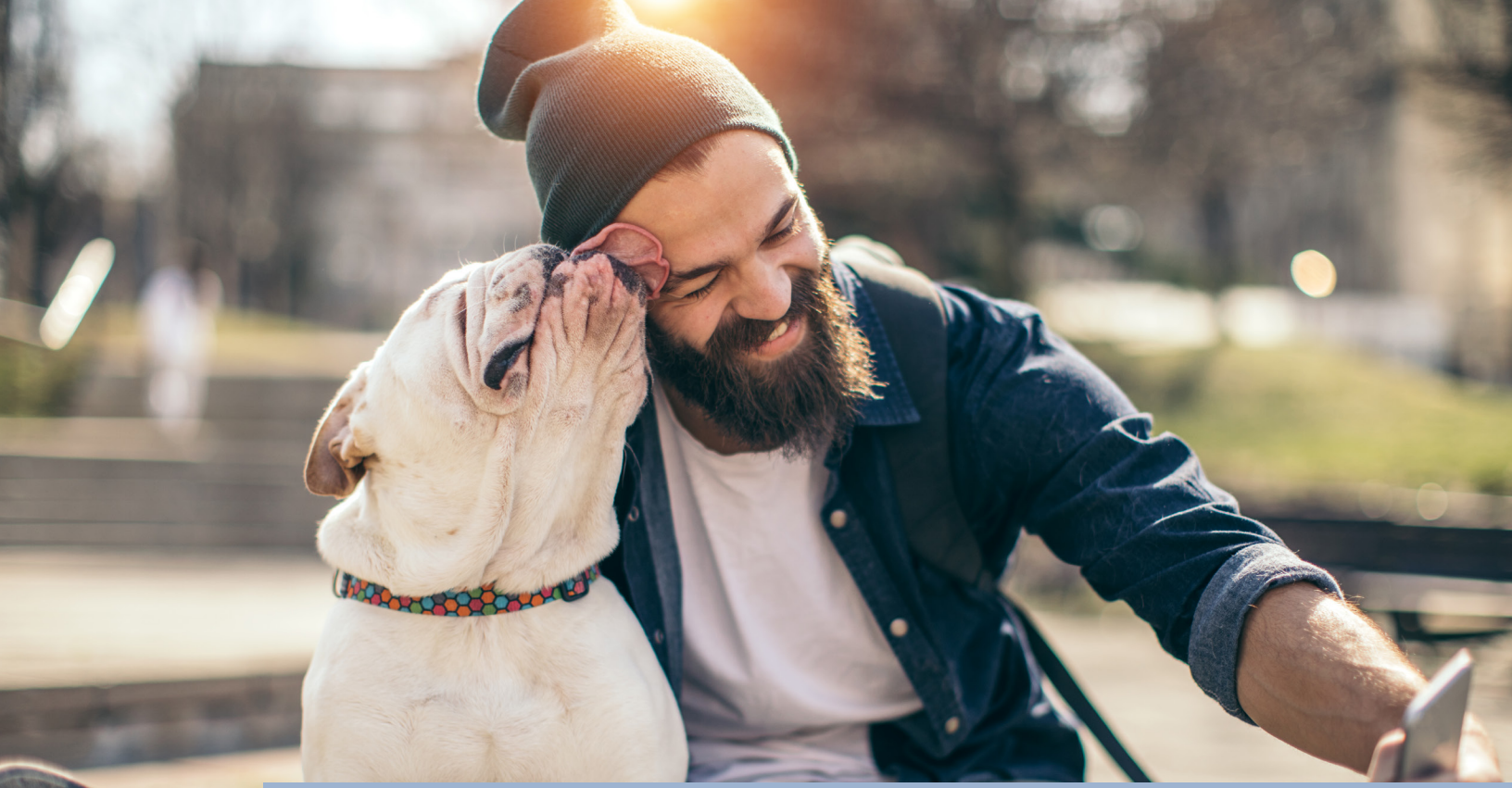
INVESTMENT ASSISTANCE

Equity Planning Group provides free assistance to associates, from rolling over a previous plan to choosing investment funds.

Call at 419-842-3300 or email **pjoseph@equitypg.com**.

529 SAVINGS PLAN

The College America plan is a savings plan that can help you build a nest egg for your children, grandchildren, nieces, nephews, or anyone else you want to help with college education expenses. The plan offers significant tax advantages to those who invest for higher education. Any earnings received on your contribution will be free from taxes as long as it is used for education purposes. Associates can sign up for this program upon date of hire. For more information or to enroll, contact Equity Planning Group at 419-842-3300.



DAILYPAY

DailyPay is a benefit that allows you to get your pay any time before payday and easily track how much you're making. It is free to create an account, and your available pay will increase every time you work. You can transfer your pay instantly for a fee. In order to sign up for DailyPay, you must be enrolled in direct deposit. You can also sign up using a prepaid debit card. **Please note:** DailyPay is only available at eligible locations.

FINANCIAL WELLNESS FEATURES

- **Free financial coaching:** DailyPay has partnered with Coordinated Assistance Network to offer you free financial wellness coaching sessions. Specialized coaches can help you to manage your expenses, build savings, make a play to pay off debt, and so much more! You can request sessions in the DailyPay app.
- **AutoSave feature:** Set aside a recurring amount to be transferred from your available balance into your savings account every payday.
- **Allocate feature:** Assign your money to different savings accounts which you label to help stay organized and motivated while saving.

The DailyPay User Support Team is available to help in both English and Spanish at 866-432-0472. Find out more by visiting **employee.dailypay.com**.

Scan or click the QR codes below to download the DailyPay app to your phone.

Download on the App Store

GET IT ON Google Play

IMPORTANT NOTICES

IMPORTANT NOTICE 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 The Company 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:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you 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.+

- The Company has determined that the prescription drug coverage offered by the Insurance plan is, on average for all plan Employees, expected to payout as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll from October 15th through December 7th. If you enroll from October 15th through December 7th, your coverage will begin on January 1.

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.

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 The Company 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 the 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 November 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 The Company

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 **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 1-800-633-4227 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 **socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D 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).

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Company coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current The Company coverage, be aware that you and your dependents will not be able to get this coverage back.

HIPAA SPECIAL ENROLLMENT NOTICE

Notice of Special Enrollment Rights for Medical Plan Coverage

As you know, if you have declined enrollment in The Company health plan for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

The Company will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days –instead of 30 – from the date of the Medicaid/ CHIP eligibility change to request enrollment in The Company group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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. Please see the Plan's Summary Plan Description for details of the Plan's deductible, benefit percentage, and copayment requirements. If you would like more information on WHCRA benefits, contact HR.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this notice because you have recently become covered under The Company's group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other Employees of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact HR.

What is COBRA Continuation Coverage?

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

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or

- Your employment ends for any reason other than your gross misconduct.

If you are the spouse/domestic partner of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse/domestic partner dies;

- Your spouse/domestic partner's hours of employment are reduced;

- Your spouse/domestic partner's employment ends for any reason other than his or her gross misconduct;

- Your spouse/domestic partner becomes enrolled in Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse/domestic partner.

If the Plan provides health care coverage to retired Employees, the following applies: filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with

respect to the bankruptcy. The retired Employee's spouse/domestic partner, surviving spouse/domestic partner, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after The Company has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, in the event of retired Employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify The Company of the qualifying event.

Required Notice

You must give notice of some qualifying events for the other qualifying events (divorce or legal separation of the Employee and spouse/domestic partner or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/ or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitle to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries, other than the Employee, lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse/domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify The Company in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact The Company and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period Of Continuation Coverage

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to The Company. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep The Company informed of any address changes. You should also keep a copy, for your records, of any notices you send to The Company.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

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, 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 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 **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 March 17, 2025. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since March 17, 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

ALABAMA – Medicaid
myalhipp.com
1-855-692-5447

ALASKA – Medicaid
Premium Payment Program
myakhipp.com
1-866-251-4861
customerservice@myakhipp.com
Medicaid Eligibility: **health.alaska.gov/dpa/pages/default.aspx**

ARKANSAS – Medicaid
myarhipp.com
1-855-692-7447

CALIFORNIA – Medicaid
http://dhcs.ca.gov/hipp
Email: **hipp@dhcs.ca.gov**
916-445-8322

COLORADO – Medicaid and CHIP
Medicaid: **healthfirstcolorado.com**
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHIP: **hcpf.colorado.gov/child-health-plan-plus**
CHIP Customer Service: 1-800-359-1991 / State Relay 711
HIBI: **mycohibi.com**
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
1-877-357-3268

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64:
in.gov/fssa/dfr/
1-800-403-0864
All other Medicaid: **in.gov/medicaid/**
1-800-457-4584

IOWA – Medicaid and CHIP
Medicaid Website: **hhs.iowa.gov/programs/welcome-iowa-medicaid**
Medicaid Phone: 1-800-338-8366
Hawki Website: **dhs.iowa.gov/hawki**
Hawki Phone: 1-800-257-8563
HIPP Website: **hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp**
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
kancare.ks.gov
1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid and CHIP
Kentucky Medicaid Website: **chfs.ky.gov/agencies/dms**
KI-HIPP Website: **chfs.ky.gov/agencies/dms/member/pages/kihipp.aspx**
1-855-459-6328
Email: **kihipp.program@ky.gov**
KCHIP Website: **kynect.ky.gov**
1-877-524-4718

LOUISIANA – Medicaid
medicaid.la.gov
ldh.la.gov/lahipp
1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
mymaineconnection.gov/benefits/
Enroll: 1-800-442-6003
Private Health Insurance Premium Webpage:
maine.gov/dhhs/ofi/applications-forms
Private HIP: 1-800-977-6740
Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
mass.gov/masshealth/pa
1-800-862-4840
TTY: 711
masspremassistance@accenture.com

MINNESOTA – Medicaid
mn.gov/dhs/health-care-coverage/
1-800-657-3739

MISSOURI – Medicaid
dss.mo.gov/mhd/participants/pages/hipp.htm
573-751-2005

MONTANA – Medicaid
dphhs.mt.gov/montanahealthcareprograms/hipp
1-800-694-3084
hhshippprogram@mt.gov

NEBRASKA – Medicaid
accessnebraska.ne.gov
1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
dhcfp.nv.gov
1-800-992-0900

NEW HAMPSHIRE – Medicaid
dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 15218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: **state.nj.us/humanservices/dmahs/clients/medicaid**
Medicaid Phone: 609-631-2392
CHIP Website: **njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
health.ny.gov/health_care/medicaid
1-800-541-2831

NORTH CAROLINA – Medicaid
medicaid.ncdhhs.gov
919-855-4100

NORTH DAKOTA – Medicaid
hhs.nd.gov/healthcare
1-844-854-4825

OKLAHOMA – Medicaid and CHIP
insureoklahoma.org
1-888-365-3742

OREGON – Medicaid
healthcare.oregon.gov/pages/index.aspx
1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Medicaid: **pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html**
1-800-692-7462
CHIP: **pa.gov/agencies/dhs/resources/chip.html**
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
eohhs.ri.gov
1-855-697-4347, or 401-462-0311(Direct RIte)

SOUTH CAROLINA – Medicaid
scdhhs.gov
1-888-549-0820

SOUTH DAKOTA – Medicaid
dss.sd.gov
1-888-828-0059

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

UTAH – Medicaid and CHIP
Medicaid Website: **medicaid.utah.gov**
CHIP Website: **health.utah.gov/chip**
Adult Expansion Website: **medicaid.utah.gov/expansion/**
Utah Medicaid Buyout Program Website: **medicaid.utah.gov/buyout-program/**
1-877-222-2542

VERMONT – Medicaid
dvha.vermont.gov/members/medicaid/hipp-program
1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid: **coverva.dmas.virginia.gov/**
CHIP: **coverva.dmas.virginia.gov/learn/coverage-for-children/**
1-800-432-5924

WASHINGTON – Medicaid
hca.wa.gov
1-800-562-3022

WEST VIRGINIA – Medicaid
dhhr.wv.gov/bms
mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Phone: 1-855-699-8447

WISCONSIN – Medicaid and CHIP
dhs.wisconsin.gov/badgercareplus
1-800-362-3002

WYOMING – Medicaid
health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
1-800-251-1269

PAPERWORK REDUCTION ACT STATEMENT

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

of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

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

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Form Approved 0MB 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.

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 on your premium 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.-12

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

1 Indexed annually; see **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.

WHEN CAN I ENROLL IN HEALTH INSURANCE COVERAGE THROUGH THE MARKETPLACE?

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

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

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

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

WHAT ABOUT ALTERNATIVES TO MARKETPLACE HEALTH INSURANCE COVERAGE?

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

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

HOW CAN I GET MORE INFORMATION?

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.

Employer Name: Remington Hotels LLC
Employer Identification Number (EIN): 20-0558870
Employer Phone Number: (972) 778-9368
Employer Address: 14185 Dallas Pkwy #1150
Dallas, TX 75254
Contact About Coverage: Jason Mansfield
Phone Number: (972) 778-9239
Email Address: **benefits@remingtonhotels.com**

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

- As your employer, we offer a health plan to:
    - » Some employees. Eligible employees are full-time employees and employees who work an average of 30 hours per week.
- With respect to dependents:
    - » We do offer coverage. Eligible dependents are spouses and children.

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 will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act (HIPAA) health plans are required to provide covered individuals with a Privacy Notice that describes, among other things, the uses and disclosures of protected health information that may be received by the plans, your rights regarding that information and the plan's responsibilities.

The Strive to Thrive Benefits Health Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. **If you would like a copy of the Plan's Notice of Privacy Practices, please contact:**

Strive to Thrive Benefits
14185 Dallas Parkway, Ste 1150
Dallas, TX 75254
benefits@remingtonhotels.com

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

WHO TO CONTACT

Contact the Benefits Team at **benefits@remingtonhotels.com** or your HR Team with questions about your benefits, eligibility, and premiums. Reach out to a vendor directly when you need help finding filing a claim.

Plan	Carrier and Network	Group Numbers (See abbreviations below.)	Website	Phone
Medical	GenerationYou™ – Health Concierge Service	AHS, POL, RED, RHC: **76415481** AHA, ASE, PPM, WIC: **76415482** REM Field, Inspire, ITW, SEB: **76415483**	**UMR.com**	844-600-0919
Prescription	SmithRx – Pharmacy Benefit Manager	N/A	**member.mysmithrx.com**	844-454-5201
Dental	MetLife (PDP Plus Network)	AHS, Inspire, ITW, POL, RED, REM Field, RHC, SEB: **0101309** AHA, ASE, PPM, WIC: **0151209**	**metlife.com/dental**	800-942-0854
Vision	MetLife (VSP Network)		**metlife.com/vision**	855-638-3931
Employee Assistance Program – Counseling Services	MetLife		**metlifeeap.lifeworks.com** (password: eap)	888-319-7819
Short-Term & Long-Term Disability	MetLife		**metlife.com**	800-438-6388
NYPFL/NYDBL	MetLife		**metlife.com**	New Claims: 866-729-9201 Ongoing: 800-858-6506
401(k)	Fidelity Investments	N/A	**401k.com**	800-835-5097
Retirement Planning	Equity Planning Group – Investment Assistance	N/A	**equityplanning.com**	419-842-3314
Critical Illness & Accident	MetLife	AHS, Inspire, ITW, POL, RED, REM Field, RHC, SEB: **0101309** AHA, ASE, PPM, WIC: **0151209**	**metlife.com**	800-438-6388
Legal Plan	MetLife		**legalplans.com**	800-821-6400
Pet Insurance	MetLife		**metlife.com/getpetquote**	800-438-6388

GROUP # ABBREVIATIONS

AHA | Ashford Hospitality

AHS | Ashford Hospitality Services

ASE | Ashford Securities

PPM | Premier Project Management

RHC | Remington Hospitality Corporate

RED | RED Hospitality

POL | Pure

WIC | Warwick

WHO'S INCLUDED UNDER 'FIELD'?

Remington Field

INSPIRE

Island Time Watersports

Sebago

Go to **StriveToThriveBenefits.com** or scan this QR code to access the StrivetoThrive website today!

NOTES

2025/2026 Benefits Guide

STRIVE to THRIVE

August 2025