CROWN LINEN

EMPLOYEE BENEFITS GUIDE

OCTOBER 1, 2025 - SEPTEMBER 30, 2026

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 30 for more details.

FLORIDA

Brown & Brown

Benefit plans are subject to change. Crown Linen LLC. reserves the right at any time, in its sole discretion, to amend, modify, reduce the benefits provided by, or terminate any of its plans. Any amendment, modification, reduction or termination may be made without prior notice to participants, except as required by law. This Benefit Booklet is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this benefit booklet conflicts in any way with the Certificate of Coverage, the COC shall prevail. It is recommended that you review your COC for an exact description of the services, and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information.

Note: While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

Information provided in this booklet is intended to serve as a convenient reference guide. If any information contained in this booklet differs from any plan documentation, please revert to plan documentation.

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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INTRODUCTION

Crown Linen LLC. offers a valuable benefits package that provides choices and flexibility for the diverse and changing needs of our employees. As a healthcare consumer, it's important you take an active role in understanding your needs, your family's needs, and the benefit options available to you.

This guide offers a comprehensive overview of your benefit options, including information on eligibility and how to enroll. We encourage you to read the information carefully and familiarize yourself with the benefits you're offered before making your selections. Throughout the year, you can use this guide as a reference.

Your benefits broker, Brown & Brown, is here to help! Reach out to your dedicated Account Executive with any benefits questions, including enrolling in benefits as a new hire, prior authorizations, finding a provider, ordering ID cards, processing life events, and more. Your Account Executive's contact information can be found on the Contacts page.

EFFECTIVE OCTOBER 1, 2025
or after satisfying the New Hire Waiting Period

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CONTACT INFORMATION

Account Executive	Benefit Coordinator
Kimberley Vera Tudela Account Executive 954-331-1471 Kim.VeraTudela@bbrown.com	**Stephanie Sanchez** Benefit Coordinator 954-331-1396 Stephanie.Sanchez@bbrown.com
Benefits Consultant	**Claims**
Sergio Castillo Employee Benefits Consultant 954-804-7834 Sergio.Castillo@bbrown.com	**Analisa VanDelinder** Client Care Advocate 954-331-1361 Analisa.Vandelinder@bbrown.com

Refer to this list when you need to contact one of your benefit vendors.
For general information, please contact Human Resources.

Human Resources	Lenis Figuera | Payroll & Benefits Generalist | (786) 483-3490 Figuera@crownlinen.net Regina Rodriguez | Corporate HR Manager | (407) 992-8479 Regina.Rodriguez@crownlinen.net
Medical	Customer Service 1-866-633-2446 myuhc.com
Dental	Customer Service 1-866-633-2446 myuhc.com
Vision	Customer Service 1-866-633-2446 myuhc.com
GAP	Customer Service 1-800-256-8606 ampublic.com
Life and AD&D, STD	Customer Service 1-800-521-3535 allstateatwork.com
Benefits Enrollment	Call Center 1-877-282-0808 Monday to Friday from 8 am to 6 pm EST

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BENEFITS OVERVIEW

Crown Linen LLC. is pleased to offer a wide variety of benefits to fit your personal and family needs. Please take the time to review all sections of this enrollment booklet carefully. If after reviewing the enclosed information you have questions on any of the items enclosed, please feel free to contact Human Resources.

CAFETERIA PLAN

Crown Linen LLC. currently offers a Cafeteria Plan, which provides a valuable tax benefit to both the Company and its employees. A cafeteria plan is a benefit plan authorized by Section 125 of the Internal Revenue Code, which allows employees to elect benefits on a pre-tax basis. Changes to your elections may be made at the next Open Enrollment unless you experience a Qualifying Event. A Family Status Change allows employees to add, change or drop coverage during the plan year due to the following reasons listed below (this list is not all inclusive):

CHANGING ELECTIONS AND QUALIFIED FAMILY STATUS CHANGES DURING THE YEAR

What is considered a “Qualified Family Status Change?”

- Marriage
- Divorce
- Legal Separation
- Birth or Adoption of a child
- Change in child’s dependent status
- Death of a spouse, child or othe qualified dependent
- Commencement or termination of adoption proceedings
- Change in spouse’s employment status

These events must be reported to Human Resources within 30 days from the effective date of the “Qualifying Event”, or a missed enrollment opportunity (no coverage) will occur. Not all Family Status Change events will allow the same election change for each benefit offered. Employees will have 30 days from the change in family status to make changes to the current plans.

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ELIGIBILITY

WHO IS ELIGIBLE?

All active, full-time employees who work 30 hours or more per week – part time, per diem, temporary & seasonal employees excluded.COBRA eligible individuals are eligible to enroll in the medical, dental and/or vision plans as applicable. If terminating during the Plan Year, you will be eligible to continue that participation through COBRA continuation.

When you enroll, you can also cover your eligible dependents.

WHO CAN BE COVERED?

- Legal spouse*
- Your unmarried natural child(ren), legally adopted children, and step children.*

THE AGE LIMITS VARY AS FOLLOWS:

- **MEDICAL, DENTAL, AND VISION COVERAGE:** Eligibility for dependent children ends at the end of the calendar year when the dependent turns 26 or up to age 30 in accordance with Florida Statute 627.6562**

**A marriage certificate is required to verify spousal eligibility. For your unmarried natural children, legally adopted children, and stepchildren, you must provide a birth certificate or other legal documentation showing your relationship to the child.*

***Florida Statute 627.6562: A covered dependent child may continue coverage past age 26 if: they are single and have no dependents, they are a Florida resident unless they are a full- or part-time student, they have no other available insurance coverage, they are not entitled to Medicare, and they do not have a child of their own.*

WAITING PERIOD

Newly hired employees are eligible to receive benefits on the first day of the month following the 60-day period (i.e., if their hire date is November 15, 2025, their benefits effective date is February 1, 2026).

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MEDICAL INSURANCE

Crown Linen LLC. is pleased to announce that our health coverage will continue with **United Healthcare** beginning **October 1, 2025**. To search for in-network providers: **myuhc.com**. Find a Doctor | Select a Plan | NHP HMO/POS

This plan requires a primary care provider.

UnitedHealthcare®	NHP - HMO OA HSA EKUY-M / RX NHES-HSA
SERVICES	**IN-NETWORK ONLY**
Calendar Year Deductible (CYD) Individual / Family	 $5,500 / $11,000
Co-Insurance	100%
Provider Services	**Open Access**
Annual Out-of-Pocket Maximum Includes Deductible Individual / Family	 Yes $6,550 / $13,100
Physician & Emergency Care	
Preventive Care	$0
PCP | Specialist	0% After CYD
Urgent Care	0% After CYD
Emergency Room (In or out of network)	0% After CYD
Hospitalization & Outpatient Care	
Inpatient	0% After CYD
Outpatient Hospital	0% After CYD
Physician Fees	0% After CYD
Outpatient Freestanding Facility	0% After CYD
Physician Fees	0% After CYD
Independent Facility Care	
Labs	0% After CYD
X-rays	0% After CYD
Complex Diagnostic Imaging	0% After CYD
Prescription Drugs (30 day supply)	**National**
Deductible	After CYD
Tier 1 / Tier 2 / Tier 3 (30 Day Supply) Preferred Specialty Retail	$10 / $35 / $70 $10 / $150 / $500
Mail Order (90 Day Supply)	$25 / $87.50 / $175

We are pleased to announce the reinstatement of Walgreens as a participating pharmacy this year.

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MEDICAL INSURANCE

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This plan requires a primary care provider.

UnitedHealthcare®	NHP HMO OA EKW3-M / RX NHDS
SERVICES	**IN-NETWORK ONLY**
Calendar Year Deductible (CYD) Individual / Family	 $5,000 / $10,000
Co-Insurance	100%
Provider Services	**Open Access**
Annual Out-of-Pocket Maximum Includes Deductible Individual / Family	 Yes $6,850 / $13,700
Physician & Emergency Care	
Preventive Care	$0
PCP | Specialist	$25 | $50
Urgent Care	$50
Emergency Room (In or out of network)	0% After CYD
Hospitalization & Outpatient Care	
Inpatient	$500 + 0% After CYD
Outpatient Hospital	$300 + 0% After CYD
Physician Fees	0% After CYD
Outpatient Freestanding Facility	$300 + 0% After CYD
Physician Fees	0% After CYD
Independent Facility Care	
Labs	$0
X-rays	$0
Complex Diagnostic Imaging	0% After CYD
Prescription Drugs (30 day supply)	**National**
Deductible	N/A
Tier 1 / Tier 2 / Tier 3 (30 Day Supply) Preferred Specialty Retail	$10 / $35 / $70 $10 / $150 / $500
Mail Order (90 Day Supply)	$25 / $87.50 / $175

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MEDICAL INSURANCE

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This plan requires a primary care provider.

UnitedHealthcare®	NHP POS OA EKY7-M / RX NHDS	
SERVICES	**IN-NETWORK ONLY**	**OUT-OF-NETWORK**
Calendar Year Deductible (CYD) Individual / Family	$1,000 / $2,000	$2,000 / $4,000
Co-Insurance	100%	70% / 30%
Provider Services	**Open Access**	**Open Access**
Annual Out-of-Pocket Maximum Includes Deductible Individual / Family	Yes $3,000 / $6,000	Yes $6,000 / $12,000
Physician & Emergency Care		
Preventive Care	$0	30% After CYD
PCP | Specialist	$30 | $60	30% After CYD
Urgent Care	$100	30% After CYD
Emergency Room	$350	$350
Hospitalization & Outpatient Care		
Inpatient	0% After CYD	30% After CYD
Outpatient Hospital	0% After CYD	30% After CYD
Physician Fees	0% After CYD	30% After CYD
Outpatient Freestanding Facility	0% After CYD	30% After CYD
Physician Fees	0% After CYD	30% After CYD
Independent Facility Care		
Labs	$0	30% After CYD
X-rays	$0	30% After CYD
Complex Diagnostic Imaging	0% After CYD	30% After CYD
Prescription Drugs (30 day supply)	**National**	**N/A**
Deductible	N/A	N/A
Tier 1 / Tier 2 / Tier 3 (30 Day Supply) Preferred Specialty Retail	$10 / $35 / $70 $10 / $150 / $500	Not Covered Not Covered
Mail Order (90 Day Supply)	$25 / $87.50 / $175	Not Covered

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MEDICAL INSURANCE

Crown Linen LLC. is pleased to announce that our health coverage will be with **United Healthcare** beginning **October 1, 2025**. To search for in-network providers: **myuhc.com**. Find a Doctor | Select Plan | Choice Plus

UnitedHealthcare®	UHC - CHOICE PLUS EKRM-M / RX 124S	
SERVICES	**IN-NETWORK ONLY**	**OUT-OF-NETWORK**
Calendar Year Deductible (CYD) Individual / Family	$1,000 / $2,000	$2,000 / $4,000
Co-Insurance	100%	70% / 30%
Provider Services	**Open Access**	**Open Access**
Annual Out-of-Pocket Maximum Includes Deductible Individual / Family	Yes $3,000 / $6,000	Yes $6,000 / $12,000
Physician & Emergency Care		
Preventive Care	$0	30% After CYD
PCP | Specialist	$30 | $60	30% After CYD
Urgent Care	$50	30% After CYD
Emergency Room	$350	$350
Hospitalization & Outpatient Care		
Inpatient	0% After CYD	30% After CYD
Outpatient Hospital	0% After CYD	30% After CYD
Physician Fees	0% After CYD	30% After CYD
Outpatient Freestanding Facility	0% After CYD	30% After CYD
Physician Fees	0% After CYD	30% After CYD
Independent Facility Care		
Labs	DDP* $0 / NDDP** 50%	30% After CYD
X-rays	$0	30% After CYD
Complex Diagnostic Imaging	0% After CYD	30% After CYD
Prescription Drugs (30 day supply)	**National**	**National**
Deductible	N/A	N/A
Tier 1 / Tier 2 / Tier 3 (30 Day Supply) Preferred Specialty Retail	$10 / $35 / $70 $10 / $150 / $500	$10 / $35 / $70 Not Covered
Mail Order (90 Day Supply)	$25 / $87.50 / $175	Not Covered

We are pleased to announce the reinstatement of Walgreens as a participating pharmacy this year.

**DDP = Designated Diagnostic Providers | **NDDP = Non Designated Diagnostic Providers*

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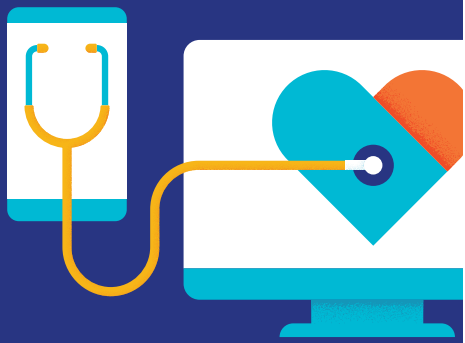

Activate your myuhc.com account

Put your health plan at your fingertips

Get the most out of your benefits

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

- **Find, price and save on care—**you can save with Virtual Visits* and other tools. You can save an average of 36%[1] when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details,** plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills,** get estimates and compare medication pricing**
- **Check your plan balances,** access financial accounts and more

Download the UnitedHealthcare® app

It's perfect for on-the-go access, help finding a nearby doctor and more.

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

**Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

continued

United Healthcare

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DESIGNATED DIAGNOSTIC PROVIDER (DDP)

Say hello to the Designated Diagnostic Provider benefit

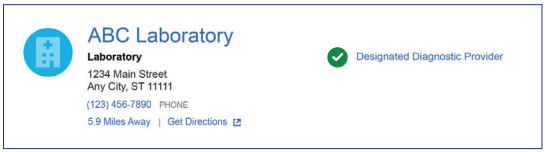
More value for you, more savings for employees

Designated Diagnostic Providers (DDPs) are laboratory and imaging services providers that meet certain quality and efficiency requirements. When your employees choose a DDP for their outpatient lab or imaging services, they'll receive the highest level of benefit from their health plan. This means more value for lab or imaging services—and more value for your employees.

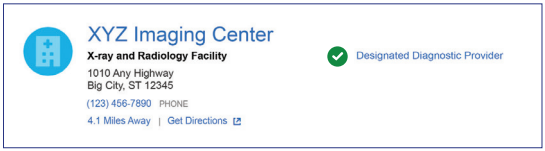
Look for the green check

Participating providers will be designated in the provider search on **myuhc.com®**.

Lab providers



Imaging centers



Preferred lab providers

- Aegis Sciences Corporation
- AmeriPath Inc.
- BioReference Laboratories, Inc.
- Clinical Pathology Laboratories, Inc.
- Invitae Corporation
- Laboratory Corporation of America (LabCorp)
- Mayo Clinic Laboratories*
- Millennium Health, LLC
- Myriad Genetic Laboratories, Inc.
- Natera, Inc.
- Neogenomics Laboratories, Inc.
- Quest Diagnostics, Inc.

Participating DDP providers are subject to change upon annual review process. Available DDPs may expand to include additional facilities.

continued

United Healthcare

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GAP INSURANCE

MEDlink® Select Gap Insurance
Group Supplemental Medical Expense Insurance

APL AMERICAN PUBLIC LIFE

WHAT IS GAP INSURANCE?

MEDlink® Gap Insurance from APL is designed to work with your major medical plan to help fill the gaps left by deductibles, coinsurance and co-pays — covering much of your out-of-pocket costs after major medical insurance has paid.

79% increase

The average annual employee **deductible increased 79%** over the last 10 years.*

HOW IT WORKS

1. **CHOOSE** the plan and coverage type that best fits your individual needs or the needs of your family.
2. **USE** your medical insurance as usual! MEDlink® helps cover charges for in-hospital services and outpatient services, including urgent care and diagnostic testing.
3. **FILE** your claim. Use your MEDlink® ID Card at your provider's office, file a claim online or mail in your claim.

KEY FEATURES

- Guarantee Issue with no medical questions or exams when covered under the other medical plan
- ID Card provided
- Convenient payroll deduction
- Cost-effective premiums
- Benefits are assignable, making the claims process simple

EXAMPLE BENEFITS

In-Hospital Benefits

- Treatment while confined in a hospital
- Inpatient treatment of a mental or emotional disorder
- Ambulance service when resulting in hospital confinement

There's no such thing as feeling **too covered, too safe or too protected!**

Outpatient Benefits

- Treatment in an urgent care facility or emergency room
- Physical therapy performed in a physical therapy facility
- Surgery in a hospital outpatient facility or freestanding outpatient surgery center
- Diagnostic testing in a hospital outpatient facility or MRI facility
- Outpatient treatment of a mental or emotional disorder
- Ambulance service
- Physician's Office Treatment
- Cancer Outpatient Treatment
- Independent Lab Facility
- Durable Medical Equipment

This MEDlink® policy provides limited benefits.

This product has limitations and exclusions, all benefits may not be available in all states, does not replace Workers' Compensation Insurance. **This product is inappropriate for people who are eligible for Medicaid coverage.**

Kaiser Family Foundation: Employer Health Benefits, 2020 Summary of Findings, October 8, 2020, p2

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GAP INSURANCE

MEDlink® Select
Group Supplemental Medical Expense Insurance

APL

Crown Linen LLC

Summary of Benefits		
	Plan 1	**Plan 2**
Funding	Voluntary	Voluntary
Plan Type	In-Hospital and Outpatient Coverage	In-Hospital and Outpatient Coverage
In-Hospital Benefit		
In-Hospital Benefit Maximum	Maximum of $1,000 per covered person per calendar year. Maximum of $3,000 per calendar year for all covered persons combined.	Maximum of $3,000 per covered person per calendar year. Maximum of $9,000 per calendar year for all covered persons combined.
In-Hospital Benefits* • Treatment incurred while confined in a hospital as an inpatient • Inpatient treatment of a mental or emotional disorder - maximum of 30 days of treatment per covered person, per calendar year • Transportation by air or ground ambulance service to a hospital or from one medical facility to another medical facility where a covered person is confined as an inpatient. A licensed ambulance company must provide the ambulance service. All benefits are subject to the in-hospital benefit maximum.		
Outpatient Benefit		
Outpatient Benefit Maximum	$300 per covered person per calendar day for covered outpatient services.	$300 per covered person per calendar day for covered outpatient services.
Outpatient Benefits* • Treatment in a hospital emergency room without subsequently being considered as an inpatient subject to emergency room per occurrence deductible, if applicable to your plan. • Treatment in an urgent care facility • Physical therapy performed in a physical therapy facility • Surgery performed in a hospital outpatient facility or a freestanding outpatient surgery center • Diagnostic testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility • Outpatient treatment of a mental or emotional disorder performed in a hospital outpatient facility - maximum of 30 days of treatment per covered person, per calendar year • Transportation by air or ground ambulance service to a hospital or from one medical facility to another medical facility where a covered person resides less than 18 hours. A licensed ambulance company must provide the ambulance service. All benefits are subject to the outpatient benefit maximum.		
Outpatient Rider(s)		
Office Treatment Rider* Physician covered charges do not include charges for durable medical equipment, cancer treatment, physical therapy or physician's office visit fee. A physician's office does not include a covered outpatient facility.	All benefits are subject to the outpatient benefit maximum	All benefits are subject to the outpatient benefit maximum
Cancer Outpatient Treatment Rider* Must be performed in a cancer treatment facility. A cancer treatment facility also includes a physician's office.	All benefits are subject to the outpatient benefit maximum	All benefits are subject to the outpatient benefit maximum
Independent Lab Facility Rider* Must be performed in an independent lab facility. An independent lab facility is not a physician's office, hospital or MRI facility.	All benefits are subject to the outpatient benefit maximum	All benefits are subject to the outpatient benefit maximum
Durable Medical Equipment Rider* Must be recommended by a physician, covered by the other medical plan and is not disposable or implantable in the body and is not useful to a person in the absence of a sickness or injury.	All benefits are subject to the outpatient benefit maximum	All benefits are subject to the outpatient benefit maximum

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EMERGENCY ROOM VS. URGENT CARE

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and it may cost hundreds, if not thousands, of dollars. In fact, Harvard University reported that 62% of personal bankruptcies are caused by medical expenses, making medical debt the leading cause of bankruptcy in America.

The Emergency Room (ER) is equipped to handle life-threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.

You should go to the nearest Emergency Room if you experience any of the following:

- Compound fractures
- Deep knife or gun shot wound
- Moderate to severe burns
- Poisoning or suspected poisoning
- Seizures or loss of consciousness
- Serious head, neck or back injuries
- Severe abdominal pain
- Severe chest pain or difficulty breathing
- Signs of a heart attack or stroke
- Suicidal or homicidal feelings
- Uncontrollable bleeding

Urgent Care Centers (UCC) are not equipped to handle life-threatening injuries or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.

Some examples of conditions that require a visit to an Urgent Care Center include:

- Control bleeding or cuts that require stitches
- Diagnostic services (X-rays, lab tests)
- Ear infections
- High fever or the flu
- Minor broken bones (e.g., toes, fingers)
- Severe sore throat or cough
- Sprains or strains
- Skin rashes and infections
- Urinary tract infections
- Vomiting, diarrhea or dehydration

Choosing the appropriate place of care will not only ensure prompt and adequate medical attention, but will also help reduce any unnecessary expenses and out-of-pocket costs. Although Urgent Care Centers are usually more cost-effective, they are not a substitute for emergency care.

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PHARMACY DISCOUNT

Lifestyle behaviors, such as physical activity, diet and tobacco use, can play a significant role in how much you spend on healthcare. With healthcare costs continuing to rise, that means it's increasingly important that you play an active role in prioritizing your health.

An important part of prioritizing your health includes utilizing your healthcare benefits wisely. Visit your doctor regularly for preventive screenings, and take steps to better understand how your medical plan works, including how to compare quality and pricing when seeking services. Being a good consumer of your healthcare will allow you to make smarter decisions while minimizing costs.

GoodRx

Since Prescription prices are not regulated, the cost of a prescription may differ by more than $100 between pharmacies. GoodRx is the #1 medical app for iOS and Android. Get prescription drug prices on-the-go, with coupons built into the app.

- **Type your drug name (like Lipitor, Gabapentin, etc.)**
- **Set your location**
- **Compare prices, print coupons, save up to 80%**

Visit *GoodRx.com*

Walmart

- **Your Medical ID Card is not required for the low prices on meds.**
- **$4.00 30 Day Supply / $10.00 90 Day Supply - Generic Only**

Visit *walmart.com/pharmacy*

AHF PHARMACY™

AHF Pharmacy Services – Specializing in Medications to treat HIV/AIDS.

Visit *AHFPharmacy.org*

Download on the App Store

GET IT ON Google Play

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DENTAL INSURANCE

Crown Linen LLC. is pleased to announce effective **October 1, 2025** our dental coverage will continue with **UnitedHealthcare.** To locate a DHMO Provider, visit **myuhc.com** | Dental Providers | Employer Plans | Zip Code | National Select Managed Care. To locate a DPPO Provider, visit **uhc.com/find-a-doctor** | Dental Providers | Employer Plans | Zip Code | National Options PPO.

UnitedHealthcare®	DHMO D1068 - S700B	DPPO	
BENEFITS	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK**
Maximum Plan Pays Per Enrolled	Unlimited	$1,500	
Orthodontic Treatment	$2,835 Child / $2,935 Adult	$1,000 Child Only (to age 19)	
Calendar Year Deductible	N/A	$50 / $150	
Co-Insurance			
Preventive (Class I)	N/A	100%	100%
Basic (Class II)	N/A	100%	80%
Major (Class III)	N/A	60%	50%
Benefits Based on	Contracted Rates	Contracted Rates	90th Percentile
Balance Billing	No	No	Yes
Deductible Waived for Preventive Services	Yes	Yes	Yes
SCHEDULE OF BENEFITS			
Routine Exams 9430	No Charge	100%	100%
Cleaning 1110	No Charge	100%	100%
Panoramic XRays 0330	$50	100%	100%
Simple Extractions 7140	$20	100%	80%
Root Canal 3330	$245	100%	80%
Periodontal Scaling & Root Planning 4341	$50 per quad	100%	80%
Dentures Full or Partial 5110	$325	60%	50%
Crowns - 2740	$245	60%	50%

For more detailed information regarding dental benefits refer to the summary of benefits.

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VISION INSURANCE

Crown Linen LLC. is pleased to announce effective **October 1, 2025** our vision coverage will continue with **United Healthcare**. To locate a participating Vision provider, log on to: **myuhc.com**.

UnitedHealthcare®	TL036 UHC STANDARD NETWORK	
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Vision Exam	$10 Copay	Reimbursement up to $40
Lenses		Reimbursement up to:
Single, Bifocal & Trifocal Lenses	$25 Copay	$40, $60, $80
Frames	$100 + 30% discount over	Reimbursement up to $45
Contact Lenses		
Medically Necessary Contact Lenses	$25 Copay	Reimbursement up to $210
Elective Contact Lenses In lieu of lenses/frames	$100 allowance	Reimbursement up to $75
FREQUENCY		
Eye Exam	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 24 Months	

For more detailed information regarding vision benefits refer to the summary of benefits.

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ALLSTATE WORKSITE INSURANCE

AllState is offering supplemental coverage, which is paid for entirely by employee payroll deductions. The company does not contribute towards the premium for these plans. Through **AllState**, you will have the option of getting more coverage should you or your immediate family become ill. Benefits are paid regardless of other coverage.

DISABILITY INSURANCE
This plan replaces a portion of your income if you become disabled because of a covered accident or a covered sickness.

CANCER INSURANCE
Cancer coverage can help offer peace of mind when a diagnosis of cancer occurs. Cancer Insurance pays cash benefits for cancer and 20 specified diseases to help with the costs associated with treatments and expenses as they happen. Cash benefits can be used for hospital stays, doctor bills, transportation childcare and more. Please refer to the plan documents for complete details for this coverage.

LIFE INSURANCE
Life Insurance helps protect your family from a sudden loss of income in the event of death. Employee Life Insurance will be paid to your beneficiary(ies) if you should pass away.

ACCIDENT INSURANCE
Supplemental accident insurance policy is a medical indemnity plan that provides employees and their families with hospital, physician, accidental death and catastrophic accidental benefits in the event of a covered accident.

Employee only and Family coverage is available.

These are your own policies. If you leave the company or retire, you can take the policy with you and pay the same premium. **AllState** will bill you directly.

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ALLSTATE WORKSITE INSURANCE (ACCIDENT)

Group Voluntary Accident (GVAP6)

24-Hour Accident Insurance from Allstate Benefits

BENEFIT AMOUNTS

Benefits are paid once per accident unless otherwise noted here or in the brochure

BASE POLICY BENEFIT		PLAN 1	PLAN 2
Initial Hospital Confinement (pays once/year)		$1,000	$1,500
Daily Hospital Confinement (pays daily)		$200	$300
Intensive Care (pays daily)		$400	$600
RIDER BENEFITS		**PLAN 1**	**PLAN 2**
Accident Treatment & Urgent Care Rider			
Ambulance	Ground	$200	$300
	Air	$600	$900
Accident Physician's Treatment		$100	$150
X-ray		$200	$300
Urgent Care		$100	$150
Dislocation or Fracture Rider[1]		$4,000	$6,000
Emergency Room Services Rider		$200	$300
Outpatient Physician's Treatment for Accident and Preventive Care Benefit Rider (OPH) (pays daily)		$50	$50
Accidental Death, Dismemberment[1] and Functional Loss[1] Rider		$40,000	$60,000
Common Carrier (fare-paying passenger)		$100,000	$150,000
BENEFIT ENHANCEMENT RIDER		**PLAN 1**	**PLAN 2**
Accident Follow-Up Treatment (pays daily)		$100	$150
Lacerations		$100	$150
Burns	< 15% body surface	$200	$300
	15% or more	$1,000	$1,500
Skin Graft (% of Burns Benefit)		50%	50%
Brain Injury Diagnosis		$600	$900
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) (pays once/year)		$100	$150
Paralysis (pays once)	Paraplegia	$15,000	$22,500
	Quadriplegia	$30,000	$45,000
Coma with Respiratory Assistance		$20,000	$30,000
Open Abdominal or Thoracic Surgery		$2,000	$3,000
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery	Surgery	$1,000	$1,500
	Exploratory	$300	$450
Ruptured Spinal Disc Surgery		$1,000	$1,500
Eye Surgery		$200	$300
General Anesthesia		$200	$300
Blood and Plasma		$600	$900
Appliance		$250	$375
Medical Supplies		$10.00	$15.00
Medicine		$10.00	$15.00
Prosthesis	1 device	$1,000	$1,500
	2 or more devices	$2,000	$3,000
Physical, Occupational or Speech Therapy (pays daily)		$60	$90
Rehabilitation Unit (pays daily)		$200	$300
Non-Local Transportation		$500	$750
Family Member Lodging (pays daily)		$200	$300
Post-Accident Transportation (pays once/year)		$400	$600
Broken Tooth		$200	$300
Residence/Vehicle Modification		$1,000	$1,500
Pain Management (Epidural Injection)		$100	$150
Miscellaneous Outpatient Surgery		$200	$300

[1]Up to amount shown; see Injury Benefit Schedule on reverse. Multiple losses from same injury pay only up to amount shown above.

INJURY BENEFIT SCHEDULE

Benefit amounts for coverage and one occurrence are shown below.

COMPLETE DISLOCATION	PLAN 1	PLAN 2
Hip joint	$4,000	$6,000
Knee or ankle joint*, bone or bones of the foot*	$1,600	$2,400
Wrist joint	$1,400	$2,100
Elbow joint	$1,200	$1,800
Shoulder joint	$800	$1,200
Bone or bones of the hand*, collarbone	$600	$900
Two or more fingers or toes	$280	$420
One finger or toe	$120	$180
COMPLETE, SIMPLE OR CLOSED FRACTURE	**PLAN 1**	**PLAN 2**
Hip, thigh (femur), pelvis**	$4,000	$6,000
Skull **	$3,800	$5,700
Arm, between shoulder and elbow (shaft), shoulder blade (scapula), leg (tibia or fibula)	$2,200	$3,300
Ankle, knee cap (patella), forearm (radius or ulna), collarbone (clavicle)	$1,600	$2,400
Foot **, hand or wrist **	$1,400	$2,100
Lower jaw **	$800	$1,200
Two or more ribs, fingers or toes, bones of face or nose	$600	$900
One rib, finger or toe, coccyx	$280	$420
LOSS	**PLAN 1**	**PLAN 2**
Life, hearing, speech, or both eyes, hands, arms, feet, or legs, or one hand or arm and one foot or leg	$40,000	$60,000
One eye, hand, arm, foot, or leg	$20,000	$30,000
One or more entire toes or fingers	$4,000	$6,000

*Knee joint (except patella). Bone or bones of the foot (except toes). Bone or bones of the hand (except fingers). **Pelvis (except coccyx). Skull (except bones of face or nose). Foot (except toes). Hand or wrist (except fingers). Lower jaw (except alveolar process).

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ALLSTATE WORKSITE INSURANCE (DISABILITY)

BENEFITS

BASE POLICY BENEFITS

Total Disability - the monthly benefit starts after the elimination period has been met. Benefits will not continue beyond the maximum benefit period

Partial Disability - 50% of the monthly benefit is paid after at least one month that the Total Disability Benefit is payable. Payments continue while partially disabled for up to 3 months, but not beyond the maximum benefit period

Pregnancy - a benefit for pregnancy is paid if total disability first begins after the certificate has been in force for at least 9 months

Organ Donor - a benefit is paid when disabled from donating an organ

Waiver of Premium - premiums are waived after monthly disability benefits are payable for 30 days in a row, for as long as monthly benefits are payable

BASE POLICY BENEFIT CONDITIONS

Concurrent Disability - one monthly benefit is paid, even if you are disabled due to more than one cause. Being disabled from more than one cause does not extend the payment of benefits under the maximum benefit period

Recurrent Disability - a benefit is paid if disabled from the same or related cause within 6 months without a new waiting period or maximum benefit period

DETAILS OF COVERAGE

Maximum Monthly Benefit – $5,000

Benefit Period – 3 Months

Elimination Period for Accident - 7 Days

Elimination Period for Sickness - 7 Days

Monthly Benefit - Your monthly disability benefit may be reduced if you receive disability payments from other deductible sources of income which include individual disability income policies, other group insurance coverage, or income from any job for wage or profit. The calculation of your monthly benefit may also be affected if your state of residence mandates state disability insurance.

DEFINITIONS

Total Disability – due to a sickness or injury, you are: (1) unable to perform the material and substantial duties of your own occupation; (2) under the regular care of a doctor; and (3) not working in any job for wage or profit (item 3 applies after you have been disabled for more than 12 months)

Partial Disability - due to a sickness or injury, you are: unable to perform the material and substantial duties of your own occupation on a full-time basis, but are able to work part-time; and under the regular care of a doctor

Elimination (Waiting) Period – a period of continuous total disability which must be satisfied before you are eligible to receive benefits

Own Occupation - during the first 12 months of disability, the job you are performing when the period of disability begins, as described in your employer's job description. After 12 months of disability, it refers to the occupation as performed in the national economy, not a specific employer in a specific location

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ALLSTATE WORKSITE INSURANCE (CANCER)

BENEFIT AMOUNTS

HOSPITAL CONFINEMENT AND RELATED BENEFITS	PLAN 1	PLAN 2
Continuous Hospital Confinement (daily)	$100	$200
Extended Benefits[1] (daily)	$100	$200
Government or Charity Hospital (daily)	$100	$200
Private Duty Nursing Services[1] (daily)	$100	$200
Extended Care Facility[1] (daily)	$100	$200
At Home Nursing[1] (daily)	$100	$200
Hospice Care Center[1] (daily) or Hospice Care Team[1] (per visit)	$100 $100	$200 $200
RADIATION/CHEMOTHERAPY	**PLAN 1**	**PLAN 2**
Radiation/Chemotherapy[1] (every 12 months)	$5,000	$10,000
Blood, Plasma, and Platelets[1] (every 12 months)	$5,000	$10,000
SURGERY AND RELATED BENEFITS	**PLAN 1**	**PLAN 2**
Surgery[2] 1. Inpatient 2. Outpatient	 $1,500 $2,250	 $3,000 $4,500
Anesthesia[1] (% of surgery benefit)	25%	25%
Bone Marrow or Stem Cell Transplant (once/year) 1. Autologous 2. Non-autologous (cancer or specified disease treatment) 3. Non-autologous (Leukemia)	 1. $500 2. $1,250 3. $2,500	 1. $1,000 2. $2,500 3. $5,000
Ambulatory Surgical Center[1] (daily)	$250	$500
Second Surgical Opinion[1]	$200	$400
TRANSPORTATION AND LODGING BENEFITS	**PLAN 1**	**PLAN 2**
Ambulance[1] (per confinement)	$100	$100
Non-Local Transportation (coach fare or amount shown per mile♦)	$0.40/mi	$0.40/mi
Outpatient Lodging[3] (daily; limit $2,000/12 mo. period)	$50	$50
Family Member Lodging[3] (daily per trip; max. 60 days) and Transportation (coach fare or amount shown per mile♦)	$50 $0.40/mi	$50 $0.40/mi
MISCELLANEOUS BENEFITS	**PLAN 1**	**PLAN 2**
Inpatient Drugs and Medicine[1] (daily)	$25	$25
Physician's Attendance[1] (daily)	$50	$50
Physical or Speech Therapy[1] (daily)	$50	$50
New or Experimental Treatment[1] (every 12 months)	$5,000	$5,000
Prosthesis[1] (per amputation)	$2,000	$2,000
Comfort/Anti-Nausea Benefit[1]	$200	$200
Waiver of Premium (employee only)	Yes	Yes
ADDITIONAL BENEFITS	**PLAN 1**	**PLAN 2**
Cancer Initial Diagnosis (one-time benefit)	$5,000	$5,000
Intensive Care (ICU) — ICU Confinement (daily) Ambulance	$200 Charges	$200 Charges
Cancer Screening	$75	$100

[1]Pays actual charges up to amount listed. [2]Pays actual charges up to amount listed in certificate Schedule of Surgical Procedures. Amount paid depends on surgery. [3]Pays actual cost up to amount listed.
♦Maximum of 700 miles.

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ALLSTATE WORKSITE INSURANCE (TERM LIFE)

Why Term Life Insurance might be right for you

Have you ever experienced a life-changing event, whether good or bad, and worried that you would not have the finances in place to handle it if you lost your spouse?

Perhaps it has crossed your mind, but you put it off because you did not want to think about the unthinkable. However, if you have a spouse, children, or even grandchildren, that is reason enough to think about planning for their future today.

Here are some additional reasons to consider:

- You can't predict when you'll die, whether from a disease, accidental injury or natural causes
  Upon your death, Term to Age 100 can provide a lump-sum cash benefit directly to your designated beneficiary
- You live on a budget, and purchasing traditional permanent life insurance would be costly
  Term to Age 100 is affordably priced
- You want a Term Life policy that offers coverage for more than 5, 10 or 20 years
  Term to Age 100 offers coverage that can be with you until age 100
- You want affordable coverage that goes with you should you leave your employer
  You can take the Term to Age 100 coverage with you; see your Certificate of Insurance for details
- You're the primary wage earner and your family would have difficulty living without your income
  If you die before age 100, Term to Age 100 offers your designated beneficiary a lump-sum death benefit that is guaranteed for the first five years of coverage and is priced to remain level under current experience factors
- You have recurring monthly debts such as a mortgage, car payment or credit cards
  Term to Age 100 provides a lump-sum death benefit that can be used to help cover monthly expenses
- You have children under 18, and they require money for daily living expenses such as food, clothing, school sports and college education
  Term to Age 100 provides a lump-sum death benefit that can be used to help with daily living expenses
- Your family may need additional money to help with health care related bills after you die
  Term to Age 100 provides a lump-sum death benefit that can be used to help cover these expenses

Benefits

Term Life Insurance Death Benefit - pays a lump-sum death benefit to your designated beneficiary when you die before age 100

ADDITIONAL RIDER BENEFIT†

Accelerated Death Benefit for Terminal Illness - an advance of the death benefit is paid when diagnosed as terminally ill

†The rider listed has exclusions and limitations.

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GLOSSARY

Applicable Cost Share

The share of costs covered by your insurance that you pay out of your own pocket. Includes deductibles, coinsurance, and copays. Does not include premiums, balance billing amounts for non-network providers, or non-covered services.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A network provider may not balance bill you for covered services.

Coinsurance

The portion of the cost for care received for which an individual is financially responsible, which is usually calculated as a percentage (such as 20%). Often coinsurance applies after a specific deductible has been met and may be subject to an individual out-of-pocket. For example, if the plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The plan pays the rest of the allowed amount.

Copayment

A payment you make at the time that selected services are rendered, and no additional payment is required. Copayments are typically flat amounts (for example, $15), covering such items as office visits, prescriptions, and emergency care.

Covered Expenses

Healthcare expenses that are covered under your health plan.

Deductible

The amount of eligible expenses you must pay, out of pocket each plan year, before the plan begins to pay. The deductible may not apply to all services.

Embedded Deductible

An embedded deductible is an individual deductible level within a family contract. For example, if there is a family deductible of $3,000 with an individual embedded deductible of $1,500, when any one individual family member reaches $1,500 in expenses, their benefit plan coverage takes effect.

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Non-Embedded Deductible

A non-embedded deductible requires that the entire family deductible be met before benefit plan coverage takes effect by any one or combination of family members.

Evidence of Insurability

A medical questionnaire used to determine whether an applicant will be approved or declined coverage.

Guarantee Issue

The amount available without providing Evidence of Insurability (EOI). EOIs are required from: new hires who purchase amounts above the Guarantee Issue amount; late enrollees for any/all amounts applied for; or increases in insurance after initial enrollment.

In-Network

Care received from physicians, facilities or suppliers that are contracted with the insurer to provide services on a negotiated discount basis.

Late Entrant

A member that becomes insured more than 30 days after initial eligibility or becomes insured again after previously waiving coverage.

Mandatory Generic

When you request a brand name drug that has an generic equivalent, you pay the generic copay plus the cost difference between the brand and generic drug. Dispense as written (DAW) may be allowed. With DAW you will not be charged a cost difference.

Out-of-Pocket Expense

Amount you pay toward the cost of healthcare services; may include deductibles, copays and/or coinsurance.

Out-of-Pocket Maximum

The maximum dollar amount a member is required to pay out of pocket during a benefit period. Plans may vary but deductibles and coinsurance generally always apply toward meeting the out-of-pocket maximum.

Preferred Provider

A provider who has a contract with your carrier/vendor to provide services to you at a discount.

Pre-existing Condition

Any Injury/Sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken in the X months prior to the day you become insured. For example: Disabilities that occur during the first 6 months of coverage due to a pre-existing condition that occurred during the 3 months prior to coverage are excluded.

Provider

Physician (medical, dental or vision), healthcare professional or facility licensed, certified or accredited as required by state law.

Prior Authorization/Pre-Service Notification

The decision by the plan or health insurer that a healthcare service, treatment plan, prescription drug, medical equipment, or other healthcare services defined in the certificate of coverage, is medically necessary. The plan may require preauthorization for certain services before receiving them, except in an emergency.

UCR (Usual, Customary & Reasonable)

The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount.

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ANNUAL NOTICES

Form Approved
OMB No. 1210-0149
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HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

PART A: General Information
Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.2% 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.

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1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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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 https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or HR contact.

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.

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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 :	Crown Linen LLC.
Employer Identification Number (EIN) :	20-0036473
Employer address :	3235 NW 62nd Street, Miami, FL 33147
Employer phone number :	(954) 935-6507
Who can we contact about employee health coverage at this job ?	Lenis Figuera | Payroll and Benefits Generalist
Email address:	figuera@crownlinen.net

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

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

  ☐ All employees. Eligible employees are:
  ☒ All Full-time Eligible Employees and COBRA Participants

- **With respect to dependents:**

  ☒ We do offer coverage. Eligible dependents are:

- Legal Spouse, Dependents of employees up to age 26; and dependents who are age 26+ under the guidelines of the State of Florida (FSS 627.6562)

  ☐ We do not offer coverage.

  ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

***Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.*

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** 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.

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MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

FOR MEDICARE-ELIGIBLE EMPLOYEES ENROLLED IN THE UNITED HEALTHCARE PLANS

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 also offer more coverage for a higher monthly premium.

2. **Crown Linen LLC.** has determined that the prescription drug coverage offered by the United Healthcare plans, are on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. **Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to 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 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.

In addition, if you lose or decide to leave employer/union-sponsored coverage, you will be eligible to join a Part D plan at the time using an Employer Group Special Enrollment Period.

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.

If you decide to join a Medicare drug plan, your Crown Linen LLC., Inc.coverage will not be affected. If you decide to join a Medicare drug plan and drop your employer sponsored prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop coverage or lose your group coverage and do not 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.

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

Note: You'll get this notice each year. You may also request a copy.

For more information about your option under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will be mailed a copy from Medicare each year. For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (or see "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 on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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NOTICE OF HEALTH CARE REFORM CHANGES

As a reminder, the following changes to our **Crown Linen LLC.** Medical Plans are still valid for the 2025 plan year.

- The lifetime benefit limit will be unlimited on essential services. There will be no annual limit on essential benefits.

Essential benefits may include:
- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care
- Mental Health and Substance Abuse Disorders
- Prescription Drugs
- Rehabilitative and Facilitative Services and Devices (including durable medical equipment)
- Laboratory Services
- Prevention and Wellness Services
- Chronic Disease Management
- Pediatric Services, including oral and vision

- Certain Preventive services are now covered 100% at no charge when you use **United Healthcare** network providers.

These include:
- Routine adult physical
- Routine Well child Exams
- Routine Gynecological exams (includes pap and related fees)
- Colorectal Cancer Screening
- Routine mammograms

- Most Generic Oral Contraceptive Medications & Products for $0 cost-share. (FDA Approved Contraceptive Methods for women). Items available without a prescription are not covered under the Health Care Reform law.

- Pre-existing Condition exclusions do not apply

- Dependents are covered until age 26 – Age 30 if specific criteria are met. Dependents under age 26 may enroll within 30 days of renewal for coverage effective October 1, 2025.

- Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

- Gynecological and obstetric services: Authorization or referral for gynecologic or obstetric care will not be required.

- Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

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CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

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Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

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NOTICE OF SPECIAL ENROLLMENT RIGHTS

This notice is being provided to help you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

- **Loss of Other Coverage** – If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- **Marriage, Birth or Adoption** – If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.
- **Medicaid or CHIP** – If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or obtain more information, please contact the plan administrator.

THE NEWBORN'S AND MOTHER'S 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member to receive assistive reproductive services.

MENTAL HEALTH PARITY & ADDICTION ACT

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (see cover page for contact information).

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WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

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). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator (see cover page for contact information).

MICHELLE'S LAW - COVERAGE FOR DEPENDENT STUDENTS

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

For additional information, contact your plan administrator (see cover page for contact information).

UNIFORMED SERVICES EMPLOYMENT & RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an employee's military leave of absence. These requirements apply to medical and dental coverage for you and your dependents. They do not apply to any Life, Short-Term or Long-Term Disability or Accidental Death & Dismemberment coverage you may have.

A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://dol.gov/vets/programs/userra. An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: https://www. dol.gov/agencies/vets. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra/.

YOUR RIGHTS & PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing.** "This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

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"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:
Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Florida law also provides some protection for balance billing. If your insurance* provider is from Florida, then you can't be balance billed for emergency services. You are only responsible for paying your copay, deductible, and coinsurance.

Certain services at an in-network hospital or ambulatory surgical center When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.
If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- **Generally, your health plan must:**

1. Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
2. Cover emergency services by out-of-network providers.
3. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
4. Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact No Surprises Help Desk at (800) 985-3059. Visit **cms.gov/nosurprises/consumers** for more information about your rights under federal law.

**Florida law does not apply to insurance plans from other states or employer -owned insurance plans. Federal law does not provide protection for those.*

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YOUR EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

What is FMLA leave?
The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 work weeks** of FMLA leave in a 12-month period for:
- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 work weeks** of FMLA leave in a single 12-month period to care for the service member.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?
You are an **eligible employee** if **all** of the following apply:
- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:
- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:
- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

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What does my employer need to do?
If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?
Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

PREMIUM ASSISTANCE: MEDICAID & CHIP

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

	**ALABAMA Medicaid**	**Website:** http://myalhipp.com/	**Phone:** 1-855-692-5447
	**ALASKA Medicaid**	**The AK Health Insurance Premium Payment Program** **Website:** http://myakhipp.com/ **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** https://health.alaska.gov/dpa/Pages/default.aspx	**Phone:** 1-866-251-4861
	**ARKANSAS Medicaid**	**Website:** http://myarhipp.com/	**Phone:** 1-855-692-7447
	**CALIFORNIA Medicaid**	**Health Insurance Premium Payment (HIPP) Program** **Website:** http://dhcs.ca.gov/hipp **Email:** hipp@dhcs.ca.gov	**Phone:** 916-445-8322
	**COLORADO Health First Colorado & Child Health Plan Plus**	**Health First Colorado Website:** https://www.healthfirstcolorado.com/ **CHP+:** https://hcpf.colorado.gov/child-health-plan-plus **Health Insurance Buy-In Program (HIBI):** https://www.mycohibi.com/	**Member Contact Center:** 1-800-221-3943/State Relay 711 **CHP+ Customer Service:** 1-800-359-1991/State Relay 711 **HIBI Customer Service:** 1-855-692-6442
	**FLORIDA Medicaid**	**Website:** https://www.flmedicaidt-plrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	**Phone:** 1-877-357-3268

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	**GEORGIA Medicaid**	**GA HIPP Website:** https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	**Phone:** 678-564-1162, Press 1
		GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	**Phone:** 678-564-1162, Press 2
	**INDIANA Medicaid**	**Health Insurance Premium Payment Program All other Medicaid** **Website:** https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/	**Family and Social Services Administration Phone:** 1-800-403-0864 **Member Services Phone:** 1-800-457-4584
	**IOWA Medicaid & CHIP (Hawki)**	**Medicaid Website:** Iowa Medicaid | Health & Human Services	**Medicaid Phone:** 1-800-338-8366
		Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services	**Hawki Phone:** 1-800-257-8563
		HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)	**HIPP Phone:** 1-888-346-9562
	**KANSAS Medicaid**	**Website:** https://www.kancare.ks.gov/	**Phone:** 1-800-792-4884 **HIPP Phone:** 1-800-967-4660
	**KENTUCKY Medicaid**	**Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:** https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx	**Phone:** 1-855-459-6328 **Email:** KIHIPP.PROGRAM@ky.gov
		KCHIP Website: https://kynect.ky.gov **Kentucky Medicaid Website:** https://chfs.ky.gov/agencies/dms	**Phone:** 1-877-524-4718
	**LOUISIANA Medicaid**	**Website:** www.medicaid.la.gov or www.ldh.la.gov/lahipp	**Phone:** 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
	**MAINE Medicaid**	**Enrollment Website:** https://www.mymaineconnection.gov/benefits/	**Phone:** 1-800-442-6003 TTY: Maine relay 711
		Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms	**Phone:** 1-800-977-6740 **TTY:** Maine relay 711
	**MASSACHUSETTS Medicaid & CHIP**	**Website:** https://www.mass.gov/masshealth/pa	**Phone:** 1-800-862-4840 **TTY:** 711
		Email: masspremassistance@accenture.com	
	**MINNESOTA Medicaid**	**Website:** https://mn.gov/dhs/health-care-coverage/	**Phone:** 1-800-657-3672
	**MISSOURI Medicaid**	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.html	**Phone:** 573-751-2005
	**NEVADA Medicaid**	**Medicaid Website:** http://dhcfp.nv.gov	**Phone:** 1-800-992-0900

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	**NEW HAMPSHIRE Medicaid**	**Website:** https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program **Email:** DHHS.ThirdPartyLiabi@dhhs.nh.gov	**Phone:** 603-271-5218 **Toll free number for the HIPP program:** 1-800-852-3345, ext. 15218
	**NEW JERSEY Medicaid & CHIP**	**Medicaid Website:** http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ **CHIP Website:** http://www.njfamilycare.org/index.html	**Phone:** 1-800-356-1561 **CHIP Premium Assistance Phone:** 609-631-2392 **CHIP Phone:** 1-800-701-0710
	**NEW YORK Medicaid**	**Website:** https://www.health.ny.gov/health_care/medicaid/	**Phone:** 1-800-541-2831
	**NORTH CAROLINA Medicaid**	**Website:** https://medicaid.ncdhhs.gov/	**Phone:** 1-919-855-4100
	**NORTH DAKOTA Medicaid**	**Website:** https://www.hhs.nd.gov/healthcare	**Phone:** 1-844-854-4825
	**OKLAHOMA Medicaid**	**Website:** http://www.insureoklahoma.org	**Phone:** 1-888-365-3742
	**OREGON Medicaid**	**Website:** http://healthcare.oregon.gov/Pages/index.aspx	**Phone:** 1-800-699-9075
	**PENNSYLVANIA Medicaid**	**Website:** https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)	**Phone:** 1-800-692-7462 **CHIP Phone:** 1-800-986-KIDS (5437)
	**RHODE ISLAND Medicaid & CHIP**	**Website:** http://www.eohhs.ri.gov/	**Phone:** 1-855-697-4347 **Phone: 1-**401-462-0311
	**SOUTH CAROLINA Medicaid**	**Website:** https://www.scdhhs.gov	**Phone:** 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
	**SOUTH DAKOTA Medicaid**	**Website:** http://dss.sd.gov	**Phone:** 1-888-828-0059
	**TEXAS Medicaid**	**Website:** Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services	**Phone:** 1-800-440-0493
	**UTAH Medicaid & CHIP**	**Utah's Premium Partnership for Health Insurance (UPP) Website:** https://medicaid.utah.gov/upp/ **Adult Expansion Website:** https://medicaid.utah.gov/expansion/ **CHIP Website:** https://chip.utah.gov/	**Phone:** 1-888-222-2542 **Email:** upp@utah.gov **Utah Medicaid Buyout Program Website:** https://medicaid.utah.gov/buyout-program/
	**VERMONT Medicaid**	**Website:** Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access	**Phone:** 1-800-250-8427
	**VIRGINIA Medicaid & CHIP**	**Website:** https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select **Phone:** 1-800-432-5924	**Website:** https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP

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	WASHINGTON Medicaid	**Website:** https://www.hca.wa.gov/	**Phone:** 1-800-562-3022
	WEST VIRGINIA Medicaid & CHIP	**Website:** https://dhhr.wv.gov/bms/ **Website :** http://mywvhipp.com/	**Medicaid Phone:** 1-304-558-1700 **CHIP Toll-free phone:** 1-855-MyWVHIPP (1-855-699-8447)
	WISCONSIN Medicaid & CHIP	**Website:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.html	**Phone:** 1-800-362-3002
	WYOMING Medicaid	**Website:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	**Phone:** 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

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)

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HIPAA: NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

You have the right to:

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

YOUR CHOICES

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

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

OUR USES AND DISCLOSURES

We may use and share your information as we:

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

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

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Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: *We use health information about you to develop better services for you.*

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

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

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

CHANGES TO THE TERMS OF THIS NOTICE

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

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Brown & Brown Insurance Services, Inc.
in CA Brown & Brown Retail Insurance Services (CA Entity License #0F56560)
1201 W. Cypress Creek Road, Suite 130 Ft Lauderdale, FL 33309 | (954) 776-2222

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