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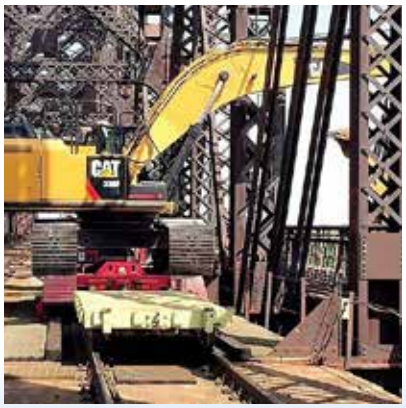
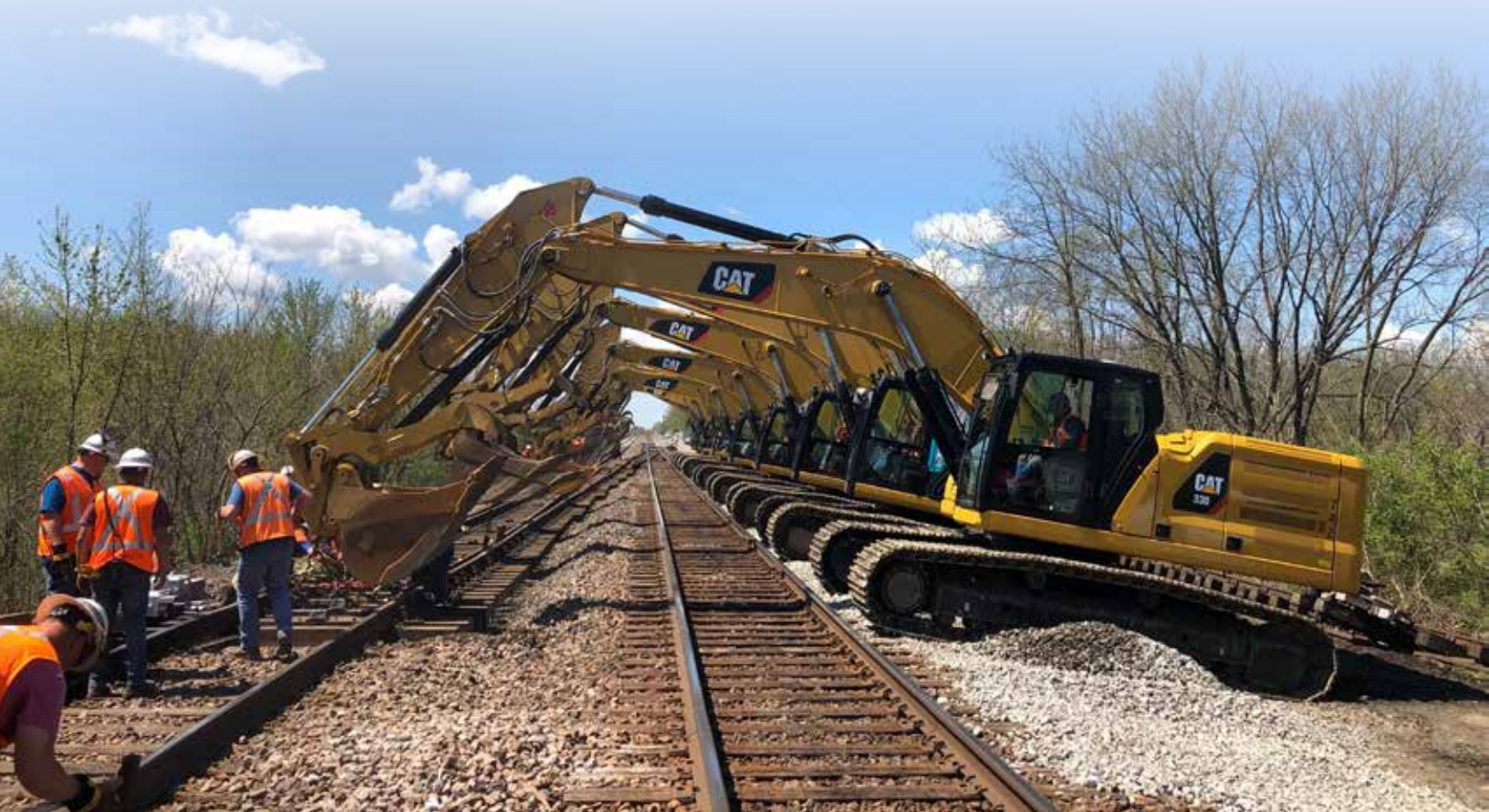
2024-2025

New Hire Employee Benefits Guide

A comprehensive guide to understanding your employee benefits program.





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IMPORTANT CONTACTS

Coverage	Provider	Policy No.	Phone	Website/Email
Medical	Blue Cross Blue Shield of MS	14784	601-664-4590 or 800-942-0278	www.bcbsms.com
Telemedicine/Virtual Visits	TelaDoc	3300576302	214-302-5200	www.teladoc.com
Dental	SunLife	910189	1-800-786-5433	sunlife.com/us
Vision	SunLife	910189	1-800-786-5433	sunlife.com/us
Basic Life/AD&D and Voluntary Life	SunLife	910189	1-800-786-5433	sunlife.com/us
Short and Long Term Disability	SunLife	910189	1-800-786-5433	sunlife.com/us
Accident	SunLife	910189	1-800-786-5433	sunlife.com/us
Hospital Indemnity	SunLife	910189	1-800-786-5433	sunlife.com/us

WELCOME

We are pleased to offer a full benefits package to help protect your wellbeing and financial health. Read this guide to learn about the benefits available to you and your eligible dependents starting **May 1, 2024.**

Each year during Open Enrollment, you may make changes to your benefit plans. The benefit choices you make this year will remain in effect through **April 30, 2025**. Take time to review these benefit options and select the plans that best meet your needs. After Open Enrollment, you may only make changes to your benefit elections if you have a Qualifying Life Event.

Availability of Summary Health Information

Your plan offers two health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available on Paylocity or by contacting Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see page 14 for more details.

ELIGIBILITY

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. Your coverage is effective your 91st day of full-time employment. You may also enroll eligible dependents for benefits coverage. The cost for coverage depends on the number of dependents you enroll and the benefits you choose. When covering dependents, you must select and be on the same plans.

Eligible Dependents Include

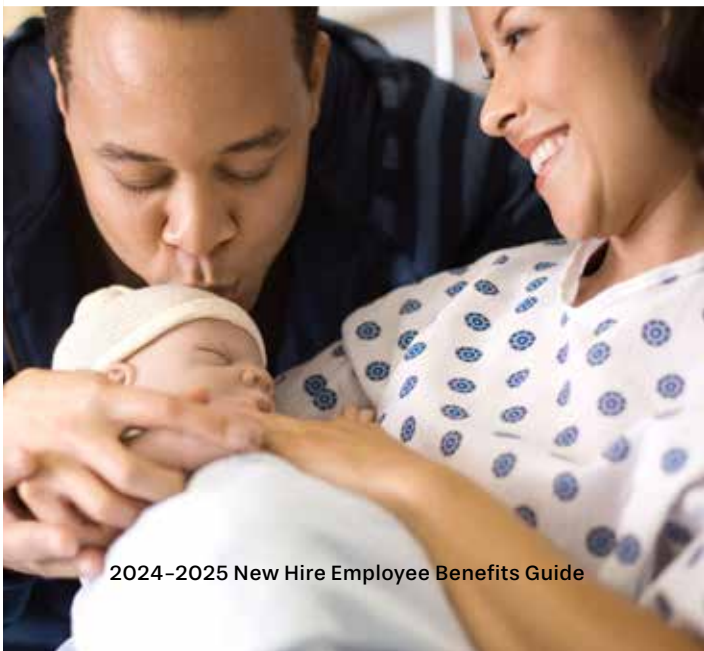
- Your legal spouse
- Children under the age of 26, regardless of student, dependency or marital status
- Children over the age of 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

Qualifying Life Events

Once you elect your benefit options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, some of which include:

- Marriage, divorce, legal separation or annulment
- Birth, adoption or placement for adoption of an eligible child
- Death of your spouse or child
- Change in your spouse's employment status that affects benefits eligibility
- Change in your child's eligibility for benefits
- Significant change in benefit plan coverage for you, your spouse or child
- FMLA leave, COBRA event, court judgment or decree
- Becoming eligible for Medicare, Medicaid or TRICARE
- Receiving a Qualified Medical Child Support Order (QMCSO)

If you have a Qualifying Life Event and want to change your elections, you must notify Human Resources and complete your changes within 30 days of the event. You may be asked to provide documentation to support the change. Contact Human Resources for specific details.



MEDICAL COVERAGE

The medical plan options through **Blue Cross Blue Shield of Mississippi (BCBSMS)** protect you and your family from major financial hardship in the event of illness or injury. You have a choice of two plans:

Plan A – This plan is a PPO with $2,500 individual or $5,000 family in-network deductible.

Plan B – This plan is an HDHP with a $3,500 individual or $7,000 family in-network deductible.

Preferred Provider Organization (PPO)

A PPO allows you to see any provider when you need care. When you see network providers for care, you will pay less and get the highest level of benefits. You will pay more for care if you use non-network providers. When you see network providers, your office visits, urgent care and prescription drugs are covered with a copay and most other network services are covered at the deductible and coinsurance level.

High Deductible Health Plan (HDHP)

An HDHP also allows you to see any provider when you need care, but you will pay less for care when you go to network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs.

Find a Network Provider
Visit www.bcbsms.com or call 800-942-0278.

MEDICAL COVERAGE

Medical Benefits Summary

	$2,500 PPO- BCBSMS		$3,500 HDHP - BCBSMS	
Network	**BUYUP PLAN**		**BASE PLAN**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible • Individual • Family	$2,500 $5,000	Unlimited	$3,500 $7,000	$7,000 $14,000
Calendar Year Out-of-Pocket Maximum Includes deductible and copays • Individual • Family	$6,350 $12,700	Unlimited	$6,550 $13,100	Unlimited
	You Pay		**You Pay**	
Preventive Care	$0	Not Covered	$0	Not Covered
Primary Care Physician	$15 copay	40% coinsurance	30% coinsurance	50% coinsurance
Specialist	$25 copay	40% coinsurance	30% coinsurance	50% coinsurance
Urgent Care	$25 copay	40% coinsurance	30% coinsurance	50% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Complex Imaging (CT/PET scan, MRI)	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Emergency Room	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Inpatient Hospital Services	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Outpatient Services	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Retail Pharmacy Up to 30-day supply • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name • Specialty	$50 Deductible for prescription drug coverage $10 copay $25 copay $50 copay $100 copay 10% up to $200 copay; minimum $100 copay	Not Covered	30% coinsurance 30% coinsurance 30% coinsurance 30% coinsurance 30% coinsurance	Not Covered
Mail Order Pharmacy Up to 90-day supply • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name • Specialty	$25 copay $62.50 copay $125 copay $250 copay Not Covered	Not Covered	30% coinsurance 30% coinsurance 30% coinsurance 30% coinsurance 30% coinsurance	Not Covered
Employee Weekly Cost				
	You Pay		**You Pay**	
Employee Only	$0.00		$0.00	
Employee + Spouse	$123.10		$93.42	
Employee + Child(ren)	$72.15		$54.73	
Employee + Family	$205.70		$156.12	

*The amount you pay after the deductible is met.

TELEMEDICINE

Your medical coverage offers telemedicine services through **Teladoc**. Connect anytime day or night with a board-certified doctor via your mobile device or computer.

When to Use Teladoc

While telemedicine does not replace your primary care physician, it is a convenient and cost-effective option when you need care and:

- Have a non-emergency issue and are considering an after-hours health care clinic, urgent care clinic or emergency room for treatment
- Are on a business trip, vacation or away from home
- Are unable to see your primary care physician

Use telehealth services for minor conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold/Flu
- Allergies
- Fever
- Urinary tract infections

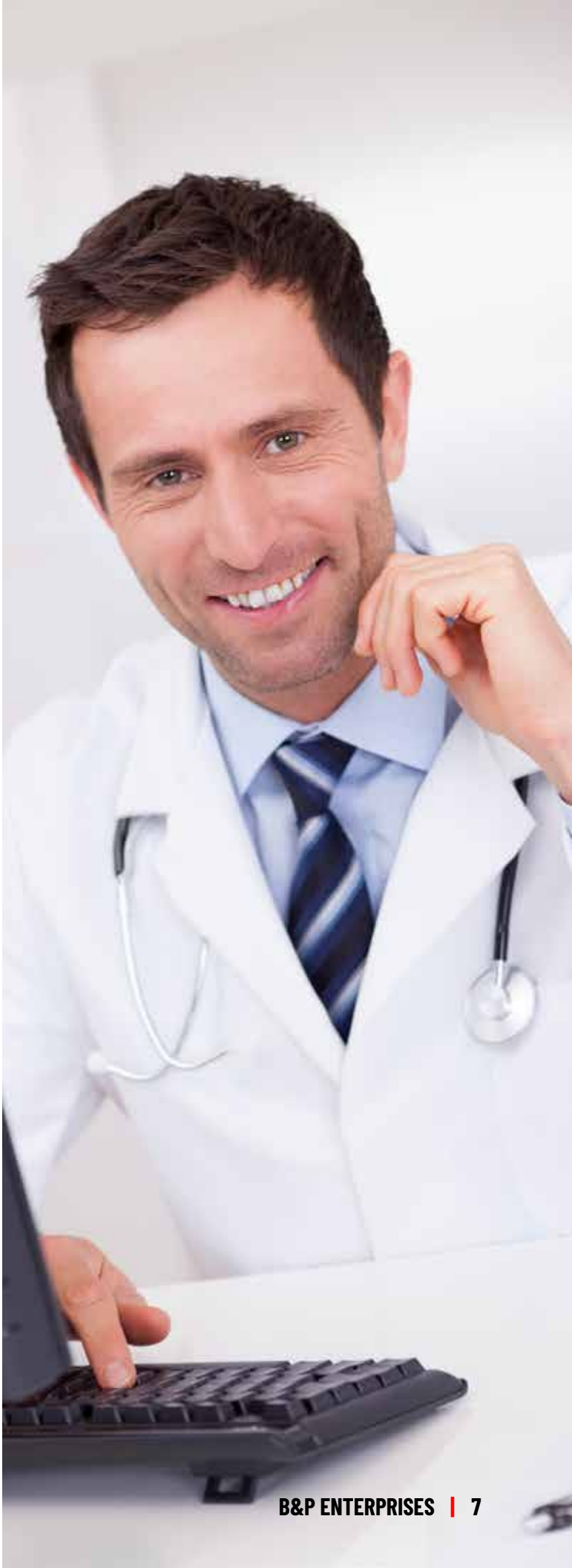
Do not use telemedicine for serious or life-threatening emergencies.

Setting up an Account is Easy

Simply download the Teladoc app and follow the steps below:

- Confirm Benefits – Provide some information about yourself to confirm your eligibility
- Select Benefit Provider – Confirm coverage that has been matched to you.
- Create your account – Provide your contact information
- Complete Account – Create a username, password and pick security questions to ensure your account is secure.

For additional information go to **www.teladoc.com** or call **800-835-2362**.



HEALTH CARE OPTIONS

Becoming familiar with your options for medical care can save you time and money.

HEALTH CARE PROVIDER		SYMPTOMS	AVERAGE COST	AVERAGE WAIT
NON-EMERGENCY CARE				
 **VIRTUAL VISITS/ TELEMEDICINE**	Access to care via phone, online video or mobile app whether you are home, work or traveling; medications can be prescribed **24 hours a day, 7 days a week**	• Allergies • Cough/cold/flu • Rash • Stomachache	**$**	**2-5 minutes**
 **DOCTOR'S OFFICE**	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history **Office hours vary**	• Infections • Sore and strep throat • Vaccinations • Minor injuries, sprains and strains	**$**	**15-20 minutes**
 **RETAIL CLINIC**	Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies **Hours vary based on store hours**	• Common infections • Minor injuries • Pregnancy tests • Vaccinations	**$**	**15 minutes**
 **URGENT CARE**	When you need immediate attention; walk-in basis is usually accepted **Generally includes evening, weekend and holiday hours**	• Sprains and strains • Minor broken bones • Small cuts that may require stitches • Minor burns and infections	**$$**	**15-30 minutes**
EMERGENCY CARE				
 **HOSPITAL ER**	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility **24 hours a day, 7 days a week**	• Chest pain • Difficulty breathing • Severe bleeding • Blurred or sudden loss of vision • Major broken bones	**$$$$**	**4+ hours**
 **FREESTANDING ER**	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week**	• Most major injuries except trauma • Severe pain	**$$$$$$**	**Minimal**

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

DENTAL COVERAGE

Our dental plan helps you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Coverage is provided through **Sun Life**.

DPPO Plan

Two levels of benefits are available with the DPPO plan: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with network providers. You could pay more if you use an out-of-network provider.

Dental Plan	SunLife	
	In-Network	**Out-of-Network***
Calendar Year Maximum Benefit	$1,500	$1,500
Orthodontia Lifetime Maximum Benefit	Not Covered	Not Covered
	You Pay	**You Pay**
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Type A - Preventive Care		
Exams, cleanings, complete series X-rays	0% deductible waived	0% deductible waived
Type B - Basic Restorative		
Fillings, extractions, periodontics, root canals, endodontics, oral surgery	20% after deductible	20% after deductible
Type C - Major Restorative		
Crowns, bridges, dentures	50% after deductible	50% after deductible
Type D - Orthodontia		
Covered Individuals	Not Covered	Not Covered
Benefit	Not Covered	Not Covered

*Payment for covered services received from an out-of-network dentist is based on the 90th percentile of UCR.

- Benefit Waiting Periods may apply for Type II and Type III Services
- Dependent children are covered to the age of 26.

Find a Network Dentist
Visit **www.sunlife.com** or call **800-786-5433**.

	SunLife
	Weekly Rate
Employee Only	$6.27
Employee + Spouse	$12.62
Employee + Child(ren)	$16.41
Employee + Family	$22.76

VISION COVERAGE

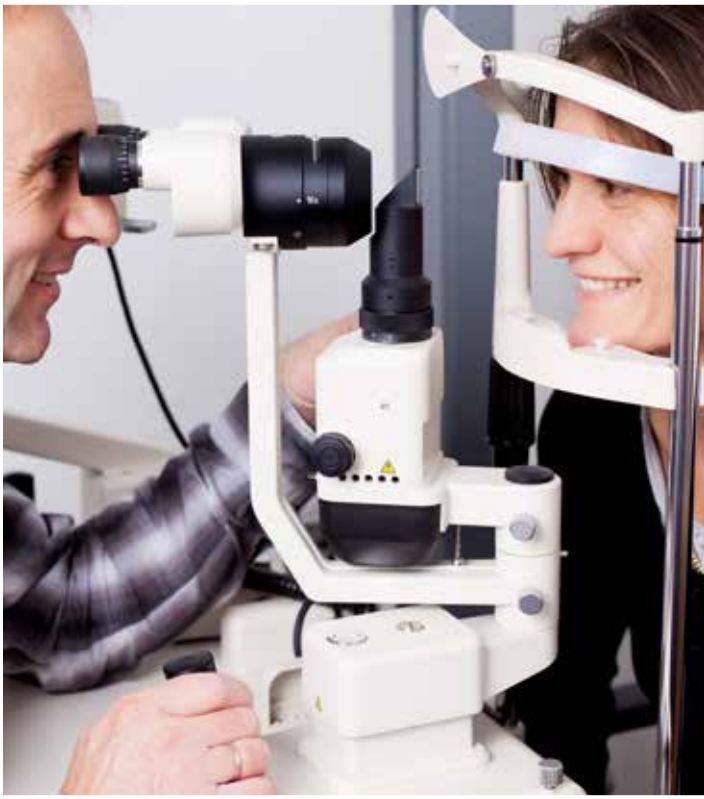
Our vision plan offers quality care to help preserve your health and eyesight. Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems. You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see a network provider. Coverage is provided through **Sun Life.**

Find a Network Vision Provider
Visit www.sunlife.com or call 800-786-5433.

Vision Plans

Network	SunLife	
	Participating Provider	Non-Participating Provider
	You Pay	Reimbursement
Exam		
Routine Examination	$10 copay	up to $52
Standard Lenses		
Single Vision	$25 copay	up to $55
Lined Bifocal	$25 copay	up to $75
Lined Trifocal	$25 copay	up to $95
Lenticular	$25 copay	up to $125
Frames	$130 allowance + 20% off the remaining balance	up to $57
Contact Lenses (in lieu of eyeglasses)		
Fitting and Evaluation	up to 15% off	up to $105
Elective	$130 allowance	up to $105
Necessary	$25 copay	up to $210
Exam	once per 12 months	
Lenses	once per 12 months	
Frames	once per 24 months	
Contacts	once per 12 months	

	Weekly Rate
Employee Only	$2.31
Employee + Spouse	$4.61
Employee + Child(ren)	$5.07
Employee + Family	$7.38



LIFE AND AD&D INSURANCE

Life insurance through **Sun Life** are important to your financial security, especially if others depend on you for support or vice versa. With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts, such as credit cards, loans and bills. Life coverage amounts reduce by 33% at age 70 and 66% at age 75. Benefit will be rounded to the next highest $10,000.

Voluntary Life

You have the opportunity to purchase Life insurance for you and your eligible dependents. If you do not elect Voluntary Life and AD&D insurance when first eligible or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before you may elect coverage for your spouse or children. If you leave the company, you may be able to take the insurance with you.

Conversion/Portability/ Waiver of Premium

Upon termination of employment, you have the option to continue your company paid Life and AD&D insurance and pay premiums direct to Vendor. Your company paid Life and AD&D insurance may be converted to an individual policy. Portability is available for Life coverage if you are enrolled in additional Life coverage. Portability is not available for AD&D. If you are disabled at the time your employment is terminated, you may be eligible for a Waiver of Premium while you are disabled. Contact the Human Resources Department for a Conversion, Portability or Waiver of Premium application.

Voluntary Life - SunLife	
Voluntary Life	**Coverage Amount**
Employee	• Increments of $10,000 up to $500,000 • New hire guaranteed issue: lesser of current amount or $130,000 (minimum election $20,000)
Spouse	• Increments of $5,000 to the lesser of $250,000 or 50% of the Employee's Voluntary Life Amount • New hire guaranteed issue: lesser of current amount or $50,000
Child(ren)	• 3 benefit amount options: $1,000, $5,000, or $10,000 to maximum 50% of employee benefit • New hire guaranteed issue: up to the maximum benefit • Employee must participate to enroll dependents • Reduction is stated above

Voluntary Life Rates		
Employee Age	**Employee Coverage Weekly Rate per $1,000**	**Spouse Coverage Weekly Rate per $1,000**
<20	0.078	$0.050
20-24	$0.099	$0.055
25-29	$0.125	$0.062
30-34	$0.150	$0.090
35-39	$0.179	$0.129
40-44	$0.219	$0.206
45-49	$0.402	$0.329
50-54	$0.687	$0.558
55-59	$1.281	$0.967
60-64	$1.667	$1.246
65-69	$2.544	$2.339
70-74	$3.821	$5.248
75+	$8.941	$12.495
Child rate per $1,000	$0.046	
Employee, Spouse, and Child AD&D rate per $1,000	$0.006	

Designating a Beneficiary

A beneficiary is the person or entity you elect to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, you must identify how much each beneficiary will receive (e.g., 50% or 25%).

DISABILITY INSURANCE

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We offer Short Term Disability (STD) insurance for you to purchase through **Sun Life**.

Short Term Disability

STD coverage pays a percentage of your weekly salary if you are temporarily disabled and unable to work due to an illness, pregnancy or non-work related injury. STD benefits are not payable if the disability is due to a job-related injury or illness. If a medical condition is job-related, it is considered Workers Compensation, not STD.

Short Term Disability	
Benefits Begin	15th day
Percentage of Earnings You Receive	60%
Maximum Weekly Benefit	$1,000
Maximum Benefit Period	26 weeks
Pre-existing Condition Exclusion	6/12*

*Benefits may not be paid for any condition treated within 6 months prior to your effective date until you have been covered under this plan for 12 months.

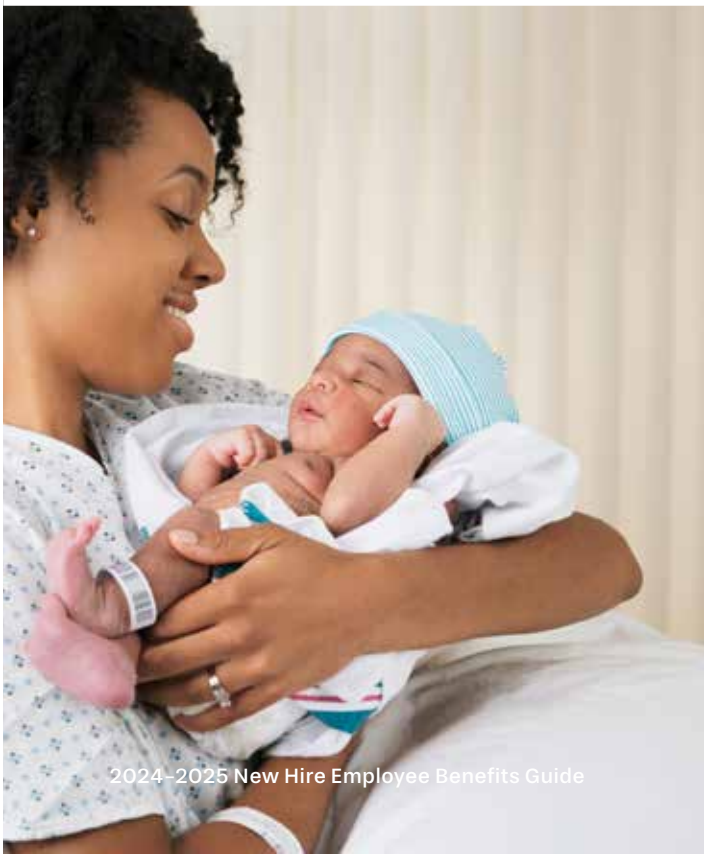
Monthly Rates per $10 of coverage	
Age Band	**Rates**
<40	$1.078
40-49	$1.498
50-59	$1.714
60+	$1.940

STD Premium Calculation

Example:

John Doe is 45 years of age, and earns $500 a week.

- $500 x 60% = **$300** weekly benefit
- $300 ÷ 10 = **$30 x $1.498** (age rate from chart)
- $44.94 monthly rate x 12 ÷ 52 = **$10.37** weekly rate



SUPPLEMENTAL BENEFITS

You and your eligible family members have the opportunity to enroll in additional coverage that complements our traditional health care programs. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs, such as deductibles, coinsurance, travel expenses, and non-medical related expenses. The plans are offered through **Sun Life** and are portable.

Accident Insurance

Accident insurance provides affordable protection against a sudden, unforeseen accident. The Accident plan helps offset the direct and indirect expenses resulting from an accident, such as copayments, deductible, ambulance, physical therapy and other costs not covered by traditional health plans.

Accident	
Service	**Benefit**
Emergency Room	$150
Ambulance – Ground/Air	$200 ground; $1,500 air
Initial Hospitalization	$1,000 per benefit year
Hospital Confinement	$250 per day up to 365 days
Intensive Care Unit	$1,500 per benefit year for admission; $500 per day up to 30 days for confinement
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, factures, lacerations, concussions, etc.	$35 - $50,000
Accidental Death & Dismemberment* • Employee Only • Employee + Spouse • Employee + Child(ren)	$25,000 $25,000 $25,000

*Percentage of benefit paid for dismemberment is dependent on type of loss.

	Weekly Rate
Employee Only	$4.82
Employee + Spouse	$6.49
Employee + Child(ren)	$7.16
Employee + Family	$8.84

Hospital Indemnity/Gap Policy

The Hospital Indemnity Plan provided helps you with the high cost of medical care by paying you a set amount when you have an inpatient hospital stay. Unlike traditional insurance which pays a benefit to the hospital or doctor, this plan pays you directly based on the care or treatment that you receive. These costs may include meals and transportation, childcare or time away from work due to a medical issue that requires hospitalization.

Service	Benefit	
	Plan 1	**Plan 2**
Inpatient Benefits	$3,000	$5,000
Outpatient Benefits	$1,500	$2,500
***Benefits are per covered person per calendar year.**	Rates are age-based.	

EMPLOYEE WEEKLY CONTRIBUTIONS

MEDICAL – PPO PLAN					
	Base Plan HDHP	Employer Pays	Employee Cost		
	Monthly	Monthly	Monthly	WEEKLY	
Employee Only	$352.72	$352.72	$0.00	**$0.00**	
Employee + Spouse	$886.14	$352.72	$533.42	**$123.10**	$
Employee + Child(ren)	$665.37	$352.72	$312.65	**$72.15**	
Employee + Family	$1,244.10	$352.72	$891.38	**$205.70**	
MEDICAL – HDHP PLAN					
	DPPO				
	Monthly	Monthly	Monthly	Weekly	
Employee Only	$267.70	$267.70	$0.00	**$0.00**	
Employee + Spouse	$672.53	$267.70	$404.83	**$93.42**	$
Employee + Child(ren)	$504.98	$267.70	$237.28	**$54.76**	
Employee + Family	$944.21	$267.70	$676.51	**$156.12**	
DENTAL					
	Monthly	Monthly	Monthly	Weekly	
Employee Only	$27.16	$0.00	$27.16	**$6.27**	
Employee + Spouse	$54.68	$0.00	$54.68	**$12.62**	$
Employee + Child(ren)	$71.09	$0.00	$71.09	**$16.41**	
Employee + Family	$98.61	$0.00	$98.61	**$22.76**	
VISION					
	Monthly	Monthly	Monthly	Weekly	$
Employee Only	$9.99	$0.00	$9.99	**$2.31**	$
Employee + Spouse	$19.98	$0.00	$19.98	**$4.61**	$
Employee + Child(ren)	$21.98	$0.00	$21.98	**$5.07**	$
Employee + Family	$31.98	$0.00	$31.98	**$7.38**	$
Voluntary Life and AD&D	See Page 17 for rates				$
Short Term Disability	See Page 18 for rates				$
Voluntary Supplemental Benefits					
Accident	See page 13 for rates				$
Hospital Indemnity					
Your Total 2024-2025 Weekly Benefit Cost					$

IMPORTANT NOTICES

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

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

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

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 enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

B&P Enterprises, Inc.
Human Resources
Michele Bloodworth
6230 Stateline Road
Walls, MS 38680
662-781-2780

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with B& P Enterprises, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. B& P Enterprises, Inc. has determined that the prescription drug coverage offered by the B& P Enterprises, Inc. medical plan is, 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 enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See

the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting B& P Enterprises, Inc. at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current B& P Enterprises, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **662-781-2780**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

For more information about your options under Medicare prescription drug coverage:

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 whether or not you are required to pay a higher premium (a penalty).

May 1, 2024
B&P Enterprises, Inc.
Human Resources
Michele Bloodworth
6230 Stateline Road
Walls, MS 38680
662-781-2780

Notice of HIPAA Privacy Practices

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan – whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by B& P Enterprises, Inc. , hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Complaints: If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer.

B&P Enterprises, Inc.
Human Resources
Michele Bloodworth
6230 Stateline Road
Walls, MS 38680
662-781-2780

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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

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

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

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

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

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

Alabama – Medicaid

Website: http://www.myalhipp.com/
Phone: 1-855-692-5447

Alaska – Medicaid

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

Arkansas – Medicaid

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

California– Medicaid

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

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

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

Florida – Medicaid

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

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

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
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
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

Louisiana – Medicaid

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

Maine – Medicaid

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

Massachusetts – Medicaid and 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

Missouri – Medicaid

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

Montana – Medicaid

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

Nebraska – Medicaid

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

Nevada – Medicaid

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

New Hampshire – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345 ext.5218

New Jersey – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
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: 919-855-4100

North Dakota – Medicaid

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

Oklahoma – Medicaid and CHIP

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

Oregon – Medicaid

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

Pennsylvania – Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid and CHIP

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

South Carolina – Medicaid

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

South Dakota - Medicaid

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

Texas – Medicaid

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

Utah – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov
CHIP Website: https://health.utah.gov/chip
Phone: 1-877-543-7669

Vermont– Medicaid

Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

Virginia – Medicaid and CHIP

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

Washington – Medicaid

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

West Virginia – Medicaid and CHIP

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

Wisconsin – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 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 **January 31, 2024**, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the B& P Enterprises, Inc. group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the B& P Enterprises, Inc. plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

B&P Enterprises, Inc.
Human Resources
Michele Bloodworth
6230 Stateline Road
Walls, MS 38680
662-781-2780

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 annual out-of-pocket limit.

"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.

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 the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- 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 may 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 cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

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

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - 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.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

Higginbotham™

This brochure highlights the main features of the B&P Enterprises, Inc. benefits program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. B&P Enterprises, Inc. reserves the right to change or discontinue its benefits plans at any time.