LET'S TALK ABOUT YOUR 2025 BENEFITS

Griffin Holdings, Inc. & Subsidiaries
(Griffin Foods)

GRIFFIN
Sharing the great tastes of life
GRIFFIN FOODS • HOUSE OF WEBSTER

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If you 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 32 - 33 for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/ Benefits Department.

OVERVIEW & ELIGIBILITY

At Griffin Holdings, Inc. & Subsidiaries, we value our people. Our goal is to offer a rewards package that enhances your and your family's health.

OVERVIEW

At Griffin Holdings, Inc. & Subsidiaries, we value our people. Our goal is to offer a benefits package that enhances you and your family's health and wellbeing. We also recognize our employees and their families each have unique needs, so we offer options in benefits so that you can choose what you need.

You share the costs of some benefits (medical, dental and vision), and Griffin Holdings, Inc. & Subsidiaries provides other benefits at no cost to you (Basic Life/AD&D and Disability Insurance). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

BENEFITS OFFERED

- Medical
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short Term Disability
- Long Term Disability
- Accident Insurance
- Critical Illness Insurance

ELIGIBILITY

You and your dependents are eligible for Griffin Holdings, Inc. & Subsidiaries benefits on the first of the month following 30 days of full-time employment.

Eligible dependents are your legal spouse, children under age 26, disabled dependents of any age, or Griffin Holdings, Inc. & Subsidiaries eligible dependents.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

MEDICAL BENEFITS

Administered by Blue Cross and BlueShield of Oklahoma

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	MOOPT0085 BLUE OPTIONS PPO℠ 0085 - INSUREOK Qualified Plan		
	BLUE PREFERRED PROVIDER	**BLUE CHOICE PROVIDER**	**OUT-OF-NETWORK**
CALENDAR YEAR DEDUCTIBLE*	$2,100 SINGLE / $6,300 FAMILY		$4,200 SINGLE / $12,600 FAMILY
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$3,000 SINGLE / $7,000 FAMILY	$4,250 SINGLE / $9,000 FAMILY	$9,000 SINGLE / $21,000 FAMILY
COINSURANCE	10%	20%	40%
PRIMARY CARE OFFICE VISIT	$40 COPAY PER VISIT		
SPECIALIST OFFICE VISIT	$45 COPAY PER VISIT		
PREVENTIVE CARE/SCREENING/ IMMUNIZATION	0%		30% AFTER DEDUCTIBLE
DIAGNOSTIC TEST (X-RAY, BLOOD WORK)	0%		
IMAGING (CT/PET SCAN, MRI)	10% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE
PRESCRIPTION DRUGS[1]			
RETAIL—PREFERRED GENERIC DRUGS (30-DAY SUPPLY)**	PREFERRED: $0 COPAY; PARTICIPATING: $10 COPAY		$10 COPAY
RETAIL—NON-PREFERRED GENERIC DRUGS (30-DAY SUPPLY)**	PREFERRED: $10 COPAY; PARTICIPATING: $20 COPAY		$20 COPAY
RETAIL—PREFERRED BRAND DRUGS (30-DAY SUPPLY)**	PREFERRED: $50 COPAY; PARTICIPATING: $70 COPAY		$70 COPAY
RETAIL—NON-PREFERRED BRAND DRUGS (30-DAY SUPPLY)**	PREFERRED: $100 COPAY PARTICIPATING: $120 COPAY		$120 COPAY
SPECIALTY DRUGS (30-DAY SUPPLY)	PREFERRED: $250 COPAY NON-PREFERRED: $350 COPAY		PREFERRED: $250 COPAY NON-PREFERRED: $350 COPAY
MAIL ORDER—PREFERRED GENERIC DRUGS (90-DAY SUPPLY)	$0 COPAY		NOT APPLICABLE
MAIL ORDER— NON-PREFERRED GENERIC DRUGS (90-DAY SUPPLY)	$30 COPAY		NOT APPLICABLE
MAIL ORDER—PREFERRED BRAND DRUGS (90-DAY SUPPLY)	$150 COPAY		NOT APPLICABLE
MAIL ORDER— NON-PREFERRED BRAND DRUGS (90-DAY SUPPLY)	$300 COPAY		NOT APPLICABLE
HOSPITAL SERVICES			
EMERGENCY ROOM (PER OCCURRENCE DEDUCTIBLE WAIVED IF ADMITTED)	$200 COPAY PER VISIT, PLUS 10% AFTER DEDUCTIBLE		
URGENT CARE	$50 COPAY PER VISIT		30% AFTER DEDUCTIBLE
INPATIENT	$750 COPAY PER VISIT, PLUS 10% AFTER DEDUCTIBLE	$750 COPAY PER VISIT, PLUS 20% AFTER DEDUCTIBLE	$750 COPAY PER VISIT, PLUS 40% AFTER DEDUCTIBLE

* ER: $200; Inpatient: $750; Outpatient Surgery: $200

** 90-day supply at a network of select retail pharmacies

[1] copay is per prescription

MEDICAL BENEFITS

Administered by Blue Cross and BlueShield of Oklahoma

	MOOPT0105 BLUE OPTIONS PPO[SM] 0105		
	BLUE PREFERRED PROVIDER	**BLUE CHOICE PROVIDER**	**OUT-OF-NETWORK**
CALENDAR YEAR DEDUCTIBLE*	$2,600 SINGLE / $7,800 FAMILY		$5,200 SINGLE / $15,600 FAMILY
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$5,450 SINGLE / $10,900 FAMILY	$5,650 SINGLE / $11,300 FAMILY	$16,350 SINGLE / $32,700 FAMILY
COINSURANCE	20%	30%	50%
PRIMARY CARE OFFICE VISIT	$40 COPAY PER VISIT		
SPECIALIST OFFICE VISIT	$45 COPAY PER VISIT		
PREVENTIVE CARE/SCREENING/ IMMUNIZATION	0%		30% AFTER DEDUCTIBLE
DIAGNOSTIC TEST (X-RAY, BLOOD WORK)	0%		
IMAGING (CT/PET SCAN, MRI)	20% AFTER DEDUCTIBLE	30% AFTER DEDUCTIBLE	50% AFTER DEDUCTIBLE
PRESCRIPTION DRUGS[1]			
RETAIL—PREFERRED GENERIC DRUGS (30-DAY SUPPLY)**	PREFERRED: $0 COPAY PARTICIPATING: $10 COPAY		$10 COPAY
RETAIL—NON-PREFERRED GENERIC DRUGS (30-DAY SUPPLY)**	PREFERRED: $10 COPAY PARTICIPATING: $20 COPAY		$20 COPAY
RETAIL—PREFERRED BRAND DRUGS (30-DAY SUPPLY)**	PREFERRED: $35 COPAY PARTICIPATING: $55 COPAY		$55 COPAY
RETAIL—NON-PREFERRED BRAND DRUGS (30-DAY SUPPLY)**	PREFERRED: $75 COPAY PARTICIPATING: $95 COPAY		$95 COPAY
SPECIALTY DRUGS (30-DAY SUPPLY)	PREFERRED: $250 COPAY NON-PREFERRED: $350 COPAY		PREFERRED: $250 COPAY PLUS 50% NON-PREFERRED: $350 COPAY PLUS 50%
MAIL ORDER—PREFERRED GENERIC DRUGS (90-DAY SUPPLY)	$0 COPAY		NOT APPLICABLE
MAIL ORDER— NON-PREFERRED GENERIC DRUGS (90-DAY SUPPLY)	$30 COPAY		NOT APPLICABLE
MAIL ORDER—PREFERRED BRAND DRUGS (90-DAY SUPPLY)	$105 COPAY		NOT APPLICABLE
MAIL ORDER— NON-PREFERRED BRAND DRUGS (90-DAY SUPPLY)	$225 COPAY		NOT APPLICABLE
HOSPITAL SERVICES			
EMERGENCY ROOM (PER OCCURRENCE DEDUCTIBLE WAIVED IF ADMITTED)	$200 COPAY PER VISIT, PLUS 20% AFTER DEDUCTIBLE		
URGENT CARE	$50 COPAY PER VISIT		30% AFTER DEDUCTIBLE
INPATIENT	$750 COPAY PER VISIT, PLUS 20% AFTER DEDUCTIBLE	$750 COPAY PER VISIT, PLUS 30% AFTER DEDUCTIBLE	$750 COPAY PER VISIT, PLUS 50% AFTER DEDUCTIBLE

* ER: $200; Inpatient: $750; Outpatient Surgery: $200

** 90-day supply at a network of select retail pharmacies

[1] copay is per prescription

MEDICAL BENEFITS

Administered by Blue Cross and BlueShield of Oklahoma

	MOBPF0135 BLUE PREFERRED PPO℠ 0135	
	IN-NETWORK	**OUT-OF-NETWORK**
CALENDAR YEAR DEDUCTIBLE*	$3,100 SINGLE / $9,300 FAMILY	$6,200 SINGLE / $18,600 FAMILY
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$7,250 SINGLE / $14,500 FAMILY	$21,750 SINGLE / $43,500 FAMILY
COINSURANCE	30%	40%
PRIMARY CARE OFFICE VISIT	$35 COPAY PER VISIT	30% AFTER DEDUCTIBLE
SPECIALIST OFFICE VISIT	$60 COPAY PER VISIT	30% AFTER DEDUCTIBLE
PREVENTIVE CARE/SCREENING/ IMMUNIZATION	0%	30% AFTER DEDUCTIBLE
DIAGNOSTIC TEST (X-RAY, BLOOD WORK)	0%	30% AFTER DEDUCTIBLE
IMAGING (CT/PET SCAN, MRI)	30% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE
PRESCRIPTION DRUGS[1]		
RETAIL—PREFERRED GENERIC DRUGS (30-DAY SUPPLY)**	PREFERRED: $0 COPAY PARTICIPATING: $10 COPAY	$10 COPAY
RETAIL— NON-PREFERRED GENERIC DRUGS (30-DAY SUPPLY)**	PREFERRED: $10 COPAY PARTICIPATING: $20 COPAY	$20 COPAY
RETAIL—PREFERRED BRAND DRUGS (30-DAY SUPPLY)**	PREFERRED: $50 COPAY PARTICIPATING: $70 COPAY	$70 COPAY
RETAIL—NON-PREFERRED BRAND DRUGS (30-DAY SUPPLY)**	PREFERRED: $100 COPAY PARTICIPATING: $120 COPAY	$120 COPAY
SPECIALTY DRUGS (30-DAY SUPPLY)	PREFERRED: $250 COPAY NON-PREFERRED: 350 COPAY	PREFERRED: $250 COPAY PLUS 50% NON-PREFERRED: $350 COPAY PLUS 50%
MAIL ORDER—PREFERRED GENERIC DRUGS (90-DAY SUPPLY)	$0 COPAY	NOT APPLICABLE
MAIL ORDER— NON-PREFERRED GENERIC DRUGS (90-DAY SUPPLY)	$30 COPAY	NOT APPLICABLE
MAIL ORDER—PREFERRED BRAND DRUGS (90-DAY SUPPLY)	$150 COPAY	NOT APPLICABLE
MAIL ORDER— NON-PREFERRED BRAND DRUGS (90-DAY SUPPLY)	$300 COPAY	NOT APPLICABLE
HOSPITAL SERVICES		
EMERGENCY ROOM (PER OCCURRENCE DEDUCTIBLE WAIVED IF ADMITTED)	$400 COPAY PER VISIT, PLUS 30% AFTER DEDUCTIBLE	$400 COPAY PER VISIT, PLUS 30% AFTER DEDUCTIBLE
URGENT CARE	$50 COPAY PER VISIT	30% AFTER DEDUCTIBLE
INPATIENT	$750 COPAY PER VISIT, PLUS 30% AFTER DEDUCTIBLE	$750 COPAY PER VISIT, PLUS 40% AFTER DEDUCTIBLE

* ER: $200; Inpatient: $750; Outpatient Surgery: $250

** 90-day supply at a network of select retail pharmacies

[1] copay is per prescription

MEDICAL BENEFITS

Choosing the right plan for you

You have the choice of three types of health plans: MOOPT0085 Blue Options PPO℠ 0085, MOOPT0105 Blue Options PPO℠ 0105 and MOBPF0135 Blue Preferred PPO℠ 0135.

HOW THE PLANS WORK

Three plans use the Blue Cross and BlueShield of Oklahoma network and cover 100% of the cost for preventive care services like calendar year physicals and routine immunizations. The way you pay for care is different with each plan.

The PPO plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your calendar year out-of-pocket maximum.

TERMS TO KNOW

Copay
A set dollar amount you pay for a covered health care Service, usually when you receive the service.

Deductible
What you pay out of pocket for health care services before the plan begins to pay a portion.

Coinsurance
Your share of the costs of covered health care services after you reach the deductible. You pay the percentage noted in the table above, and the medical plan pays the rest.

Out-of-pocket Maximum
What you have to pay before the plan pays 100% of your covered costs.

Network
The facilities and providers the medical plan has contracted with to provide health care services. In-network providers typically provide services at a lower negotiated rate.

MEDICAL BENEFITS

The Importance of your calendar year preventive care exam

Calendar Year preventive exams are covered at 100% under three plan options.

Haven't seen your doctor for your calendar year preventive exams in awhile?

Here are fives reasons to schedule it now.

PREVENT HEALTH PROBLEMS.
Calendar year physicals allow your doctor to review any changes that have occurred since your last visit.

BUILD A RELATIONSHIP WITH YOUR DOCTOR
The more comfortable you are with your doctor, the more likely you are to see him or her when you don't feel right.

ESTABLISH BASELINES
Getting a routine physical will help establish baselines for your weight, blood pressure and cholesterol, which can help identify future progression or regression.

UPDATE VACCINATIONS
Staying up-to-date on your vaccinations (e.g. your flu and tetanus shots) is an important way to prevent illness and its consequences such as missed work.

REVIEW AND RENEW MEDICATION PRESCRIPTIONS.
Reviewing your medications with your physician, including over-the-counter medications, will ensure you are treating your medical problems the best way possible and with minimal side effects.

TO FIND A PHYSICIAN:
To locate a primary care physician in-network, use the tool on www.bcbsok.com/blueoptions / www.bcbsok.com/**bluepreferred** or call the number on the back of ID Card.

Insure Oklahoma

2025 ESI Income Guidelines			
Family Size	Minimum Monthly Income	Maximum Monthly Income	Annual Income
1	$1,814	$2,975	$35,700
2	$2,451	$4,019	$48,228
3	$3,088	$5,063	$60,756
4	$3,726	$6,110	$73,320
5	$4,362	$7,154	$85,848
6	$4,999	$8,198	$98,376
7	$5,637	$9,245	$110,940
8	$6,274	$10,289	$123,468

DENTAL BENEFITS

Administered by Delta Dental of Oklahoma

Great dental care can contribute to great overall health. As many as 120 systemic diseases can be visible in your mouth. Research shows that people who have regular dental care have lower healthcare cost burdens—thanks to prevention and early detection.

SERVICES	IN-NETWORK DELTA DENTAL PPO / PREMIER NETWORK PPO
CALENDAR YEAR DEDUCTIBLE	$100 PER PERSON; $300 FAMILY LIMIT
CALENDAR YEAR BENEFIT MAXIMUM	$1,500*
PREVENTIVE DENTAL SERVICES (DIAGNOSTIC AND PREVENTIVE SERVICES)	100%
BASIC DENTAL SERVICES (AMALGAM AND COMPOSITE FILLINGS)	80% AFTER DEDUCTIBLE
MAJOR DENTAL SERVICES (CROWNS, DENTURES AND IMPLANTS)	50% AFTER DEDUCTIBLE
ORTHODONTIA SERVICES (COVERED TO AGE 26)	50% TO $2,000 LIFETIME MAXIMUM

***Benefits paid by the plan for covered oral evaluations and routine prophylaxis (cleanings) will not reduce your Annual Maximum Benefit Per Person for Classes I, II and III combined services.**

TO FIND A DENTIST:
To locate an in-network dentist, use the tool on www.DeltaDentalOK.org or call **800.522.0188**

VISION BENEFITS

Administered by Vision Service Plan

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

SERVICE	IN-NETWORK EXAM ONLY PLAN (ANY VSP SIGNATURE PROVIDER)	IN-NETWORK VSP SIGNATURE PLAN (ANY VSP SIGNATURE PROVIDER)
EYE EXAM — ONCE EVERY 12 MONTHS	$10 COPAY	$10 COPAY
LENSES — ONCE EVERY 12 MONTHS		
SINGLE VISION LENSES	NOT APPLICABLE	$25 COPAY
LINED BIFOCAL LENSES	NOT APPLICABLE	$25 COPAY
LINED TRIFOCAL LENSES	NOT APPLICABLE	$25 COPAY
FRAMES — ONCE EVERY 12 MONTHS	NOT APPLICABLE	FRAME: $120 ALLOWANCE; 20% SAVINGS ON THE AMOUNT OVER YOUR ALLOWANCE
CONTACT LENSES — ONCE EVERY 12 MONTHS IF YOU ELECT CONTACTS INSTEAD OF LENSES/FRAMES		
ELECTIVE	NOT APPLICABLE	$120 ALLOWANCE
FITTING AND EVALUATION	NOT APPLICABLE	$60 ALLOWANCE

TO FIND A VISION PROVIDER:
To locate an in-network vision provider, use the tool on **www.vsp.com** or call **800.877.7195**

LIFE INSURANCE

Administered by Mutual of Omaha

Life insurance provides financial security for the people who depend on you.

LIFE INSURANCE

Your beneficiaries will receive a lump sum payment if you die while employed by Griffin Holdings, Inc. & Subsidiaries. The company provides basic life insurance for 2 times your annual salary, up to $100,000 maximum at no cost to you.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Griffin Holdings, Inc. & Subsidiaries provides AD&D coverage for 2 times your annual salary, up to $100,000 maximum at no cost to you. This coverage is in addition to your company-paid life insurance described above.

VOLUNTARY LIFE AND AD&D INSURANCE

You may purchase life and AD&D insurance in addition to the company provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (5x Annual Earnings up to $100,000, and up to 100% of employee's benefit for your legal spouse) without answering medical questions if you enroll when you are first eligible.

Voluntary Life and AD&D Insurance Details:

Employee— Up to five times your salary in increments of $10,000; $500,000 maximum amount

Spouse— In increments of $5,000 up to $250,000 (not to exceed 100% of EE's amount)

Children— In increments of $2,500 up to $10,000 (not to exceed 100% of EE's amount)

BENEFICIARY DESIGNATION

Making and maintaining beneficiary designations is an essential part of everyone’s financial plan. Neglecting your beneficiary designations might mean that assets that typically avoid probate may become part of your estate and be subject to the associated time and costs of that process.

Be sure to update your beneficiary’s when you complete open enrollment this year.

DISABILITY INSURANCE

Griffin Holdings, Inc. & Subsidiaries also provides disability insurance through Mutual of Omaha. This benefit replaces a portion of your Income if you become disabled and are unable to work.

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
Short-term Disability	You receive 60% of your income up to $1,385 per week. Benefits begin on 15th calendar days of injury and illness of absence from work and continue for up to 24 weeks.	Company
Long-term Disability	You receive 60% of your income up to $6,000 per month. Benefits begin on the later of 180 calendar days of injury and illness or the date your short-term disability ends and continue until you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.	Company

Voluntary Term Life and AD&D Coverage Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life and AD&D section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 29	$0.52	$1.04	$1.56	$2.08	$2.60	$3.12	$3.64	$4.16	$4.68	$5.20
30 - 34	$0.61	$1.22	$1.83	$2.44	$3.05	$3.66	$4.27	$4.88	$5.49	$6.10
35 - 39	$0.87	$1.74	$2.61	$3.48	$4.35	$5.22	$6.09	$6.96	$7.83	$8.70
40 - 44	$1.35	$2.70	$4.05	$5.40	$6.75	$8.10	$9.45	$10.80	$12.15	$13.50
45 - 49	$2.39	$4.78	$7.17	$9.56	$11.95	$14.34	$16.73	$19.12	$21.51	$23.90
50 - 54	$3.70	$7.40	$11.10	$14.80	$18.50	$22.20	$25.90	$29.60	$33.30	$37.00
55 - 59	$6.30	$12.60	$18.90	$25.20	$31.50	$37.80	$44.10	$50.40	$56.70	$63.00
60 - 64	$8.91	$17.82	$26.73	$35.64	$44.55	$53.46	$62.37	$71.28	$80.19	$89.10
65 - 69	$13.70	$27.40	$41.10	$54.80	$68.50	$82.20	$95.90	$109.60	$123.30	$137.00
70+	$25.43	$50.86	$76.29	$101.72	$127.15	$152.58	$178.01	$203.44	$228.87	$254.30

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.26	$0.52	$0.78	$1.04	$1.30	$1.56	$1.82	$2.08	$2.34	$2.60
30 - 34	$0.31	$0.61	$0.92	$1.22	$1.53	$1.83	$2.14	$2.44	$2.75	$3.05
35 - 39	$0.44	$0.87	$1.31	$1.74	$2.18	$2.61	$3.05	$3.48	$3.92	$4.35
40 - 44	$0.68	$1.35	$2.03	$2.70	$3.38	$4.05	$4.73	$5.40	$6.08	$6.75
45 - 49	$1.20	$2.39	$3.59	$4.78	$5.98	$7.17	$8.37	$9.56	$10.76	$11.95
50 - 54	$1.85	$3.70	$5.55	$7.40	$9.25	$11.10	$12.95	$14.80	$16.65	$18.50
55 - 59	$3.15	$6.30	$9.45	$12.60	$15.75	$18.90	$22.05	$25.20	$28.35	$31.50
60 - 64	$4.46	$8.91	$13.37	$17.82	$22.28	$26.73	$31.19	$35.64	$40.10	$44.55
65 - 69	$6.85	$13.70	$20.55	$27.40	$34.25	$41.10	$47.95	$54.80	$61.65	$68.50

ALL CHILDREN PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)*

$2,500	$5,000	$7,500	$10,000
$0.44	$0.87	$1.31	$1.74

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

Allstate®
BENEFITS

Protection for accidental injuries on- and off-the-job, 24 hours a day

Accident Insurance

Today, active lifestyles in or out of the home may result in bumps, bruises and sometimes breaks. Getting the right treatment can be vital to recovery, but it can also be expensive. And if an accident keeps you away from work during recovery, the financial worries can grow quickly.

Most major medical insurance plans only pay a portion of the bills. Our coverage can help pick up where other insurance leaves off and provide cash to help cover the expenses.

With Accident insurance from Allstate Benefits, you can gain the advantage of financial support, thanks to the cash benefits paid directly to you. You also gain the financial empowerment to seek the treatment needed to be on the mend.

Here's How It Works

Our coverage pays you cash benefits that correspond with hospital and intensive care confinement. Your plan may also include coverage for a variety of occurrences, such as: dismemberment; dislocation or fracture; ambulance services; physical therapy and more. The cash benefits can be used to help pay for deductibles, treatment, rent and more.

Meeting Your Needs

- Guaranteed Issue coverage, subject to exclusions and limitations*
- Benefits are paid directly to you unless otherwise assigned
- Pays in addition to other insurance coverage
- Coverage also available for your dependents
- Premiums are affordable and can be conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details

With Allstate Benefits, you can protect your finances against life's slips and falls.
Practical benefits for everyday living.®

*Please refer to the Exclusions and Limitations section of this brochure. [1]National Safety Council, Injury

DID YOU KNOW?

The number of injuries sustained by workers in one year, both on- and off-the-job, includes:[1]

ON-THE-JOB (in millions)

Work **4.4**

OFF-THE-JOB (in millions)

Home **25.0**

Non-Auto **12.6**

Auto **4.3**

Meet Daniel & Sandy

Daniel and Sandy are like most active couples: they enjoy the outdoors and a great adventure. They have seen their share of bumps, bruises and breaks. Sandy knows an accidental injury could happen to either of them. Most importantly, she worries about how they will pay for it.

Here is what weighs heavily on her mind:

- **Major medical will only pay a portion of the expenses associated with injury treatments**
- **They have copays they are responsible for until they meet their deductible**
- **If they miss work because of an injury, they must cover the bills, rent/mortgage, groceries and their child's education**
- **If they need to seek treatment not available locally, they will have to pay for it**

Daniel's story of injury and treatment turned into a happy ending, because he had supplemental Accident Insurance to help with expenses.

CHOOSE

Daniel and Sandy choose benefits to help protect their family if they suffer an accidental injury.

USE

Daniel was playing a pick-up game of basketball with his friends when he went up for a jump-shot and, on his way back down, twisted his foot and ruptured his Achilles tendon.

Here's Daniel's treatment path:

- Taken by ambulance to the emergency room
- Examined by a doctor and X-rays were taken
- Underwent surgery to reattach the tendon
- Was visited by his doctor and released after a one-day stay in the hospital
- Had to immobilize his ankle for 6 weeks
- Was seen by the doctor during a follow-up visit and sent to physical therapy to strengthen his leg and improve his mobility

Daniel would go online after each of his treatments to file claims. The cash benefits were direct deposited into his bank account.

Daniel is back playing basketball and enjoying life.

CLAIM

Daniel's Accident claim paid cash benefits for the following:

Ambulance Services
Medicine
Medical Expenses (Emergency Room and X-rays)
Initial Hospital Confinement
Hospital Confinement
Tendon Surgery
General Anesthesia
Accident Follow-Up Treatment
Physical Therapy (3 days/week)

For a listing of benefits and benefit amounts, see your company's rate insert.

Using your cash benefits

Cash benefits provide you with options, because you decide how to use them.

Finances
Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.

Travel
Can help pay for expenses while receiving treatment in another city.

Home
Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.

Expenses
Can help pay your family's living expenses such as bills, electricity, and gas.

MyBenefits: 24/7 Access
allstatebenefits.com/mybenefits

An easy-to-use website that offers 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

Dependent Eligibility

Coverage may include you, your spouse and your children.

[1]Multiple dismemberments, dislocations or fractures are limited to the amount shown in the rate insert. [2]Up to three times per covered person, per accident. [3]Two or more surgeries done at the same time are considered one operation. [4]Paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. [5]Two treatments per covered person, per accident. *Must begin or be received within 180 days of the accident. **Within 3 days after the accident.

Benefits (subject to maximums as listed on the attached rate insert)

BASE POLICY BENEFITS

Accidental Death*

Common Carrier Accidental Death - riding as a fare-paying passenger on a scheduled common-carrier

Dismemberment[1]* - amount paid depends on type of dismemberment. See Injury Benefit Schedule in rate insert

Dislocation or Fracture[1] - amount paid depends on type of dislocation or fracture. See Injury Benefit Schedule in rate insert

Initial Hospitalization Confinement - initial hospitalization after the effective date

Hospital Confinement - up to 90 days for any one injury

Intensive Care - up to 90 days for each period of continuous confinement

Ambulance Services - transfer to or from hospital by ambulance service

Medical Expenses - expenses incurred for medical or surgical treatment. Expenses are limited to physician fees, X-rays and emergency room services. Includes treatment for dental repair to sound natural teeth if repair is diagnosed by a dentist as necessary and as a result of injury

Outpatient Physician's Treatment - treatment outside the hospital for any cause. Payable up to 2 visits per covered person, per calendar year and a maximum of 4 visits per calendar year if dependents are covered

BENEFIT ENHANCEMENT RIDER

Hospital Admission -** first hospital confinement occurring during a calendar year, and 12 months after rider effective date. Payable when a benefit has been paid under the Hospital Confinement Benefit in the base policy

Lacerations -** treatment for one or more lacerations (cuts)

Burns -** treatment for one or more burns, other than sunburns

Skin Graft - receiving a skin graft for which a benefit is paid under the Burns benefit

Brain Injury Diagnosis -** first diagnosis of concussion, cerebral laceration, cerebral contusion or intracranial hemorrhage within three days of an accident. Must be diagnosed within 30 days after the accident by CT Scan, MRI, EEG, PET scan or X-ray

Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI)* - must first be treated by a physician within 30 days after the accident

Paralysis -** spinal cord injury resulting in complete/permanent loss of use of two or more limbs for at least 90 days

Coma with Respiratory Assistance - unconsciousness lasting 7 or more days; intubation required. Medically induced comas excluded

**Open Abdominal or Thoracic Surgery[3], **

Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery[3], * - surgery received for torn, ruptured, or severed tendon, ligament, rotator cuff or knee cartilage; pays the reduced amount shown for arthroscopic exploratory surgery

Ruptured Disc Surgery[3], * - diagnosis and surgical repair to a ruptured disc of the spine by a physician

Eye Surgery - surgery or removal of a foreign object by a physician

General Anesthesia* - payable only if the policy Surgery benefit is paid

Blood and Plasma -** transfusion after an accident

Appliance - physician-prescribed wheelchair, crutches or walker to help with personal locomotion or mobility

Medical Supplies - purchased over-the-counter medical supplies. Payable only if the policy Medical Expenses benefit is paid

Medicine - purchased prescription or over-the-counter medicines. Payable only if the policy Medical Expenses benefit is paid

Prosthesis* - physician-prescribed prosthetic arm, leg, hand, foot or eye lost as a result of an accident. Payable only if a benefit is paid for loss of arm, leg, hand, foot or eye under the Dismemberment benefit

Physical Therapy - one treatment per day; maximum of 6 treatments per accident. Chiropractic services are excluded. Not payable for same visit for which Accident Follow-Up Treatment benefit is paid. Must take place no longer than 6 months after accident

Rehabilitation Unit[4] - must be hospital-confined due to an injury immediately prior to being transferred to rehab. Not payable for the days on which the Hospital Confinement benefit is paid

Non-Local Transportation[2] - treatment obtained at a non-local hospital or freestanding treatment center more than 100 miles from your home. Does not cover ambulance or physician's office or clinic visits for services other than treatment

Family Member Lodging - one adult family member to be with you while you are confined in a non-local hospital or freestanding treatment center. Not payable if family member lives within 100 miles one-way of the treatment facility. Up to 30 days per accident. Only payable if the Non-Local Transportation benefit is paid

Post-Accident Transportation - after a three-day hospital stay more than 250 miles from your home, with a flight on a common carrier to return home. Payable only if a benefit is paid for Hospital Confinement

Accident Follow-Up Treatment[5] - must take place no longer than 6 months after the accident. Payable only if the policy Medical Expenses benefit is paid. Not payable for the same visit for which the Physical Therapy benefit is paid

Group Voluntary Accident (GVAP1)

On- and Off-the-Job Accident Insurance from Allstate Benefits

BENEFIT AMOUNTS

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

BASE POLICY BENEFITS		PLAN 1	PLAN 2
Accidental Death	Employee	$40,000	$60,000
	Spouse	$20,000	$30,000
	Children	$10,000	$15,000
Common Carrier Accidental Death (fare-paying passenger)	Employee	$200,000	$300,000
	Spouse	$100,000	$150,000
	Children	$50,000	$75,000
Dismemberment[1]	Employee	$40,000	$60,000
	Spouse	$20,000	$30,000
	Children	$10,000	$15,000
Dislocation or Fracture[1]	Employee	$4,000	$6,000
	Spouse	$2,000	$3,000
	Children	$1,000	$1,500
Initial Hospitalization Confinement (pays once)		$1,000	$1,500
Hospital Confinement (pays daily)		$200	$300
Intensive Care (pays daily)		$400	$600
Ambulance Services	Ground	$200	$300
	Air	$600	$900
Medical Expenses (pays up to amount shown)		$500	$750
Outpatient Physician's Treatment (pays per visit)		$50.00	$75.00
BENEFIT ENHANCEMENT RIDER		**PLAN 1**	**PLAN 2**
Hospital Admission (pays once/year)		$500	$500
Lacerations (pays once/year)		$50	$50
Burns	< 15% body surface	$100	$100
	15% or more	$500	$500
Skin Graft (% of Burns Benefit)		50%	50%
Brain Injury Diagnosis (pays once)		$150	$150
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) (pays once/accident/year)		$50	$50
Paralysis (pays once)	Paraplegia	$7,500	$7,500
	Quadriplegia	$15,000	$15,000
Coma with Respiratory Assistance (pays once)		$10,000	$10,000
Open Abdominal or Thoracic Surgery		$1,000	$1,000
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery	Surgery	$500	$500
	Exploratory	$150	$150
Ruptured Disc Surgery		$500	$500
Eye Surgery		$100	$100
General Anesthesia		$100	$100
Blood and Plasma		$300	$300
Appliance		$125	$125
Medical Supplies		$5	$5
Medicine		$5	$5
Prosthesis	1 device	$500	$500
	2 or more devices	$1,000	$1,000
Physical Therapy (pays daily)		$30	$30
Rehabilitation Unit (pays daily)		$100	$100
Non-Local Transportation		$400	$400
Family Member Lodging (pays daily)		$100	$100
Post-Accident Transportation (pays once/year)		$200	$200
Accident Follow-Up Treatment (pays daily)		$50	$50

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

Offered to the employees of:

Griffin Food Company

PLAN 1 PREMIUMS

MODE	EE	EE + SP	EE + CH	F
Monthly	$17.99	$33.86	$36.84	$44.89

PLAN 2 PREMIUMS

MODE	EE	EE + SP	EE + CH	F
Monthly	$24.67	$47.22	$51.68	$63.45

Issue ages: 18 and over if actively at work

EE=Employee; **EE + SP** = Employee + Spouse;
EE + CH = Employee + Child(ren); **F** = Family

Injury Benefit Schedule is on reverse

FOR HOME OFFICE USE ONLY - GVAP1
Opt 1 - 2.0U Base; 1.0U BER
Opt 2 - 3.0U Base; 1.0U BER
ABQ V03.01.2023 Rate Insert Creation Date: 6/9/2023

INJURY BENEFIT SCHEDULE

Benefit amounts for coverage and one occurrence are shown below.
Covered spouse gets 50% of the amount shown and children 25%.

COMPLETE DISLOCATION	PLAN 1	PLAN 2
Hip joint	$4,000	$6,000
Knee or ankle joint[3], bone or bones of the foot[3]	$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[3], 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]	$4,000	$6,000
Skull[4]	$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[4], hand or wrist[4]	$1,400	$2,100
Lower jaw[4]	$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 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

[3]Knee joint (except patella). Bone or bones of the foot (except toes). Bone or bones of the hand (except fingers). [4]Pelvis (except coccyx). Skull (except bones of face or nose). Foot (except toes). Hand or wrist (except fingers). Lower jaw (except alveolar process).

Allstate®
BENEFITS

Protection when faced with a critical illness diagnosis and you need treatment

Critical Illness Insurance

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels.

The treatment to recovery is vital, but it can also be expensive. Your medical coverage may only cover some of the costs associated with treatment. You're still responsible for deductibles and coinsurance. If treatment keeps you out of work, the financial worries can grow quickly and stress levels may rise.

Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness. With the expense of treatment often high, seeking the treatment you need could seem like a financial burden. When a diagnosis occurs, you need to be focused on getting better and taking control of your health, not stressing over financial worries.

Here's How It Works

You choose benefits to protect yourself and any family members if diagnosed with a critical illness. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

Meeting Your Needs

- Guaranteed Issue coverage with a Pre-Existing Condition Limitation*
- Coverage available for dependents
- Covered dependents receive 50% of your Basic-Benefit Amount
- Benefits paid regardless of any other medical or disability plan coverage
- Premiums are affordable and conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details
- 25% of your Basic-Benefit Amount is paid for Advanced Alzheimer's Disease and Advanced Parkinson's Disease

With Allstate Benefits, you can make treatment decisions without putting your finances at risk. **Practical benefits for everyday living.®**

*Please refer to the Exclusions and Limitations section of this brochure.
[1]https://www.cdc.gov/heartdisease/heart_attack.htm
[2]https://www.cdc.gov/stroke/facts.htm

DID YOU KNOW ?

Every **40** seconds, an American will suffer a heart attack[1]

Every **40** seconds, someone in the U.S. has a stroke[2]

Meet Ashley

Ashley is like any single parent who has been diagnosed with a critical illness. She's worried about her future, her children and how they will cope with her treatments. Most importantly, she worries about how she will pay for it all.

Here is what weighs heavily on her mind:

- **Major medical only pays a portion of the expenses associated with my treatment**
- **I have copays I am responsible for until I meet my deductible**
- **If I am not working due to my treatments, I must cover my bills, rent/mortgage, groceries and my children's education**
- **If the right treatment is not available locally, I will have to travel to get the treatment I need**

Ashley's story of diagnosis and treatment turned into a happy ending, because she had supplemental Critical Illness Insurance to help with expenses.

CHOOSE

Ashley chooses Critical Illness benefits to help protect her and her children, if they are diagnosed with a critical illness.

USE

During Ashley's annual wellness exam, her doctor noticed an irregular heartbeat. She underwent an electrocardiogram (EKG) test and stress test, which confirmed she had a blockage in one of her coronary arteries.

Here's Ashley's treatment path:

- Ashley has her annual wellness exam
- Her doctor notices an abnormality in her heartbeat; tests are performed and she is diagnosed with coronary artery disease
- After visits with doctors, surgeons and an anesthesiologist, Ashley undergoes surgery
- Surgery is performed to remove the blockage with a bypass graft. She is visited by her doctor during a 4-day hospital stay and released
- Ashley follows her doctor required treatment during a 2-month recovery period, and has regular doctor office visits

Ashley is doing well and is on the road to recovery.

CLAIM

Ashley's Critical Illness claim paid her cash benefits for the following:

Wellness

Coronary Artery Bypass Surgery

The cash benefits were direct deposited into her bank account.

For a listing of benefits and benefit amounts, see your company's rate insert.

Using your cash benefits
Cash benefits provide you with options, because you decide how to use them.

Finances
Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.

Travel
Can help pay for expenses while receiving treatment in another city.

Home
Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.

Expenses
Can help pay your family's living expenses such as bills, electricity, and gas.

MyBenefits: 24/7 Access
allstatebenefits.com/mybenefits

An easy-to-use website that offers 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

Wellness - Biopsy for skin cancer; Bone Marrow Testing; Blood tests for triglycerides, CA15-3 (breast cancer), CA125 (ovarian cancer), CEA (colon cancer), PSA (prostate cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids or peripheral vascular disease; Echocardiogram; EKG; Flexible sigmoidoscopy; Hemoccult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Pap Smear, including ThinPrep Pap Test; Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; Ultrasound screening for abdominal aortic aneurysms.

Benefits (subject to maximums as listed on the attached rate insert)

Benefit paid upon diagnosis of one of the following conditions

INITIAL CRITICAL ILLNESS BENEFITS*

Heart Attack - the death of a portion of the heart muscle due to inadequate blood supply. Established (old) myocardial infarction and cardiac arrest are not covered

Stroke - the death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. Transient ischemic attacks (TIAs), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are not covered

Major Organ Transplant - transplant of heart, lung, liver, pancreas or kidneys. Transplanted organ must come from a human donor

End Stage Renal Failure - irreversible failure of both kidneys, resulting in peritoneal dialysis or hemodialysis. Renal failure caused by traumatic events, including surgical trauma, are not covered

Coronary Artery Bypass Surgery - to correct narrowing or blockage of one or more coronary arteries with bypass graft. Abdominal aortic bypass, balloon angioplasty, laser embolectomy, atherectomy, stent placement and non-surgical procedures are not covered

Waiver of Premium (employee only) - premiums waived if disabled for 90 consecutive days due to a critical illness

CANCER CRITICAL ILLNESS BENEFITS*

Invasive Cancer - malignant tumor with uncontrolled growth, including Leukemia and Lymphoma. Carcinoma in situ, non-invasive or metastasized skin cancer and early prostate cancer are not covered

Carcinoma In Situ - non-invasive cancer, including early prostate cancer (stages A, I, II) and melanoma that has not invaded the dermis. Other skin malignancies, pre-malignant lesions (such as intraepithelial neoplasia), benign tumors and polyps are not covered

SUPPLEMENTAL CRITICAL ILLNESS II BENEFITS*

Advanced Alzheimer's Disease - must exhibit impaired memory and judgment and be certified unable to perform at least three daily activities[1] without adult assistance

Advanced Parkinson's Disease - must exhibit two or more of the following: muscle rigidity, tremor, or bradykinesis (slowness in physical and mental responses); and be certified unable to perform at least three daily activities[1] without adult assistance

Benign Brain Tumor - a non-cancerous tumor confirmed by biopsy or surgical excision, or specific neuroradiological examination, and persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption. Tumors of the skull, pituitary adenomas, and germinomas are not covered

Coma - unconsciousness due to sickness or traumatic brain injury, with severe neurologic dysfunction and unresponsiveness for 14 consecutive days. Requires significant medical intervention and life support. Medically induced Coma is not covered

Complete Blindness - irreversible reduction of sight in both eyes

Complete Loss of Hearing - total and irreversible loss of hearing in both ears

Paralysis - total and permanent loss of voluntary movement or motor function of 2 or more limbs

OPTIONAL/ADDITIONAL BENEFIT

Wellness Benefit - 23 exams. Once per person, per calendar year; see left for list of wellness services and tests

*Benefits paid once per covered person. When all benefits have been used, the coverage terminates.
[1] Daily activities include: bathing, dressing, toileting, bladder and bowel continence, transferring and eating.

Critical Illness Insurance (GVCIP2)

from Allstate Benefits

Offered to the employees of:

Griffin Food Company

BENEFIT AMOUNTS

†Covered dependents receive 50% of your benefit amount

INITIAL CRITICAL ILLNESS BENEFITS†	PLAN 1	PLAN 2
Heart Attack (100%)	$10,000	$20,000
Stroke (100%)	$10,000	$20,000
Major Organ Transplant (100%)	$10,000	$20,000
End Stage Renal Failure (100%)	$10,000	$20,000
Coronary Artery Bypass Surgery (25%)	$2,500	$5,000
Waiver of Premium (employee only)	Yes	Yes
CANCER CRITICAL ILLNESS BENEFITS†	**PLAN 1**	**PLAN 2**
Invasive Cancer (100%)	$10,000	$20,000
Carcinoma in Situ (25%)	$2,500	$5,000
SUPPLEMENTAL CRITICAL ILLNESS BENEFITS II†	**PLAN 1**	**PLAN 2**
Advanced Alzheimer's Disease (25%)	$2,500	$5,000
Advanced Parkinson's Disease (25%)	$2,500	$5,000
Benign Brain Tumor (100%)	$10,000	$20,000
Coma (100%)	$10,000	$20,000
Complete Blindness (100%)	$10,000	$20,000
Complete Loss of Hearing (100%)	$10,000	$20,000
Paralysis (100%)	$10,000	$20,000
OPTIONAL/ADDITIONAL BENEFIT	**PLAN 1**	**PLAN 2**
Wellness Benefit (per year)	$50	$50

See reverse for premiums

PLAN 1 - MONTHLY PREMIUMS

$10,000 Basic Benefit Amount

AGE	EE, EE + CH	EE + SP, F
	Non-Tobacco	
18-35	$7.65	$11.60
36-50	$17.55	$26.45
51-60	$35.95	$54.05
61-63	$56.15	$84.35
64+	$82.45	$123.80
	Tobacco	
18-35	$11.75	$17.75
36-50	$28.85	$43.40
51-60	$59.45	$89.30
61-63	$85.95	$129.05
64+	$126.65	$190.10

PLAN 2 - MONTHLY PREMIUMS

$20,000 Basic Benefit Amount

AGE	EE, EE + CH	EE + SP, F
	Non-Tobacco	
18-35	$13.04	$19.69
36-50	$32.85	$49.40
51-60	$69.67	$104.62
61-63	$110.06	$165.21
64+	$162.64	$244.09
	Tobacco	
18-35	$21.23	$31.98
36-50	$55.43	$83.28
51-60	$116.67	$175.12
61-63	$169.67	$254.62
64+	$251.05	$376.70

EE=Employee; EE + SP = Employee + Spouse;
EE + CH = Employee + Child(ren); F = Family

FOR HOME OFFICE USE ONLY - GVCIP2
Opt 1 - PX; 1.0U Base; CR; SBR W/O; 2.0U WR;
Opt 2 - PX; 2.0U Base; CR; SBR W/O; 2.0U WR;
ABQ V 06.01.2023 Rate Insert Creation Date: 7/19/2023

EMPLOYEE CONTRIBUTIONS

Premium contributions for 2025 are as follows on a per pay period basis:

BENEFIT PLAN	BI-WEEKLY
Medical/Rx MOOPT0085 Blue Options PPO($2100 Ded. INSURE OK)	
Employee	See HR
Employee + Spouse	See HR
Employee + Child(ren)	See HR
Family	See HR
Medical/Rx MOOPT0105 Blue Options PPO ($2600 Ded.)	
Employee	$68.98
Employee + Spouse	$132.70
Employee + Child(ren)	$118.45
Family	$214.66
Medical/Rx MOBPF0135 Blue Preferred PPO ($3100 Ded.)	
Employee	$47.74
Employee + Spouse	$103.66
Employee + Child(ren)	$73.65
Family	$167.08

BENEFIT PLAN	BI-WEEKLY
Dental Rates	
Employee	$10.83
Employee + Spouse	$21.65
Employee + Child(ren)	$33.37
Family	$44.20
Exam Only Plan Vision Rates	
Employee	$.0
Employee + Family	$.47
VSP Signature Plan Vision Rates	
Employee	$5.04
Employee + Family	$11.29

IMPORTANT CONTACTS

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	Blue Cross and BlueShield of Oklahoma	800.942.5837	www.bcbsok.com/blueoptions / www.bcbsok.com/bluepreferred
Dental	Delta Dental of Oklahoma	800.522.0188	www.DeltaDentalOK.org
Vision	Vision Service Plan	800.877.7195	www.vsp.com
Life and AD&D	Mutual of Omaha	800.228.7104	www.mutualofomaha.com
Voluntary Life and AD&D	Mutual of Omaha	800.228.7104	www.mutualofomaha.com
Short Term Disability	Mutual of Omaha	800.228.7104	www.mutualofomaha.com
Long Term Disability	Mutual of Omaha	800.228.7104	www.mutualofomaha.com
Accident Insurance	Allstate	800.521.3535	abcustomersupportservices@allstate.com
Critical Illness Insurance	Allstate	800.521.3535	abcustomersupportservices@allstate.com
Human Resources	Valerie Arnold	918.686.2238	valeriearnold@griffinfoods.com

LEGAL NOTICES

Patient Protections Disclosure

The Griffin Holdings, Inc. & Subsidiaries Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Cross and BlueShield of Oklahoma designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Blue Cross and BlueShield of Oklahoma at 800.942.5837 or www.bcbsok.com/blueoptions / www.bcbsok.com/bluepreferred.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Blue Cross and BlueShield of Oklahoma or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Blue Cross and BlueShield of Oklahoma at 800.942.5837 or www.bcbsok.com/blueoptions / www.bcbsok.com/bluepreferred.

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: MOOPT0085 BLUE OPTIONS PPO^{SM} 0085 - INSUREOK Qualified Plan (Blue Preferred Provider: Individual: 10% coinsurance and $2,100 deductible; Family: 10% coinsurance and $6,300 deductible and Blue Choice Provider: Individual: 20% coinsurance and $2,100 deductible; Family: 20% coinsurance and $6,300 deductible)
Plan 2: MOOPT0105 BLUE OPTIONS PPO^{SM} 0105 (Blue Preferred Provider: Individual: 20% coinsurance and $2,600 deductible; Family: 20% coinsurance and $7,800 deductible and Blue Choice Provider: Individual: 30% coinsurance and $2,600 deductible; Family: 30% coinsurance and $7,800 deductible)
Plan 3: MOBPF0135 BLUE PREFERRED PPO^{SM} 0135 (Individual: 30% coinsurance and $3,100 deductible; Family: 30% coinsurance and $9,300 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 918.686.2238 or valariearnold@griffinfoods.com.

Newborns' and Mothers' Health Protection Act

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

LEGAL NOTICES

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

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

LEGAL NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

LEGAL NOTICES

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

LEGAL NOTICES

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

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)

LEGAL NOTICES

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Griffin Holdings, Inc. & Subsidiaries is committed to the privacy of your health information. The administrators of the Griffin Holdings, Inc. & Subsidiaries Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Valarie Arnold - Human Resources at 918.686.2238 or valariearnold@griffinfoods.com.

HIPAA Special Enrollment Rights

Griffin Holdings, Inc. & Subsidiaries Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Griffin Holdings, Inc. & Subsidiaries Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Valarie Arnold - Human Resources at 918.686.2238 or valariearnold@griffinfoods.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

LEGAL NOTICES

Notice of Creditable Coverage

Important Notice from Griffin Holdings, Inc. & Subsidiaries

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Griffin Holdings, Inc. & Subsidiaries and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Griffin Holdings, Inc. & Subsidiaries has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Griffin Holdings, Inc. & Subsidiaries coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Griffin Holdings, Inc. & Subsidiaries coverage, be aware that you and your dependents will be able to get this coverage back only during open enrollment or a special enrollment event.

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

You should also know that if you drop or lose your current coverage with Griffin Holdings, Inc. & Subsidiaries and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Griffin Holdings, Inc. & Subsidiaries changes. You also may request a copy of this notice at any time.

LEGAL NOTICES

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**August 01, 2025**
Name of Entity/Sender:	**Griffin Holdings, Inc. & Subsidiaries**
Contact—Position/Office:	**Valarie Arnold - Human Resources**
Office Address:	**111 S Cherokee St**
	Muskogee, Oklahoma 74403-5420
	United States
Phone Number:	**918.686.2238**

LEGAL NOTICES

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

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."

LEGAL NOTICES

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: Valarie Arnold.

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.

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/**.

LEGAL NOTICES

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[1] 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 the contact or contacts identified below. 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.

Plan contact information

Griffin Holdings, Inc. & Subsidiaries
Valarie Arnold - Human Resources
111 S Cherokee St
Muskogee, Oklahoma 74403-5420
United States
918.686.2238

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

LEGAL NOTICES

Marketplace Notice

Health Insurance Marketplace Coverage Options and 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 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.[1] [2]

[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.

LEGAL NOTICES

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 contact Valarie Arnold.

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.

LEGAL NOTICES

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Griffin Holdings, Inc. & Subsidiaries		4. Employer Identification Number (EIN) 73-0265410
5. Employer address 111 S Cherokee St		6. Employer phone number 918.686.2238
7. City Muskogee	8. State Oklahoma	9. ZIP code 74403-5420
10. Who can we contact about employee health coverage at this job? Valarie Arnold		
11. Phone number (if different from above)	12. Email address valariearnold@griffinfoods.com	

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

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

  All employees. Eligible employees are:

  X Some employees. Eligible employees are: As defined in the plan document.

- With respect to dependents:

  X We do offer coverage. Eligible dependents are: As defined in the plan document.

  We do not offer coverage.

X 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.

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This benefit summary prepared by

Gallagher

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