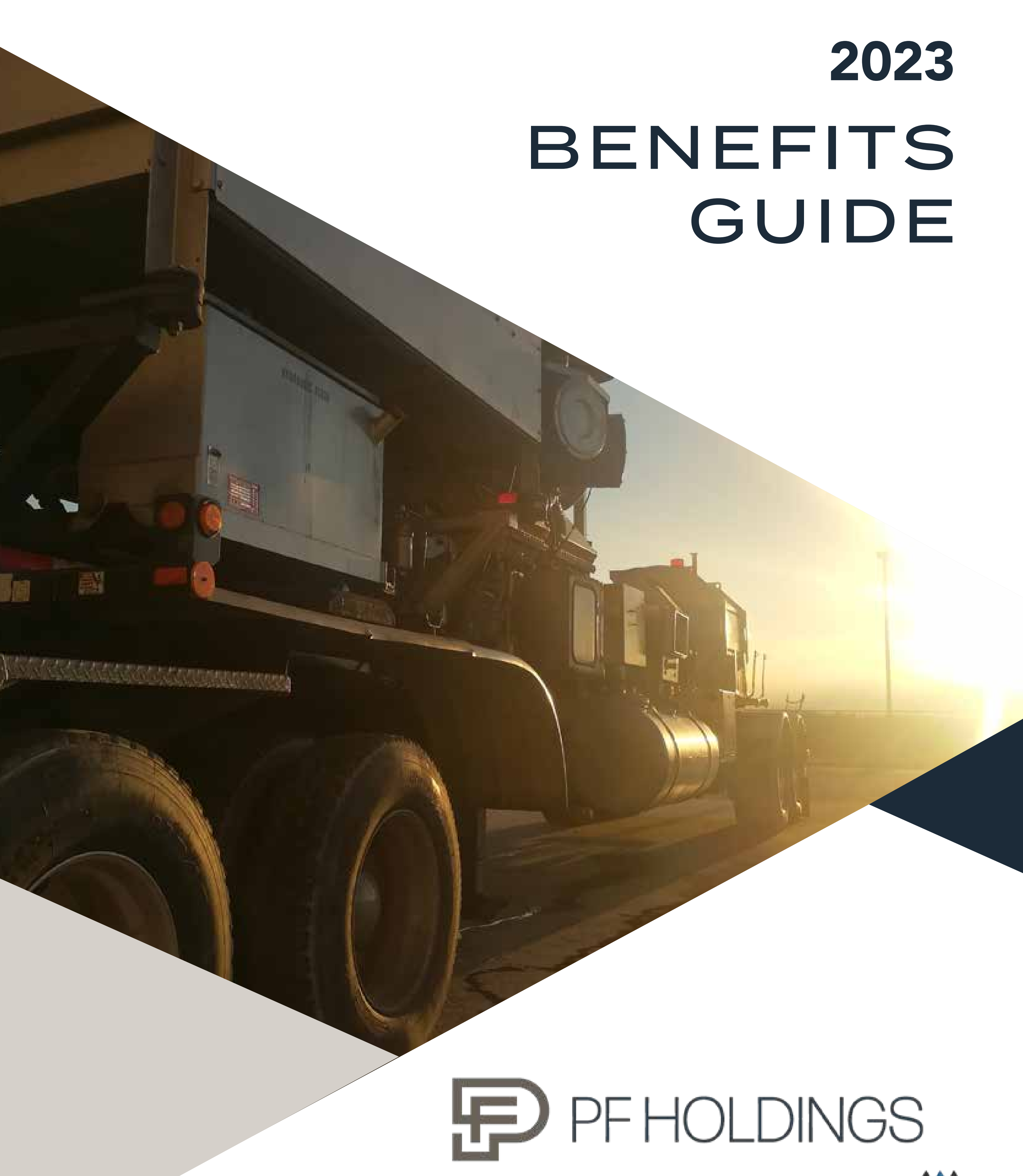
2023

BENEFITS GUIDE



PF HOLDINGS

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Each year, PF Holdings evaluates our plans and what options are available in the market to provide you and your family comprehensive, competitive and best-in-class options. We encourage you to consider how you can make the most of PF Holdings benefits to get the care you need and reduce your out-of-pocket costs. Take a look at your healthcare usage from previous years — understanding you and your family's specific needs is the first step to becoming a wise healthcare consumer.

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Information on your 2023 benefits is available through the Benefits Resource Center. Scan to get started! PFHCBenefits.com

See **page 31** for important information concerning Medicare Part D coverage.

In this Guide, we use the term Company to refer to PF Holdings. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

ELIGIBILITY & ENROLLMENT

You and your family have unique needs, which is why PF Holdings offers a variety of benefit plans from which you may choose. If applicable, please make sure to consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

If you are a full-time employee of PF Holdings who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in the medical, dental, vision, life and disability plans, along with additional supplemental insurance plans.

When Does Coverage Begin?

The elections you make during your enrollment are effective on your eligibility date, which is the first of the month following 30 days of service.

Annual Enrollment elections are effective January 1. Due to IRS regulations, once you have made your choices for the plan year, you won't be able to change your benefits until the next plan year unless you experience a qualifying life event.

Eligible Dependents

Dependents eligible for coverage in the PF Holdings benefits plans include:

- Your legal spouse*.
- Children up to age 26 (includes birth children, stepchildren, legally-adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by the medical carrier to continue coverage past age 26.

If you are married to another PF Holdings employee, you may not cover your spouse as a dependent, and only one of you may cover any dependent children.

*Working Spouse Exclusion

If your spouse is employed full-time and has medical coverage available through his or her employer, then that spouse is not eligible to enroll in the PF Holdings medical plan. This restriction applies only to medical coverage. Other eligible dependents may continue to enroll in the PF Holdings plan.

If your spouse is not currently enrolled in his or her employer's plan, then he or she will need to apply for that coverage. The loss of eligibility on the PF Holdings plan will qualify as a "change of status" for your spouse so that he or she will be able to enroll outside of the Annual Enrollment period with their employer.

Note: The company reserves the right to verify whether your spouse is provided coverage elsewhere. We expect this information to be consistent with the information you reported during Annual Enrollment. Misrepresenting whether your spouse has access to medical coverage outside of PF Holdings may result in disciplinary action.

Qualifying Life Events

When one of the following events occurs, you have 31 days from the date of the event to notify Human Resources and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in a gain or loss of eligibility. NOTE: If you drop below 30 hours per week you may be able to extend your coverage due to Affordable Care Act requirements.
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace (during a Marketplace special or annual enrollment period)
- Change in your address or location that may affect the coverage for which you are eligible

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to the Benefits Department at 855-449-4785 (press option 2).

Preparing to Enroll

PF Holdings provides its employees the best coverage possible. As a committed partner in your health, PF Holdings will be absorbing a significant amount of the costs. Your share of the contributions for medical, dental and vision benefits are deducted on a pre-tax basis, which lessens your tax liability. Please note that employee contributions for medical, dental and vision coverage vary depending on the level of coverage you select. In general, the more coverage you have, the higher your contribution will be.

Keep in mind that you may select any combination of medical, dental and/or vision plan coverage categories. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of PF Holdings, must elect coverage for yourself in order to elect any dependent coverage. Be sure to have the Social Security numbers and birth dates for any eligible dependent(s) that you plan to enroll.

Annual Enrollment is October 25, 2022, through November 11, 2022. This is an active enrollment. If you wish to make changes or waive coverage, you still must complete the Annual Enrollment process. All benefits elected during Annual Enrollment will be effective on January 1, 2023.

To enroll in benefits (Medical, Dental, Vision, Life & Disability insurance, etc.) for 2023, you must meet with a Benefit Counselor during the Benefits Annual Enrollment. Your current elections WILL NOT continue in 2023 unless you take action and schedule an appointment. Benefit Counselors will be available for personal individual meetings beginning Tuesday, October 25 through Friday, November 11, 2022. During the meeting, the Benefit Counselors will:

- Review the medical, dental, vision, life, disability, and voluntary benefit options
- Enroll employees and their dependent(s) in their selected benefits for the 2023 plan year
- Answer questions and provide additional information

To schedule your appointment with a Benefit Counselor, visit PFHCBenefits.com, scan the QR code, or call 888-610-4599.

PREVENTIVE CARE

Did you know that most health plans must cover a set of preventive services — such as immunizations and screening tests — at no cost to you? Work with your Primary Care Physician to stay up to date on preventive services — identifying and treating illnesses early will save you time and money, and promote a healthy lifestyle in the long run!

Any screening test done in order to catch a disease early is considered a preventive service. Due to the U.S. Patient Protection and Affordable Care Act (ACA), many services, screenings and supplies are paid at 100% including, but not limited to, the following:

- Wellness visits, yearly physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and Type 2 diabetes
- Pediatric screenings for hearing, vision, obesity, depression, autism and developmental disorders
- Anemia screenings, breastfeeding support and breastfeeding pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Key Things to Remember:

- Many preventive care services and tests are covered at 100%. You can find a list of covered services in your plan documents.
- Think of preventive care visits as routine check-ups. Things that may occur during a preventive visit include immunizations, blood pressure and cholesterol measurement, diabetes screening, or counseling on healthy weight.
- Diagnostic care to identify potential health risks are covered according to plan benefits, even if recommended or done during a preventive care visit.
- If your physician finds a specific health risk or new medical condition during your appointment, your doctor may bill those services as diagnostic medicine. These types of diagnostic services may result in out-of-pocket costs for you (i.e., deductibles, coinsurance, or copayments) because they are no longer considered preventive care.
- The COVID-19 vaccine itself is considered preventive. For the vast majority of individuals who have insurance through an employer, the vaccine will be at no cost.

Check your Summary Plan Description (SPD) to see what preventive services are available to you at no cost.

LOOK! Take advantage of preventive care offered by an in-network physician. This will save you time and money in the long run!

MEDICAL BENEFITS

Our medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as affordable prescription medication. Medical benefits are offered through BlueCross BlueShield of Texas. Choose the plan that best matches your needs and please keep in mind that the option you elect will be in place for all of the 2023 plan year, unless you experience a qualifying life event.

Two Options

PF Holdings offers two plan options to fit your needs: a PPO Plan and a High Deductible Plan. Each plan is designed to allow you to select the option that best fits your needs.

Airrosti Muskoskeletal Benefit

PF Holdings offers an Airrosti benefit at a lower office visit copay under the PPO Plan. A remote Airrosti benefit is also available. The visit will be subject to deductible and coinsurance under the High Deductible Plan.

Airrosti providers are experts at quickly diagnosing and resolving the source of musculoskeletal injuries. You can get an assessment, diagnosis, treatment and exercise therapy designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to normal activity — usually within 3-6 visits; however, you are allowed up to 12 visits per calendar year. Call 800-404-6050 or visit www.airrosti.com to schedule your in-person or remote appointment!

Note: Airrosti providers are not available in all areas. Remote appointments may not be available in some areas.

BlueCross BlueShield of Texas Holistic Health Management Clinical Management

If you or a family member has certain risk factors that could develop into more serious conditions, such as diabetes or heart disease, you may receive a call from BlueCross BlueShield of Texas offering education and assistance with managing and/or improving your condition. This is a confidential program and details of your participation will not be shared with PF Holdings.

In addition, prior authorization may be required for certain services, such as a sleep study, an MRI, back surgery or pain management. These protocols are being implemented to evaluate medical necessity, identify alternate methods of treatment and reduce future medical spend. Your network provider will handle this process but we want you to be aware, as it may take a little more time to schedule your appointment.

Blue365 Discount Program

Blue365 helps you save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or pre-authorizations. Once you sign up for Blue365, weekly featured deals will be emailed to you. Register now for free at www.blue365deals.com/bcbstx.

Medical Contributions

Premium contributions for medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your bi-weekly contributions.

How to Find a Provider

To see a current list of BlueCross BlueShield of Texas network providers, visit www.bcbstx.com or call Customer Care at 800-445-2227 for assistance.

Blue Access for Members

Get information about your health benefits, anytime, anywhere. Use your computer, phone or tablet to access the BlueCross BlueShield of Texas (BCBSTX) secure member website, Blue Access for Members (BAM℠). With BAM, you can:

- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Locate a doctor or hospital in your plan's network
- Find Spanish-speaking providers
- Request a new ID card — or print a temporary one

All you have to do is:

1. Go to https://members.hcsc.net/wps/portal/bam
2. Click Register Now
3. Use the information on your BCBSTX ID card to complete the registration process

Text* BCBSTXAPP to 33633 to get the BlueCross BlueShield of Texas App that lets you use BAM while you're on the go.

*Message and data rates may apply.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms may look a lot like urgent care centers, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns rather than an ER could save you hundreds of dollars.

VIRTUAL MEDICINE

When you're under the weather, there's no place like home. And when you're constantly on the go, scheduling a doctor's appointment can easily move down your priority list. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

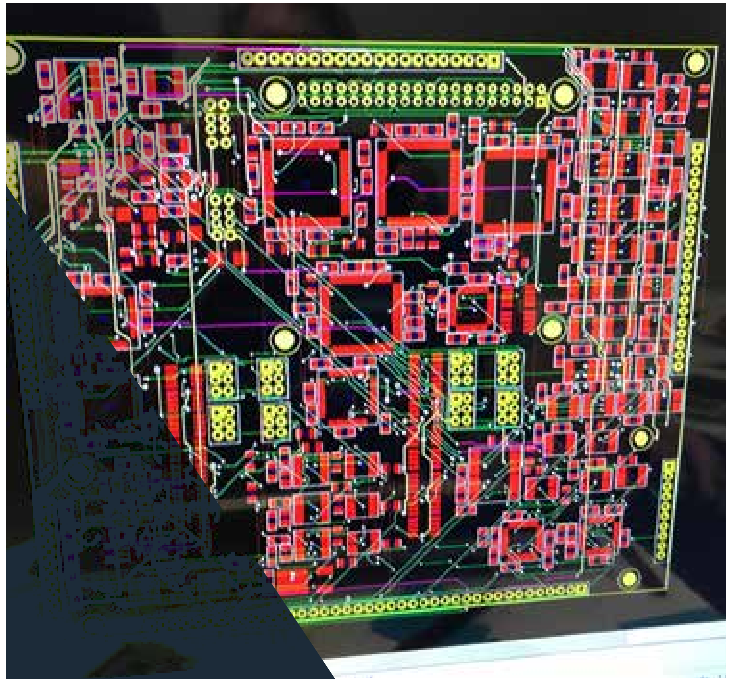
Virtual Visits

A virtual visit with MDLIVE through BlueCross BlueShield of Texas lets you see and talk to a doctor from your phone, tablet, or computer without an appointment. Most visits take about ten to fifteen minutes, and doctors can write a prescription (in participating states). Try a virtual visit when your doctor is not available or when you're traveling.

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Allergies
- Asthma
- Bladder infection/ Urinary tract infection
- Bronchitis
- Cold/Flu
- Ear problems (age 12+)
- Fever (age 3+)
- Nausea
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomachache

The cost for a visit is $0 if you are enrolled in the PPO Plan or $40 if you are enrolled in the High Deductible Plan.



Behavioral Health Virtual Visits

Talk Therapy, offered by MDLIVE, allows members to speak with a licensed counselor, therapist, or psychiatrist for support. You can choose who you want to work with for issues including:

- Addiction
- Stress and anxiety
- Bipolar disorders
- Depression
- Eating disorders
- Grief and loss
- Panic disorders
- Trauma and PTSD
- Relationship issues

The cost for a behavioral health visit is $0 if you are enrolled in the PPO Plan. If you are enrolled in the High Deductible Plan, the cost will vary by the type of provider you select (counselor vs psychiatrist).

Access Virtual Visits With MDLIVE

Visit mdlive.com/bcbstx to request a virtual visit. Once you register and request a consult, you will pay your portion of the service costs according to your medical plan and then enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms, and treatment options.

Activate your account and schedule a Virtual Visit:

- Your doctor is not available
- Register/Log in at www.mdlive.com/bcbstx
- Download the MDLIVE Mobile App from Apple's App Store™ or Google Play™
- Text BCBSTX to 635-483
- Call MDLIVE at 888-680-8646

NOTE: A virtual visit or Facetime with your primary care physician (vs. MDLIVE) might also be an option — and typically costs the same as an office visit.

Medical Plan Summary

The chart below gives a summary of the 2023 medical coverage administered by BlueCross BlueShield of Texas. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	PPO PLAN		HIGH DEDUCTIBLE PLAN	
BI-WEEKLY CONTRIBUTIONS				
	Bi-weekly Contributions		Bi-weekly Contributions	
EMPLOYEE ONLY	$63.00		$35.00	
EMPLOYEE + SPOUSE	$214.00		$155.00	
EMPLOYEE + CHILD(REN)	$166.00		$112.00	
EMPLOYEE + FAMILY	$300.00		$210.00	
	In-Network	Out-of-Network	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE				
	Calendar Year (January 1 - December 31)		Calendar Year (January 1 - December 31)	
INDIVIDUAL	$1,500	$4,500	$3,500	$10,500
FAMILY	$3,750	$9,000	$8,750	$21,000
COINSURANCE (PLAN PAYS)	80%*	60%*	80%*	60%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$6,450	$19,350	$6,450	$12,900
FAMILY	$12,900	$38,700	$12,900	$25,800
COPAYS/COINSURANCE				
PREVENTIVE CARE	100%; no deductible	60%*	100%; no deductible	60%*
PRIMARY CARE PROVIDER OFFICE VISIT	$30 copay	60%*	80%*	60%*
SPECIALIST OFFICE VISIT	$50 copay	60%*	80%*	60%*
VIRTUAL VISIT (TELEMEDICINE)	$0		$40 copay*	
AIRROSTI VISIT	$25 copay	60%*	$25 copay*	60%*
URGENT CARE	$75 copay	60%*	80%*	60%*
EMERGENCY ROOM	80%*	80%*	80%*	80%*
INPATIENT HOSPITAL STAY	80%	60% after $250 per admission deductible	80%*	60%*
OUTPATIENT HOSPITAL STAY	80%*	60%*	80%*	60%*

*After Deductible

The Plans have an embedded deductible, which means the individual deductible amount must be met by each member enrolled under your medical coverage before coinsurance applies; however, if you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount.

BlueCross BlueShield of Texas provides a 24/7 Nurseline for members to call; they can be reached at 800-581-0393. The Nurseline is available 24/7 for any medical questions or concerns you may have, such as what type of care you should seek or finding a provider.

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

Pharmacy benefits are administered by CVS Caremark. You can fill prescriptions at CVS along with many other national pharmacy chains!

When you enroll in one of the medical plan options, you will only have one ID card for both medical care and prescriptions. You may find information on your benefits coverage and search for network pharmacies by logging on to www.caremark.com or call the toll-free number on your ID Card.

Your cost is determined by the tier assigned to the prescription drug product. All products on the list are assigned as generic, preferred, non-preferred or specialty.

	PPO PLAN	HIGH DEDUCTIBLE PLAN
	In-Network	In-Network
RETAIL RX (30-DAY SUPPLY)		
PREVENTIVE	Varies by Preventive Prescription Tier**	Varies by Preventive Prescription Tier**
GENERIC	$10 copay	80%*
PREFERRED BRAND	$40 copay	80%*
NON-PREFERRED BRAND	$60 copay	80%*
SPECIALTY	$75 copay	80%*

*After Medical Deductible

**Preventive Prescriptions

Under both the PPO Plan and High Deductible Plan, certain preventive medications will be covered at a 100%. Please go to www.caremark.com to review the preventive drug coverage.

Increased Cost to Brand Name Drugs When a Generic Is Available

If you or your physician request a brand name drug when a generic is available, you will be required to pay the brand copay plus the difference between the generic and brand drug cost.

A monthly generic drug is typically $150-$300 less than a brand name drug; increased use of generics will help manage increasing health plan costs. Be sure to always ask your doctor if there is a generic or generic equivalent available!

PHARMACY BENEFITS

	PPO PLAN	HIGH DEDUCTIBLE PLAN
	In-Network	In-Network
MAIL ORDER RX (90-DAY SUPPLY)		
GENERIC	$25 copay	80%*
PREFERRED BRAND	$100 copay	80%*
NON-PREFERRED BRAND	$150 copay	80%*

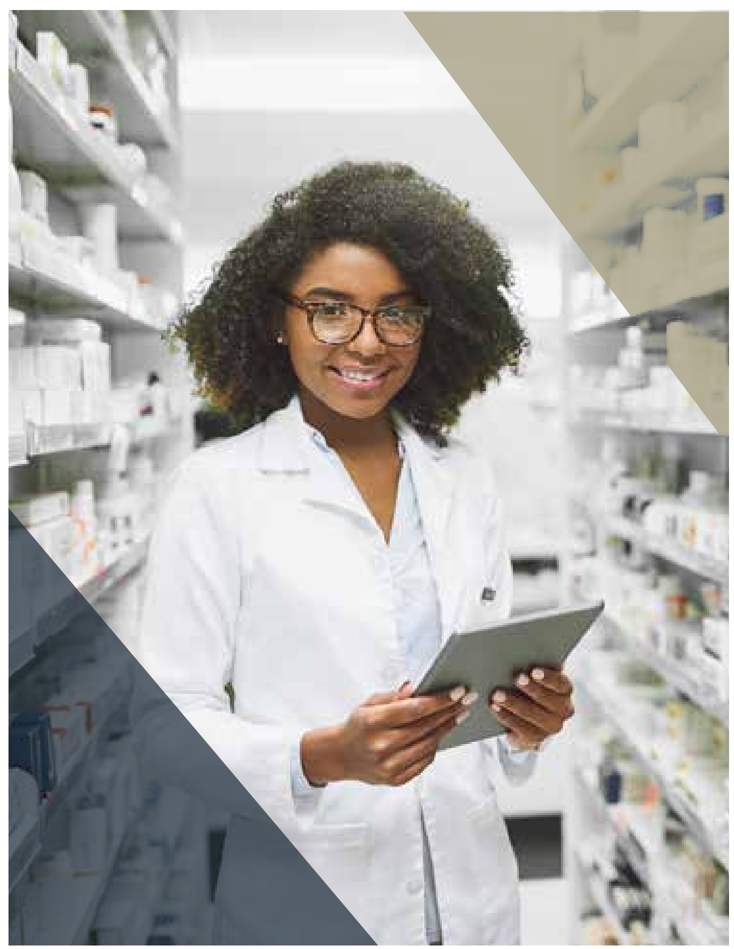
*After Medical Deductible

Note: If you visit an out-of-network pharmacy, you will need to file a claim for reimbursement. If you use an out-of-network pharmacy under the PPO Plan, you will pay an additional 20%. Out-of-Network mail order is not covered. Specialty drugs must be obtained from CVS Caremark Specialty Pharmacy.

CVS Caremark Home Delivery Service

CVS Caremark delivers your maintenance medicines anywhere in the U.S., and shipping is free! To order a prescription using the mail order option, log on to www.caremark.com and follow the guided steps to request a prescription. You can also call the toll-free number on your ID card. Home Delivery Service offers a 3-month supply for less than the retail cost and prescription management services are available 24/7 at www.caremark.com.

GENERIC DRUGS



Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they undergo the same rigid FDA standards. But generic versions cost 80% to 85% less on average than the brand-name equivalent. To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

NOTE: Apps and prescription discount programs such as GoodRx, Amazon Prime RX Savings, and Optum Perks let you compare prices of prescription drugs and find possible discounts.

How do they work?

These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: if you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription will not count toward your deductible or out-of-pocket maximum under the benefit plan.

GoodRX is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80%.

Optum Perks also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data.

Amazon Prime RX Savings provides a discount card and is included with an Amazon Prime membership and is administered by InsideRX. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies.

HEALTH SAVINGS ACCOUNT

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in a High Deductible Plan to participate.

Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependent(s), even if they are not covered by your plan. If you are not currently enrolled in a High Deductible Plan but you have unused HSA funds from a previous account, those funds can still be used for qualified healthcare expenses.

How It Works

HSA Bank will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses. No need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible High Deductible Plan.
- You are not covered by your spouse's non-High Deductible Plan.
- Your spouse does not have a healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Individually Owned Account

You own and administer your Health Savings Account. You determine how much you'll contribute to the account, when to use the money to pay for qualified medical expenses, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. The money in this account is portable, even if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

You must elect the High Deductible Plan with PF Holdings and make an HSA election. Once you make your election, HSA Bank will send you a Debit Card and a Welcome Letter with instructions on how to set up your new user account.

Maximize Your Tax Savings

Contributions to an HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open an account with HSA Bank). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified medical expenses, they are spent tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

LOOK! An HSA is a great way to save for post-retirement healthcare needs. Aim to contribute the maximum amount allowed each year.

HSA Funding Limits

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts.

2023 IRS HSA FUNDING LIMITS	
EMPLOYEE	$3,850
FAMILY	$7,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

The HSA is your individually owned account. It is your responsibility to ensure that contributions made to the account throughout the calendar year do not exceed the 2023 Calendar Year maximum of $3,850 for single coverage and $7,750 for family coverage.

HSA contributions in excess of the IRS annual contribution limits are not tax deductible and are generally subject to a 6% excise tax. If you've contributed too much to your HSA this year, you can do one of two things:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed from your HSA.
- Leave the excess contributions in your HSA and pay 6% excise tax on excess contributions. Next year you may want to consider contributing less than the annual limit to your HSA to make up for the excess contribution during the previous year.

If you open a Health Savings Account mid-year, your calendar limit will be prorated based upon the number of months within the calendar year that you were enrolled in a qualified High Deductible Plan. However, you could contribute the full calendar year maximum as long as you stay enrolled in a qualified High Deductible Plan for 12 months following the close of the calendar year to avoid excise tax on the contributions that exceed the annual prorated amount.

The HSA will be established with HSA Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.hsabank.com/hsabank/members.

SUPPLEMENTING YOUR MEDICAL PLAN

PF Holdings offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Allstate, provides benefits for you and your covered family members if you have expenses related to an accident that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you to use as you wish.

BRIEF SUMMARY OF BENEFITS*	
HOSPITAL CONFINEMENT	$1,500 + $300 per day ($600 per day for ICU)
DISLOCATIONS AND FRACTURES	Up to $24,000
AMBULANCE	Ground: $400 / Air: $1,200
EMERGENCY VISIT - PHYSICIAN, URGENT CARE, OR EMERGENCY ROOM	$200
X-RAY	$400
FOLLOW-UP OFFICE VISIT	$100
BURNS	up to $1,000
BRAIN INJURY DIAGNOSIS (CONCUSSION)	$600
CT OR MRI	$200
COMA	$20,000
OPEN ABDOMINAL OR THORACIC SURGERY	$2,000
TENDON, LIGAMENT, ROTATOR CUFF, OR KNEE CARTILAGE SURGERY WITH REPAIR	$1,000
RUPTURED DISC SURGERY	$1,000
BLOOD AND PLASMA	$600
PHYSICAL THERAPY	$60
APPLIANCE	$250

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

OUTPATIENT PHYSICIANS TREATMENT

This plan pays $50 for each day a covered person is treated by a physician outside of a hospital for an injury sustained as a result of an accident or preventive care. This benefit is payable only once per day per covered person and is limited to two days per covered person per calendar year and a maximum of four days per calendar year if coverage includes eligible dependents. This benefit does not cover sickness.

BI-WEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	$5.03
EMPLOYEE + SPOUSE	$9.12
EMPLOYEE + CHILD(REN)	$11.44
EMPLOYEE + FAMILY	$14.86

Hospital Indemnity Coverage

Hospital Indemnity coverage through Allstate pays cash benefits directly to you if you have a covered stay in a hospital or intensive care unit. You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

- Benefits are payable for pregnancy after you have had the policy for 10 months
- Pre-existing condition limitations apply. Refer to plan document for details
- Coverage is guaranteed issue; no medical questions

SUMMARY OF BENEFITS*	
FIRST DAY HOSPITAL CONFINEMENT BENEFIT	$1,700 (max one time per month)
DAILY HOSPITAL CONFINEMENT BENEFIT	$200 per day (max 30 days per confinement)
DAILY HOSPITAL INTENSIVE CARE UNIT BENEFIT	$400 per day (max 30 days per confinement)

*This is a summary. Refer to plan documents for details.

BI-WEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	$10.62
EMPLOYEE + SPOUSE	$23.08
EMPLOYEE + CHILD(REN)	$16.15
EMPLOYEE + FAMILY	$27.69

Critical Illness Coverage

Critical Illness coverage through Allstate pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. For example, you can use it to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home healthcare costs, or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
- **Rates are based on your age and the amount of coverage selected. Please speak to your enrollment counselor for additional details.**
- Children are covered at NO COST when you elect employee coverage
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis; illnesses or occurrences prior to the effective date of coverage will not be payable events
- $75 annual Wellness Benefit is payable for each covered member for completing certain wellness screenings, such as a pap test, cholesterol test, mammogram, colonoscopy, or stress test (once per year per covered person)

Plan Options

- Employee: $15,000 or $30,000
- Spouse: 100% of employee benefit
- Children: 50% of employee benefit (for free)

COVERED CONDITIONS

Enrolled employees and spouses receive 100% of the below benefit amount when a diagnosis or event occurs after your plan is effective. Children receive 50% of the below benefit amount for NO COST.

CRITICAL ILLNESS BENEFITS	
HEART ATTACK	100%
STROKE	100%
END STATE RENAL FAILURE	100%
MAJOR ORGAN FAIILURE	100%
CORONARY ARTERY DISEASE / CORONARY ARTERY BYPASS GRAFT	25%
TRANSIENT ISCHEMIC ATTACK (TIA) OR REVERSIBLE ISCHEMIC NEUROLOGIC DEFICIT (RIND)	25%
CROHN'S DISEASE	25%
BONE MARROW OR STEM CELL TRANSPLANT	100%
INVASIVE CANCER	100%
CARCINOMA IN SITU	25%
SKIN CANCER RIDER	$250 per year
CARDIO BENEFITS	
SUDDEN CARDIAC ARREST	25%
IDIOPATHIC PULMONARY FIBROSIS	25%
PULMONARY EMBOLISM	25%
CORONARY ARTERY DISEASE / CORONARY ANGIOPLASTY	10%
CARDIAC VALVE DISEASE / AORTIC VALVE OR MITRAL VALVE REPAIR OR REPLACEMENT	10%
CARDIAC ARRHYTHMIAS / INTERNAL CARDIOVERTER DEFIBRILLATOR (ICD) PLACEMENT	10%
CARDIAC ARRHYTHMIAS / PACEMAKER PLACEMENT	10%
SUPPLEMENTAL CRITICAL ILLNESS BENEFITS	
ADVANCED ALZHEIMER'S DISEASE	100%
ADVANCED PARKINSON'S DISEASE	100%
BENIGN BRAIN TUMOR	100%
COMA	100%
LOSS OF HEARING	100%
LOSS OF SIGHT	100%
LOSS OF SPEECH	100%
PARALYSIS	100%

CHILDHOOD BENEFITS - 100% OF THE CHILD BENEFIT

CEREBRAL PALSY, CLEFT LIP OR CLEFT PALATE, CONGENITAL HEART DISEASE, CYSTIC FIBROSIS, TYPE 1 DIABETES, DOWN SYNDROME, MUSCULAR DYSTROPHY, SPINA BIFIDA, STRUCTURAL CONGENITAL DEFECT

SPECIFIED CONDITION AND INFECTIOUS DISEASE RIDER - 25%

ACUTE RESPIRATORY DISTRESS SYNDROME; ADRENAL INSUFFICIENCY, LOU GEHRIG'S DISEASE (ALS); BACTERIALMENINGITIS; DIPHTHERIA, ENCEPHALITIS; HUNTINGTON'S CHOREA; LEGIONNAIRES' DISEASE, MALARIA; MULTIPLE SCLEROSIS; MYASTHENIA GRAVIS; NECROTIZING FASCIITIS; OSTEOMYELITIS; POLIOMYELITIS; RABIES; SCLERODERMA; SICKLE CELL ANEMIA; SYSTEMIC LUPUS; TETANUS; TUBERCULOSIS

DENTAL BENEFITS

Regular dental checkups do more for your well-being than just preserve a healthy smile. PF Holdings dental coverage will provide you and your family an affordable option to help maintain overall health. Dental coverage is available through MetLife.

Network Dentists

If you choose to use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit www.metlife.com/dental

Dental Contributions

Premium contributions for dental will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your bi-weekly contribution.

Dental Plan Summary

Dental plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2023 dental coverage provided by MetLife. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	DENTAL BASE PLAN (PDP PLUS NETWORK)		DENTAL BUY-UP PLAN (PDP PLUS NETWORK)	
BI-WEEKLY CONTRIBUTIONS				
EMPLOYEE ONLY	$11.35		$14.01	
EMPLOYEE + SPOUSE	$22.60		$27.90	
EMPLOYEE + CHILD(REN)	$24.34		$30.05	
EMPLOYEE + FAMILY	$38.01		$46.92	
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****
CALENDAR YEAR DEDUCTIBLE				
INDIVIDUAL	$75	$75	$25	$25
FAMILY	$225	$225	$75	$75
CALENDAR YEAR MAXIMUM				
PER PERSON	$1,500	$1,500	$2,000	$2,000
COVERED SERVICES				
PREVENTIVE SERVICES	100%; deductible waived	100%; deductible waived	100%; deductible waived	100%; deductible waived
BASIC SERVICES	80%*	80%*	80%*	80%*
MAJOR SERVICES	50%*	50%*	50%*	50%*
ORTHODONTICS	50%; deductible waived	50%; deductible waived	50%; deductible waived	50%; deductible waived
ORTHODONTICS COVERAGE	Child(ren) Only		Adult and Child(ren)	
ORTHODONTIC LIFETIME MAXIMUM	$1,000	$1,000	$2,000	$2,000

*After Deductible

**Out-of-Network care is subject to Reasonable and Customary limitations, and you are responsible for any additional charges. Reasonable and Customary charges are based on what providers in the area usually charge for the same or similar dental service.

LOOK! As many as 120 systemic diseases can be visible in your mouth. Regular checkups can reveal the signs of diseases before they even cross your mind.

VISION BENEFITS

Even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, PF Holdings offers a comprehensive vision plan provided by MetLife To find a network provider, visit www.metlife.com/vision and select Superior Vision by MetLife.

Vision Plan Summary

The chart below gives a summary of the 2023 vision coverage provided by MetLife. All out-of-network services are subject to Reasonable and Customary (R&C) limitations. Premium contributions for vision will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your bi-weekly contribution.

	VISION PLAN (SUPERIOR NETWORK)	
BI-WEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$3.11	
EMPLOYEE + SPOUSE	$6.22	
EMPLOYEE + CHILD(REN)	$7.29	
EMPLOYEE + FAMILY	$11.19	
	In-Network	**Out-of-Network**
COPAYS		
EXAMINATION	$10 copay	Up to $45 allowance
MATERIALS	$10 copay	N/A
COVERED MATERIALS		
LENSES		
SINGLE VISION LENSES	$10 copay	Up to $30 allowance
BIFOCAL LENSES	$10 copay	Up to $50 allowance
TRIFOCAL LENSES	$10 copay	Up to $65 allowance
FRAMES		
RETAIL FRAME	$150 allowance plus a 20% discount on overage after $10 copay	Up to $70 allowance
CONTACT LENSES		
NECESSARY	Covered in full after $10 copay	Up to $210 allowance
ELECTIVE	$150 allowance after $10 copay	Up to $105 allowance
BENEFIT FREQUENCY		
EXAMINATION	Once per calendar year	
LENSES	Twice per calendar year*	
FRAMES	Twice per calendar year*	
CONTACTS (in lieu of Lenses and Frames)	Twice per calendar year	

*Benefit provides for two (2) complete orders for eyewear. Eyewear purchases must be separate; allowances cannot be combined for a single eyewear purchase.

Second Pair Glasses/Contacts Benefit

This benefit gives you additional eyewear coverage. You can get:

- Two pairs of prescription eyeglasses, or
- One pair of prescription eyeglasses and an allowance toward contact lenses, or
- Double your contact lens allowance

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $3,050 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA as well — whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 per household per calendar year. ($2,500 per year if you are married and filing taxes separately)
- Eligible dependents include children under 13, a spouse, or other individuals who are physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

LOOK! Your FSA money can cover the cost of medical, dental and vision services even if they are not covered under the Plan.

Eligible Dependent Care Flexible Spending Account Expenses

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time.

Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not by an individual you claim as a dependent)
- Care of a Preschool Child by a Licensed Nursery or Day Care Provider
- Before- and After-School Care
- Day Camp
- In-House Dependent Day Care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the Flexible Spending Account programs. Please check with your tax advisor to determine if any exceptions apply to you.

How to Use the Account

You can use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The swipe transaction will be denied if you attempt to use the card at an ineligible location.

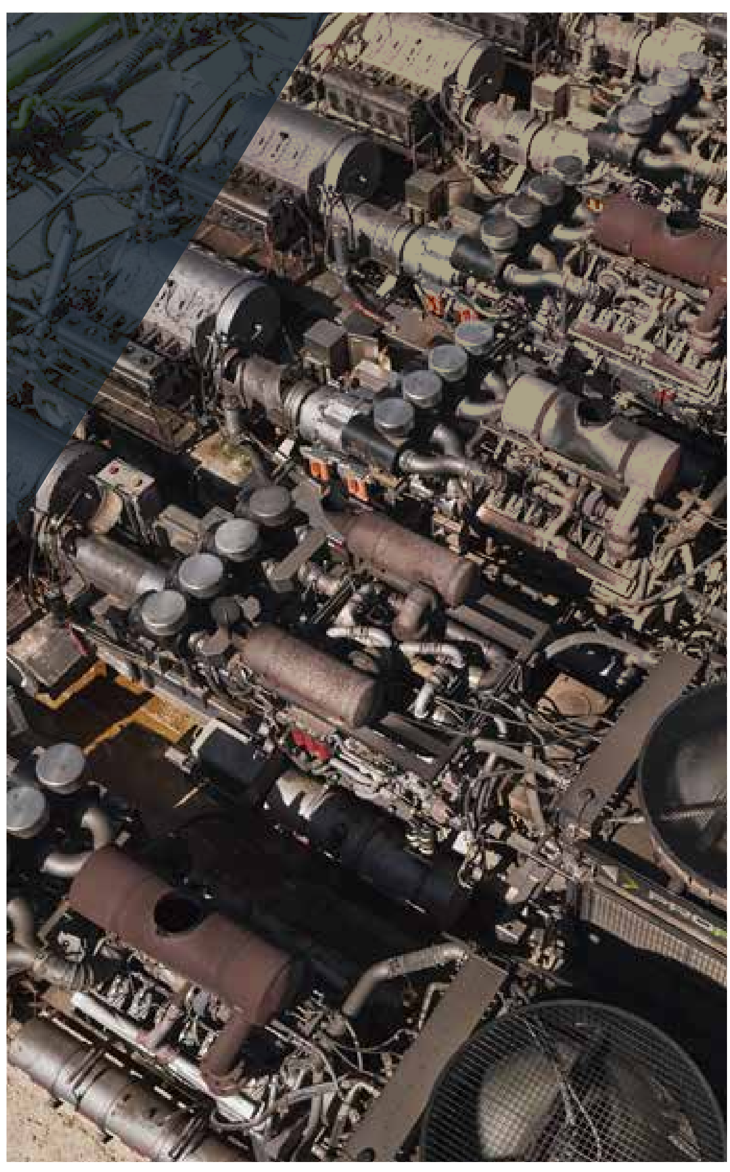
Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact WageWorks in partnership with HealthEquity. Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from WageWorks. You should always retain a receipt for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. If you don't provide proof that an expense was valid, it can result in your card being turned off and your expense being deemed taxable.

General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Healthcare and Dependent Care FSAs:

- Your expenses must be incurred during the 2023 plan year.
- Your dollars cannot be transferred from one FSA to another.
- You cannot participate in Dependent Care FSA and claim a dependent care tax deduction at the same time.
- For the Dependent Care FSA, you must "use it or lose it." Any unused funds will be forfeited.
- You may rollover up to $610 for the Healthcare FSA.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event like marriage, divorce or birth of a child.
- You are not eligible for a health FSA while contributing to an HSA.
- Those considered highly compensated employees (family gross earnings were $125,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.



Deadline for Claims

April 30, 2024, is the deadline to submit claims incurred in the previous plan year for reimbursement from your account. If you have a Healthcare FSA, up to $610 remaining from the previous plan year will roll over into the new plan year. Any remaining Dependent Care money will be forfeited at the end of the plan year.

FSA VS. HSA: WHICH IS RIGHT FOR YOU?

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are two ways to save pre-tax money to pay for your eligible healthcare costs. But how do you know which one is right for you?

	FSA	HSA
OWNERSHIP	The FSA is owned by your employer. If you leave your employer, you lose access to the account unless you have a COBRA right.	The HSA is an account owned by you. It is a savings account in your name and you always have access to the funds, even if you leave your employer or are no longer enrolled in a High Deductible Plan.
ELIGIBILITY & ENROLLMENT	The employer determines eligibility for an FSA. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.	You must be enrolled in a Qualified High Deductible Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible Plan or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax-free via payroll deduction.	The money in the account is "triple tax-free," meaning: 1. Contributions are tax-free. 2. The account grows tax-free. 3. Funds are spent tax-free (if used for qualified expenses).
CONTRIBUTIONS	The contribution limit for 2023 is $3,050.	The contribution limit for 2023 is $3,850 for individuals and $7,750 for families. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and get reimbursed from the account. You must submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook. You may use the debit card to pay for qualified expenses directly. You could also use online bill payment services from the HSA financial bank to pay for qualified expenses. You decide when and if you should use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future qualified expenses or retirement.
ROLL OVER OR GRACE PERIOD	You must use the money in the account by end of Plan Year, however some plans allow up to $610 to roll over to the next year. Other plans include a 2.5-month grace period after the end of the Plan Year for any extra expenses to be incurred and reimbursed. A plan can have either a rollover or a grace period, but not both. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, dental care and vision care. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, dental care, vision care, Medicare Part D plans, COBRA premiums and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.
OTHER TYPES	Other types of FSAs include: • Dependent Care FSA – Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as baby-sitting, day care and before- and after-school care. • Limited Use FSA – Some employers offer a Limited Use FSA that only covers eligible Dental and Vision expenses. Limited Use FSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Health FSA and an HSA.	There is only one type of HSA.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

SURVIVOR BENEFITS

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Life and AD&D benefits are essential to your family's financial security. As such, it is important to understand how your plan works and what benefits you will receive. Basic Life and AD&D benefits are provided to you as a part of your core coverage. PF Holdings provides employees with Basic Life and AD&D insurance through The Hartford, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life and AD&D insurance benefit is:

- Two times your annual base salary to a maximum of $1,000,000

Accidental death benefits are payable to your beneficiary, in addition to your life insurance benefit, if you die within 365 days after a covered accident and the cause of your death can be attributed to the covered accident.

*The IRS limits the amount of tax-free group term Life insurance to $50,000. This means that if the amount of Life insurance is greater than $50,000, the value of your Life insurance (as determined by the IRS, based upon age) over $50,000 will be considered taxable income. (The IRS calls this imputed income.) A minimal tax will be assessed and will appear on your W-2.

Beneficiary Designation

A beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life and AD&D offered by PF Holdings. You receive the benefit payment for a dependent's death under the The Hartford insurance.

Make sure your beneficiary designation is clear so there is no question as to your intentions, and remember to name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. If the beneficiary is not legally related, insert the words "Not Related" in the relationship field.

Please note that in most states, benefit payments cannot be made to a minor younger than 18. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name, and will earn interest until the minor reaches majority age at 18.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages. If you need assistance, contact Human Resources or your own legal counsel.

LOOK! Your beneficiary doesn't have to be a person. A trust, or a legal agreement that lets you place property under the control of a trust manager, can be named the beneficiary. The beneficiary can also be a charity or simply your estate.

Life Insurance: Term vs. Universal Life

TERM LIFE BY THE HARTFORD	UNIVERSAL LIFE BY ALLSTATE
WHAT IS IT?	
• Provides protection during your working years • Affordable coverage to help survivors weather an unexpected loss	• Provides benefits for a lifetime • More than just a death benefit — value you can use during times of need
WHY DO YOU NEED IT?	
Income replacement Kind of like renting a house: employees use the protection for a set period of time • Can help pay the costs families face during the working years if the breadwinner dies prematurely; Housing, Education, Saving for Retirement • Can be used to pay for the expenses associated with terminal illness	Final expenses plus cash accumulation Kind of like owning a house: you keep the benefit for a lifetime • Can help pay final expenses • Can also be used to pay for the expenses associated with terminal illness — including long term care • Accumulates cash value at a guaranteed interest rate; employees can borrow against this value
HOW DOES IT WORK?	
Flexible, normally ends at retirement • You may increase coverage as your needs evolve • The benefit typically decreases after age 65, and can end at retirement, when income replacement may no longer be necessary • Guaranteed issue means you can get coverage with no health questions or exams	Guaranteed premium, level benefit — for life • Your premium is locked-in for the amount of coverage you desire — the younger you are, the lower the premium. Rates this affordable with guaranteed issue are usually only available in the workplace • The level death benefit does not decrease with age • The coverage continues for life • Guaranteed issue — generally available only in the workplace — means you can get coverage with no health questions or exams
HOW LONG DO THEY WORK TOGETHER?	
Protection for now, helpful benefits for later With valuable protection for your working years and benefits that carry into retirement, a combination of Term Life and Permanent Life provide comprehensive protection for your loved ones.	

Voluntary Universal Life with Long Term Care

Employees are eligible for the Universal life insurance by Allstate, which offers you a permanent life insurance option with guaranteed premiums based on your current age. In addition to Universal life insurance, this plan also includes a long term care (LTC) benefit which you can use in times of need.

HYPOTHETICAL EXAMPLE

Employee elects $100,000 Life Insurance Policy
Accelerated death benefit for Long Term Care pays 4% of your death benefit up to $4,000 per month
Payments reduce the death benefit until the lesser of 25 months or your death benefit is exhausted
Benefits are payable after 90-days if you are unable to perform two activities of daily living (eating, bathing, dressing, toileting, transferring)

Guaranteed issue—during this Annual Enrollment, coverage is offered to you without any medical questions; if you choose to enroll at a later date, you will be asked medical questions and may be denied coverage

- **Employee**: Maximum guarantee issue face amount of $150,000. Simplified issue for employees over age 65
- **Spouse**: Working spouse guarantee issue maximum $75,000. Non-working spouse up to $10,000*
- **Child(ren)**: Guarantee issue of $20,000 (up to age 18). Simplified issue for children between the ages of 19 and 24

* Additional restrictions apply. Employee must enroll in coverage for Spouse or Child(ren) to be eligible. Spouse/Child(ren) coverage cannot exceed employee coverage amount. View plan document or speak to a benefit counselor for details.

- **Portable**—you own this policy; you can keep the policy if you leave or retire and you will pay the same premium
- **Level premiums**—premiums are level for life and are locked in at your current age; the death benefit is level as well and remains the same throughout your lifetime
- **Cash value**—this policy accumulates cash value; you can borrow funds from this value as needed
- **Tax-free benefit**—premiums for this policy will be deducted on a post-tax basis which means any benefits you receive will not be taxed

Premiums are based on your current age and tobacco usage and will be available during enrollment along with additional plan details.

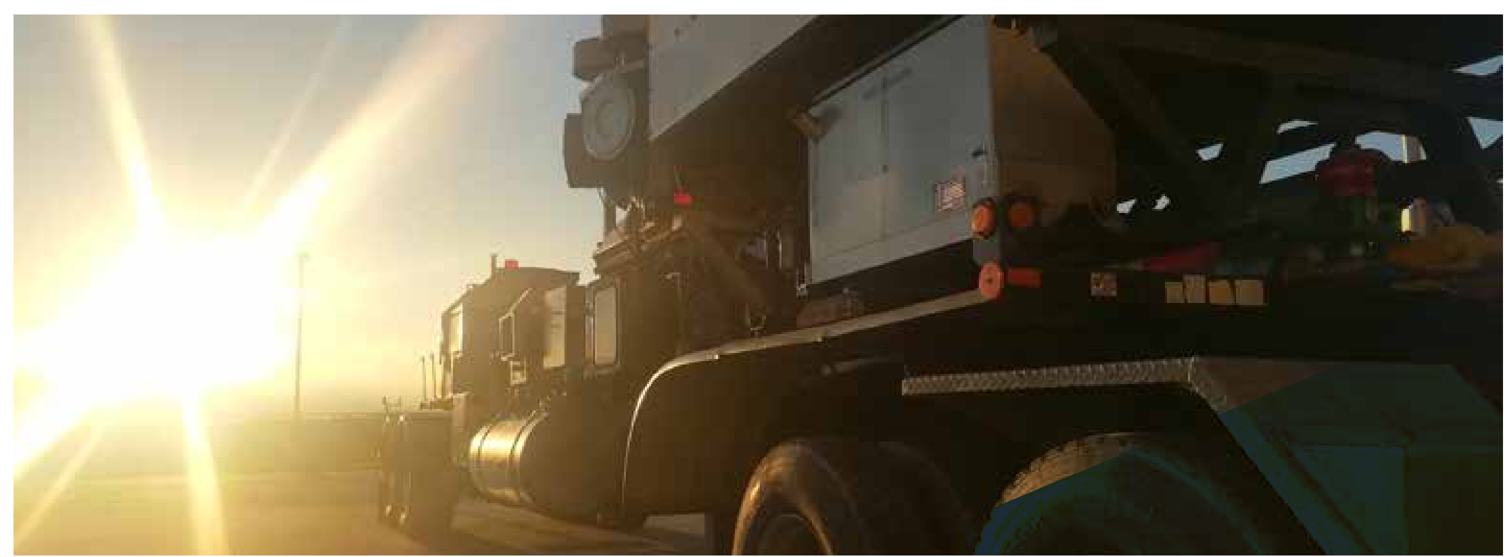
Voluntary Term Life and AD&D Insurance

Eligible employees may purchase Voluntary Life and AD&D insurance for themselves and their families. To purchase Life or AD&D coverage for your spouse or child, you must first purchase Life or AD&D coverage for yourself.

Additional AD&D insurance is also available for purchase with the same Life plan limits shown below. You may purchase AD&D regardless of whether you purchase Life coverage. Premiums are paid through post-tax payroll deductions.

VOLUNTARY EMPLOYEE TERM LIFE AND AD&D	
COVERAGE AMOUNT*	Up to the lesser of $500,000 or five times your base annual salary in $10,000 increments
GUARANTEED ISSUE	$400,000
MAXIMUM BENEFIT	The lesser of $500,000 or five times your base annual salary
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes**
VOLUNTARY SPOUSE TERM LIFE AND AD&D	
COVERAGE AMOUNT*	Up to 100% of voluntary employee life in $5,000 increments
GUARANTEED ISSUE	The lesser of 100% of employee life amount or $50,000
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes**
VOLUNTARY CHILD TERM LIFE AND AD&D	
COVERAGE AMOUNT	$2,000 to $10,000 in $2,000 increments
GUARANTEED ISSUE	$10,000
MAXIMUM BENEFIT	$10,000 (Guaranteed Issue of $10,000)
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Child(ren) coverage is not subject to EOI.

* Benefits reduce to 65% at age 70, 45% at age 75, 30% at age 80, 20% at age 85.
** Evidence of insurability is a medical questionnaire that may be required for those enrolling after initial eligibility period that elect any amount of coverage. It may also be required for anyone requesting an increase in coverage. AD&D insurance is not subject to Evidence of Insurability. **Special Annual Enrollment Opportunity for 2023 Only** — You may elect (even if you previously waived coverage) or increase your voluntary employee and spouse life coverage up to the guaranteed issue amounts.



VOLUNTARY LIFE INSURANCE

RATES/$1,000 (BI-WEEKLY)

EMPLOYEE AGE (AS OF 1/1/2023)	EMPLOYEE	SPOUSE AGE (AS OF 1/1/2023)	SPOUSE
<25	$0.030	<25	$0.031
25-29	$0.041	25-29	$0.036
30-34	$0.061	30-34	$0.045
35-39	$0.096	35-39	$0.066
40-44	$0.132	40-44	$0.095
45-49	$0.162	45-49	$0.148
50-54	$0.269	50-54	$0.230
55-59	$0.467	55-59	$0.354
60-64	$0.716	60-64	$0.605
65-69	$1.208	65-69	$1.032
70-74	$1.208	70-74	$1.840
75+	$1.208	75+	$1.840

VOLUNTARY CHILD LIFE INSURANCE

RATES/$1,000 (BI-WEEKLY)

CHILD(REN)	$0.199

VOLUNTARY AD&D INSURANCE

RATES/$1,000 (BI-WEEKLY)

EMPLOYEE	$0.025
SPOUSE	$0.026
CHILD(REN)	$0.016

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$200,000	÷ 1,000 =	$200	x Age Based Rate =	$26.40
Benefit Elected (Employee)			Age 42: $0.132	Bi-Weekly Premium

INCOME PROTECTION

PF Holdings offers disability coverage to protect you against any debilitating injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

Short Term Disability (STD) Insurance

Employee Paid

Voluntary STD insurance, provided by Allstate, replaces up to 60% of your income and is intended to help replace lost income if you are unable to work due to a covered accident or sickness.

You choose the monthly benefit amount that meets your needs. Then, if you are faced with a period of unexpected sickness or off-the-job injury, you will receive cash benefits to use as you see fit. This could include medical treatments, daily expenses and more.

- You choose the monthly maximum benefit level that meets your needs (subject to plan maximums)
- Benefits start on the 8th day for an accident or sickness
- Premiums lock in at the age when you enroll
- The plan is portable so you can take it with you if you no longer work for the company

Certain exclusions, along with a pre-existing condition limitation apply. Please refer to the plan documents for details or visit https://allstatevoluntary.com/pfholdings/.

MONTHLY MAXIMUM BENEFIT	$5,000
ELIMINATION PERIOD	7 days
MAXIMUM BENEFIT PERIOD	3 months

Long Term Disability (LTD) Insurance

Employer Paid

LTD insurance, provided by The Hartford, replaces 60% of your income if you become partially or totally disabled for an extended period of time. Certain exclusions, along with any preexisting condition limitations, may apply. Please refer to your plan documents for details or contact Human Resources for specific benefits.

MONTHLY MAXIMUM BENEFIT	$10,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.
MENTAL ILLNESS/SELF-REPORTED SYMPTOM LIMITATION	24-month maximum benefit
PRE-EXISTING CONDITION:	Disability not covered if it occurs within the first 12 months of coverage and was treated or diagnosed in the 3 months prior to effective date of coverage

RETIREMENT PLANNING

It's never too early — or too late — to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. The PF Holdings 401(k) plan provides you with the tools and flexibility you need to retire comfortably and securely.

Eligible employees can invest for retirement while receiving certain tax advantages. Administrative and record-keeping services for this plan are provided by Fidelity Investments.

Eligibility

You are eligible to begin participating the first of the month following three months of service. You must also be at least 18 years of age to be eligible. Non-resident aliens or leased employees are excluded from participating in the plan. (See plan document for details on excluded employees.)

Contributing to the Plan

You may defer up to 100% of your compensation or the maximum allowed by law on a pre-tax OR Roth after-tax basis. In 2023, the maximum you can contribute to the Plan is $22,500, but if you are 50 years old or older, you may contribute an additional $7,500.

- Company contributions: At its discretion, PF Holdings may make a lump sum contribution and/or initiate an employer match.
- Vesting: Your contributions are always 100% vested. Future employer contributions (including matching contributions) will be vested as follows:

VESTING SCHEDULE

Years of Service	Percentage Vested
1 Year	0%
2 Years	33%
3 Years	66%
4 Years	100%

Catch-up Contributions

If you are or will be age 50 or older during this calendar year and you already contribute the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." This additional deposit of funds accelerates your progress toward your retirement goals. The maximum catch-up contribution is $7,500 — for a combined total contribution allowance of $30,000. See your plan administrator for more details.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions any time. If you stop making contributions, you may start again at any time.

Distributions and Withdrawals:

Funds may be withdrawn only in the event of:

- Retirement
- Death
- Disability
- In-service at age 59½ years of age
- Termination of employment

Distributions made prior to age 59½ may be subject to a 10% excise tax if not rolled into a new qualified plan or an IRA. In the event of death, your beneficiary will receive 100% of your investment account balance.

Loans

PF Holdings allows 401(k) loans. Loans are not considered distributions and are not subject to federal or state income taxes, provided they are repaid as required. Loans are subject to regulatory criteria and provisions. For additional details, contact Fidelity at 800-835-5097, refer to your 401(k) Plan Document, contact Human Resources or log on to www.401k.com.

Hardship Withdrawals

Hardship withdrawals are permitted. To request a hardship withdrawal, please contact Fidelity Investments at 800-835-5097. Fidelity customer service representatives are available 8:30 am – 8 pm ET.

Investment Options

A wide variety of investment options are available to you. Contributions may be divided in whole percentages among the investment options offered in the plan.

Investment Changes

Transfers between investments and changes to future allocations may be made by calling the interactive voice response system at 800-835-5097, or at www.401k.com. Some restrictions may apply.

Communications

In addition to account access online, you will receive an easy-to-read quarterly retirement account statement with your account details.

ADDITIONAL BENEFITS

PF Holdings knows the value of well-rounded, balanced employees, which is why we offer a variety of additional benefits to help manage life's daily stresses.

Employee Assistance Program

PF Holdings cares about you and your family's total health management — mental, emotional and physical. For that reason, we provide an Employee Assistance Program (EAP) at no cost to you.

Whether you are interested in work/life resources, mental health assistance, or legal and financial advice, the EAP service can connect you and members of your household with a variety of professionals. With just one phone call, at any hour of the day or night, you can have access to helpful resources. The EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with PF Holdings. You may also access information, benefits, educational materials and more either by phone at 800-964-3577 or online at www.guidanceresources.com.

The Program provides referrals to help with:

- Emotional Health and Well-Being
- Alcohol or Drug Dependency
- Marriage or Family Relationship Problems
- Job Pressures
- Stress, Anxiety, Depression
- Grief and Loss
- Financial or Legal Advice

Home/Auto Insurance

PF Holdings provides you access to discounted Auto and Homeowners insurance through Farmers Insurance. Your coverage will belong to you and stay with you, even if you leave the company, so you can always take advantage of low rates. Homeowners insurance includes coverage for your house, condo or rental property. Residency restrictions may apply.

Auto insurance includes coverage for your automobile, boat, motor home or recreational vehicle. You may start or stop your coverage at any time during the year. Call Farmers Insurance at 800-438-6381 to sign up today.

Cares Program

PF Holdings knows the value of well rounded, balanced employees, which is why PF Holdings offers personal support services through the Cares Program to help you and your family. The Cares Coordinators will:

- Provide care for grief, family deaths and funerals
- Discuss confidential issues, such as stress, parenting, marriage, financial concerns, addiction, aging parents, serious illness, and more
- Upon your request, visit with you at your work, home or a location of your choosing.

The services are available 24/7/365 for all employees and immediate family members at no cost. The Care Coordinators will not:

- Break confidentiality
- Judge your lifestyle or personal conduct
- Force a conversation
- Interfere with your work
- Report to management about your work
- Promote a particular religious organization

The services are confidential, and you choose if, when, where and what you want to discuss.

Prepaid Legal Coverage

As a PF Holdings employee, you may sign up for a discounted MetLife Legal plan. Telephone and in-person legal consultations are available. Your coverage is portable, so you can continue to take advantage of low rates even if you leave PF Holdings. Covered services include:

- Credit card debt or debt collection defense
- Traffic tickets
- Purchase of a home or condo
- Landlord negotiations and lease review
- Adoption
- Will and trust preparation
- Power of attorney
- Medicare/medicaid questions
- Tax audits
- Refinancing
- Estate planning

For more information, visit info.legalplans.com and enter access code GetLaw or call 800-821-6400.

Coverage is available for $8.31 per paycheck (bi-weekly) and covers yourself as well as your dependents.

Pet Insurance

PF Holdings knows that pets are valued members of the family. This insurance covers everything from preventive care to accidents or illness, including costs of x-rays, office visits, medications, surgeries and hospital stays. You have the option of choosing your own vet or using a licensed in-network vet. Cost depends on your pet's age, species and coverage level selected. For more information or to enroll, call MetLife at 800-438-6388 or visit www.metlife.com/PFH/.

Travel Assistance

With the Travel Assistance Program, toll-free emergency assistance is available to you and any dependent(s) 24 hours a day, seven days a week, when traveling 100 or more miles from your primary home for 90 days or less.

Get around-the-clock help when you need it:

- Hospital admission guarantee
- Emergency medical evacuation
- Medically supervised return travel when medically authorized
- Transportation for a friend/relative if you expect to be hospitalized more than seven days
- Prescription replacement insurance
- Medical consultation and evaluation
- Medical referrals to Western-trained, English-speaking medical providers
- Care and transport of unattended minor children

For more information, call IMG at 800-243-6108 and use ID Number GLD-09012.

Identity Theft Protection

LifeLock™ with Norton™ Benefit Plans help protect your digital life by combining leading identity theft protection, device security, and more in an always-connected world. These plans are enhanced and exclusive with features and pricing only available through your employer.

Learn more about this new benefit offering by reviewing the attached information and enroll during Annual Enrollment!

	BENEFIT ESSENTIAL	BENEFIT PREMIER
IDENTITY LOCK	✔	✔
HOME TITLE MONITORING		✔
SOCIAL MEDIA MONITORING	✔	✔
CREDIT, BANK & UTILITY ACCOUNT FREEZES	✔	✔
LIFELOCK IDENTITY ALERT™ SYSTEM	✔	✔
• IDENTITY VERIFICATION MONITORING	✔	✔
• TELECOM & CABLE APPLICATIONS FOR NEW SERVICE	✔	✔
• PAYDAY - ONLINE LENDING ALERTS	✔	✔
• CREDIT ALERTS & SOCIAL SECURITY ALERTS	✔	✔
MOBILE APP (ANDROID™ & IOS)	✔	✔
DARK WEB MONITORING	✔	✔
• DARK WEB MONITORING – GAMER TAGS	✔	✔
• DARK WEB MONITORING – PASSWORD COMBO LIST	✔	✔
COURTS RECORDS SANNING		✔
USPS ADDRESS CHANGE VERIFICATION	✔	✔
STOLEN WALLET PROTECTION	✔	✔
REDUCED PRE-APPROVED CREDIT CARD OFFERS FICTITIOUS IDENTITY MONITORING	✔	✔
PHONE TAKEOVER MONITORING DATA BREACH NOTIFICATIONS		✔
BANK & CREDIT CARD ACTIVITY ALERTS	✔	✔
• UNUSUAL CHARGE ALERTS	✔	✔
• RECURRING CHARGE ALERT	✔	✔
CHECKING & SAVINGS ACCOUNT APPLICATION ALERTS		✔
BANK ACCOUNT TAKEOVER ALERTS		✔
401K & INVESTMENT ACCOUNT ACTIVITY ALERTS	✔	✔
FILE SHARING NETWORK SEARCHES	✔	✔
SEX OFFENDER REGISTRY REPORTS PRIOR	✔	✔
IDENTITY THEFT REMEDIATION	✔	✔
U.S.-BASED IDENTITY RESTORATION SPECIALISTS 24/7 LIVE MEMBER SUPPORT	✔	✔
MILLION DOLLAR PROTECTION™ PACKAGE • STOLEN FUNDS REIMBURSEMENT • PERSONAL EXPENSE COMPENSATION • COVERAGE FOR LAWYERS AND EXPERTS CREDIT APPLICATION ALERTS	Up to $1 Million Each	
CREDIT MONITORING	One Bureau	
CREDIT REPORTS & CREDIT SCORES	One Bureau Monthly	On Deman – One Bureau Daily / Three Bureau Annual
MONTHLY CREDIT SCORE TRACKING		One Bureau
SECURES PCS, MAC & MOBILE DEVICES	Up to 3 devices (family gets 6)	Up to 5 devices (family gets 10)
ONLINE THREAT PROTECTION	✔	✔
PASSWORD MANAGER, PARENTAL CONTROL, SMART FIREWALL, CLOUD BACKUP, SECURE VPN, PRIVACY MONITOR	✔	✔
SAFECAM	✔	✔

BI-WEEKLY CONTRIBUTIONS

	BENEFIT ESSENTIAL	BENEFIT PREMIER
EMPLOYEE ONLY	$3.46	$4.61
EMPLOYEE + FAMILY	$6.91	$8.76

This plan is available via payroll deduction and is yours to keep via direct billing if you retire or no longer work for the company.

GLOSSARY

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,500, your plan does not pay anything until you've met your $1,500 deductible for covered healthcare services. This deductible may not apply to all services, including preventive care.

Employee Contribution – The amount you pay for your insurance coverage.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. This means you'll save an amount equal to the taxes you would have paid on the money you set aside.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code. Please note that over-the-counter medications are not eligible for reimbursement without a doctor's prescription with the Healthcare FSA.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before- or after-school programs, and child or elder daycare. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Flexible Spending Accounts are "use it or lose it," meaning that any funds over $610 (the rollover limit) not used by the end of the plan year will be lost.

Healthcare Cost Transparency – Also known as Market Transparency or Medical Transparency. Healthcare provider costs can vary widely, even within the same geographic area. To make it easier for you to get the most cost-effective healthcare products and services, online cost transparency tools, which are typically available through health insurance carriers, allow you to search an extensive national database to compare costs for everything from prescription drugs and office visits to MRIs and major surgeries.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a High Deductible Plan to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

High Deductible Plan – A plan option that provides choice, flexibility and control when it comes to spending money on healthcare. Preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Network – A group of physicians, hospitals, and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

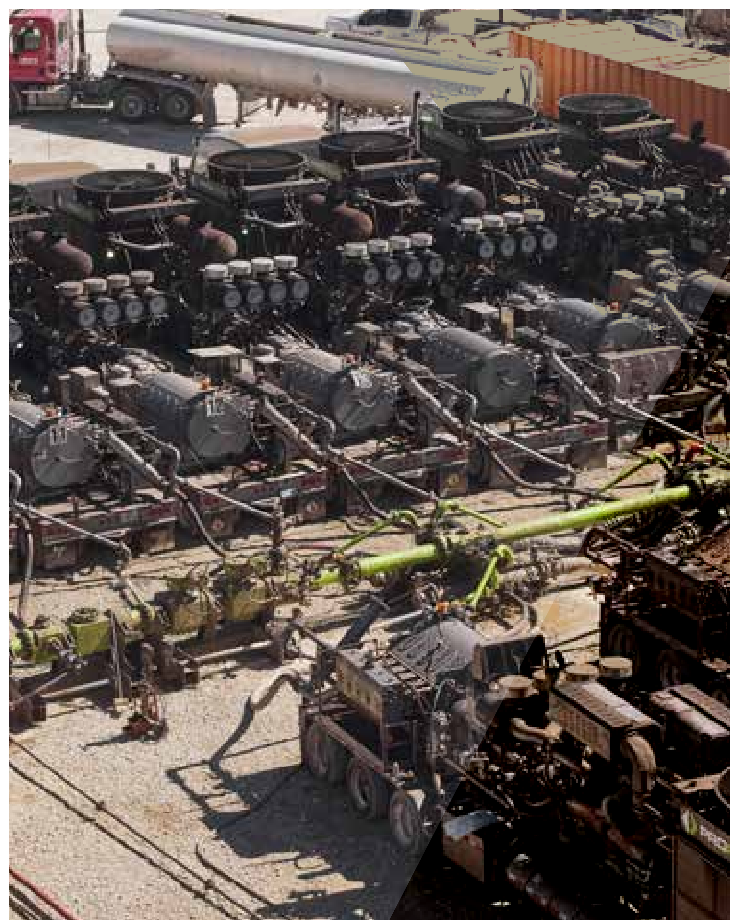
- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance company. They may not accept any insurance, and you could pay for all costs out of pocket.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications made available without a prescription.

Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions and is usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic and often costly conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Because of the high cost of these specialty drugs, many insurers require that specific criteria be met before a drug is covered. These requirements often include:
  - Performing a prior authorization to request coverage of the medication
  - Having a specific disease that the drug is FDA-approved to treat
  - Having a history of trying and failing cheaper medications
  - Creating high out-of-pocket costs when purchasing the medication
  - Restricting what pharmacy can dispense these medications
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.



Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from PF Holdings About Your Prescription Drug Coverage and Medicare under the BlueCross BlueShield of Texas PPO Plan, BlueCross BlueShield of Texas High Deductible Plan and CVS Caremark Rx Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PF Holdings 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. PF Holdings has determined that the prescription drug coverage offered by the BlueCross BlueShield of Texas PPO Plan, BlueCross BlueShield of Texas High Deductible Plan and Employers Health -CVS Rx plan(s) 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 PF Holdings coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

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

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 PF Holdings 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 at the end of these notices 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 PF Holdings changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

Date:	January 1, 2023
Name of Entity/Sender:	PF Holdings
Contact—Position/Office:	Human Resources
Address:	333 Shops Blvd, Suite 301 Willow Park, TX 76087
Phone Number:	254-776-3722

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 254-776-3722.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 254-776-3722.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 254-776-3722.

IMPORTANT CONTACTS

MEDICAL
BlueCross BlueShield of Texas
800-445-2227
www.bcbstx.com

24/7 NURSELINE
BlueCross BlueShield of Texas
800-581-0393

PHARMACY
CVS Caremark
866-477-1626
www.caremark.com

MUSKOSKELETAL BENEFIT
Airrosti
800-404-6050
www.airrosti.com

VIRTUAL VISITS
MDLive
888-680-8646
www.MDLIVE.com/bcbstx

DENTAL
MetLife
800-438-6388
www.metlife.com/mybenefits

VISION
MetLife
833-393-5433
www.metlife.com/mybenefits

HEALTH SAVINGS ACCOUNT
HSA Bank
855-731-5220 (available 24/7)
www.hsabank.com/hsabank/members

FLEXIBLE SPENDING ACCOUNTS
HealthEquity
877-924-3967
participant.wageworks.com

LIFE AND AD&D
The Hartford
800-523-2233
gbdcustomerservice@thehartford.com

LONG TERM DISABILITY AND FMLA
The Hartford
Ph: 888-650-6355
Fx: 833-357-5153
AbilityAdvantage.TheHartford.com

RETIREMENT
Fidelity Investments
800-835-5097
www.401k.com

EMPLOYEE ASSISTANCE PROGRAM
ComPsych
800-964-3577
www.guidanceresources.com
Organization Web ID: HLF902
Company Name: ABILI

LEGAL ASSISTANCE
MetLife Legal
800-821-6400
info.legalplans.com

TRAVEL ASSISTANCE
IMG through The Hartford
U.S. & Canada: 800-243-6108
Outside U.S.: 202-828-5885
Email: assist@imglobal.com
ID Number: GLD-09012

SHORT TERM DISABILITY, ACCIDENT, CRITICAL ILLNESS, HOSPITAL INDEMNITY AND UNIVERSAL LIFE
Allstate
800-521-3535
https://allstatevoluntary.com/pfholdings/

IDENTITY THEFT
LifeLock
800-543-3562
www.lifelock.com

HOME AND AUTO
Farmers Insurance
800-438-6381
www.myautohome.farmers.com

PET INSURANCE
MetLife
800-438-6388
www.metlife.com/PFH/

PF HOLDINGS BENEFITS CENTER
855-449-4785
7:00 a.m. – 6:00 p.m. CST
PFHCBenefits.com

COBRA PARTICIPANT SERVICES
Health Equity
877-722-2667
www.myhealthequity.com

QUESTIONS?
If you have questions about your benefits, please contact the applicable plan administrator. If you have any other questions or need further assistance, please contact Human Resources.

PF HOLDINGS

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