Appendix D

Employee Benefits

EMPLOYEE BENEFITS GUIDE

2023

ROYAL WINE CORP.

63 LeFante Way · Bayonne, NJ 07002
718.384.2400 · RoyalWine.com

2023 EMPLOYEE BENEFITS

We are pleased to present the details of the Royal Wine Corp. employee Health Care program and overall Benefits package for 2023. This year we are continuing with all our existing insurance carriers. Once again, Royal Wine will be paying for a much greater portion of the premium this year on the Value and Basic Health Plans. More on this in the Detailed Plan Descriptions booklet. If you already participate in the health plan and you select to stay with the same benefit group (buy-up plan to buy-up plan, or value to value) there is no application necessary as we will maintain that coverage for you. If you change groups, opt out, or you are newly enrolling, you will need to complete an application.

Please read each one of the sections within this booklet carefully, as they each have different requirements, benefit levels and contributions. We have put together a comprehensive package of all available benefits to help protect and secure the well-being of your family. All responses for your participation must be received by Mrs. Lefkowitz no later than **Monday, December 19, 2022** by email, (rifky@kedem.com) or in person. No verbal instructions will be accepted. Except for Qualifying Life Events (described later in this memo) there can be no changes after this enrollment period.

CONTENTS

Comprehensive Coverage for You and Your Family

A Snapshot

You may elect all or any of the following welfare benefits for you and your dependents in 2023, including:

Healthcare Insurance*

- Offered through CIGNA Insurance
  - Buy-up Plan (Open Access Plus)
    - Provides "in-network" and out "out-of-network" benefits
    - Lower deductible for in-network
    - Higher premiums
  - Value Plan (Open Access)
    - Provides "in-network" benefits only
    - Higher deductible
    - Lower Affordable premiums
  - Basic Plan (HSA Open Access)
    - Provides "in-network" benefits only
    - Complies with the requirements of the Affordable Care Act
    - All subject to higher deductible and coinsurance
    - Lowest premiums

Profit Sharing Plan & Trust (401K)

- Pre-tax contributions
- After-tax contributions, Roth account
- New participants must complete an application*

Flexible Spending Accounts – Pre-tax dollars*

- Health Care Maximum = $3,050 per year
- Dependent Care Maximum = $5,000 per year

Dental

- Benefits for Dental Insurance*

Vision

- Benefits for Vision Care*

Hospital Select II*

- Reimbursement for days spent in hospital

Disability

- Benefits for Short Term and Long Term Disability
- NJFMLA

Life Insurance

- All full-time employees (after a 90 day waiting period) are automatically covered for $150,000
- You may purchase additional life insurance*
  - No physical exam or medical required

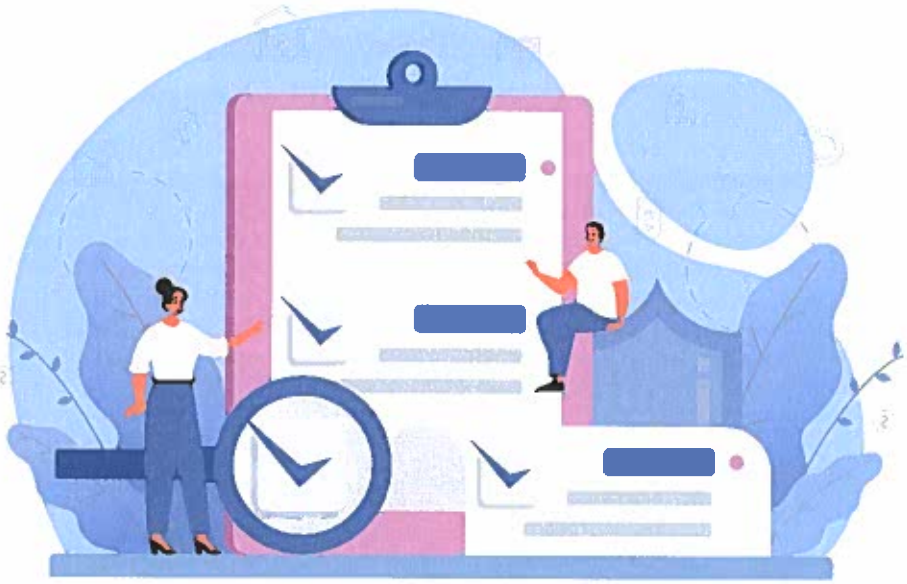
Commuter Tax Benefit

- Allows for certain commuter costs to be on a pre-tax basis*
- Daily shuttle service from Light Rail station to Royal Wine and back

The Money Network® Service*

- Debit Card

Each benefit above requires that a completed application be submitted to Mrs. Lefkowitz by Monday, December 19, 2022.



About Your Benefits

From eligibility to making changes during the year, this is what you need to know to understand how your benefit programs work.

Benefits Eligibility

All regular full-time employees who work 35 hours or more per week are benefits-eligible after 90 days of service. For Health Insurance you are eligible for benefits if working 30 hours a week. In addition, the following family members can be covered for some benefits:

- Legal spouses
- Any children up to the end of the month in which their 26th birthday occurs; includes children born to you, and stepchildren who live with you and adopted children
- For 401k Savings Plan, employees must be 21 years and complele 1,000 hours to be eligible for the employer contribution. Employees may contribute after 30 days.

Making Changes During the Year

Generally, you can only change your health benefit elections during the Open Enrollment period, unless you experience a Qualifying Life Event. This includes, but is not limited to, the following:

- Adding a dependent through marriage, birth or adoption
- Losing a dependent through legal separation, divorce or death
- Losing other health insurance coverage involuntarily that you had through a spouse's employer (e.g., layoff, termination or disability)

You can also make midyear changes if:

- You or your eligible dependents lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you're no longer eligible
- You or your eligible dependents become eligible for a state's premium assistance program under Medicaid or CHIP

Note: You are required to show proof of your Qualifying Life Event.

For Continuing Coverage with COBRA, please turn to page 22.

ENROLL IN YOUR BENEFITS

This year we are continuing with our existing health care carrier - CIGNA Insurance as they have again offered the best value for renewed coverage. If you already participate in the health plan and you select to stay with the same benefit group (buy-up plan to buy-up plan, or value to value) there is no application necessaryas we will maintain that coverage for you. If you change groups, opt out, or you are newly enrolling, you will need to complete an application. All responses for your participation must be received by Mrs. Lefkowitz no later than Monday, December 19, 2022 by email, (rifky@kedem.com) or in person.
No verbal instructions will be accepted.

Please remember to enroll in benefits during Open Enrollment or notify Mrs. Lefkowitz within 30 days of a Qualifying Event during the year. The IRS has very strict guidelines about when you can make enrollment changes. You cannot make enrollment changes during the year unless you have a Qualifying Life Event. **You are required to report a Qualifying Life Event to the Benefits Department within 30 days of its occurrence in order to change your benefits, and any changes must be consistent with the event.** See your Summary Plan Descriptions for a extensive list of Qualifying Life Events and special enrollment periods.

ARE YOU BENEFITS-ELIGIBLE?

You must be employed by the company for a 90 day period before you are eligible to enroll in Royal Wine health care plans. You may be considered benefits-eligible if you are full time working at least 30 hours per week. If you are eligible, then your dependents are also eligible for healthcare benefits. Those who qualify as a dependent include:

- Your spouse. *Note: Spouses must not be legally separated or divorced.*
- Your child(ren), until the end of the month in which he or she reaches age 26. *Note: Child(ren) who are eligible must be natural or adopted children, or stepchildren. Your child(ren) cannot be residing outside the US.*
  - **Important – Dependents of children are not covered and if your child has a baby, the baby is not covered for hospital or newborn costs.**
- Any child(ren) who are incapable of self-support due to physical or mental disability.

Health Care Insurance

As we do every year, we have explored many different healthcare options including the ability to become self-insured. In the end, our existing carrier - CIGNA Insurance - has offered Royal Wine and its employees the best value for the cost.

Importantly, this year, once again, Royal Wine is very pleased to be able to offer all employees healthcare coverage in the Value Plan and in the Basic Plan at very attractive, lower reduced premium costs. For these plans, Royal Wine will be paying over 75% of all premiums costs.

While the company may not be able to offer this very low level of premiums every single year – we did want to make them available to all employees for 2023. More about these lower rates in the Detailed Plan Descriptions booklet.

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

If you are eligible for benefits but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. 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, you can contact your state Medicaid or CHIP office or dial 877-KIDS NOW or insuredkidsnow.gov. Attached to this memo is additional information about Children's Health Insurance Program.

Please also carefully read the Summary of Coverage in the Detailed Plan Descriptions booklet to best understand your coverage choices and your

Available Medical Coverages

This year, as in the past, we are offering 3 choices for your medical coverage. Please read these very carefully as the "Value" and "Basic" Plans plan only allows for coverage with in-network physicians and has no coverage out of network. You may choose the option that best reflects your personal needs. Also, please note that the employee premium contribution for the single Basic Plan has been specifically developed to more than comply with the parameters of the Affordable Care Act. Plan summary information is detailed in the Detailed PlanDescriptions booklet.

Buy-up Plan (Open Access Plus)

The pre-tax costs per weekly payroll for medical insurance under Buy-up Plan for 2023 are as follows:

Single	$137.00
Couple	$288.00
Employee & Child	$239.00
Family	$417.00

overall healthcare coverage.

Cigna On-Call

Questions about your health can come up at any time. Maybe when you can't reach your regular doctor. Maybe when you child has a fever in the middle of the night or a twisted ankle on vacation. It could even be when you have a cold that doesn't seem important enough for a doctor's appointment. No matter the issue, you can turn to Cigna On–Call 24 hours a day, seven days a week for health care information. Cigna On-Call lets you talk with a registered nurse who can offer you suggestions and help guide you to the care that is right for you.

Cigna On-Call nurses (1-866-494-2111) can offer you helpful information about many topics. You could call about illness, injury, chronic conditions, prevention, healthy living and even just basic men's women's and children's health.

There is a complete list of in-network physicians in our Human Resource area or you can go online at www.cigna.com.

IMPORTANT DEADLINE MONDAY DECEMBER 19TH, 2022:

- If you already participate and wish to continue in the plan within the same option you currently have, there are no new forms to complete. There is nothing you must do.
- If you want to participate for the first time, please complete the health care enrollment form (in the Benefit Application booklet) and clearly indicate whether you are selecting "Buy up Plan" or "Value Plan" or "Basic Plan". If you do not indicate a plan your application will not be accepted.
- If you wish to change from one plan to the other, you must indicate this on Additional Change form (see Benefit Application booklet)
- If you are a current member but want to opt out for the 2023 year, you must also contact Mrs. Lefkowitz by Monday, December 19, 2022.

Value Plan (Open Access)

This plan has 'in network' coverage only. **There is no coverage of reimbursements for any medical costs incurred with a physician that is not in the Cigna network. The pre-tax costs per weekly payroll are being paid by Royal Wine up to 75% pre-tax and the employee at a level of approximately 25%. The pre-tax weekly costs for medical insurance under Value Plan for 2023 are as follows**

Single	$59.00
Couple	$125.00
Employee & Child	$104.00
Family	$181.00

Basic Plan (HSA Open Access)

This plan has 'in network' coverage only **with a higher deductible level. The pre-tax costs per weekly payroll are being paid more than 75% by Royal Wine with the employee paying a much reduced premium. The pre-tax weekly costs for medical insurance under Basic Plan for 2023 are as follows:**

Single	**$18.00**
Couple	$101.00
Employee & Child	$84.00
Family	$147.00

See plan summaries and details in the Detailed Plan Descriptions booklet. Please read this carefully as it contains not only a detail of each level of benefits but also information pertaining to the Health Care Reform Act.

Healthcare Plan Summary for 2023

Plan Basics	Buy-up Plan	Value Plan	Basic Plan
Referrals:	Not required	Not Required	Not required
On call 24 hours per day:	Included	Included	Included
Preventive Care (i)*:	Covered 100%	Covered 100%	Covered 100%
In-network doctor visit: (PCP/specialist)	$25/$40	$20/$40	Deductible and Co-Insurance
Emergency room visit:	$100	$100	Deductible and Co-Insurance
In-network deductible:	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000	Single: $2,500 Family: $5,000
In-network co-insurance	80%/20% total in network out of pocket annual max. - $5000 Individual and $10,000 Family	70%/30%, total in network out of pocket annual max. - $6350 Individual and $12,700 Family	70%/30%, total in network out of pocket annual max. - $6450 Individual and $12,900 Family
Out-of-network deductible	Single: $2,000 Family: $4,000	**No Benefits**	**No Benefits**
Out-of-network co-pay	60%/40% total out of network out of pocket annual max. $10,000 Individual and $20,000 Family	**No Benefits**	**No Benefits**
Pharmacy co-pay Pharmacy deductible	$15/$35/$75 $0.00	$15/$35/$75 $100	$25/$50/$75 Deductible
UCR	300% of Medicare	N/A	N/A
Your pre-tax contribution per weekly payroll	Single: $137	Single: $59	Single: $18
	Couple: $288	Couple: $125	Couple: $101
	Employee and Child: $239	Employee and Child: $104	Employee and Child: $84
	Family: $417	Family: $181	Family: $147

*(i) Usually meaning annual physical, well-child care, immunizations

Important Note: Value Plan and Basic Plan do not provide any out of network benefits.

Frequently Asked Questions

What does in-network mean?
Choosing a doctor or facility in the Cigna Healthcare network. You can obtain a list of in network doctors or verify if your doctor is in the network by going to www.cigna.com.

Why do I pay more if I do not stay in network?
Because every time an employee chooses to use an out-of-network doctor it costs the insurance company more money.

Can I go to a private, out-of-network doctor if I want?
Yes – only in the Buy-up Plan and you will pay more for that service. In the other plans the cost for out-of-network would be 100% the employee's responsibility.

What is a co-payment?
It is your pre-defined cost for a medical service.

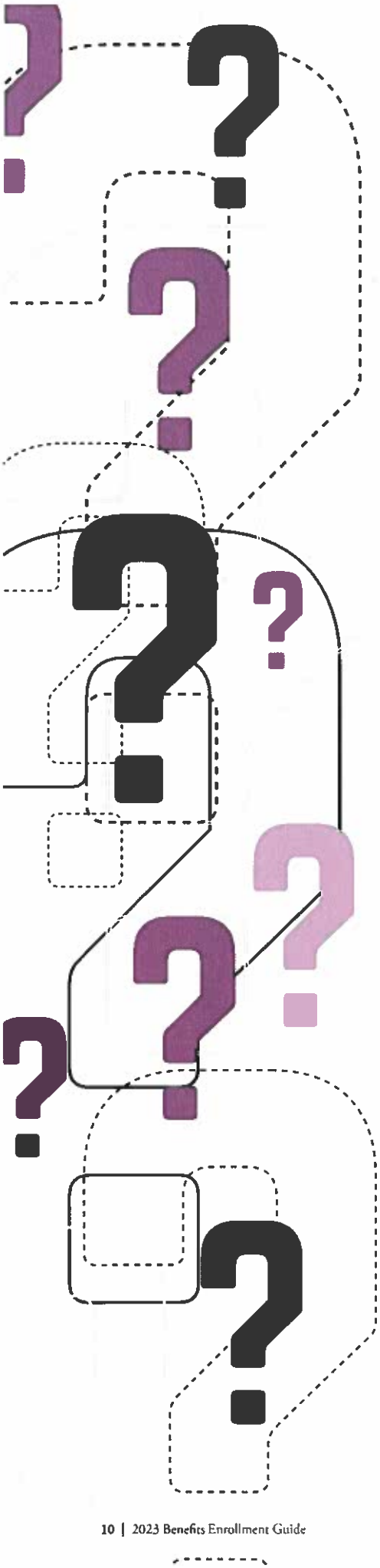
What is a deductible?
It is a set amount of money the plan requires you to spend on your own before you can be reimbursed.

What are out-of-pocket maximum costs?
Out-of-pocket maximum costs is the maximum amount of money you will pay after your co-payments and deductibles.

What is "reasonable and customary charges"?
Reasonable and customary charges are the accepted charges for specific medical procedures as determined by Cigna. If Cigna believes your out-of-network doctor charges more than their "reasonable and customary charges" you are responsible for paying the additional charges.

What is a referral?
Referral is the process in which the primary doctor sends a patient to another practitioner (such as a specialist) for consultation or a health care service that the referring source believes is necessary but is not prepared or qualified to provide.

What is the individual mandate?
The individual mandate is a provision of the federal health law that requires you, your children and anyone else that you claim as a dependent on your taxes to have health insurance in 2023 or pay a penalty in the state of New Jersey. That coverage can be supplied through your job, your spouse, public programs such as Medicare or Medicaid, or an individual policy that you purchase.



How do I satisfy the mandate?
Health coverage provided through a job-based plan (including COBRA or a retirement plan), policies that you bought for yourself or your family, including coverage through the Health Care Exchange, Medicare (and Medicare Advantage), Medicaid, CHIP, some Veterans Administration health programs or TRICARE coverage for members of the military and their dependents will satisfy the mandate.

What are State or Federal Exchanges?
The Exchanges, also referred to as the Marketplaces, are a new way for people to buy health insurance.

How does this new law affect Royal Wine employees who are eligible for medical coverage and instead buy coverage through the State Exchange?
Royal Wine has chosen to continue to provide "affordable" coverage in 2023 to all who are currently benefits eligible.

What kind of plans will the exchange offer?
The exchange will offer four plan levels you can purchase:

- Platinum plan (covers roughly 90% of costs)
- Gold plan (covers 80%)
- Silver plan (covers 70%)
- Bronze plan (covers 60%)

Please note that the plan designs and costs may not yet be finalized nor are providers yet clearly defined. You should consult the 'exchange' directly.

Am I eligible for a subsidy to help me pay for the coverage under the Exchange?
You may be eligible if your family income is between 133% and 400% of the poverty level. However, if the premium you would pay under the single coverage Basic Plan offered by Royal Wine on an annual basis is less than 9.61% of your household income, you will not be eligible for any subsidy. If your family income level is below 133% of the poverty level, you may be eligible for Medicaid.

What if I am interested to see the options offered on the new State or Federal Exchange? Even though I am eligible for the Royal Wine plan, am I allowed to switch plans?
Yes, you can waive the healthcare coverage through Royal Wine and elect coverage through the Exchange, but be sure to do your homework first – you may or may not be eligible for any subsidy through the exchange.

Are there penalties if you do not have insurance in New Jersey?
Yes, and they may increase each year you do not have health insurance.

For more information about the Exchanges or to enroll, visit www.healthcare.gov or www.nystateofhealth.ny.gov

Profit Sharing Plan & Trust 401k Plan

Royal Wine Corporation Profit Sharing Plan & Trust (401k Plan)

All full time employees who are at least 21 years old and have at least 1000 hours of service are eligible to fully participate in the Royal Wine 401k Plan. More specifically, all full time employees will be able to participate in the plan on the first day of the month following their employment. However, full time employees will only be eligible for the employer contribution after 1,000 hours of service.

The 401k Plan allows you to save for retirement with funds deducted from your paycheck on either a pre-tax or after-tax basis. This is your choice.

The difference between pre and post-tax contributions:

- Pre-tax contributions allow you to contribute to your 401K Plan with funds prior to the deduction of taxes. These funds will grow tax free and will be taxable to you only when they are withdrawn upon retirement.
- After-tax contributions known as Roth contributions: allows you to deduct after tax funds and deposit them into your retirement account. These funds grow tax free and they are also tax free when you withdraw these funds upon your retirement.

The company has a very detailed "enrollment kit" that is available to you by requesting it from Mrs. Lefkowitz. You may contribute from 1% to 99% of your pay up to $22,500 for both plans or either plan in total, in 2023, with an additional $7,500 (catch up contribution) for a total of $30,000 if you are over 50 years old.

These are self-directed plans. This means that you elect how your contribution is invested and you have the right and the ability to transfer your investments between investment options at any time at your discretion. These investment features are an on-line feature that is available to all participants. The company offers many different funds as investment options to meet all investments objectives. The investments are listed in the Benefit Application booklet enrollment form and are described in detail in the package available from Human Resources.

TO ENROLL

If you are already enrolled in the company's 401k Plan you do not have to complete any forms or documents and your current election will continue. If you are not currently contributing to the 401k or if you want to change the amount of your contribution level you MUST complete the forms in the Benefit Application booklet and return them to Mrs. Lefkowitz.

Your forms in the Benefit Application booklet must be returned by Monday, December 19, 2022.

The company presently makes an annual contribution of 3% of compensation for all eligible employees (whether you participate in the plan or not) and at its discretion may make additional contributions.

Should you want any help/guidance/advice in selecting investment options or need additional information, you can contact Mr. Ross Ginsberg of AXA Equitable at (212) 541-1949 or email ross@theemergygroup.com or contact a Customer Service Representative at (800) 528-0204 from 8:30 a.m. to 7 p.m. ET, Monday-Thursday, and 8:30 a.m. to 5 p.m. ET on Friday. (Available in English and Spanish.)

Should you need any assistance in completing the application, please see Mrs. Lefkowitz.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside before-tax dollars on a per paycheck basis to save for expenses not covered under your medical plan or for dependent care costs. It is a great way to save money. If you elect this benefit, you will receive a debit card with the amount of your election. This debit card can be used for co-insurance, deductibles, etc. when you visit a physician. More detailed information is contained in the Detailed Plan Descriptions booklet.

AS AN EXAMPLE

If you elected the Flexible Spending Health Care Account at a level of $1,300 for the year - $25 per payroll ($1,300/52) would be deducted pre-tax from your paycheck. You would then submit receipts for unreimbursed medical costs (including deductibles, co-insurance, child's braces, eye glasses, etc.). You will be reimbursed up to the amount you elected, in this case $1,300. If you are in the 25% tax bracket, this should save you $325 for the year ($1300 x 25%)

CAUTION:

1. **Once you elect an amount for the year you cannot change it.**
2. **If you do not use the full amount elected by March 15, 2024 and claim by March 31, 2024 (a three month grace period from the end of the year) you will lose the unused amount.**

Health Care:

FSAs allow you to set aside before-tax dollars on a per paycheck basis to save for expenses not otherwise covered under your medical plan. "Eligible Expenses" include but are not limited to copays, deductibles, pharmacy, eyeglasses, dental, etc. A more complete list and application is in the Detailed Plan Descriptions booklet You can set aside as little as you want, up to a maximum of $3,050 for the year, to pay for medical expenses not otherwise covered
in the plan.

Dependent Care:

FSA can be used for yourself and your dependents. Expenses may be claimed for a dependent who is under age 13 and is claimed as a deduction on your income tax return, or, if 13 or older, is physically or mentally incapable of caring for him or herself, or if the spouse or parent of the taxpayer is physically or mentally incapable of caring for him or herself.

Examples of covered expenses include:

- Cost of day care inside or outside your home
- After school care
- Nursery school
- Day camp
- Elder care

The maximum amount you can deposit for a married couple in the Dependent Child FSA is $5,000 for the year.

A detailed brochure about this benefit and an application is in the Detailed Plan Descriptions booklet.

Even if you participated in 2022 you must submit an "FSA Election Form" (see Benefit Application booklet) for 2023. Your forms must be returned by Monday, December 19, 2022. If you do not submit this form you cannot participate.

Dental Insurance

Royal Wine is offering dental insurance coverage through Principal Insurance for 2023. We offer two different plans. A summary of the dental benefit is as follows:

BASIC PLAN

Plan Basics	Plan Basics	Out/Network
Preventive	100%	100%
Basic	100%	80%
Major	60%	50%
Annual Maximum	$1,500	$1,500
Orthodontics	50%	50%
Adult Ortho	INCLUDED	INCLUDED
Ortho Maximum	$1,500	$1,500
Deductible	$50/$150	$50/$150
Deductible for Preventive	Waived	Waived

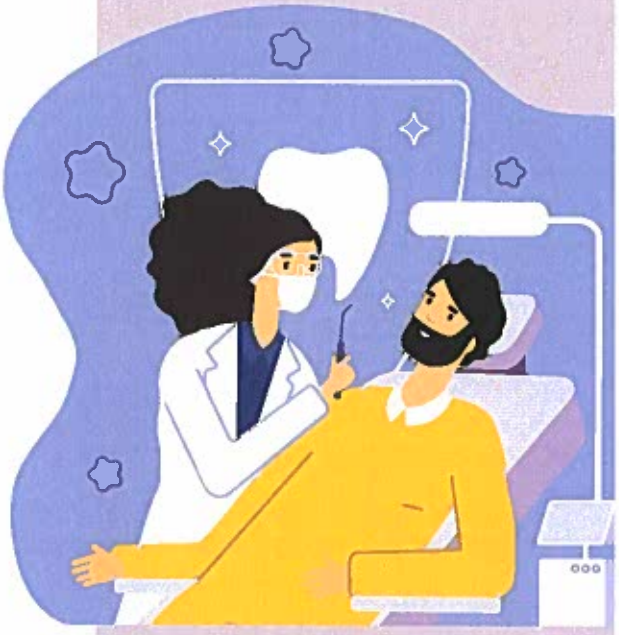
BUY-UP PLAN

Plan Basics	In/Network	Out/Network
Preventive	100%	100%
Basic	100%	80%
Major	60%	50%
Annual Maximum	$2,000	$2,000
Orthodontics	50%	50%
Adult Ortho	INCLUDED	INCLUDED
Ortho Maximum	$2,000	$2,000
Deductible	$50/$150	$50/$150
Deductible for Preventive	Waived	Waived

A more detailed listing of the benefits and limits are in the Detailed Plan Descriptions booklet.

Important – Deadline Monday December 19th, 2022:

- If you already participate in dental insurance and wish to continue in the benefit level you currently have, there are no new forms to complete. There is nothing you must do.
- If you want to participate for the first time, please complete the Enrollment form (and clearly indicate whether you are selecting "Basic Plan" or "Buy-up Plan". If you do not indicate a plan, your application will not be accepted.
- If you wish to change from one plan to the other, you must indicate this on the form in the Benefit Application booklet and resubmit a completed enrollment form.
- If you are a current member but want to opt out for the 2023 year, you must also contact Mrs. Lefkowitz by Monday, December 19, 2022.

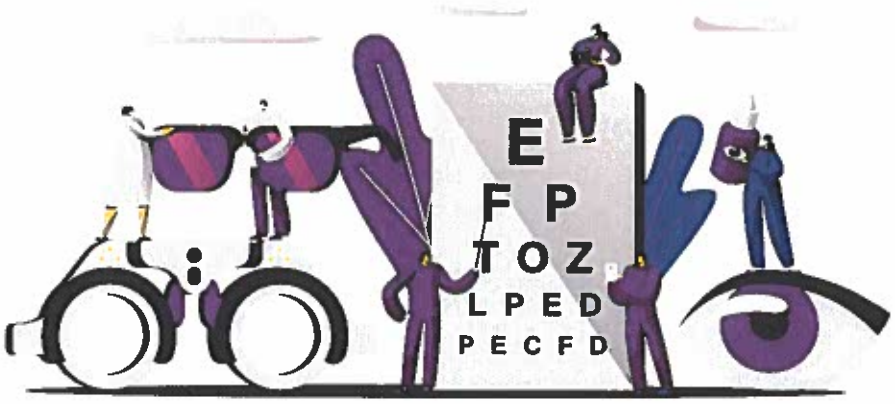


THE PRE-TAX COST OF THE PLANS IS AS FOLLOWS
PER WEEKLY PAYROLL

	Basic	Buy-up
Single	$9.35	$11.31
Employee & Spouse	$18.79	$21.86
Employee & Child(ren)	$22.75	$27.89
Family	$33.79	$40.42

The cost of this benfit is paid fully by the emplyee on a pretax basis.

Applications are in the Benefit Application booklet and must be returned by Monday, December 19, 2022.



Vision Care

Vision Care will help you and your family with costs related to eye examinations, eyeglasses, and contact lenses. In the Detailed Plan Descriptions booklet there is a very complete presentation and summary of benefits analysis. The cost of this plan to you per weekly payroll on a pre-tax basis is as follows:

- Single $1.67
- Employee and Spouse $3.59
- Employee and Children $3.37
- Family $5.29

TO ENROLL

If you already enrolled in the Vision Care plan you will be automatically renewed into this plan. There is nothing for you to do. New participants must submit their forms by Monday, December 19, 2022. Forms are in the Benefit Application booklet

BASIC BENEFITS PER PERSON:

	In-Network	Out of Network Reimbursement
Exam	$10 Copay	$45 in each 12 month period
Lenses	$25 Copay	Up to $65 in each 12 month period
Frames	$130 / $70 in each 12 mo. Period	$70 in each 12 month period
Contact Lenses - Necessary	$25 Copay	$210 in each 12 month period instead of frames and lenses in each 12 month period
Contact Lenses - Elective	Up to $60 Copay / $130 allowance	$105 instead of frames and lenses

Hospital Select Indemnity

Hospital Indemnity insurance pays an amount for each day you or a covered person is hospitalized, up to specific maximum limits. Because the benefits are paid to you directly, you can use them to help pay for out-of-pocket expenses, such as deductibles and copays, as well as costs that may be hard to pay due to the work missed, like a car payment, rent, and childcare. See more details in the Detailed Plan Descriptions booklet

Note: this does cover pregnancies BUT only after having this insurance for more than one year. For example, if you take out this coverage for the first time in 2023 – then in 2024 this would cover pregnancy related hospitalization.

Hospital Select II features:

- For full-time employees (as well as eligible family members)
- No coinsurance, co-pays, waiting periods and deductibles
- Benefits paid in addition to other insurances the insured may have
- Portability that allows employees to keep insurances after you retire or leave the company

The cost of this plan to you per weekly payroll on a pre-tax basis is as follows:

- Single..... $3.21
- Employee & Spouse..... $6.80
- Employee & Child..... $4.70
- Family $7.69

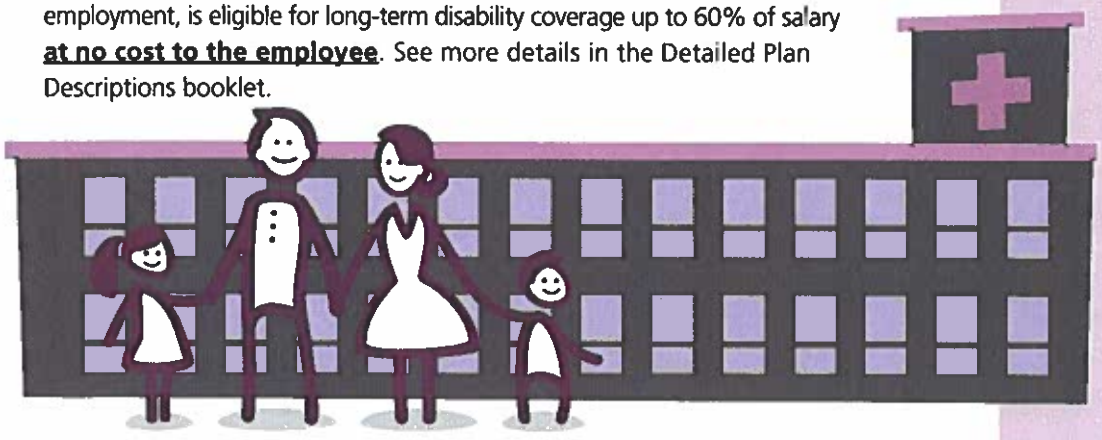
In summary: this program pays the patient $750 for the first day of confinement and $100 per day thereafter up to a total of 31 days.

If you are enrolled in the Hospital Plan, you will be automatically renewed into this plan. There is nothing for you to do. New participants must submit their forms in the Benefit Application booklet by Monday, December 19, 2022.

DISABILITY

LONG TERM DISABILITY INSURANCE

Should the need arise, a full-time employee, after ninety (90) days of employment, is eligible for long-term disability coverage up to 60% of salary **at no cost to the employee**. See more details in the Detailed Plan Descriptions booklet.



EMPLOYEE ELIGIBILITY

To be eligible for FMLA benefits, an employee must:

1. Work for a covered employer;
2. Have worked for the employer for a total of 12 months (other than special rules for returning reservists);
3. Have worked at least 1,250 hours over the previous 12 months (other than special rules for returning reservists); and
4. Work at a location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles.

FAMILY AND MEDICAL LEAVE

Under the federal Family and Medical Leave Act of 1993 ("FMLA"), as amended, eligible employees may take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. The Company may elect to use the calendar year, a fixed 12-month leave or fiscal year, or a 12-month period prior to or after the commencement of leave as the 12-month period. As relevant here, the FMLA applies to private-sector employers who employed fifty (50) or more employees in twenty (20) or more work weeks in the current or preceding calendar year and who are engaged in commerce or in any industry or activity affecting commerce. An employee may be entitled to a maximum of twenty-six (26) weeks in a case involving leave to care for a qualifying recovering parent, child, spouse or next of kin who is a service member in the Armed Forces.

The State of New Jersey, in addition to the above federal statute, has also adopted the New Jersey Family Leave Act ("NJFLA") which overlaps the federal law but has certain distinctions, as described below. An employee will be eligible for appropriate benefits as applicable under the federal FMLA and the NJFLA. Please note that New York State follows the federal FMLA and has not enacted its own family leave statute.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

A covered employer must grant an eligible employee up to a total of 12 work weeks of unpaid, job-protected leave during any 12-month period for one or more of the following reasons:

- For the birth and care of the newborn child of the employee;
- For the placement with the employee of a son or daughter for adoption or foster care;
- To care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- Because of a serious health condition that makes the employee unable to perform the functions of the job.

Spouses employed by the same employer are jointly entitled to a combined total of 12 work weeks of family leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition.

Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

Under some circumstances, employees may take FMLA intermittently – which means taking leave in blocks of time, or by reducing their normal weekly or daily work schedule.

- If FMLA leave is for birth and care or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.
- FMLA leave may be taken intermittently whenever medically

necessary to care for a seriously ill family member, or because the employee is seriously ill and unable to work.

Also, subject to certain conditions, employees or employers may choose to use accrued paid leave (such as sick or vacation leave) to cover some or all of the FMLA leave.

The employer is responsible for designating whether an employee's use of paid leave counts as FMLA leave, based on information from the employee

- Podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law; or
- Nurse practitioners, nurse-midwives and clinical social workers authorized to practice, and performing within the scope of their practice, as defined under state law; or
- Christian Science practitioners listed with the First Church of Christ, Scientist, in Boston, Massachusetts; or
- Any health care provider recognized by the employer or the employer's group health plan benefits manager.

Maintenance of Health Benefits

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance premiums while on leave.

In some instances, the employer may recover premiums it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

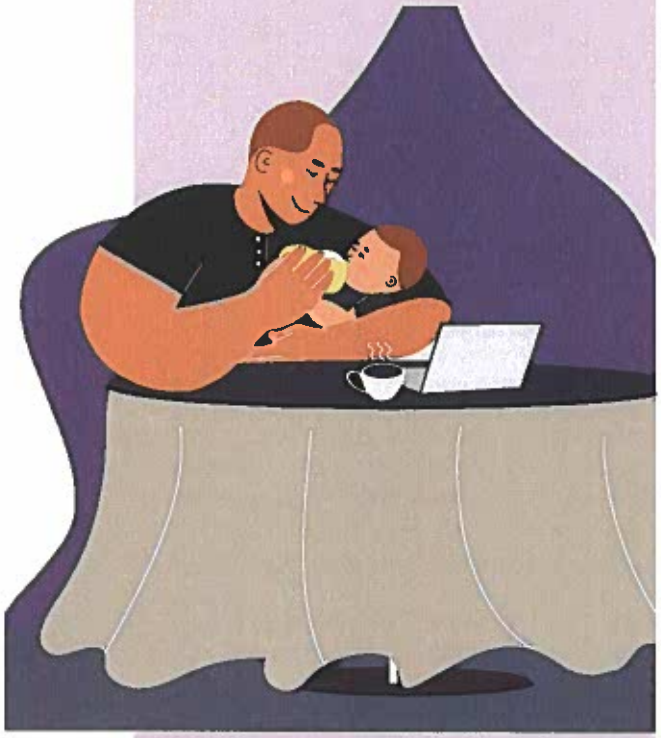
Job Restoration

Upon return from FMLA leave, an employee must be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment.

In addition, an employee's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave, nor be counted against the employee under a "no fault" attendance policy.

Under specified and limited circumstances where restoration to employment will cause substantial and grievous economic injury to its operations, an employer may refuse to reinstate certain highly-paid "key" employees after using FMLA leave during which health coverage was maintained. In order to do so, the employer must:

- Notify the employee of his/her status as a "key" employee in response to the employee's notice of intent to take FMLA leave;
- Notify the employee as soon as the employer decides it will deny job restoration, and explain the reasons for this decision;



- Offer the employee a reasonable opportunity to return to work from FMLA leave after giving this notice; and
- Make a final determination as to whether reinstatement will be denied at the end of the leave period if the employee then requests restoration.

A "key" employee is a salaried "eligible" employee who is among the highest paid ten percent of employees within 75 miles of the work site.

Notice and Certification

Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable.

Notice "as soon as practicable" is required when the need to take FMLA leave is not foreseeable ("as soon as practicable" generally means at least verbal notice to the employer within one or two business days of learning of the need to take FMLA leave).

The employee must provide sufficient information to the employer to understand that the employee needs leave for FMLA-qualifying reasons (the employee need not mention FMLA when requesting leave to meet this requirement, but may only explain why the leave is needed).

Where the employer was not made aware that an employee was absent for FMLA reasons and the employee wants the leave counted as FMLA leave, timely notice must be provided to the employer (generally within two business days of returning to work) that leave was taken for an FMLA-qualifying reason.

Employers may also require employees to provide:

- Medical certification supporting the need for leave due to a serious health condition affecting the employee or an immediate family member; and
- Periodic reports during FMLA leave regarding the employee's status and intent to return to work.
- The employer may also require second or third opinions (at the employer's expense) and a fitness for duty report prior to return to work.

When intermittent leave is needed to care for an immediate family member or the employee's own illness, and is planned medical treatment, the employee must try to schedule treatment so as not to unduly disrupt the employer's operation.

NEW JERSEY FAMILY LEAVE ACT ("NJFLA")

Similar to the federal FMLA but with some distinctions, the New Jersey Family Leave Act ("NJFLA") requires covered employers to grant eligible employees time off from work in connection with the birth or adoption of a child or the serious illness of a parent, child or spouse, but not for an employee's own disability. The NJFLA's definition of "parent" includes a parent-in-law or stepparent. The NJFLA provides for up to twelve

(12) weeks of leave in a 24-month period, which period begins on the first day of the employee's first NJFLA leave. All employers with 50 or more employees anywhere must comply with the NJFLA for their New Jersey employees. For an employee to be eligible, the employee: (i) must be employed in New Jersey by a covered employer; (ii) must have been employed for at least twelve (12) months with the employer; and (iii) must have worked 1,000 base hours in the preceding 12 months.

When an employee takes a leave for a purpose covered by both the FMLA and the NJFLA, e.g., for the birth or adoption of a child or the serious illness of a parent, child or spouse, the leave simultaneously counts against the employee's entitlement under both laws. However, while the FMLA provides time off from work due to an employee's own disability, the NJFLA does not provide covered employees with leave for their own disabilities. Thus, while the employee may utilize all of his or her allotted time under the federal FMLA due to his or her disability, an employee may subsequently be entitled to time off under the NJFLA in connection with the birth or adoption of a child or the serious illness of a parent, child or spouse.

THE NEW JERSEY PAID FAMILY LEAVE LAW

The New Jersey Paid Family Leave Law ("Paid Family Leave"), formally titled the Family Temporary Disability Leave Law, allows eligible employees to take up to six (6) weeks of partially paid leave, comprised of two-thirds of their average weekly pay, to take care for a newborn, within 12 months of birth; to care for a newly adopted child within 12 months of placement; or to care for a family member with a serious health condition. All employees who have worked 20 calendar weeks of covered New Jersey employment, or who have earned 1000 times the New Jersey minimum wage during the 52 weeks preceding leave, are eligible.

Paid Family Leave is funded through payroll deductions and administered through the State's Temporary Disability Benefits Program. Paid Family Leave runs concurrently with unpaid FMLA and/or NJFLA leaves and does not reduce or impact leave rights under either FMLA or NJFLA. Paid Family Leave is not a protected leave and does not provide any independent right to reinstatement or other job protection, but employees may be afforded such rights through the FMLA and NJFLA. Employees may first be required to use sick, vacation or other fully paid time off that has accrued under Company policy before using Paid Family Leave.

MATERNITY LEAVE

Under the federal Family Medical Leave Act ("FMLA"), an eligible employee may be entitled to up to a total of 12 work weeks of unpaid, protected leave during any 12-month period for the birth (or adoption) and care of a newborn child. The FMLA also permits such employee to take up to 12 weeks of protected unpaid leave to address her own serious medical condition arising out of pregnancy complications, which time is inclusive within a total period of 12 weeks.

In addition, New Jersey provides eligible employees with certain benefits and rights under (i) the New Jersey Family Leave Act ("NJFLA"); (ii) New Jersey Paid Family Leave Act; and (iii) Temporary Disability Insurance. Briefly, those laws provide, in relevant part, as follows:

The New Jersey Family Leave Act (NJFLA) provides for 12 weeks of unpaid leave during a 24 month period for the birth of a child of the employee, or placement of a child with the employee for adoption or foster care, in order to care for such newborn child during the first 12 months after the birth (or adoption) of the child. Please note that the NJFLA does not provide leave for the employee's own medical reasons (which is available under the FMLA). If an employee qualifies for leave under both the FMLA and NJFLA simultaneously, that is, for the same reasons, e.g., to care for a newborn child, then both the FMLA and NJFLA will run concurrently.

The Paid Family Leave Law (Family Temporary Disability Leave Law) allows for up to two-thirds of the employee's average weekly pay for six (6) weeks of partially paid leave for employees to take care for a newborn, within 12 months of birth, or to care for a newly adopted child within 12 months of placement.

As the laws governing paid and unpaid leave are complex, it is important that all employees who believe they may qualify for some type of medical, family, or maternity leave, or anticipate such circumstances arising shortly, should promptly discuss these issues with Human Resources to ascertain their eligibility and the benefits they may expect based on their particular situation.

Group Life Insurance

All employees are entitled to enroll in Royal Wine's Group Life Insurance program. As a full time employee, after a 90 day waiting period, you are covered for $150,000 of Life Insurance that Royal Wine provides for you **at no cost**. Please note: Once an employee reaches 65 years of age, the benefit amount is lowered to $97,500 & then at age 70 the benefit amount is lowered one more final time to $75,000. In addition, Royal Wine offers you the ability to purchase additional insurance for you, your spouse and your children.

You may purchase Life Insurance up to $500,000 (less the $150,000 for which you are already covered) up to 5 times your salary. There is no physical exam or medical required for this insurance. A more detailed explanation, rate schedule, and calculations are in the Benefit Detail Booklet.

Applications must be returned by Monday, December 19, 2022. See Benefit Application booklet for an applications

For example, if you were 32 years old and wanted an additional $150,000 in insurance, your premium would be $9.00 per payroll. (This is calculated as follows: .13 per thousand – per chart x 150 (the number of thousands) = $19.50 per month. This amount times 12 months divided by 52 pay periods = $4.50 [19.5 x 12/52]). If you are 50 years old and wanted an additional $50,000 in insurance, the cost would be $7.59 per payroll. These are after-tax amounts and will be automatically deducted from your payroll.

Should you need any additional information or help in completing any of these documents, you can contact Mrs. Lefkowitz, or Ross Ginsberg at AXA Equitable (212) 541-1949, or email ross@theemergygroup.com.

The Money Network® Service

With the Money Network Service, your wages are deposited directly into your Account each payday and can be accessed using your debit card.

The benefits are:

- Convenience – No need to pick up a payroll check from your employer or wait in line to cash it.
- Easy access – Multiple options to access your wages at no cost.
- Flexibility – Make purchases, use or cash Money Network Checks, access 55,000+ surcharge-free in-network ATMs.
- Control – You can spend only what is available in your Account, avoiding overdraft fees.
- Security – Funds are held in a FDIC insured Account[2] and you're protected if your Card is lost or stolen with the Visa® Zero Liability Policy.[3]

Enjoy features such as:

1. **A Money Network Card** – Use the Card wherever Debit Visa is accepted, in-store, online or by phone, plus get cash back at the register with PIN debit purchases.
2. **The Money Network Mobile App[4]** – Available on Google Play™ or the App Store®, you can access your Account on the go, set money aside with Piggy Bank, access your balance without logging in using the Quick View feature and more.
3. **Fee-Free Services and Transactions[1]** – Surcharge-free in-network ATM withdrawals, signature and PIN debit POS transactions, bank over the counter cash withdrawals, unlimited Money Network Checks and more.
4. **Money Network Checks[1]** – Pay bills or write a Check to yourself for cash, without a fee, at any of the 6,000+ participating check cashing locations.
5. **Alerts** – Set up alerts with the Money Network Mobile App4 or online at MoneyNetwork.com.
6. **A Secure Website** – Login at MoneyNetwork.com to view balance, transaction history and more.

Applications are in the Benefit Application booklet and must be returned by Monday, December 19, 2022.

7. **Account Reloads**[1] – Add other funds to your Account using direct deposit (tax refunds, child support, etc.), electronic funds transfer, remote check deposit in the mobile app4, or use the Money Network Locator to find participating cash reload agents.
8. **Secondary Card**[5] – Request and fund a Secondary Card for a family member or dependent.

[1]See Fee Schedule and Balance and Transaction Limit Schedule for the Money Network Service for details.
[2]Card funds will be FDIC insured provided the Card is registered to the name of the primary cardholder.
[3]For more information on your liability related to unauthorized transactions and the Visa Zero Liability policy, please reference your Money Network Service Account Holder Agreement.
[4]Standard message and data rates may apply.
[5]You can request a Secondary Card for family members, dependents, or other individuals who are at least 14 years old. To process a Secondary Card request, we must obtain certain identifying information about the Secondary Cardholder to validate their identity in accordance with the USA PATRIOT Act. You will not have any rights to the Secondary Card or its Account balance. See your Fee Schedule, Balance and Transaction Limit Schedule and Cardholder Agreement for more details.

See the Detailed Plan Descriptions booklet for more details.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefits provisions, require group health plans to provide a temporary continuation of group health coverage to covered employees, their spouses, former spouses and dependent children when group health coverage would otherwise be lost due to certain specific events. COBRA continuation coverage is often more expensive than the amount that active employees are required to pay for group health coverage, since the employer usually pays part of the cost of employees' coverage and all of that cost can be charged to individuals receiving continuation coverage.

Additional information regarding Federal Health Insurance Requierments, HIPAA Notice of Privacy Practices, and Health Benefits Covrage of children under the age of 21 can be found in the Detailed Plan Descriptions booklet.

Payroll Portal

Our payroll portal allows you to see your weekly payrolls, w-2 documents, request time off for vacation & sick time, make changes to your personal information and much more.

Please see your H/R representative to make sure you are registered and have access to this important employee tool.

Important Contacts

Questions About	Contact	Phone/email	Website	Group#
Medical Insurance	Cigna	1-866-494-2111	www.Cigna.com	00621196
Dental Insurance	Principal	1-800-247-4695	www.principal.com	1059290-1001
Vision Insurance	Principal	1-800-247-4695	www.principal.com	1059290-1001
Hospital Indemnity	Transamerica	1-888-763-7474	www.tebcs.com	G000032550
Disablility Insurance	Mrs. Lefkowits / HR	1-718-534-0204 rlef@kedem.com		
FMLA	Mrs. Lefkowits / HR	1-718-534-0204 rlef@kedem.com		
Life Insurance		1-877-854-5662	www.axa.us.com/ employeebenefits	000373 Royal Wine
401K Savings Plan	AXA	1-800-528-0204 Ross Ginsberg 1-212-541-1949 ross@theemergygroup.com	www.equitable.com	690251
Flex Spending Accounts	Flex Facts	1-877-943-2287 info@flexfacts.com	www.flexfacts.com	

Important Dates and Holidays

2023

Royal Wine will be closed the following days:

3/7 ..... Purim

4/6 - 4/7 ..... Passover

4/9 - 4/11 ..... Passover Chol Hamoed

4/12 - 4/13 ..... Passover (second days)

5/26 ..... Shavuos

7/4 ..... Independence Day

7/27 ..... Tish'a B'Av

9/17 ..... Rosh Hashana*

9/25 ..... Yom Kippur

10/1 ..... Sukkot*

10/2 - 10/5 ..... Sukkot Chol Hamoed*

10/8 ..... Sukkot (second days)*

12/25 ..... December 25th*

The company is open but recognizes it as a holiday for those celebrating the day.

* If Scheduled

JANUARY

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FEBRUARY

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MARCH

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APRIL

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MAY

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JUNE

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JULY

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30	31					

AUGUST

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	28	29	30	31		

SEPTEMBER

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OCTOBER

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NOVEMBER

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DECEMBER

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24	25	26	27	28	29	30
31						

Paycheck Date **Holiday*** **Chol Hamoed****

*Holiday Pay = Paid Holidays in accordance with the employee manual

*Intermediate Holiday days in accordance with employee manual

NOTES

NOTES

NOTES

ROYAL WINE CORP.

DETAILED PLAN DESCRIPTIONS

2023

ROYAL WINE CORP.

63 LeFante Way · Bayonne, NJ 07002
718.384.2400 · RoyalWine.com

DETAILED PLAN DESCRIPTIONS

CONTENTS

Buy Up

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Cigna Health and Life Insurance Co.: Open Access Plus

Coverage Period: 01/01/2022 - 12/31/2022
Coverage for: Individual/Individual + Family | **Plan Type:** OAP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $1,000/individual or $2,000/family For out-of-network providers: $2,000/individual or $4,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, diagnostic test, prescription drugs, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $5,000/individual or $10,000/family For out-of-network providers: $10,000/individual or $20,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-866-494-2111 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit Deductible does not apply	40% coinsurance	None
	Specialist visit	$40 copay/visit Deductible does not apply	40% coinsurance	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **Deductible does not apply	40% coinsurance/visit 40% coinsurance/other services 40% coinsurance/ immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance/x-ray No charge/blood work** No charge/independent lab** **Deductible does not apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance at an outpatient facility 20% coinsurance in the office	40% coinsurance at an outpatient facility 40% coinsurance in the office	The lesser of 50% or $750 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$15 copay/prescription (retail 30 days), $45 copay/prescription (retail & home delivery 90 days) Deductible does not apply	50% coinsurance/prescription (retail and home delivery) Deductible does not apply	Coverage is limited up to a 90-day supply (retail and home delivery). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$35 copay/prescription (retail 30 days), $105 copay/prescription (retail & home delivery 90 days) Deductible does not apply	50% coinsurance/prescription (retail and home delivery) Deductible does not apply	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $225 copay/prescription (retail & home delivery 90 days) Deductible does not apply	50% coinsurance/prescription (retail and home delivery) Deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	The lesser of 50% or $750 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	The lesser of 50% or $750 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	$100 copay/visit Deductible does not apply	$100 copay/visit Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$40 copay/visit Deductible does not apply	$40 copay/visit Deductible does not apply	Per visit copay is waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	The lesser of 50% or $750 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	The lesser of 50% or $750 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/office visit** 20% coinsurance/all other services **Deductible does not apply	40% coinsurance/office visit 40% coinsurance/all other services	The lesser of 50% or $750 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).
	Inpatient services	20% coinsurance	40% coinsurance	The lesser of 50% or $750 penalty for no out-of-network precertification.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	The lesser of 50% or $750 penalty for no out-of-network precertification. Coverage is limited to 60 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$40 copay/visit for Physical, Speech, Hearing & Occupational therapy** $40 copay/visit for Chiropractic care** **Deductible does not apply	40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 40% coinsurance/visit for Chiropractic care	The lesser of 50% or $750 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to an annual max of 60 visits for Physical therapy, Speech, Hearing & Occupational therapy and 25 visits annual max for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$40 copay/visit for Physical, Speech, Hearing & Occupational therapy** **Deductible does not apply	40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy	The lesser of 50% or $750 penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	20% coinsurance	40% coinsurance	The lesser of 50% or $750 penalty for no out-of-network precertification. Coverage is limited to 30 days annual max.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	40% coinsurance	The lesser of 50% or $750 penalty for no out-of-network precertification.
	Hospice services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	40% coinsurance/inpatient services 40% coinsurance/outpatient services	The lesser of 50% or $750 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (25 visits)
- Hearing aids (2 (one per ear) devices per 24 months, through age 15)
- Infertility treatment

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New Jersey Department of Banking and Insurance at 1-800-446-SHOP and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or New Jersey Department of Banking and Insurance at 1-800-446-SHOP. Additionally, a consumer assistance program can help you file your appeal. Contact: New Jersey Department of Banking and Insurance at (800) 446-7467.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$40
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,160**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$980
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,280**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAP Mid **Ben Ver:** 22 **Plan ID:** 15038666 HP-POL/HP-APP 9/23/12

Value

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Cigna Health and Life Insurance Co.: Open Access Plus Net Only

Coverage Period: 01/01/2022 - 12/31/2022
Coverage for: Individual/Individual + Family | **Plan Type:** OAP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $1,500/individual or $3,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, diagnostic test, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes.$100/individual or $200/family for in-network prescription drugs There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers: $6,350/individual or $12,700/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-866-494-2111 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit Deductible does not apply	Not covered	None
	Specialist visit	$40 copay/visit Deductible does not apply	Not covered	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance/x-ray No charge/blood work** No charge/independent lab** **Deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance at an outpatient facility 30% coinsurance in the office	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$15 copay/prescription (retail 30 days), $45 copay/prescription (retail & home delivery 90 days)	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$35 copay/prescription (retail 30 days), $105 copay/prescription (retail & home delivery 90 days)	Not covered	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $225 copay/prescription (retail & home delivery 90 days)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$100 copay/visit Deductible does not apply	$100 copay/visit Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$40 copay/visit Deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/office visit** 30% coinsurance/all other services **Deductible does not apply	Not covered	None
	Inpatient services	30% coinsurance	Not covered	None
If you are pregnant	Office visits	30% coinsurance	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Coverage is limited to 60 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$40 copay/visit for Physical, Speech, Hearing & Occupational therapy** $40 copay/visit for Chiropractic care** **Deductible does not apply	Not covered	Coverage is limited to an annual max of 60 visits for Physical therapy, Speech, Hearing & Occupational therapy and 25 visits annual max for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$40 copay/visit for Physical, Speech, Hearing & Occupational therapy** **Deductible does not apply	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	30% coinsurance	Not covered	Coverage is limited to 30 days annual max.
	Durable medical equipment	30% coinsurance	Not covered	None
	Hospice services	30% coinsurance/inpatient services 30% coinsurance/outpatient services	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult) • Dental care (Children)	• Long-term care • Non-emergency care when traveling outside of the U.S. • Private-duty nursing • Routine eye care (Adult)	• Routine eye care (Children) • Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care (25 visits)	• Hearing aids (2 (one per ear) devices per 24 months, through age 15)	• Infertility treatment

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New Jersey Department of Banking and Insurance at 1-800-446-SHOP and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or New Jersey Department of Banking and Insurance at 1-800-446-SHOP. Additionally, a consumer assistance program can help you file your appeal. Contact: New Jersey Department of Banking and Insurance at (800) 446-7467.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,510
Copayments	$20
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$4,550**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$990
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,290**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAPIN Low **Ben Ver:** 22 **Plan ID:** 15038569 HP-POL/HP-APP 9/23/12

Basic

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Cigna Health and Life Insurance Co.: OAP Net Only

Coverage Period: 01/01/2022 - 12/31/2022
Coverage for: Individual/Individual + Family | **Plan Type:** OAP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $2,500/individual - employee only or $5,000/family maximum (no more than $2,800 per individual - within a family) Combined medical/behavioral and pharmacy deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $6,450/individual - employee only or $12,900/family maximum (no more than $6,450 per individual - within a family) Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-866-494-2111 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance/visit	Not covered	None
	Specialist visit	30% coinsurance/visit	Not covered	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge at an outpatient facility 30% coinsurance in the office	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$25 copay/prescription (retail 30 days), $50 copay/prescription (retail & home delivery 90 days)	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$50 copay/prescription (retail 30 days), $100 copay/prescription (retail & home delivery 90 days)	Not covered	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $150 copay/prescription (retail & home delivery 90 days)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance/office visit 30% coinsurance/all other services	Not covered	None
	Inpatient services	30% coinsurance	Not covered	None
If you are pregnant	Office visits	30% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Coverage is limited to 60 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	30% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 30% coinsurance/visit for Chiropractic care	Not covered	Coverage is limited to an annual max of 60 visits for Physical therapy, Speech, Hearing & Occupational therapy and 25 visits annual max for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	30% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	30% coinsurance	Not covered	Coverage is limited to 30 days annual max.
	Durable medical equipment	30% coinsurance	Not covered	None
	Hospice services	30% coinsurance/inpatient services 30% coinsurance/outpatient services	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New Jersey Department of Banking and Insurance at 1-800-446-SHOP and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or New Jersey Department of Banking and Insurance at 1-800-446-SHOP. Additionally, a consumer assistance program can help you file your appeal. Contact: New Jersey Department of Banking and Insurance at (800) 446-7467.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$5,530**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,590**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HDHPQ OAPIN HDHPQ **Ben Ver:** 22 **Plan ID:** 15038733 HP-POL/HP-APP 9/23/12

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

896375a 05/17

Medicare Part D Creditable Coverage Notice

Important Notice from
Royal Wine Corp.
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 Royal Wine Corp. 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 three 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. Creditable Plans
Royal Wine Corp. has determined that the prescription drug coverage offered by the following CIGNA Plans(s) are, 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.

Creditable CIGNA PPO / EPO

3. Non-Creditable Plans
Royal Wine Corp. has determined that the prescription drug coverage offered by the CIGNA Plans(s) is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the CIGNA Plans(s). This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

Non-Creditable CIGNA HSA

3B. You can keep your current coverage from CIGNA Plans(s). However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

Creditable Coverage - 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.

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 Royal Wine Corp. coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Royal Wine Corp. coverage, be aware that you and your dependents will 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 Royal Wine Corp. 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.

Non-Creditable Coverage - When Can You 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.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

if you decide to drop your current coverage with Royal Wine Corp., since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under CIGNA Plans(s)

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under CIGNA Plans(s) is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join,

If you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (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 Royal Wine Corp. 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 and 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).

09/25/19
Royal Wine Corp.
Human Resources
63 North Hook Road, Bayonne, NJ 07002
845-236-4370

CHIPRA/CHIP Notice

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 July 31, 2019. Contact your State for more information on eligibility

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp x	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshe alth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HI PP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.ht m Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.p df Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, 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.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Royal Wine Corp. Employee Benefits Plans

Notice of Privacy Practices

Date: September 28, 2015

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health plan.

This Notice of Privacy Practices ("Notice") covers the following group health plans (collectively referred to as the "Plan"):

- Medical
- Dental
- Vision
- MEC

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

Section 1. USES AND DISCLOSURES OF YOUR PHI

Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions. However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit management services. However, Business Associates will receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of the Royal Wine Corp.. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral

Authorization

Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2. RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. *You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.*

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. *You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.*

"Designated Record Set" includes the medical records and billing records about an individual maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30-day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very

limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. *If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.*

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. *You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in accordance with your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.*

The Right to Receive a Paper Copy of This Notice Upon Request. *You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.*

To exercise any of your HIPAA rights described above, you or your personal representative must contact the HIPAA Privacy Officer in writing at Human Resources at 63 North Hook Road, Bayonne, NJ 07002. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

Section 3. THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to **all** individuals covered under the Plan within 60 days of the effective date of such change **by first-class U.S. mail** or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI

Minimum Necessary Standard. When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure. However, the minimum necessary standard will not apply in the following situations:

- Disclosure to or requests by a health care provider for treatment;
- Uses or disclosures made to you; and
- Uses or disclosures that are required by law.

Section 4. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the HIPAA Privacy Officer in writing at Human Resources at 63 North Hook Road, Bayonne, NJ 07002

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

Section 5. ADDITIONAL INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the HIPAA Privacy Officer in writing at Human Resources at 63 North Hook Road, Bayonne, NJ 07002

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 provisions as any other benefits provided under the plan in which you are enrolled. If you would like more information on WHCRA benefits, contact Human Resources at 845-236-4370.

Model COBRA Continuation Coverage General Notice

Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice, to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do *not* need to include this instruction page with the model general notice.

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 four 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, 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 1210-0123.

OMB Control Number 1210-0123 (expires 12/31/2019)

General Notice of COBRA Continuation Coverage Rights

**** 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."

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 Human Resources **at 63 North Hook Road, Bayonne, NJ 07002**

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, Medicaid, 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**.

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

Administrator
Royal Wine Corp.
63 North Hook Road, Bayonne, NJ 07002
845-236-4370

Notice of Patient Protection

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

Royal Wine Corp. Medical 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. 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan Administrator at 845-236-4370

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from CIGNA Plans(s) 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 plan administrator at www.CIGNA.com

Notice of 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 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).

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) 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' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact
Royal Wine Corp., Human Resource Dept. at 63 North Hook Road, Bayonne, NJ 07002.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

MATERNITY BENEFITS

Under Federal and state law you have certain rights and protections regarding your Maternity benefits under the Plan.

Under federal law known as the **"Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act** Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under State law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and Copayments that are no less favorable than for physical Illness generally.

FLEXFACTS
a company of grant benefit solutions

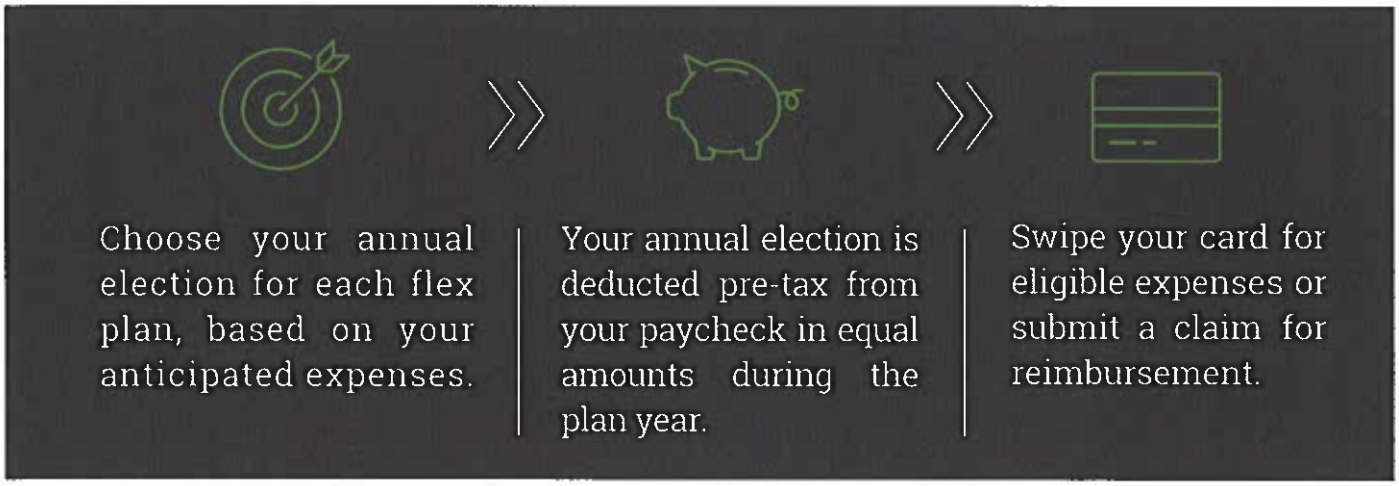
Plan Year: 1/1/2023-12/31/2023

Flexible Spending Account

Plan Enrollment Materials

No matter which health insurance plan you enroll in this year, you will likely have out-of-pocket costs. Save up to 30% on qualifying out-of-pocket expenses by setting aside pre-tax dollars from your paycheck with a flex account!

How does it work? It's simple.



This lowers your taxable income!

Questions? Contact us at info@flexfacts.com or 877-943-2287

FLEXFACTS
a company of grant benefit solutions

Medical FSA

Save up to $915 on medical expenses this year!

Participating in an FSA is like receiving a 30% discount from your medical providers.

How does an FSA work?

A medical FSA is a flexible spending account that allows you to set aside pre-tax dollars for eligible medical, dental, and vision expenses for you and your dependents.

Choose an annual election amount, up to **$3,050***. This amount will be deducted from your paychecks in equal installments throughout the year. Your full election will be available for spending on the first day of the plan year!

Why should I enroll in an FSA?

Almost everyone has some level of out of pocket medical costs. If you expect to incur medical expenses, you'll want to take advantage of the savings this plan offers.

Money contributed to a healthcare FSA is free from federal and most state taxes. On average, participants enjoy a 30% tax savings on their annual contribution, saving up to **$915** per year!

Helpful hints...

- Your election can only be changed during the plan year if you experience a qualifying event.
- Save your receipts. You may need itemized invoices to verify card swipes or for claim reimbursements.
- If your employment terminates, your account will be terminated.
- You will have an additional 2.5 month grace period to spend your FSA funds after the plan ends. Be sure to spend your funds by then, as unspent funds will be forfeited.
- Reminder: You can't contribute to an FSA and HSA within the same plan year.

Spending your FSA funds

Swipe your Flex Facts debit card to pay for eligible expenses or pay with your personal funds and submit a claim for reimbursement.

Common eligible expenses

- Copays, deductible, coinsurance
- Doctor office visits, lab work, x-rays
- Hospital charges
- Dental and orthodontia
- Vision exams, glasses, contact lenses, laser vision correction
- Physical therapy
- Chiropractic care
- Medical supplies and first aid kits
- Rx and over-the-counter meds
- And much more...

Visit http://fsastore.com/FlexfactsEL for full list.

Download our app

Search 'Flex Facts' on the App Store or Google Play.

*based on **2023** IRS Contribution Limit.
Please note: Your employer may limit the maximum annual limit to a lesser amount.

Questions? Contact us at info@flexfacts.com or 877-943-2287

FLEXFACTS
a company of grant benefit solutions

Dependent Care FSA

Save up to $1,500 on dependent care expenses this year!

Participating in a dependent care FSA is like receiving a 30% discount from your care providers.

How does a DCA work?

A dependent care FSA (DCA) is a flexible spending account that allows you to set aside pre-tax dollars for dependent care expenses that allow you to work or look for work. This includes daycares, babysitters and before/after school care.

Choose an annual election amount, up to $5,000/family. This amount will be deducted from your paychecks in equal installments throughout the year.

Why should I enroll in an DCA?

Child and dependent care is a large expense for many families. If you pay for care of dependents in order to work, you'll want to take advantage of the savings this plan offers.

Money contributed to a dependent care FSA (DCA) is free from federal and most state taxes. On average, participants enjoy a 30% tax savings on their annual contribution, saving up to $1,500 per year!

Helpful hints...

- Funds will be made available in your DCA account, as deductions are taken each payroll.
- Your election can only be changed during the plan year if you experience a qualifying event.
- Save your receipts. You may need itemized invoices to verify card swipes or for claim reimbursements.
- If your employment terminates, your account will be terminated.
- You will have an additional 2.5 month grace period to spend your DCA funds after the plan ends. Be sure to spend your funds by then, as unspent funds will be forfeited.

Spending your funds

Swipe your Flex Facts debit card to pay for eligible expenses or pay with your personal funds and submit a claim for reimbursement.

Qualifying Dependents*

- Your qualifying child under age 13
- Your spouse or qualifying adult child or relative who is physically or mentally incapable of self-care

Eligible Expenses

- Before school or after school care for children 12 and younger
- Custodial care for adult dependents
- Licensed day care centers
- Nanny / Au Pair
- Nursery Schools or preschools
- Late Pick-up fees
- Summer or Holiday day camps

A full list of eligible expenses can be found at www.flexfacts.com.

Download our app

Search 'Flex Facts' on the App Store or Google Play.

*additional restrictions may apply. See Internal Revenue Code Section 152.

Questions? Contact us at info@flexfacts.com or 877-943-2287

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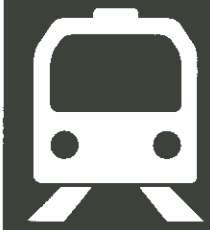
Transit Account



Save up to $1,080 on commuting expenses this year!

Participating in a transit account is like receiving a 30% discount on mass transit expenses.

How does a transit account work?

A transit account allows you to set aside pre-tax dollars for mass transit expenses associated with your daily commute to work. Choose a monthly election amount, up to **$300/month**.

Why should I enroll in a transit account?

If you take public transportation to work, you'll want to take advantage of the savings these plans offer.

Money contributed to a transit account is free from federal and most state taxes. On average, participants enjoy a 30% tax savings on their annual contribution, saving up to **$1,080** per year!

Helpful hints...

- Funds will be made available in your transit account, as deductions are taken each payroll.
- You can change or cancel your election amount at any time.
- Save your receipts. You may need itemized invoices to verify card swipes.
- If your employment terminates, your account will be terminated.
- Any unused funds that remain in your account at the end of the year will be carried over into the next plan year.

Spending your funds

Swipe your Flex Facts debit card to pay for commuting expenses such as the bus, ferry, or metro, as well as ride sharing apps.

Eligible Expenses

- Bus, ferry, train, subway tickets and passes
- Ride sharing apps, such as UberPool, Lyft Line and Via

Ineligible Expenses

- Tolls
- Taxis
- Gas/ fuel
- Mileage
- Non-shared Uber or Lyft rides

Download our app

Search 'Flex Facts' on the App Store or Google Play.

Policyholder: Royal Wine Corp

Group dental insurance benefit summary

Effective date: 01/01/2022

What's available to me?

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Option 1 (members elect low plan): Combined annual benefit maximum

This is the total amount your insurance will cover annually for all services combined.

Combined annual benefit maximum - all	
In-network	Out-of-network
$1,500	$1,500

Option 1: Preventive

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$0	$0	100%	100%

- Routine exams - once per six months
- Routine cleanings - once per six months
- Bitewing X-rays - once per calendar year
- Fluoride -- once per calendar year (covered only for dependent children under age 19)

Option 1: Basic

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$50	$50	100%	80%

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- Full mouth X-rays – once every 60 months
- Sealants – covered only for dependent children under age 19 once per tooth each 36 months
- Emergency exams – subject to Routine exam frequency limit
- Periodontal maintenance - If three months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit
- Fillings - covered once every 24 months
- Simple oral surgery (simple extractions)
- Complex oral surgical procedures (impacted teeth)
- General anesthesia / IV sedation (covered only for specific procedures)
- Simple endodontics (root canal therapy for anterior teeth)
- Complex endodontics (root canal therapy for molar teeth)
- Non-surgical periodontics, including scaling and root planing - once per quadrant per 24 months
- Periodontal surgical procedures - once per quadrant per 36 months

Option 1: Major

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$50	$50	60%	50%

- Crowns – each 120 months per tooth
- Core buildup - each 120 months per tooth
- Bridges (initial placement / replacement) - 120 months old
- Dentures (initial placement / replacement) - 60 months old

Option 1: Orthodontia

Calendar year deductible		Coinsurance your policy pays		Lifetime maximum	
In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
$0	$0	50%	50%	$1,500	$1,500

- Child and adult coverage

Option 1: Additional benefits

- Family deductible - 3 times the per person deductible amount
- Combined deductible - Your deductibles that are in-network for basic and major services are combined. Your deductibles that are out-of-network for basic and major services are combined.
- Prevailing charge - When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
- Emergency services - If you have a dental emergency and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider.

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- Periodontal program - If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
- Second opinion program - You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
- Cancer treatment oral health program - If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.

Option 2 (members elect high plan): Combined annual benefit maximum

This is the total amount your insurance will cover annually for all services combined.

Combined annual benefit maximum - all	
In-network	Out-of-network
$2,000	$2,000

Option 2: Preventive

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$0	$0	100%	100%

- Routine exams - once per six months
- Routine cleanings - once per six months
- Bitewing X-rays - once per calendar year
- Fluoride – once per calendar year (covered only for dependent children under age 19)

Option 2: Basic

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$50	$50	100%	80%

- Full mouth X-rays – once every 60 months
- Sealants – covered only for dependent children under age 19 once per tooth each 36 months
- Emergency exams – subject to Routine exam frequency limit
- Periodontal maintenance - if three months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit
- Fillings - covered once every 24 months
- Simple oral surgery (simple extractions)
- Complex oral surgical procedures (impacted teeth)
- General anesthesia / IV sedation (covered only for specific procedures)
- Simple endodontics (root canal therapy for anterior teeth)
- Complex endodontics (root canal therapy for molar teeth)
- Non-surgical periodontics, including scaling and root planing - once per quadrant per 24 months
- Periodontal surgical procedures - once per quadrant per 36 months

Option 2: Major

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$50	$50	60%	50%

- Crowns – each 120 months per tooth
- Core buildup - each 120 months
- Bridges (initial placement / replacement) - 120 months old
- Dentures (initial placement / replacement) - 60 months old

Option 2: Orthodontia

Calendar year deductible		Coinsurance your policy pays		Lifetime maximum	
In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
$0	$0	50%	50%	$2,000	$2,000

- Child and adult coverage

Option 2: Additional benefits

- Family deductible - 3 times the per person deductible amount
- Combined deductible - Your deductibles that are in-network for basic and major services are combined. Your deductibles that are out-of-network for basic and major services are combined.
- Prevailing charge - When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
- Emergency services - If you have a dental emergency and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider.

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- Periodontal program - If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
- Second opinion program - You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
- Cancer treatment oral health program - If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.

There are additional limitations to your coverage. A complete list is included in your booklet.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees aren't eligible.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-832-4450, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

- Missing tooth –The initial placement of bridges, partials, and dentures to replace teeth missing before this coverage starts won't be covered. If this policy replaces coverage with another carrier, continuous coverage under the prior plan may be applied to the missing tooth provision requirement. This doesn't apply to pediatric essential benefits.
- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information.

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What are the restrictions of my coverage?

Orthodontia	If there is orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group coverage for ortho, there will be immediate coverage for treatment if proof is submitted that shows: 1) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and 2) Ortho treatment has been continued while insured under this policy. You will not be covered if ortho treatment is in progress prior to the effective date with Principal Life and you are not covered under any prior group coverage for ortho.

There are additional limitations to your coverage. A complete list is included in your booklet.

principal.com

This is a summary of dental coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Dental insurance

Principal®

Save money with network dentists

You'll enjoy lower out-of-pocket costs and pay less for dental services when you visit a dentist in our large network.

When it comes to visiting a dentist, you want quality dentists to choose from and value for your money. That's where we can help. With dental coverage from Principal®, you have access to a preferred provider organization (PPO). These network dentists include general dentists and those who specialize in root canals, pulling teeth and more.

When you receive services from a dentist in our network, your cost may be lower. Why? Network dentists agree to lower their fees for dental services and not charge you the difference. But, if you use a non-network dentist, you're responsible for paying any fees above the amount most dentists charge for a dental service in the area.* This means you may pay more for the same procedure if you visit a non-network dentist.

Let's look at an example

Phil has an infected tooth that requires a root canal. His out-of-pocket expenses will be lower if he visits a network (PPO) dentist.

Comparing out-of-pocket costs on a root canal

Phil visits a **network** dentist		Phil visits a **non-network** dentist	
Dentist charge	$1,400	Dentist charge	$1,400
Negotiated fee	$980	Fee most dentists charge in area	$1,370
Coinsurance 20% ($980 x .20)	$196	Coinsurance 20% ($1,370 x .20)	$274
Difference of dentist charge and negotiated fee. Phil **isn't responsible** for the difference because it's in-network.	$420	Difference of dentist charge and fee most dentists charge in the area. Phil **is responsible** for the difference because it's non-network.	$30
Coverage pays	$784	Coverage pays	$1,096
Phil pays	**$196**	**Phil pays ($274 + 30)**	**$304**

Example is for illustrative purposes only.

*The difference may also be determined by the amount agreed to by network dentists.

Find a network dentist

Go to principal.com/dentist. You can find a network dentist, listed by specialty. And if your favorite dentist isn't in the network, click the link to refer your provider.

principal.com

Dental insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This is an overview of the benefits dental insurance provides, but there are limitations and exclusions. For additional details, contact your employer. If your dental benefits are self-funded, then your employer assumes financial responsibility for paying claims, and Principal® is contracted to administer the coverage on your employer's behalf.

Principal

Simplify your dental care experience

Let's face it, for many of us, visiting the dentist isn't always our favorite activity. That's why the insurance side of the experience should be simple – and we get that.

This handy step-by-step guide can help you better understand your dental insurance journey.

Path 1: You need a routine visit

They say an ounce of prevention is worth a pound of cure. Seeing your dentist regularly for routine care helps you avoid problems down the line. So, how do you make it happen?

Find a network dentist.

Your out-of-pocket costs will be lower and you may even qualify for in-network discounts. How?

Check your ID card for your network **and** Go online to **principal.com/dentist** **or** Give us a call: **800-247-4695**

Confirm network participation.

When you schedule your appointment, confirm the provider is still in the network.

Make sure you're eligible.

Depending on your policy, it may be too soon to schedule an appointment.

Example 1
One check-up every 6 months

Jan – Dec

April 3 1st check-up
Oct. 3 Next eligible

Example 2
Check-ups twice a year

Jan – Dec

April 3 1st check-up
Eligible for one more check-up anytime until the **next Jan. 1**

Principal®

Policyholder: ROYAL WINE CORP

Vision Care Coverage

Effective Date: 01/01/2021

This chart provides you a brief summary of the key benefits of the vision coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your vision coverage benefits and restrictions, please refer to your booklet or contact your employer.

Your Coverage with a VSP Preferred Provider		
Doctor Network	VSP Choice Network	
Covered Charges	**Benefit**	**Frequency**
Exams	$10 copay	One exam every 12 months
Prescription Glasses	$ 25 copay	
Lenses	Single vision, lined bifocal, lined trifocal and lenticular lenses; polycarbonate lenses for dependent children under age 18	Two lenses (one pair) every 12 months
Frames	$130 allowance for a wide selection of frames; 20% off amount over allowance***	One set every 12 months
Elective Contacts	Up to $60 copay for your elective contact lens exam (fitting and evaluation) $130 allowance for elective contacts	Once every 12 months Contacts are instead of frames and lenses
Necessary Contacts**	$ 25 copay Covered in full for members who have specific conditions	Once every 12 months Contacts are instead of frames and lenses
Additional Savings ***		
Glasses and Sunglasses	Lens enhancements are covered after a copay, saving members an average of 20-25% off additional glasses and sunglasses, including lens options from any VSP doctor within 12 months of your last covered vision exam	
Contacts	15% off cost of contact lens exam (fitting and evaluation)	
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	
Your Coverage with Other Providers (Non-Network)		
Covered Charges	**Scheduled Benefit Amount**	**Frequency**
Vision Exams	Up to $45	One per 12 month period
Single Vision lenses	Up to $30	One pair per 12 month period
Lined bifocal lenses	Up to $50	One pair per 12 month period
Lined trifocal lenses	Up to $65	One pair per 12 month period
Lenticular lenses	Up to $100	One pair per 12 month period
Frames	Up to $70	One set per 12 months period
Elective Contacts	Up to $105	In lieu of lens and frame benefits
Necessary Contacts**	Up to $210	In lieu of lens and frame benefits

**Necessary contact lenses are prescribed to correct extreme visual problems that cannot be corrected with regular lenses.

*** Based on applicable laws, benefits may vary by doctor location.

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Am I Eligible For Coverage?
To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.
You may be able to elect coverage for eligible dependents. See your employer for details on the definition of eligible dependent.

How Do I Find A VSP Provider?
Use the Provider Directory on www.vsp.com to locate nearby VSP providers or to see if your current eye care professional participates in the VSP network. To speak to a representative by phone, please call 800-877-7195.

If treatment or service for a listed covered charge is not available through a Preferred Provider due to an emergency and you or one of your Dependents receive such treatment or service from a Non-Preferred Provider, that provider will be reimbursed at the same rate as would have been applied had you or one of your Dependents been treated by a Preferred Provider.

How Do I Submit A Claim?
When visiting a VSP provider for services, the provider submits the claim for payment. If visiting a non-network provider for services, you are responsible for submitting the claim to VSP. Obtain a claim form by logging on to vsp.com or by calling 800-877-7195. Include a copy of your itemized receipt with your claim form and mail it to the following address:

Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

What Are The Restrictions Of My Coverage?
This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Late Entrant Waiting Period	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to coverage guidelines .
Non-Medically Necessary Services	The coverage does not pay for visual analysis or vision aids that are not medically necessary.
Benefit Limitations	The following items are excluded under this coverage: • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training or supplemental testing • Plano lenses (lenses with refractive correction of less than ± .50 diopter)
Contact Lens Limitations	The following items are not covered under the contact lens coverage: • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning • Refitting of contact lenses after the initial (90 day) fitting period
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of vision coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of the rights, benefits, limitations or exclusions of the coverage. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

Vision insurance

Set your sights on healthy eyes

Vision coverage that gives you choice of provider options for exams and eyewear

Everyone likes choices – especially when it comes to choosing your eye doctor and eyewear. Managed care vision insurance through Principal® and vision expert VSP® Vision Care puts you in the driver's seat.

Whether you're looking to visit an eye doctor or want to enjoy the convenience of online shopping, we've got you covered. Through an established network of providers, you'll get access to the highest level of care and low out-of-pocket costs.[1]

VSP Full-service locations with satisfaction guaranteed, offering a WellVision Exam® that can detect signs of eye and overall health conditions, such as diabetes. Plus, a wide selection of eyewear and 24-hour access to emergency care.	• Early morning, evening and weekend appointments offered by 91% of providers • Special savings on preferred frame brands, contact lens services and sunglasses • Integrated medical management with VSP's Eye Health Management Program® • Extra $20 to spend on featured frame brands, like bebe®, ck Calvin Klein®, Flexon®, Lacoste®, Nike®, Nine West® and more • 20% off any amount over the allowance for frames
Online shopping With Eyeconic®, you get the convenience of shopping online plus the personal touch from a VSP® network doctor. Visit **eyeconic.com**.	• Free shipping and returns • Virtual try on tool • Free frame adjustment or contact lens consultation • All-inclusive pricing • Average savings of $220
Retail chains 5,100+ retail parter chain locations, plus 3,400+ independent chain locations nationwide.	• Same benefits you'd receive if you visited a VSP doctor[2] • No required forms – you pay only copays, costs over coverage amounts and/or for non-covered options • Providers report Eye Health Management Program data to VSP • Retail partners include Walmart®, Sam's Club®, Costco® Optical, Visionworks®, Wisconsin Vision, Heartland Vision, RxOptical®, Cohen's Fashion Optical® and Pearle Vision.
Out-of-network Coverage includes a reimbursement schedule for any out-of-network provider.	• Visit **VSP.com** or call **800-877-7195** to submit claims.

How to access your vision benefits

It's as easy as 1-2-3 to look up your benefits, locate providers near you and use your benefits.

1 Access your benefits

- Visit **VSP.com** and click on "Create an account."
- Follow the online Member Registration form using your member ID found on your vision ID card.

2 Search for providers

- Visit **VSP.com** or **principal.com/vsp**.
- Enter your ZIP code or address and click Search.

3 Use your benefits

- Schedule your appointment with your provider of choice.
- At your appointment, present your vision ID card and remind the provider to look up your benefits using the member ID on your card (not your Social Security number).

Prefer to access your vision ID card on your mobile device? It's simple.

1. Set up your username and password at **principal.com**.
2. Download Principal® Mobile from the App Store® or Google Play™.
3. Log in to the app using your principal.com username and password.

Let's connect

Contact your employer or call the VSP member support line at **800-877-7195**.

[1] Based on your coverage options and national averages for comprehensive eye exams and most commonly purchased brands.

[2] Frame allowances can vary at participating retailers.

Principal®

VSP Vision care for life

principal.com

Managed care vision insurance is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392, and is administered by VSP. VSP is not a member of the Principal Financial Group.

This is an overview of the benefits vision insurance provides, but there are limitations and exclusions. For additional details, contact your employer.

VSP and WellVision Exam are registered trademarks of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other company names and brands are trademarks or registered trademarks of their respective owners.

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TRANSAMERICA®

Underwritten by Transamerica Life Insurance Company
Customer Service: 1-888-763-7474 or www.tebcs.com

When Talia comes down with a particularly nasty cough, what she thought was just a cold soon turns into pneumonia that puts her in the hospital. She and her family are relieved that she responds well to treatment and is discharged within a few days without lasting effects.

Her finances would not recover nearly so easily if she hadn't signed up for her employer's hospital indemnity insurance. With benefits that help complement her major medical insurance, her family is able to overcome financial repercussions after her body overcomes the infection.

Choose flexible benefits to manage health care expenses.

Hospital indemnity insurance pays an amount for each day the insured is hospitalized, up to specific maximum limits. Because the benefits are paid to the insured directly, Talia can use them to help pay for her out-of-pocket expenses, such as her $1,500 deductible and copays, as well as costs that would be hard to pay due to the work she missed, like her car payment, rent and childcare.

Hospital Select® II features:

- benefits for full-time, part-time, hourly, seasonal and temporary workers (as well as eligible family members)
- no coinsurance, co-pays, waiting periods or deductibles
- benefits paid in addition to other insurance the insured may have
- portability that allows employees to keep insurance after they retire or leave the job

Product Highlights

No lifetime maximum

No waiting period

Benefits paid directly to you

Payroll-deducted premiums

Family options available

Qualify easily with broad eligibility.

This policy is available for individuals, single-parent families, individuals with spouses or another adult dependent and families. There is no maximum issue age for employees and their adult dependents including common-law marriage partners, domestic partners or civil union partners. Children under the age of 26 can be insured.

THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE.
IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.

Up to date information regarding our compensation practices can be found in the Disclosures section of our website at: www.tebcs.com.

This is a brief summary of Hospital Select® II Limited Group Hospital Indemnity Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy Form Series CPGHI400 AND CCGHI400. Forms and form numbers may vary. Insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy and riders for complete details.

PRODUCT DETAILS

The following benefits are included in your plan option(s). Unless otherwise noted, all benefits and maximums are per covered person.

Daily In-Hospital Indemnity Benefit	Plan 1
Pays each day a covered person is confined to a hospital as the result of a covered accident or sickness.	Day 1 Benefit: $750 Day 2 Benefit: $100
Maximum	31 Days per Confinement

QT0000100897-01

PRODUCT DETAILS

Plan 1 Monthly Rates Hospital Select II				Ver 3.L3.00.0.00
Age	**Employee**	**Employee and Spouse**	**Employee and Child**	**Family**
All Ages	**$13.88**	**$29.44**	**$20.36**	**$33.30**

*The illustrated rates DO NOT contain a pre-existing condition limitation.

The above rates are quoted for this group with 70 eligible lives.
Should this plan design sell and the submitted group size is different, rates may be different.

**HSA Compatible - Based on its understanding of available guidance, Transamerica Life Insurance Company views the insurance benefits shown in this proposal as compatible with High-Deductible Health Plans and Health Savings Accounts. However, there is no guarantee that the relevant authorities will agree with Transamerica's understanding. Current guidance is not complete and is subject to change. Neither Transamerica nor its agents or representatives provide legal or tax advice. Accordingly, Transamerica encourages its customers to consult with and rely upon independent tax and legal advisors regarding their particular situations, the use of the products presented here with High-Deductible Health Plans and Health Savings Accounts, and the persons/dependents that may be covered under such plans and accounts.*

Issue State: New Jersey
Rate generation date: November 24, 2015

QT0000100897-01

LIMITATIONS AND EXCLUSIONS

Hospital Select II

Confinement for the same or related condition within 90 days of discharge will be treated as a continuation of the prior confinement. Successive confinements separated by more than 90 days will be treated as a new and separate confinement.

No benefits under this contract will be payable as the result of the following:

- suicide or attempted suicide, whether while sane or insane.
- intentionally self-inflicted injury.
- rest care or rehabilitative care and treatment.
- immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings.
- any pregnancy of a dependent child including confinement rendered to her child after birth.
- routine newborn care.
- a covered person's abortion, except for medically necessary abortions performed to save the mother's life.
- treatment of mental or emotional disorder.
- treatment of alcoholism or drug addiction.
- commission of or attempt to commit a felony or the covered person's engagement in an illegal occupation.
- being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.
- dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- sex change, reversal of tubal ligation or reversal of vasectomy.
- artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician's services, unless required by law.
- aviation, other than as a fare paying passenger on a regulary scheduled airline.
- any loss incurred on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.)
- an accident or sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits my be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made.
- involvement in any war or act of war, whether declared or undeclared; participation in a riot or insurrection.

Termination of Insurance

The insurance terminates on the earliest of:

- the insured's death.
- the premium due date when we fail to receive a premium, subject to the grace period.
- the date of written notice to cancel insurance.
- the date the policy terminates.
- the date the insured ceases to be eligible for insurance.

Dependent insurance ends on the earliest of:

- the date the insured's insurance terminates for any of the reasons above.
- the date the dependent no longer meets the definition of a dependent.
- the premium due date when we fail to receive a premium, subject to the grace period.
- the date of written notice to cancel insurance.
- the date the policy is modified so as to exclude dependent insurance.

The insurance company has the right to terminate the insurance of any insured who submits a fraudulent claim. Termination will not impact any claim which begins before the date of termination.

QT0000100897-01

Products Included

Life/AD&D

Long-Term Disability

Employee Benefits Proposal for:

Royal Wine Corporation

Presented by:

ROSS GINSBERG, CFP

AXA Advisors

Effective Date:	January 01, 2017
Prepared On:	November 18, 2016
Valid Until:	January 01, 2017

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Group Term Life - Option 1

Eligibility		
Class Description	Class 1: All Active Full Time Executives Class 2: All Other Full Time Employees	
Minimum Hours Requirement	30 Hours per Week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	$150,000	
Benefit Maximum	$150,000	
Guarantee Issue	$150,000	
Age Reduction	35% of the original life amount at age 65 60% of the original life amount at age 70 75% of the original life amount at age 80	
Minimum Benefit Amount	$10,000	
Round to the Next	$1,000	
Waiver of Premium	Total Disability Prior to Age 60 6 Month Elimination Period Terminates at age 70	
Accelerated Death Benefit	75% to $250,000	
Conversion Benefit	Included	
Takeover	Yes	
Premium Contribution		
Employer Contribution	100%	
Participation Requirement	100%	
Cost Summary	Volume	Monthly Rate per $1,000
	$23,400,000	$0.195
Monthly Premium	$4,563.00	
Eligible Employees	166	
Covered Employees	166	
Rate Guarantee	24 Months	

Group Accidental Death & Dismemberment - Option 1

Eligibility		
Class Description	Class 1: All Active Full Time Executives Class 2: All Other Full Time Employees	
Minimum Hours Requirement	30 Hours per Week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	$150,000	
Benefit Maximum	$150,000	
Definition of Loss	365 Days	
Dismemberment Benefit	100% Both Hands or Both Feet 100% Sight In Both Eyes 100% One Hand and One Foot 100% Hand or Foot and Sight in One Eye 50% One Hand or One Foot 50% Sight in One Eye	
Age Reduction	35% of the original life amount at age 65 60% of the original life amount at age 70 75% of the original life amount at age 80	
Minimum Benefit Amount	$10,000	
Round to the Next	$1,000	
Waiver of Premium	Not Included	
Common Carrier	100% of AD&D benefit up to $250,000	
Seat Belt	$10,000	
Airbag	$10,000	
Premium Contribution		
Employer Contribution	100%	
Participation Requirement	100%	
Cost Summary	Volume	Monthly Rate per $1,000
	$23,400,000	$0.019
Monthly Premium	$444.60	
Eligible Employees	166	
Covered Employees	166	
Rate Guarantee	24 Months	

Group Supplemental Life - Option 1

Eligibility		
Class Description	Class 1: All Active Full Time Executives Class 2: All Other Full Time Employees	
Minimum Hours Requirement	30 Hours per Week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	$10,000 to $500,000 in $10,000 increments, not to exceed 5 times employee's Basic Annual Earnings	
Benefit Maximum	$500,000	
Guarantee Issue	$150,000	
Age Reduction	35% of the original life amount at age 65 60% of the original life amount at age 70 75% of the original life amount at age 80	
Minimum Benefit Amount	$10,000	
Round to the Next	$1,000	
Waiver of Premium	Total Disability Prior to Age 60 6 Month Elimination Period Terminates at age 70	
Accelerated Death Benefit	75% to $250,000	
Portability	Included	
Conversion Benefit	Included	
Takeover	Yes	
Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 10 enrolled lives or 25% of eligible employees	
Cost Summary	Volume	Monthly Rate per $1,000
<25	TBD	$0.065
25-29		$0.060
30-34		$0.080
35-39		$0.090
40-44		$0.124
45-49		$0.196
50-54		$0.306
55-59		$0.481
60-64		$0.660
65-69		$1.270
70-74		$2.080
75-79		$4,178
80+		$9.290
Monthly Premium	TBD	
Eligible Employees	166	
Covered Employees	TBD	
Rate Guarantee	24 Months	

Group Supplemental Accidental Death & Dismemberment - Option 1

Eligibility		
Class Description	Class 1: All Active Full Time Executives Class 2: All Other Full Time Employees	
Minimum Hours Requirement	30 Hours per Week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	$10,000 to $500,000 in $10,000 increments, not to exceed 5 times employee's Basic Annual Earnings	
Benefit Maximum	$500,000	
Definition of Loss	365 Days	
Dismemberment Benefit	100% Both Hands or Both Feet 100% Sight in Both Eyes 100% One Hand and One Foot 100% Hand or Foot and Sight in One Eye 50% One Hand or One Foot 50% Sight in One Eye	
Age Reduction	35% of the original life amount at age 65 60% of the original life amount at age 70 75% of the original life amount at age 80	
Minimum Benefit Amount	$10,000	
Round to the Next	$1,000	
Waiver of Premium	Not Included	
Common Carrier	100% of AD&D benefit up to $250,000	
Seat Belt	$10,000	
Airbag	$10,000	
Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 10 enrolled lives or 25% of eligible employees	
Cost Summary	Volume	Monthly Rate per $1,000
	TBD	$0.019
Monthly Premium	TBD	
Eligible Employees	166	
Covered Employees	TBD	
Rate Guarantee	24 Months	

Group Supplemental Dependent Life - Option 1

Eligibility		
Class Description	Class 1: All Active Full Time Executives Class 2: All Other Full Time Employees	
Minimum Hours Requirement	30 Hours per Week	
Eligibility Waiting Period	TBD	
Definition (as defined in the policy)	Spouse and Child(ren) must be living in the United States and performing the normal activities of a person of like age/sex on the effective date of insurance. Child(ren) covered from 15 days to age 26; and is not hospital-confined.	
Benefit Plan and Features		
Plan Schedule	Spouse: $5,000 to $250,000 in $5,000 increments, not to exceed 50% of the employee's Voluntary life amount Child: $10,000 to $10,000	
Guarantee Issue	Spouse: $30,000	
Age Reduction	35% of the original life amount at age 65 60% of the original life amount at age 70 75% of the original life amount at age 80	
Minimum Benefit Amount	Spouse: $5,000 Child: $10,000	
Round to the Next	$1,000	
Waiver of Premium	Total Disability Prior to Age 60 6 Month Elimination Period Terminates at age 70	
Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 10 enrolled lives or 25% of eligible employees	
Cost Summary	Volume	Monthly Rate per $1,000
SPOUSE		
<25	TBD	$0.065
25-29		$0.060
30-34		$0.080
35-39		$0.090
40-44		$0.124
45-49		$0.196
50-54		$0.306
55-59		$0.481
60-64		$0.660
65-69		$1.270
70-74		$2.060
75-79		$4,178
80+		$9.290
CHILD(REN)		$0.090
Monthly Premium	TBD	
Eligible Employees with Dependents	TBD	
Enrolled Employees with Dependents	TBD	
Rate Guarantee	24 Months	

Group Supplemental Dependent Accidental Death & Dismemberment - Option 1

Eligibility		
Class Description	Class 1: All Active Full Time Executives Class 2: All Other Full Time Employees	
Minimum Hours Requirement	30 Hours per Week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Plan Schedule	Spouse: $5,000 to $250,000 in $5,000 increments, not to exceed 50% of the employee's Supplementary life amount Child: $10,000 to $10,000	
Benefit Maximum	Spouse: $250,000 Child: $10,000	
Definition of Loss	365 Days	
Dismemberment Benefit	100% Both Hands or Both Feet 100% Sight in Both Eyes 100% One Hand and One Foot 100% Hand or Foot and Sight in One Eye 50% One Hand or One Foot 50% Sight in One Eye	
Age Reduction	35% of the original life amount at age 65 60% of the original life amount at age 70 75% of the original life amount at age 80	
Minimum Benefit Amount	Spouse: $5,000 Child: $10,000	
Round to the Next	$1,000	
Waiver of Premium	Not Included	
Premium Contribution		
Employer Contribution	0%	
Participation Requirement	Greater of 10 enrolled lives or 25% of eligible employees	
Cost Summary	Volume	Monthly Rate per $1,000
SPOUSE	TBD	$0.014
CHILD(REN)	TBD	$0.066
Monthly Premium	TBD	
Eligible Employees with Dependents	TBD	
Enrolled Employees with Dependents	TBD	
Rate Guarantee	24 Months	

Group Long-Term Disability

Eligibility		
Class Description	Class 1: All Active Full Time Executives Class 2: All Other Full Time Employees	
Minimum Hours Requirement	30 Hours per Week	
Eligibility Waiting Period	TBD	
Benefit Plan and Features		
Benefit Percentage	60%	
Elimination Period	180 Days	
Maximum Monthly Benefit	Class 1: $15,000 Class 2: $10,000	
Minimum Monthly Benefit	Greater of $100 or 10% of Gross benefit	
Guaranteed Issue Benefit	Class 1: $15,000 Class 2: $10,000	
Own Occupation Period	24 Month Own Occ/ Any Occ After	
Earnings Test	Own 80%, Any 60%	
Social Security Integration	Direct Family	
Maximum Payment Duration	ADEA1 with SSNRA	
Definition of Disability	Residual	
Recurrent Disability	6 months	
Pre-Existing Condition Limitation	3/12	
Coverage Basis	24 Hour	
Mental Illness/Substance Abuse Limitation	24 Months Lifetime Benefit	
Special Conditions Limitation	Not Included	
Return to Work Incentive Benefit	12 Months	
Survivor Income Benefit	3 Month Gross Lump Sum	
Rehabilitation Program	Included	
Family Care Deduction Benefit	Included	
Workplace Modification Benefit	Included	
Waiver of Disability Premium	Included	
Activities of Daily Living Benefit	10%	
Takeover	Yes	
Premium Contribution		
Employer Contribution	100%	
Participation Requirement	100%	
Cost Summary	Monthly Covered Payroll (MCP)	Monthly Rate per $100 of MCP
	$928,177	$0.27
Monthly Premium	$2,506.07	
Eligible Employees	166	
Covered Employees	166	
Rate Guarantee	24 Months	

General Assumptions

- Final terms and rates are based on AXA's standard policy language unless otherwise specifically indicated in this proposal. It is recommended that existing coverage be kept in force until AXA has accepted any requested non-standard language and reviewed the final census. State filings or specially drafted contract language is not assumed in the quoted rates in this proposal.
- This proposal is intended to explain certain portions of the group plan being considered and does not constitute a contract. Any discrepancies between this proposal and the contract will be resolved by the wording in the contract.
- Quote assumes a situs state of NJ.
- The employer's assumed primary business is classified as an SIC Code of 5181.
- AXA reserves the right to re-evaluate and adjust the rates:
    - For any change of 10% or more to the amount of lives or coverage (volume) since the effective date.
    - If the sold plan design differs from the proposed/quoted plan design.
    - For changes in State or Federal Insurance regulations.
    - If a material misstatement of the information provided in the RFP, bid specifications, claim experience or plan of benefits is discovered post-sale, final rates will be calculated on the effective date of the plan based on the actual participants, volume and benefits elected.
- AXA reserves the right to change the plan to comply with any state mandated benefits, including charging additional premium for such changes, if applicable.
- Claims incurred prior to the effective date of the contract will be the liability of the prior carrier.
- If required product participation requirements are not met, AXA reserves the right to either re-price or to decline to accept the risk if the minimum participation threshold is not met. Evidence of Insurability may also be required.
- This proposal assumes an employer/employee relationship for all eligible classes of employees. 1099 employees are not eligible for coverage.
- Quote does not include temporary or seasonal employees.
- Quote assumes all eligible employees are U.S. citizens or U.S. residents working in U.S. locations who have met the full time eligibility requirements.
- Quote assumes employees must be Actively at Work on the effective date. The deferred effective date provision applies unless the employer's contract is currently inforce with AXA.
- Quote assumes that the proposed plans are subject to ERISA regulations.
- The agent certifies that he/she is appropriately licensed and appointed to solicit insurance business in accordance with applicable state law requirements.
- Basic Annual Earnings definition is the average monthly earnings received from the covered person's employer for the 12-month period ending just prior to the date of Death & Disability. It does not include commissions, bonuses, overtime pay or any extra earnings.
- A current billing statement or census will be required at time of sale to verify current enrollees and insurance amounts.
- Proposal is not subject to Collective Bargaining Agreements.

- There will be no initial or annual open enrollments unless previously approved.

Life Coverage

- An employee must be approved for Basic Life Insurance in order to be eligible for Supplemental Life Insurance.
- Insured benefit amounts from the previous carrier will be grandfathered up to the class benefit maximum illustrated in the benefit summary section. All future amounts are subject to the guarantee issue limit and actively at work provision.
- Evidence of Insurability is required for all late entrants or coverage amounts in excess of any specified Guarantee Issue amount.
- AD&D coverage is packaged with the Life.
- Basic Life and AD&D rates include standard commissions.
- Supplemental Life and AD&D rates include standard commissions.

Long-Term Disability Coverage

- LTD quote is only valid if sold with another AXA coverage.
- Quote assumes the employer participates in Workers' Compensation, Social Security and statutory disability where mandated for all eligible employees.
- Evidence of Insurability is required for all late entrants or coverage amounts in excess of any specified Guarantee Issue amount.
- A new pre-existing condition limitation period will apply on the date of any increase in coverage.
- The employer must be in business for at least 2 years and be in good financial standing. If otherwise, additional underwriting approval will be required prior to sale.
- Quote includes W-2 preparation unless the employer requests otherwise.
- Long-Term Disability rates include standard commissions.

AD&D Limitations and Exclusions (State variations may apply)

We will not pay any Accidental Death and Dismemberment Benefit for a loss:

1) caused or contributed to by disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity;
2) caused or contributed to by an infection not occurring as a direct result or consequence of the accidental bodily injury;
3) caused or contributed to by suicide, attempted suicide, or intentionally self-inflicted injury, while sane or insane;
4) caused or contributed to by travel in or descent from an aircraft, if the Insured Person acted in a capacity other than as a passenger;
5) caused or contributed to by travel in an aircraft or device used for testing or experimental purposes, used by or for any military authority, used for travel beyond the earth's atmosphere;
6) declared or undeclared war, or any act of war, or any conflict involving the armed forces of one or more countries;
7) caused or contributed to by active participation in a riot, insurrection, or terrorist activity;
8) while the Insured Person is incarcerated;
9) caused or contributed to by the Insured Person's participation in a felony or illegal activity ("felony" is defined by the law of the jurisdiction in which the activity takes place);
10) caused or contributed to by voluntary intake or use of any drug, unless prescribed or administered by a Physician and taken in accordance with the Physician's instructions, an over the counter drug taken in accordance with the manufacturer's instructions, or the voluntary inhalation of poison, gas, or fumes except as the direct result of an occupational accident;
11) caused or contributed to by intoxication as defined by the jurisdiction where the accident occurred;
12) caused or contributed to by riding or driving an air, land or water vehicle in a race, speed or endurance contest;
13) caused or contributed to by bungee jumping, rock climbing, mountain climbing, hang-gliding, skydiving, parachuting, ultralight, soaring, ballooning and parasailing).

Long-Term Disability Limitations and Exclusions (State variations may apply)

Exclusions: *What Disabilities are not covered?*

The Policy does not cover, and We will not pay a benefit for, any Disability:

1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war, whether declared or not;
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation; or
5) caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by Your Employer; and
2) was terminated before the Effective Date of The Policy;

no benefits will be payable for that Disability under The Policy.

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*
We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled You have been continuously covered under The Policy for 365 consecutive days.

Pre-existing Condition means:

1) any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse; for which You received Medical Care during the 180 consecutive days period that ends the day before:
    1) Your effective date of coverage; or
    2) the effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment

THE EMERGY GROUP

SUPPLEMENTAL INSURANCE RATES

Age	Employee & Spouse Bi-Weekly Rate/$1,000	Cost per Paycheck for Additional Coverage						
		$ 10,000	$ 20,000	$ 30,000	$ 50,000	$ 100,000	$ 250,000	$ 500,000
<25	$ 0.030	$ 0.30	$ 0.60	$ 0.90	$ 1.50	$ 3.00	$ 7.50	$ 15.00
25-29	$ 0.028	$ 0.28	$ 0.55	$ 0.83	$ 1.38	$ 2.77	$ 6.92	$ 13.85
30-34	$ 0.037	$ 0.37	$ 0.74	$ 1.11	$ 1.85	$ 3.69	$ 9.23	$ 18.46
35-39	$ 0.042	$ 0.42	$ 0.83	$ 1.25	$ 2.08	$ 4.15	$ 10.38	$ 20.77
40-44	$ 0.057	$ 0.57	$ 1.14	$ 1.72	$ 2.86	$ 5.72	$ 14.31	$ 28.62
45-49	$ 0.090	$ 0.90	$ 1.81	$ 2.71	$ 4.52	$ 9.05	$ 22.62	$ 45.23
50-54	$ 0.141	$ 1.41	$ 2.82	$ 4.24	$ 7.06	$ 14.12	$ 35.31	$ 70.62
55-59	$ 0.222	$ 2.22	$ 4.44	$ 6.66	$ 11.10	$ 22.20	$ 55.50	$ 111.00
60-64	$ 0.305	$ 3.05	$ 6.09	$ 9.14	$ 15.23	$ 30.46	$ 76.15	$ 152.31
65-69	$ 0.586	$ 5.86	$ 11.72	$ 17.58	$ 29.31	$ 58.62	$ 146.54	$ 293.08
70-74	$ 0.951	$ 9.51	$ 19.02	$ 28.52	$ 47.54	$ 95.08	$ 237.69	$ 475.38
75-79	$ 1.928	$ 19.28	$ 38.57	$ 57.85	$ 96.42	$ 192.83	$ 482.08	$ 964.15
80+	$ 4.288	$ 42.88	$ 85.75	$ 128.63	$ 214.38	$ 428.77	$ 1,071.92	$ 2,143.85

		$ 10,000
Child(ren)	$ 0.042	$ 0.42

Example

Employee Name: John Smith
Age: 46
Salary: $50,000
Immediate Benefit: $150,000 = what Royal Wine pays for
Voluntary Benefit: Since 5x Salary = $250,000, John is capped at $250,000 (see above). If he elects the full $250,000, the first $150,000 is issued no questions asked, the next $100,000 requires medical questions
This will cost John $22.62 per weekly paycheck. This can be calculated 2 ways:
1. **By finding the box that lines up with his age and desired amount**
2. **By using his age band of 45-49, taking the corresponding rate/$1,000 benefit of $.09 and multiplying it by 250**

Spouse Benefit: By electing supplemental coverage for himself of $250,000, his spouse is eligible for up to $125,000 of coverage. Rates are based on John's age, not spouse
This will cost John $11.31 per weekly paycheck. See grid above
Child Benefit: By electing supplemental coverage for himself, his child(ren) are eligible for $10,000 each. Assuming John has 1 child:
This will cost John $0.42 per weekly paycheck. See grid above

John's total cost for his additional $250,000, his spouses $125,000 and his child's $10,000 = $34.35 per weekly paycheck

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Long-Term Disability Benefit Summary

Royal Wine Corporation **Original Effective Date:** January 01, 2017

Class Definition: Class 2: All Active Full Time Employees **Employer Contribution:** 100%

Long-term disability benefits can replace income in challenging times

Even with careful saving and planning, most people count on a steady paycheck to cover their monthly expenses. Unfortunately, it only takes a brief time away from work to upset the balance. You can protect the income you depend on with disability insurance. When you need to take time off to recover from an illness or injury, disability insurance from AXA provides a portion of lost income for a period of time, helping alleviate the financial hardship and cover regular expenses—from paying rent to buying groceries.

What your benefits cover:

Benefit Plan and Features	
Monthly Benefit[1]	$10,000
Guaranteed Issue Benefit	$10,000
Minimum Monthly Benefit *(the greater of)*	$100 or 10% of benefit
Elimination Period[2]	180 days
Benefit Period Percentage	60%
Own Occupation	24 Month Own Occ/ Any Occ After
Pre-Existing Condition Limitation[3]	3 / 12

[1] *Reduced by other income benefits*
[2] *Time must be continuous*
[3] *Pre-existing Conditions means any Disability, diagnosed or undiagnosed, for which Medical Care is received by You:*
1) within the 3 month period prior to the date Your coverage starts; and
3) the Disability began more than 12 months after the date Your coverage starts.

More about your Long-Term Disability coverage

If you are working for your employer on the effective date – the waiting period is 0 continuous days.
If you start working for your employer after the effective date – the waiting period is 90 continuous days.

Manage your Benefits

Go to www.axa.us.com/employeebenefits and log on to **EB360**℠ to view your account details.

If you have any questions, please don't hesitate to contact us at 1-877-854-5662.

We look forward to helping you managing your benefits with confidence and ease.

What is not covered?

Exclusions: *What Disabilities are not covered?*

The Policy does not cover, and We will not pay a benefit for, any Disability:

1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war, whether declared or not;
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation; or
5) caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by Your Employer; and
2) was terminated before the Effective Date of The Policy;

no benefits will be payable for that Disability under The Policy.

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*
We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled You have been continuously covered under The Policy for 365 consecutive days.

Pre-existing Condition means:

1) any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse; for which You received Medical Care during the 90 consecutive days period that ends the day before:

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment

These products only provide disability income insurance. THESE POLICIES ARE NOT MEDICARE SUPPLEMENT PLANS. They do NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. The policies have limitations and exclusions. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Policy Form/Contract AXEBP15DI; MOEBP15DI and State Variations.

PREPAID DISCLOSURES

Payroll Card Short Form

You do not have to accept this payroll card.
Ask your employer about other ways to receive your wages.

Monthly fee	Per purchase	ATM withdrawal	Cash reload
$0	**$0**	**$0** in-network **$2.75** out-of-network	**5.95***

ATM balance inquiry (in-network or out-of-network)	$0 or $2.75
Customer service	$0 per call
Inactivity	$0

We charge 8 other types of fees. Here are some of them:

ATM decline (in-network or out-of-network)	$0 or $2.75*
Transfer to customer bank	$3

* This fee can be lower depending on how and where the card is used.

No overdraft/credit feature

Your funds are eligible for FDIC insurance.

For general information about prepaid accounts, visit *cfpb.gov/prepaid.*

Find details and conditions for all fees and services on the next page, or call **888-913-0900** or visit ***moneynetwork.com***.

Money Network Service Employer Program and MyMoneyNetwork Program. The Visa Card is issued by MetaBank®, Member FDIC, pursuant to a license from Visa U.S.A. Inc. The Mastercard Card is issued by MetaBank®, Member FDIC, pursuant to a license from Mastercard International Incorporated. Card is serviced by Money Network Financial, LLC

List of all fees (Long Form) for the Money Network® Service Employer Program and MyMoneyNetwork Program

All Fees	Employer Program	My MoneyNetwork Program	Details
Monthly Usage			
Account Opening, Check, and Card Receipt	$0.00	$0.00	No fee for Account Opening, Checks, and initial Card.
Monthly Maintenance Fee	Not Applicable	$5.00	Fee is waived in any Monthly Statement Cycle in which Account loads total $400 or more.
Add Money			
Payroll Deposit	$0.00	$0.00	Funds loaded by your Employer.
ACH Deposit of Other Funds	$0.00	$0.00	Loads of other types of funds or payments, e.g. a tax refund.
Spend Money			
Signature Debit Transactions	$0.00	$0.00	Select "Credit" or sign at point-of-sale (POS). Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to International Transactions.
PIN Debit Transactions	$0.00	$0.00	Select "Debit" and enter PIN at POS; cash back option at participating merchants. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to International Transactions.
Money Network® Check	$0.00	$0.00	Participating check cashing locations do not charge fees to cash Money Network Checks. To find these locations, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service. Non-participating check cashing locations may charge fees that are not monitored by us. Check cashing locations may also limit the dollar amount of checks they will cash.
Get Cash or Send Cash			
ATM Withdrawal Fee or ATM Decline Fee | In-Network	$0.00	$0.00	Withdrawal or Decline from ATM that is a part of our network. If you live in CT or IL, we will waive our fee for the first two ATM Declines (In-Network, Out-of-Network, or Non-US) in a calendar month. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service.
ATM Withdrawal Fee| Out-of-Network	$2.75	$2.75	This is our fee. If you live in CT or IL, we will waive our fee for the first two ATM Declines (In-Network, Out-of-Network, or Non-US) in a calendar month. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
ATM Decline Fee | Out-of-Network			
Bank Teller Over the Counter Cash Withdrawal	$0.00	$0.00	At banks displaying the card association logo on the front side of your Card. This is our fee. You may also be charged a fee by the bank. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to International Transactions.
Transfer to Customer Bank Fee (ACH)	$3.00	$3.00	Domestic ACH transactions are subject to additional terms that are disclosed when a transaction is initiated.
International ACH Withdrawal Fee	$7.00 plus 3.5% of the exchange rate	$7.00 plus 3.5% of the exchange rate	This transaction allows you to transfer funds via ACH to an international bank account. We charge transfer fees consisting of a flat fee of up to $7.00 plus a mark-up on the exchange rate of up to 3.5%. The transfer fees may be less depending on the amount transferred and market conditions. Applicable transfer taxes will also be charged. The exact amount of transfer fees and transfer taxes charged by us will be disclosed to you before you complete the transaction. Your transaction is subject to an exchange rate conversion, and may be subject to additional fees and taxes, from 3rd parties. Recipient's financial institution may also charge fees and taxes. We do not monitor exchange rates or fees established by 3rd parties and these amounts are subject to change. These transactions are subject to additional terms that are disclosed when a transaction is initiated. See Website for more information. You may call Customer Service for assistance.
Information			
Monthly Paper Statement	$0.00	$0.00	You may also obtain account activity without a fee via Mobile App (data rates may apply), moneynetwork.com, or Customer Service.
Customer Service	$0.00	$0.00	24/7 toll free Account access, including account balance inquiries.
ATM Balance Inquiry Fee | In-Network	$0.00	$0.00	To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service.
ATM Balance Inquiry Fee | Out-of-Network	$2.75	$2.75	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
Using Your Card Outside the U.S. (International Transactions)			
ATM Withdrawal INT Fee (Non-U.S.)	$2.50	$2.50	This is our fee. If you live in CT or IL, we will waive our fee for the first two ATM Declines (In-Network, Out-of-Network, or Non-US) in a calendar month. You may also be charged a fee by the ATM operator, even if you do not complete a transaction. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to these transactions.
ATM Decline INT Fee (Non-U.S.)			
ATM Balance Inquiry INT Fee (Non-U.S.)			

Visa International Service Assessment *(applies if transaction is initiated in non-U.S. dollars and a currency conversion rate applies)* **or** Visa Cross Border Assessment *(applies if transaction is initiated in U.S. dollars by a merchant with a non-U.S. country Code)*	2.0% / 0.8%	2.0% / 0.8%	Of the U.S. dollar amount of each International Transaction made with a Visa branded card. Only one of these fees may apply to your transaction and be assessed. See *Using Your Account and Card - International Transactions* in your Agreement's terms and conditions for additional information. Transaction fees on your statement will include these fees if they apply to your transaction.
Mastercard Currency Conversion Assessment Fee *(applies if transaction is initiated in non-U.S. dollars)* **and/or** Mastercard Cross Border Assessment Fee *(applies if transaction is initiated with merchant with non-U.S. country code)*	0.2% / 2.0%	0.2% / 2.0%	Of the U.S. dollar amount of each International Transaction made with a Mastercard branded card. Either or both of these fees may apply to your transaction and be assessed. See *Using Your Account and Card - International Transactions* in your Agreement's terms and conditions for additional information. Transaction fees on your statement will include these fees if they apply to your transaction.
Other			
Reissuance of Lost/Stolen Card	$5.00	$5.00	Reissued Card shipped via U.S. mail 7-10 business days after order placed. One replacement Card provided at no charge each calendar year.
Priority Shipping Fee	$10.00	$10.00	Additional fee to ship replacement Card 4-7 business days after order placed. Reissuance of Card Fee also applies.
Request Secondary Account	$0.00	$0.00	Request an additional account for family or dependents.
Transfer Funds to Secondary Account	$0.00	$0.00	Transfer of funds to Secondary Account.
Money Network Check Stock Order	$0.00	$0.00	Shipped 7-10 business days after order placed. Up to 30 checks per order.
3rd Party Fees (We do not charge you these fees.)			
Cash Deposit at Reload Provider	$5.95	$5.95	3rd party fees, known to be up to $5.95 as of 8/15/2018, may apply when reloading your Card at reload providers. To find reload providers, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service.
Deposit Check Funds via Mobile App | Standard	$0.00	$0.00	A 3rd party provides this service subject to its enrollment process, terms, conditions, fees, and privacy policy. Checks are subject to the 3rd party's approval in their sole discretion; dollar limits and other restrictions apply. Approved checks are loaded net of applicable fees. **Expedited Service**: 3rd party fees are 1% of approved check amount for preprinted payroll & government checks and 4% of approved check amount for other check types, with a $5 minimum fee. 3rd party approval process usually takes 3-5 minutes but may take an hour. Most issuers post funds within 24 hours. **Standard Service**: No 3rd party fee for 10 days delayed funding. See Mobile App (message and data rates may apply) for more information.
Deposit Check Funds via Mobile App | Expedited • Preprinted payroll & government checks • Other check types	Greater of: • 1% or $5.00 • 4% or $5.00	Greater of: • 1% or $5.00 • 4% or $5.00	
Additional Disclosures			
Your funds are eligible for FDIC insurance. Your funds will be held at or transferred to MetaBank®, an FDIC-insured institution. Once there, your funds are insured up to $250,000 by the FDIC in the event MetaBank fails, if specific deposit insurance requirements are met. See fdic.gov/deposit/deposits/prepaid.html for details. No overdraft/credit feature. Contact Customer Service by calling 888-913-0900, by mail at 5565 Glenridge Connector N.E., Mail Stop GH-52, Atlanta, GA 30342, or visit moneynetwork.com. For general information about prepaid accounts, visit cfpb.gov/prepaid. If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit cfpb.gov/complaint.			

ROYAL WINE CORP.

BENEFIT APPLICATIONS

2023

ROYAL WINE CORP.

63 LeFante Way · Bayonne, NJ 07002
718.384.2400 · RoyalWine.com

BENEFIT APPLICATIONS

CONTENTS

ROYAL WINE CORPORATION
INSURANCE ENROLLMENT & WAIVER FORM

Effective January 2023

BENEFITS			
	OPTION 1	**OPTION 2**	**OPTION 3**
Product	OPEN ACCESS PLUS	OPEN ACCESS PLUS	HSA OPEN ACCESS
Network	OPEN ACCESS	OPEN ACCESS	OPEN ACCESS
Referrals	NOT NEEDED	NOT NEEDED	NOT NEEDED
IN NETWORK			
Office Copay	$25	$20	DEDUCTIBLE & COINSURANCE
Specialist Copay	$40	$40	DEDUCTIBLE & COINSURANCE
ER Copay	$100	$100	DEDUCTIBLE & COINSURANCE
Hospital Inpatient	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE
Hospital Outpatient	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE	DEDUCTIBLE & COINSURANCE
In Network Deductible	$1,000 / $2,000	$1,500 / $3,000	$2,500 / $5,000
In Network Coinsurance	80%	70%	70%
In Network Out of Pocket Max	$5,000 / $10,000	$6,350 / $12,700	$6,450 / $12,900
OUT OF NETWORK			
Out of Network Deductible	$2,000 / $4,000	NO COVERAGE	NO COVERAGE
Out of Network Coinsurance	60%	NO COVERAGE	NO COVERAGE
Out of Network Out of Pocket Max	$10,000 / $20,000	NO COVERAGE	NO COVERAGE
UCR	300% OF MEDICARE	NO COVERAGE	NO COVERAGE
RX			
Pharmacy Copays	$15/$35/$75	$15/$35/$75	$25/$50/$75
Pharmacy Deductible	N/A	$100	MEDICAL

PLEASE REVIEW THE ABOVE PLAN SUMMARY AND RETURN RATES AND SIGNATURE PORTION FOR PROCESSING. THE ABOVE IS NOT A CONTRACT. A BENEFIT PACKET WILL BE ISSUED AFTER THE PAPERWORK IS PROCESSED.

WEEKLY RATES					
Single	☐	$137.00	☐	$59.00	☐ $18.00
Couple	☐	$288.00	☐	$125.00	☐ $101.00
Employee & Children	☐	$239.00	☐	$104.00	☐ $84.00
Family	☐	$417.00	☐	$181.00	☐ $147.00
Decline Coverage	☐	Reason_____			

Sign_____

Print Name _____

SS# __ __ __ - __ __ - __ __ __ __

Date_____

Enrollment / Change Form (Consolidated)

Employer: Complete Section A
Employee: Complete Sections B-H

Insured and/or Administered by
Cigna Health and Life Insurance Company
Cigna HealthCare

Cigna.

Please print and thank you for providing this information

A

☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME			EMPLOYER ADDRESS				
CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	MEDICAL BEN. OPTION	DENTAL BEN. OPTION	VISION BEN. OPTION	CIGNA CHOICE FUND ANNUAL AMOUNT

TYPE OF CHANGE:
- ☐ Add Dependent(s)* Date: ____
- ☐ Cancel Employee Last Date of Coverage: ____
- ☐ Cancel Dependent(s)* Last Date of Coverage: ____
- ☐ Address Change
- ☐ Transfer to COBRA – ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ Family Security Benefit/Surviving Spouse
- ☐ Retirement
- ☐ Other ____

*List Names In Section B

B

EMPLOYEE NAME (Last)	(First)	(M.I.)	SOCIAL SECURITY NO.

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE	WORK PHONE	HOME E-MAIL ADDRESS	EMPLOYEE IDENTIFICATION NUMBER
	( )	( )		

MAILING ADDRESS (Street)	(City)	(State)	(Zip Code)

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS: (Specify last name if different from yours) Last Name / First Name / M.I.	DEPENDENT'S SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	COVERAGE SELECTION	FULL-TIME STUDENT? Yes No	If you choose a Managed Care Medical Option, select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID numbers below. Note: PCP selection is optional for Open Access Plans.	EXISTING PATIENT? Yes No	If you choose the Cigna Dental Care Option, enter your 1st and 2nd choice of Dental Office Number below.	EXISTING PATIENT? Yes No	(check one)
Employee			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel
Spouse			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel
Dependent* Relationship			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel
Dependent* Relationship			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel
Dependent* Relationship			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel

*DEPENDENTS - Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.

C

MANAGED CARE MEDICAL OPTIONS:
- ☐ Point-of-Service (or DPP or CHA)
- ☐ HMO
- ☐ Network (or EPP)
- ☐ Point-of-Service Open Access
- ☐ HMO Open Access
- ☐ Network Open Access
- ☐ Open Access Plus
- ☐ Open Access Plus In-Network

OTHER MEDICAL OPTIONS:
- ☐ Preferred Provider Option (PPO)
- ☐ In-Network PPO or EPO
- ☐ Preferred Provider Access (PPA)
- ☐ Medical Indemnity
- ☐ ____

CIGNA CHOICE FUND® OPTIONS:
- ☐ HRA
- ☐ HSA
- ☐ Pharmacy HRA
- ☐ Dental HRA
- ☐ with PPO
- ☐ with Open Access Plus
- ☐ with Open Access Plus In-Network
- ☐ with EPO
- ☐ with Indemnity

- ☐ Cigna Care Network®
- ☐ Decline Coverage

OPTION # (if applicable): ☐ 1 ☐ 2 ☐ 3

If you choose a Managed Care Medical Option other than Open Access Plus, print the name of the Cigna HealthCare network. (See the cover or first page of the physician directory). Include the name of the city and state.

Cigna HealthCare of (city/state):

D FLEXIBLE SPENDING ACCOUNT OPTIONS:
- ☐ Health Care*
- ☐ Dependent Day Care*
- ☐ Decline Coverage

E DENTAL OPTIONS:
- ☐ DHMO (Cigna Dental Care®)
- ☐ Dental PPO
- ☐ Dental EPO
- ☐ Dental Indemnity
- ☐ Decline Coverage

F VISION OPTIONS:
- ☐ Cigna Vision
- ☐ Decline Coverage

*If you have checked off one of the Flexible Spending Accounts in Section D, please make sure you have completed the corresponding enrollment form included in this package.

G OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No *If yes, please provide the following:*

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICARE ID #	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

H SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE / DATE	SPOUSE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE

HC-ENR23 DISTRIBUTION: Original: Cigna HealthCare / Eligibility Services 2nd Ply: Cigna Eligibility Services / CDH / Dental Claim Office 3rd Ply: Employee 4th Ply: Employer Cat. #740000c Rev. 7-12 (OVER)

Retirement Gateway ®

Enrollment Form
(Bundled)

Mailing Instructions:
Processing Office:
PO Box 219489 Kansas City, MO 64121-9489
www.equitable.com

EQUITABLE

PLEASE PRINT

1. Background Information

Participant's First Name, Middle Initial | Last Name | Social Security Number

Participant's Address

Number / Street | Suite

City | State | Zip Code

☐ Male ☐ Female Date of Birth ____ / ____ / ____ (Month / Day / Year) Participant's Daytime Phone Number ____

Participant's Date of Hire ____ / ____ / ____ (Month / Day / Year) Participant's Eligibility Date ____ / ____ / ____ (Month / Day / Year)

ROYAL WINE CORPORATION
Employer's Name

690251
Contract ID Number

FOR 401(K) PLANS ONLY:

☐ Check this box if you do not wish to contribute.

If contributing to the Plan, please indicate the percentage below:
_____% Salary Deferral Percentage (based on the limitations in your Employer's Plan)

2. Instructions

* All future contributions, including rollover amounts, will be invested according to the investment percentages you choose in Part 4. These elections may be changed via touch-tone telephone by using our automated voice response unit (VRU) at (866) 528-0204 or on the internet at www.equitable.com
* If your Employer's plan permits investments in both the Guaranteed Interest Option and the EQ/Money Market Fund, certain limitations may apply to assets transferred out of the Guaranteed Interest Option into any other investment option. Refer to your program summary before allocating any amounts to the Guaranteed Interest Option if your plan also permits use of the Money Market Fund.
* If your Employer's Plan permits investments in the Stable Value Fund, certain limitations may apply to assets transferred out of the Stable Value Fund before they can be transferred to the Money Market Fund. Refer to your program summary before allocating any amounts to the Stable Value Fund.
* The Personal Income Benefit (PIB) guarantees that for an additional charge, and subject to certain conditions, you can take Guaranteed Annual Withdrawal Amount (GAWA) payments from the PIB Variable Investment Option up to a certain amount per year (based on the Participant's Birthday Anniversary) for life. You must be at least age 21, but not older than age 85, in order to allocate or transfer amounts to the PIB Variable Investment Option. You should carefully review the Retirement Gateway Program Summary before investing in the PIB Variable Investment Option. The annual charge is deducted from amounts in the PIB Variable Investment Option at the end of each calendar quarter.

3. Beneficiary Designation

(To be completed by Participant.)

BENEFICIARY STATEMENT - Check the appropriate box below. If you check B but have not filed a Beneficiary Form, or if the Beneficiary Form is not valid, the Plan Beneficiary Statement below will apply in the event of death.

A. ☐ I hereby agree to the Plan Beneficiary Statement below.

PLAN BENEFICIARY STATEMENT: Unless a beneficiary designation by me is in effect at the time an amount becomes payable, any amount which becomes payable to my Beneficiary under the Plan shall be payable to the first surviving class of the following:
(A1) Widow or Widower
(A2) Surviving Children
(A3) Surviving Parents
(A4) Surviving Brothers and Sisters
(A5) The Executors or Administrators of the person upon whose death the payment becomes due

B. ☐ I have attached a Designation or Change of Beneficiary Form.

4. Fund Section

If your percentages total to more than 100%, any contributions received will be invested 100% to the "default" option under your Employer's plan. If your percentages total to less than 100%, then the contributions received will be invested according to your instructions, with the remaining amount invested in the "default" option. Please note: Percentages cannot be allocated into the IDA. Use whole percentages only.

AMERICAN FUNDS AMERICAN MUTUAL R6	%	AMERICAN FUNDS GLOBAL BALANCED R6	%
AMERICAN FUNDS GLOBAL GROWTH PORT R6	%	AMERICAN FUNDS GROWTH FUND OF AMER R6	%
DFA COMMODITY STRATEGY INSTITUTIONAL	%	DFA EMERGING MARKETS CORE EQUITY I	%
DFA GLOBAL EQUITY I	%	DFA INFLATION-PROTECTED SECURITIES I	%
DFA ONE-YEAR FIXED-INCOME I	%	DFA US SMALL CAP I	%
DFA US SMALL CAP VALUE I	%	DFA WORLD EX US GOVERNMENT FXD INC I	%
EQ / MONEY MARKET	%	FRANKLIN HIGH INCOME R6	%
FRANKLIN STRATEGIC INCOME R6	%	GUARANTEED INTEREST OPTION	%
GUARANTEED INTEREST OPTION	%	INVESCO DISCOVERY MID CAP GROWTH R6	%
INVESCO GLOBAL REAL ESTATE R6	%	ISHARES S&P 500 INDEX K	%
JANUS HENDERSON TRITON N	%	PGIM JENNISON NATURAL RESOURCES R6	%
PUTNAM INCOME R6	%	VANGUARD LIFESTRATEGY CNSRV GR INV	%
VANGUARD LIFESTRATEGY GROWTH INV	%	VANGUARD LIFESTRATEGY MODERATE GR INV	%
VANGUARD MID CAP GROWTH INV	%	VANGUARD MID-CAP GROWTH INDEX ADMIRAL	%
VANGUARD TARGET RETIREMENT 2020 INV	%	VANGUARD TARGET RETIREMENT 2025 INV	%
VANGUARD TARGET RETIREMENT 2030 INV	%	VANGUARD TARGET RETIREMENT 2035 INV	%
VANGUARD TARGET RETIREMENT 2040 INV	%	VANGUARD TARGET RETIREMENT 2045 INV	%
VANGUARD TARGET RETIREMENT 2050 INV	%	VANGUARD TARGET RETIREMENT 2055 INV	%
VANGUARD TARGET RETIREMENT 2060 INV	%	VANGUARD TARGET RETIREMENT 2065 INV	%
VANGUARD TARGET RETIREMENT 2070 INV	%	VANGUARD TARGET RETIREMENT INCOME INV	%
		TOTAL	100 %

5. Signatures

PLEASE REVIEW, SIGN AND DATE THIS FORM. This Form must be signed by the Plan Administrator/ Trustee and Participant then forwarded to the Processing Office address or faxed to (816) 218- 0412. Elections on this Form become effective upon receipt of this Notice, provided all information is completed correctly. This Form may not be accepted upon failure to complete the Form correctly.

I, the participant, have received and reviewed the program summary that describes the appropriate Retirement Gateway Program.

Fraud warnings:
In Arkansas, District of Columbia, Louisiana, Maryland, New Jersey, New Mexico, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In Colorado, Kentucky, Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

In Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

In Pennsylvania and all other states: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

In Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

In Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

X _____ _____ _____
Signature of Participant | Date | Social Security Number

X _____ _____ _____
Signature of Plan Administrator/Trustee | Print Name | Date

Home Office:
EQUITABLE FINANCIAL LIFE INSURANCE COMPANY
1290 Avenue of the Americas, New York, NY 10104 - (800) 528-0204 - Fax (816) 218-0412 - www.equitable.com

EQUITABLE

Employee Contribution Election Form
for Plans with Roth Savings Features

Please complete, sign, date and return to your Employer, even if you do not wish to participate in the plan at this time. Do not return this Form to Equitable or your Financial Professional.

PLEASE PRINT

Section 1

Employer's Name: _____

Employee's Name: _____

Social Security Number: _____ *Effective Date:* _____ *(mm/dd/yyyy)*

I, the undersigned employee, acknowledge that:
- I am eligible to participate in this Plan;
- the provisions of this Plan have been explained to me; and
- I understand the provisions of this Plan as well as my rights and obligations under the Plan.

Section 2

I hereby make the choice indicated below: (check either one of the choices under A or B, not both)

A. I wish to contribute to the Plan, and authorize my Employer to withhold from my pay an amount equal to (check only one option below, and then fill in the amount):

☐ I wish to contribute *only* Salary Deferral contributions.
I authorize my Employer to defer _____% or deduct $_____ from each pay check as a Salary Deferral contribution to the plan.

☐ I wish to contribute *only* Roth contributions.
I authorize my Employer to defer _____% or deduct $_____ from each pay check as a Roth contribution to the plan.

☐ I wish to contribute *both* Salary Deferral and Roth contributions.
I authorize my Employer to defer _____% or deduct $_____ from each pay check as a Salary Deferral contribution to the plan and defer _____% or deduct $_____ from each pay check as a Roth contribution to the plan.

Salary Deferral contributions are taken from your pay on a pre tax basis. Taxation will be deferred until you receive a distribution of these amounts plus earnings. They may be subject to a 10% penalty tax if these amounts and earnings are withdrawn prematurely.

Roth contributions are taken from your pay on an after tax basis. There are no taxes on the contributions or earnings if they are withdrawn from the trust pursuant to the Internal Revenue Code requirements. However, earnings may be subject to taxation and a 10% penalty tax if withdrawn prematurely.

I understand that the amount specified above to be invested for me under the Plan, shall be withheld by my Employer effective as of the earliest date specified in the Plan and/or the Plan's administrative rules established by the Plan Administrator. I also understand that I will be allowed to change this election in accordance with the provisions of the Plan and/or the Plan's administrative rules.

☐ **B. I do not wish to contribute to the Plan.** I understand that I may elect to contribute to the Plan in the future as long as I remain eligible to participate in the Plan. Further, I understand that any future election to contribute may only be made in accordance with the provisions of the Plan and/or the Plan's administrative rules established by the Plan Administrator.

Employee Authorization

I hereby authorize and direct my Employer to implement my instructions provided above.

_____ _____
(Signature) *(Date mm/dd/yyyy)*

(04/2021) E15157

EQUITABLE

Designation or Change of Beneficiary Form
Bundled/Full Service

Return via Mail or Fax:
Equitable-Retirement
PO Box 219489
Kansas City, MO 64121-9489
Street and Overnight Address:
Equitable-Retirement
430 W. 7th Street STE 219489
Kansas City, MO 64105-1407
Fax Number: (816) 218-0412
For Assistance Call: (800) 528-0204
www.equitable.com

PLEASE PRINT

1. Participant Information

First Name, Middle Initial _____ Last Name _____ Social Security Number _____

Address _____

Daytime Phone Number _____ Mobile Phone Number _____ Email Address _____

Employer's Name _____ Contract ID Number _____

Are you married? ☐ Yes ☐ No Participant's Date of Birth (mm/dd/yyyy) ____/____/____

2. Beneficiary Designation

I hereby designate the following as my beneficiary(ies) under the Master Plan adopted by my Employer subject to my right to change this designation as provided in said plan:

Primary Beneficiary(ies)

1. Name _____ % of Share _____
   Relationship _____ Sex ☐ Male ☐ Female
   Social Security Number _____ Date of Birth _____
   Address _____
   Preferred Phone Number _____ Email Address _____
2. Name _____ % of Share _____
   Relationship _____ Sex ☐ Male ☐ Female
   Social Security Number _____ Date of Birth _____
   Address _____
   Preferred Phone Number _____ Email Address _____

Contingent Beneficiary(ies)

1. Name _____ % of Share _____
   Relationship _____ Sex ☐ Male ☐ Female
   Social Security Number _____ Date of Birth _____
   Address _____
   Preferred Phone Number _____ Email Address _____
2. Name _____ % of Share _____
   Relationship _____ Sex ☐ Male ☐ Female
   Social Security Number _____ Date of Birth _____
   Address _____
   Preferred Phone Number _____ Email Address _____

3. General Provisions

1. Except to the extent otherwise expressly provided on the face of this Designation, all sums payable under the Plan to a beneficiary(ies) at or by reason of the death of the participant:
   (a) Shall be equally divided between such of the primary beneficiaries named on the face of this Designation as survive the Participant, except where a nonsurviving primary beneficiary has been survived by a contingent beneficiary or beneficiaries who were living at the time of the Participant's death. Such beneficiaries shall receive the share such primary beneficiary would have received if he or she had survived the Participant.
   (b) If any primary beneficiary is not living at the time of the Participant's death, his or her share of such payment shall be equally divided between such of the contingent beneficiaries designated for such primary beneficiary who are living at the time of the Participant's death.
   (c) If upon the death of a person there is no designated beneficiary then living entitled to receive any amount which becomes payable to a beneficiary, such amount shall be payable to the first surviving class of the following classes of successive preference beneficiaries: (1) the Participant's widow or widower; (2) the Participant's surviving children; (3) the Participant's surviving parents; (4) the Participant's surviving brothers and sisters; (5) the executors or administrators of the person upon whose death the payment becomes due.
   (d) By expressly providing on the face of this Form the manner in which you wish your beneficiary designation to be executed, you may override the provisions outlined in a, b or c above.

2. A Beneficiary Designation or Change dated and signed by the Participant and the spouse, if applicable, and witnessed by a Plan Representative or a Notary Public shall be valid upon receipt by the Plan Administrator of said notice and shall be effective as of the date shown on said notice as the date on which it was signed, whether or not the person making such Designation or Change is living at the time of receipt, but without further liability on the part of the Trustees and the Insurer with respect to any payment made before receipt of said notice.

3. The terms, provisions and limitations of the Plan and Trust Agreement and any amendments thereof which may hereafter be made from time to time are controlling over the above-stated General Provisions and shall govern all the rights of the Participant, his or her designated beneficiaries, and any person claiming rights under such Agreements.

IMPORTANT NOTICE: This beneficiary designation under the plan should be carefully reviewed from time to time as changes occur in the law or in your personal or financial situation. Please advise us if any of your beneficiaries change their addresses.

4. Signatures/Authorization

If you name your spouse as the primary beneficiary disregard the spousal consent signature lines below.

This designation is subject to the General Provisions. Under the terms of your Employer's plan, pre-retirement survivor benefits will be provided to the spouse of a married participant unless the spouse consents below to waive such benefits. In addition, the law provides that a married participant who is under age 35 may only make a qualified election to designate a beneficiary other than his or her spouse. The qualified election requires the consent of his or her spouse and is effective for the period beginning on the date of such election and ending on the first day of the Plan Year in which the participant will attain age 35. At that time a new election, also consented to by his or her spouse, is required in order for the beneficiary to continue to be other than the spouse. The spouse's consent, given below, must be witnessed by a Plan Representative or Notary Public. *Note: the date of the witnesses signature must be the same date as the spouse's signature.*
I, as the spouse indicated below, understand that I am waiving my right to receive survivor benefits under the plan which would otherwise be paid to me automatically upon the above-named Participant's death.

X _____ Signature of Participant (required at all times)	Print Name	Date (mm/dd/yyyy)
X _____ Signature of Trustee/Authorized Individual for the Plan (required at all times)	Print Name	Date (mm/dd/yyyy)
X _____ Signature of Spouse (if indicated above that Participant is married)	Print Name	Date (mm/dd/yyyy)
X _____ Signature of Plan Representative (or Notary Public) as Witness to Spouse's Signature	Print Name	Date (mm/dd/yyyy)

(08/2020)

E13746
Page 2 of 2

Flex Facts Enrollment Form

Please return this form to your human resources representative

Personal Information

Employer: _____

Full Name: _____ (Last) _____ (First) _____ (M.I.)

Address: _____ (Street Address) _____ (Apartment/Unit #)

_____ (City) _____ (State) _____ (ZIP Code)

Phone: _____ Social Security Number: _____

Birth Date: _____ E-mail Address: _____

Effective Date: _____ Plan Year Start: _____

Benefit Election

I ELECT THE FOLLOWING:	Amount Per Pay Period	# of Pay Periods	Annual Election
☐ Medical FSA Account	$ _____	_____	$ _____
☐ Dependent Care Account	$ _____	_____	$ _____
☐ Limited Purpose FSA (HSA only)	$ _____	_____	$ _____
☐ Transit Account	**Monthly Election:**	$ _____	

Frequency of Pay: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other

Date of First Deduction: _____

Spouse or Dependent Card Information

Full Name: _____ (Last) _____ (First) _____ (M.I.)

Mail Card to: ☐ Address listed above ☐ Alternate Address: _____ (Street Address) _____ (Apt. /Unit #)

Date of Birth: _____ _____ (City) _____ (State) _____ (ZIP Code)

Soc. Sec. Number: _____ Relationship: _____

Employee Authorization

- If this form is not returned to your employer by your effective date, you will not be able to participate in the plan until the following plan year.
- Your accounts will not automatically renew. You must sign a new election form each year at open enrollment.
- You cannot change the FSA election during the plan year unless you have an eligible change in status.
- This agreement is subject to the terms of the company's Flexible Benefits Plan.
- By signing this form, I agree that my cash compensation will be redirected by the amounts set forth above.

Signature: _____ Date: _____

Flex Facts | 1200 River Avenue, Suite 10E | Lakewood, NJ 08701 | www.flexfacts.com | 877-94-FACTS

FLEXFACTS
a company of grant benefit solutions

Please send the completed claim form and detailed bills/ EOBs to:
Email: claims@flexfacts.com **Fax:** 877-747-8564
Mail: 1200 River Avenue, Suite 10E, Lakewood, NJ 08701

Medical & Dependent Care Claim Form

STEP 1 Employee Information

Full Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

Employer: _____ Last 4 digits of Social Security #: _____

Phone: _____ Email: _____

Address: _____ (Address) _____ (City) _____ (State) _____ (Zip)

☐ Check here if submitting a Change of Address

STEP 2 Medical Claim

FSA	HRA	Date of Service	Patient Name	Name of Provider	Description of Service	Amount Requested	Pay Me	Pay Provider*
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐

*if pay provider is selected, please be sure to include bill with provider's mailing address

STEP 3 Dependent Care Claim

Service Period (From)	(To)	Dependent Name	Dependent Date of Birth	Name of Provider	Description of Service (Day Care, Pre-K, Day Camp, etc.)	Provider Tax ID/ SSN	Amount Requested

Dependent Care Provider Signature (if bill is not available): _____

STEP 4 Direct Deposit (skip this step if you are already enrolled in direct deposit)

Bank Name	Account #	Routing #	Account Type (Checking/ Savings)

By signing this form, I authorize Flex Facts to initiate debits and/or credits to or from my bank account indicated above. Debits will only be initiated in order to correct a reimbursement error. My authorization will remain in effect until I provide written notification of termination of this authorization or change my direct deposit information online. A reasonable amount of time will be provided for Flex Facts to apply any requested changes.

STEP 5 Employee Certification

By signing this form, I agree to have my benefit account(s) reduced by the amount(s) requested. I certify that the expenses above were incurred by me (and/ or my spouse and/or eligible dependents) during the applicable plan year and are eligible for reimbursement under my Plans. (Please refer to your SPD/ Plan Document for information on eligible expenses). I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source and will not be claimed as an income tax deduction. I understand that I may be asked to provide further details or documentation. I understand and agree that I am obligated to inform Flex Facts in writing if the amount charged for the dependent care services change, the service is terminated, or if there is any reason the expenses are not incurred.

Employee Signature: X_____ Date: _____

STEP 6 Submit this signed form and copy of required bill(s)/ EOB(s).

- ✓ **HRA:** Explanation of Benefits (EOB)
- ✓ **FSA/ Non-HRA Medical:** Medical bill (must include Provider Name, Patient Name, Date of Service, Description of Service, Amount)
- ✓ **DCA:** Dependent care bill (must include Provider Name, Amount)

Reliable Brokerage, Inc.
We get you protected.

ROYAL WINE CORPORATION
DENTAL INSURANCE ENROLLMENT & WAIVER

Effective January 2023

DENTAL PLAN ELECTION FORM.xls
By Reliable Brokerage
Prepared at 12/5/22 3:22 PM
888-783-6286
www.reliablebrokerage.com

DENTAL BENEFITS	HIGH		LOW	
	In Network	Out of Network	In Network	Out of Network
Preventive	100%	100%	100%	100%
Basic	100%	80%	100%	80%
Major	60%	50%	60%	50%
Annual Maximum	$2,000	$2,000	$1,500	$1,500
Ortho	50%	50%	50%	50%
Adult Ortho	50%	50%	50%	50%
Ortho Maximum	$2,000	$2,000	$1,500	$1,500
Deductible	$50/$150	$50/$150	$50/$150	$50/$150
Out of Network Reimbursement		90th UCR		90th UCR

PLEASE REVIEW THE ABOVE PLAN SUMMARY AND RETURN RATES AND SIGNATURE PORTION FOR PROCESSING. THE ABOVE IS NOT A CONTRACT. A BENEFIT PACKET WILL BE ISSUED AFTER THE PAPERWORK IS PROCESSED.

WEEKLY RATES				
Single	☐	$11.31	☐	$9.35
Couple	☐	$21.86	☐	$18.79
Employee & Children	☐	$27.89	☐	$22.75
Family	☐	$40.42	☐	$33.79
Decline Coverage	☐			

Sign_____

Print Name _____

SS# ___-___-____

Date_____

Principal®

Mailing Address	Principal Life	*Enrollment/Change*
Des Moines, IA 50392-0002	Insurance Company	*Request - NJ*

Employer Group Information - To be completed by employer.

Company name	Division level	Account number/unit number
Royal Wine Corp	All Members	

A. Type of Activity - To be completed by employer. Refer to Instructions section before completing this form. Print clearly.

	Effective date	Date of hire
1. Enrollment ☐ new employee		

2. Add - Check all that apply.	**Effective Date/ Date of Event**	**Reason for Change**
☐ add spouse/civil union partner		
☐ add domestic partner		
☐ add dependent child		

3. Remove - Check all that apply.	**Effective Date/ Date of Event**	**Reason for Change**
☐ employee withdrawal/termination		
☐ remove spouse/civil union partner*		
☐ remove domestic partner*		
☐ remove dependent child*		

NOTE: Employee must be enrolled for spouse/dependents to have coverage. The term "Civil Union Partner" wherever used includes partners in a legally recognized union of the same sex which provides substantially all of the rights and benefits of marriage. The term "domestic partner" wherever used includes partners in relationships defined in the group policy which provide some, but not all of the rights and obligations of marriage.
*Please complete Section D.

4. Other Change	**Effective Date/ Date of Event**	**Reason for Change**
☐ name change		
☐ change plan		
☐ other		

5. Coverage Continuation

☐ for employee
- ☐ COBRA/NJSGC
- ☐ Length of continuation (in months): ☐ 18 ☐ 29 Date of loss of coverage: _____
- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

☐ for spouse/civil union partner*
- ☐ COBRA/NJSGC
- ☐ Length of continuation (in months): ☐ 18 ☐ 36 Date of loss of coverage: _____
- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

* Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.

☐ for dependent child
- ☐ COBRA/NJSGC
- ☐ Length of continuation (in months): ☐ 18 ☐ 36 Date of loss of coverage: _____
- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

** Qualifying event numbers: see list in Instructions.

B. Employee information - To be completed by the employee.

Name (last, first, middle initial)			Social security number
Mailing address (street)		Birth date	☐ male ☐ female
(city)	(state)		(ZIP code)
Date employed full-time	Hours worked per week	Job occupation/class	Location
E-mail		Phone number	

Do you have an eligible spouse or Civil Union Partner or domestic partner or child? ☐ yes ☐ no

Employer name
Kenover Marketing Corp

Employer address		(city)	
(state)	(ZIP code) 07002		Employer phone
Other dental or vision coverage ☐ yes ☐ no	If yes, payer name		Policy number
Salary amount (for owners, include business income)	Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly		

Payroll mode ☐ monthly ☐ bi-monthly ☐ weekly ☐ bi-weekly

C. Plan Options - To be completed by the employee. (Check all you elect coverage for.)

Coverage	Employee	Spouse or Civil Union Partner or Domestic Partner*	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ yes ☐ no

If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.

If your dental coverage includes Pediatric Dental Essential Benefits, please refer to GP61845 for information about free language services that may be available to you.

Vision	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

If I refuse vision coverage, I and my dependents may enroll later but this will affect the level of benefits.

*NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60468).

Declining Coverage

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

☐ spouse's or Civil Union Partner's or domestic partner's group coverage ☐ individual insurance

☐ other coverage offered by my employer ☐ other _____

If I refuse coverage, I cannot enroll after retirement.

D. Other Individuals Covered - To be completed by the employee. Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated.

1. Spouse, domestic or civil union partner

☐ add ☐ remove ☐ other ☐ continue spouse ☐ continue civil union partner (NJSGC)

Name (last, first, middle initial)		Birth date
☐ male ☐ female	Social security number	Employed ☐ yes ☐ no If yes, complete Section E1.

Home or billing address same as employee ☐ yes ☐ no If no, complete Section E2.

2. Child

☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial)		Birth date
☐ foster child* ☐ disabled**		
☐ male ☐ female	Social security number	Living with employee ☐ yes ☐ no If no, complete Section F.

If last name is different from employee's, please explain

3. Child

☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial)		Birth date
☐ foster child* ☐ disabled**		
☐ male ☐ female	Social security number	Living with employee ☐ yes ☐ no If no, complete Section F.

If last name is different from employee's, please explain

4. Child

☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial)	Birth date

☐ foster child* ☐ disabled**

☐ male ☐ female	Social security number	Living with employee ☐ yes ☐ no	If no, complete Section F.

If last name is different from employee's, please explain

* If you check foster child, was the child placed with you by an authorized state placement agency or by a court?

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

E. Additional Spouse/Civil Union Partner/Domestic Partner Information - To be completed by the employee. If not applicable, please mark as "N/A".

1. Employer name

Employer address

(city)	(state)	(ZIP code)	Employer phone

2a. Street/apartment

(city)	(state)	(ZIP code)

2b. Please explain why the address is different

F. Additional Child Information - To be completed by the employee. Provide information below about children listed in section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s)

Street/apartment

(city)	(state)	(ZIP code)

Reason

Name(s)

Street/apartment

(city)	(state)	(ZIP code)

Reason

G. Race/Ethnicity - To be completed by the employee, at his/her option. Note: your response is appreciated but NOT required!

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic
☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature	Date

I. Employer Verification

The requested activity is believed eligible and is approved by the employer.

Employer representative

Representative's title	Date

Instructions

Employer - You must complete the Employer Group Information and Sections A and I in order for this application to be processed.

Employee - You must complete all sections in order for this application to be processed.

- Please PRINT except when a signature is requested.
- Complete your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birth date, and Social security number for each individual listed.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC election. Instead, select "Other" in Section A4, and attach an Application to Continue Disabled Child form.
- Employee must sign and date the application in order for it to be processed.

Qualifying Events - COBRA and NJSGC

C1. termination of job or reduction in hours
C2. employee enrollment in Medicare (COBRA only)
C3. divorce (COBRA/NJSGC; civil union dissolution (NJSGC))
C4. death of employee
C5. loss of dependent child status under the plan
C6. disability (occurring subsequent to another qualifying event)

Conditions of Enrollment - Employee Acknowledgments and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer, reporting agency, and any employer to give Principal Life, or any consumer reporting agency acting on behalf of Principal Life, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Principal Life has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Principal Life will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my employer to withhold payments from my wages as contribution to the premium, as appropriate.

Misrepresentation

6. Any person who includes any false or misleading information on an Enrollment/Change form for a health benefits plan is subject to criminal and civil penalties.

Principal®

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Enrollment/Change Request - NJ

Employer Group Information - To be completed by employer.

Company name	Division level	Account number/unit number
Royal Wine Corp	All Members	

A. Type of Activity - To be completed by employer. Refer to Instructions section before completing this form. Print clearly.

	Effective date	Date of hire
1. Enrollment ☐ new employee		

2. Add - Check all that apply.	**Effective Date/ Date of Event**	**Reason for Change**
☐ add spouse/civil union partner		
☐ add domestic partner		
☐ add dependent child		

3. Remove - Check all that apply.	**Effective Date/ Date of Event**	**Reason for Change**
☐ employee withdrawal/termination		
☐ remove spouse/civil union partner*		
☐ remove domestic partner*		
☐ remove dependent child*		

NOTE: Employee must be enrolled for spouse/dependents to have coverage. The term "Civil Union Partner" wherever used includes partners in a legally recognized union of the same sex which provides substantially all of the rights and benefits of marriage. The term "domestic partner" wherever used includes partners in relationships defined in the group policy which provide some, but not all of the rights and obligations of marriage.
*Please complete Section D.

4. Other Change	**Effective Date/ Date of Event**	**Reason for Change**
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☐ change plan		
☐ other		

5. Coverage Continuation

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- ☐ Length of continuation (in months): ☐ 18 ☐ 29 Date of loss of coverage: _____
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- ☐ Length of continuation (in months): ☐ 18 ☐ 36 Date of loss of coverage: _____
- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

* Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.

☐ for dependent child
- ☐ COBRA/NJSGC
- ☐ Length of continuation (in months): ☐ 18 ☐ 36 Date of loss of coverage: _____
- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

** Qualifying event numbers: see list in Instructions.

Principal®

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Enrollment/Change Request - NJ

Employer Group Information - To be completed by employer.

Company name	Division level	Account number/unit number
Royal Wine Corp	All Members	

A. Type of Activity - To be completed by employer. Refer to Instructions section before completing this form. Print clearly.

	Effective date	Date of hire
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☐ employee withdrawal/termination		
☐ remove spouse/civil union partner*		
☐ remove domestic partner*		
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NOTE: Employee must be enrolled for spouse/dependents to have coverage. The term "Civil Union Partner" wherever used includes partners in a legally recognized union of the same sex which provides substantially all of the rights and benefits of marriage. The term "domestic partner" wherever used includes partners in relationships defined in the group policy which provide some, but not all of the rights and obligations of marriage.
*Please complete Section D.

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☐ change plan		
☐ other		

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☐ for dependent child
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- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

** Qualifying event numbers: see list in Instructions.

B. Employee Information - To be completed by the employee.

Name (last, first, middle initial)		Social security number
Mailing address (street)	Birth date	☐ male ☐ female
(city)	(state)	(ZIP code)

Date employed full-time	Hours worked per week	Job occupation/class	Location

E-mail	Phone number

Do you have an eligible spouse or Civil Union Partner or domestic partner or child? ☐ yes ☐ no

Employer name
Kenover Marketing Corp

Employer address	(city)

(state)	(ZIP code)	Employer phone
	07002	

Other dental or vision coverage ☐ yes ☐ no	If yes, payer name	Policy number

Salary amount (for owners, include business income)	Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly

Payroll mode ☐ monthly ☐ bi-monthly ☐ weekly ☐ bi-weekly

C. Plan Options - To be completed by the employee. (Check all you elect coverage for.)

Coverage	Employee	Spouse or Civil Union Partner or Domestic Partner*	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline
Vision	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ yes ☐ no

If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.

If your dental coverage includes Pediatric Dental Essential Benefits, please refer to GP61845 for information about free language services that may be available to you.

If I refuse vision coverage, I and my dependents may enroll later but this will affect the level of benefits.

*NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60468).

Declining Coverage

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

☐ spouse's or Civil Union Partner's or domestic partner's group coverage ☐ individual insurance

☐ other coverage offered by my employer ☐ other _____

If I refuse coverage, I cannot enroll after retirement.

D. Other Individuals Covered - To be completed by the employee. Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated.

1. Spouse, domestic or civil union partner
☐ add ☐ remove ☐ other ☐ continue spouse ☐ continue civil union partner (NJSGC)

Name (last, first, middle initial) | Birth date

☐ male ☐ female | Social security number | Employed ☐ yes ☐ no If yes, complete Section E1.

Home or billing address same as employee
☐ yes ☐ no If no, complete Section E2.

2. Child
☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial) | Birth date

☐ foster child* ☐ disabled**

☐ male ☐ female | Social security number | Living with employee ☐ yes ☐ no If no, complete Section F.

If last name is different from employee's, please explain

3. Child
☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial) | Birth date

☐ foster child* ☐ disabled**

☐ male ☐ female | Social security number | Living with employee ☐ yes ☐ no If no, complete Section F.

If last name is different from employee's, please explain

4. Child
☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial) | Birth date

☐ foster child* ☐ disabled**

☐ male ☐ female	Social security number	Living with employee ☐ yes ☐ no	If no, complete Section F.

If last name is different from employee's, please explain

* If you check foster child, was the child placed with you by an authorized state placement agency or by a court?

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

E. Additional Spouse/Civil Union Partner/Domestic Partner Information - To be completed by the employee. If not applicable, please mark as "N/A".

1. Employer name

Employer address

(city)	(state)	(ZIP code)	Employer phone

2a. Street/apartment

(city)	(state)	(ZIP code)

2b. Please explain why the address is different

F. Additional Child Information - To be completed by the employee. Provide information below about children listed in section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s)

Street/apartment

(city)	(state)	(ZIP code)

Reason

Name(s)

Street/apartment

(city)	(state)	(ZIP code)

Reason

G. Race/Ethnicity - To be completed by the employee, at his/her option. Note: your response is appreciated but NOT required!

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic
☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature	Date

I. Employer Verification

The requested activity is believed eligible and is approved by the employer.

Employer representative

Representative's title	Date

Instructions

Employer - You must complete the Employer Group Information and Sections A and I in order for this application to be processed.

Employee - You must complete all sections in order for this application to be processed.

- Please PRINT except when a signature is requested.
- Complete your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birth date, and Social security number for each individual listed.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC election. Instead, select "Other" in Section A4, and attach an Application to Continue Disabled Child form.
- Employee must sign and date the application in order for it to be processed.

Qualifying Events - COBRA and NJSGC

C1. termination of job or reduction in hours
C2. employee enrollment in Medicare (COBRA only)
C3. divorce (COBRA/NJSGC; civil union dissolution (NJSGC))
C4. death of employee
C5. loss of dependent child status under the plan
C6. disability (occurring subsequent to another qualifying event)

Conditions of Enrollment - Employee Acknowledgments and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer, reporting agency, and any employer to give Principal Life, or any consumer reporting agency acting on behalf of Principal Life, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Principal Life has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Principal Life will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my employer to withhold payments from my wages as contribution to the premium, as appropriate.

Misrepresentation

6. Any person who includes any false or misleading information on an Enrollment/Change form for a health benefits plan is subject to criminal and civil penalties.

TRANSAMERICA LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("Insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, AR 72203-8063

HospitalSelect II Enrollment Form

☐ First Application ☐ Add Dependents – Policy # _____ ☐ Change Coverage – Policy # _____

Group Name | Group Number | Location

Applicant (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	Date of marriage
Spouse[1] (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	

Email Address	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No	Work phone/ext.	Home phone

Date of hire	Avg hours worked per week	Occupation	Applicant ID

Home address

City	State	Zip code

Child(ren) name	Social Security No.	Date of birth	Child(ren) name	Social Security No.	Date of birth

Primary Beneficiary: (Last, First, M.I.)	Relationship:
Contingent Beneficiary: (Last, First, M.I.)	Relationship:

Applicant will be the beneficiary for any dependent coverage

[1] *Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction.*

Premium Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

I Am Applying For:					Premium per pay period*
☐ Employee	☐ Employee Plus Spouse**	☐ Employee Plus Children	☐ Employee Plus Family	☑ Hospital Indemnity Coverage	Plan _____	$

Eligibility Questions

1. Are you actively at work on a full time basis and able to perform the regular duties of your occupation? If "No", you and your dependents are not eligible for coverage.	☐ Yes ☐ No
2. If applying for dependent coverage, is any proposed insured currently disabled? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No
3. **For residents of all states, except AZ, CO, KS, KY, NC, OR, SC, or VA:** Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? If "Yes", List name(s) _____, who will be excluded from coverage.	☐ Yes ☐ No

STATEMENTS AND AGREEMENTS:

For residents of CA or CO: Are all proposed insureds covered under one of the following: a major medical, hospital, or medical expense insurance plan; or an HMO contract; or any other plan that provides "minimum essential coverage" as defined in section 5000A of the Internal Revenue Code?
For residents of MA, MN or VT: Are all proposed insureds covered under a major medical, hospital or medical expense insurance, or an HMO contract?
☐ Yes ☐ No If "No", list names _____, who will be excluded from coverage.
Coverage will not be issued to anyone who does not have comprehensive medical coverage. If applicant answers "No", no coverage will be issued.

I have read or had read to me the completed enrollment form. I represent *(Residents of MN and VA:* I certify*)* that all statements and answers made on or attached to this enrollment form are true to the best of my knowledge and belief. I realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate. I have read the Fraud Warning for my state shown on the back of this form.

For residents of CO: THIS IS A SUPPLEMENTAL POLICY/CERTIFICATE THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS POLICY/CERTIFICATE CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

I understand that completion of this enrollment form in no way implies that I will be accepted for insurance coverage. I understand that coverage will take effect only if this enrollment form is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate. The policy provides limited benefits. Review your certificate carefully.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____

Applicant's Signature | Spouse's Signature (if applicable)

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded in this enrollment form all of the information supplied by the enrollee. The enrollee has read or had read to him/her the completed enrollment form.

Licensed Agent/Representative's Name _____ Licensed Agent/Representative's Signature _____ Agent # _____

Fraud Warning

CA: I understand that any false statement made with actual intent to deceive or which materially affects either the acceptance of the risk or the hazard assumed could bar the right to receive benefits under the policy to which this application is attached.

AL, DC, LA, NM, & RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FL: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

KS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

MA, NC & OR: I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OK: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TN & WA: It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VA: I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT: I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.

ME and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Group Employee Benefits
Enrollment Form/Change Form

Regular Mail:
Equitable Employee Benefits Group
PO Box 2107
Secaucus, NJ 07096

Express Mail:
Equitable Employee Benefits Group
500 Plaza Drive, 6th Floor
Secaucus, NJ 07094

EQUITABLE *

For Assistance Call (866) 274-9887

Email: EBCustomerservice@Equitable.com

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America

SECTION 1 PROPOSED INSURED INFORMATION - PLEASE PRINT USING DARK INK

Employer Name and Address
Royal Wine Corporation - 63 Lefante Dr Bayonne NJ 07002

Group Number#	Class#	Dept/Loc#	Effective Date (subject to underwriting approval as needed)
000373			

Employee Name *First, MI, Last*	Social Security Number (SSN)	☐Male ☐ Female	☐Single ☐ Married**	Date of Birth (DOB) *(mm/dd/yyyy)*

Home Address 123 Any Street	City Anytown	State US	Zip 12345	County	Worksite Zip

Job Title	Annual Salary	Hours Per Week	☐ Salaried ☐ Hourly	Employment/Rehire Date

Race/Ethnicity to be completed by the Employee, at his/her option. NOTE your response is appreciated by NOT required!

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic
☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

Status Change Additions:	Effective Date/Date of Event:	Reason for Change:
☐ New [Enrollee]	☐___/___/___	
☐ Spouse/Civil Union Partner	☐___/___/___	
☐ Domestic Partner	☐___/___/___	
☐ Dependent Child	☐___/___/___	
☐ New [Enrollee] Retiree	☐___/___/___	
☐ Late [Enrollee]	☐___/___/___	
☐ Other	☐___/___/___	

COVERAGE(S) ELECTED

The following coverages are only available if your Employer offers them. Please check the applicable insurance cove you are electing.

NOTE: If you are declining coverage offered by your Employer, please complete the Employee Waiver of Insurance se this form .

SECTION 2. COMPLETE THIS SECTION IF APPLYING FOR LIFE - PLAN DESIGN COVERAGE OPTIONS

**"Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY), Equitable Financial Life Insurance Company of America (AZ stock corp., admin. office: Jersey City, NJ), and Equitable Distributors, LLC..

☐ Basic Life/AD&D ☐ Waive*	☐ Supplemental Life/AD&D – Enter Amount Requested $ _____ ☐ Supplemental Life/AD&D-Spouse** – Enter Amount Requested $_____ ☐Supplemental Life/AD&D-Child(ren) – Enter Amount Requested $ _____ ☐ Waive*

SECTION 3 COMPLETE THIS SECTION IF APPLYING FOR AD&D – PLAN DESIGN COVERAGE OPTIONS

☐ AD&D* ☐ Waive*	☐Supplemental AD&D* – Enter Amount Requested $ _____ ☐ Supplemental Life AD&D*-Spouse – Enter Amount Requested $_____ ☐ Supplemental Life AD&D*-Child(ren) – Enter Amount Requested $ _____ ☐ Waive*

SECTION 6 COMPLETE THIS SECTION IF APPLYING FOR DISABILITY INSURANCE

	☐ Long-Term Disability [/(Buy-up) Amount $_ _____ ☐ Voluntary Long -Term Disability Enter Amount Requested $ _____ ☐ Waive*

SECTION 7 SPOUSE AND DEPENDENT CHILDREN INFORMATION (COMPLETE IF PROPOSED INSURED IS APPLYING FOR DEPENDENT'S COVERAGE).

Person Proposed for Insurance *(first, middle and last name)*	Gender	Date of Birth *(mm/dd/yyyy)*	Social Security Number	Covered by employee's major medical plan?	Coverage Election	
					Life	_
Child	☐Male ☐	/ /		☐Yes ☐ No	☐	–
Child	☐Male ☐	/ /		☐Yes ☐ No	☐	–
Child	☐Male ☐	/ /		☐Yes ☐No	☐	–
Child	☐Male ☐	/ /		☐Yes ☐No	☐	–

For any dependent above with other health coverage [Employee] to provide information below. If not applicable, please mark N/A. Attach additional pages as necessary, signed and dated.

Dependent's Name: _____ Payer Name:_____ Policy Number:_____ Medicare ID Number:	Dependent's Name: _____ Payer Name:_____ Policy Number:_____ Medicare ID Number:	Dependent's Name: _____ Payer Name:_____ Policy Number:_____ Medicare ID Number:
If Spouse/Civil Union Partner/Domestic Partner	Employer name:	

[1] References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company

Is employed – to be completed by [Employee]. If not applicable, please mark N/A	Employer Address: City, State, Zip Code: Employer Phone ( )
If Spouse/Civil Union Partner/Domestic Partner has different billing address – to be completed by [Employee]. If not applicable, please mark N/A	Street Address/Apt: Street Address/Apt: City, State, Zip Code: Please explain why the address is different:

If Child has a different address than Employee – Employee to provide information below. If multiple children at one address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s): Street/Apt: Street/Apt: City, State, Zip Code: Reason:	Name(s): Street/Apt: Street/Apt: City, State, Zip Code: Reason:

- *Waivers are not allowed for non-contributory coverages*

** Note: Spouse includes the Proposed Insured's legally married spouse, or civil union partner or domestic partner if legally recognized in New Jersey.*

[For additional children, please attach a separate sheet of paper signed by the Proposed Insured, including the above information for each child.]

SECTION 8 BENEFICIARIES

Indicate your beneficiary designation in the space below. If you need more space, please use another sheet.

(1) If you are married, or, where permitted by law, in a domestic partnership or civil union, a primary beneficiary designation of a person or organization other than your Spouse/partner may not be valid under your state law. Please consult your legal advisor before making such a designation

(2) You may designate more than one primary or secondary beneficiary. Please be sure to indicate the percentage share that each beneficiary should receive. The total within each class – primary and secondary – must equal 100%.

PRIMARY BENEFICIARY(IES) Basic Life Basic AD&D Supplemental/Voluntary Life Supplemental/Voluntary AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security Number	Relationship	% of Benefit

SECONDARY/CONTINGENT BENEFICIARY(IES) Basic Life Basic AD&D Supplemental/Voluntary Life Supplemental/Voluntary AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security Number	Relationship	% of Benefit

PRIMARY BENEFICIARY(IES) Basic Life Basic AD&D Supplemental/Voluntary Life Supplemental/Voluntary AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security	Relationshi	% of Benefit

[1] References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company

		Number	p	

SECONDARY/CONTINGENT BENEFICIARY(IES) Basic Life Basic AD&D Supplemental/Voluntary Life Supplemental/Voluntary AD&D

Name (Last, First, MI)	Address (Street, City, State, Zip)	Social Security Number	Relationship	% of Benefit

PLEASE NOTE: Equitable does not act or serve as a record keeper or a third party administrator in any capacity in connection with an employee's designation of beneficiaries under any group life insurance policy. Equitable assumes no responsibility for an employee's designation of beneficiaries or the transmission, maintenance or use of such information by the Benefits Administrator, Plan Sponsor or the employee. The Benefits Administrator and Plan Sponsor remain solely responsible for maintaining the Plan's official record of such designation and the accuracy of the information

SECTION 9 ACKNOWLEDGEMENTS

By signing this Enrollment form, I understand and agree that:

(1) I authorize my Employer to make required deductions, if any, from my salary to pay the premium for my insurance as elected above once in effect.

(2) All statements and answers I have given are complete and true to the best of my knowledge and belief.

(3) Coverage is not in effect until final approval is given by the Company[1].

(4) No person, except an officer of the Company, is authorized to vary or modify a contract.

(5) I have read and acknowledge the applicable fraud warning attached.

(6) I, the undersigned agree that statements and answers in all parts of the enrollment form are true and complete to the best of my knowledge and belief.

SECTION 10 CONDITIONS OF ENROLLMENT – APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

(1) I authorize any dentist or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give the Company or any consumer reporting agency acting on behalf of the Company, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.

(2) I understand that an investigative consumer report commonly includes information involving personal character, general reputation, personal characteristics and mode of living. A copy of the consumer report can be provided upon written request.

(3) I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that the Company has taken in reliance on the authorization.

(4) I understand I may receive a copy of this authorization if I request one.

(5) I agree the Company will provide coverage in accordance with the terms of the contract for the group policy. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

SECTION 4 EMPLOYEE WAIVER OF INSURANCE

☐ I have been given the opportunity to apply for the group insurance plan coverage as presented to me, but do **NOT** wish to enroll in the insurance plans offered. Coverage offered by my Employer and not elected in the Insurance Coverage Election portion of this form is assumed to be coverage that I have refused. No waivers are allowed for non-contributory coverage. I understand that if I or my dependents decide to apply for this group insurance plan at a later date, Late entrant penalty and/or Evidence of Insurability will be required at my own expense. The Evidence of Insurability must be approved by the Company.

[1] References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company

Sign Here	**Employee/Applicant Signature**	**Date**
	Spouse Signature Voluntary/Supplemental	**Date**
Employer Verification	**The requested enrollment/change in status is believed eligible and is approved by the [Employer].** **Employer Representative** **Date** **Representative Title**	

[1] References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company

FRAUD WARNINGS

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with an intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Note: Does not apply to Life Insurance. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.

[1] References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company

Pennsylvania: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

All Other States: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

[1] References herein to the "Company" refer to either Equitable Financial Life Insurance Company or Equitable Financial Life Insurance Company of America as the applicable issuing company

Catalog No. XXXXXX [fulfillment name] (May 2016)

Money Network Enrollment Form

If you prefer a Debit Card rather than Direct Deposit or Payroll Check please indicate your interest on this form

Name _____

Address _____

You deserve *more* from your money.

MORE ACCESS. Your pay goes straight into your **Money Network® Account** each payday and can be accessed using your **Money Network® Card** or **Money Network® Checks.**

MORE KNOWLEDGE. Access and manage your Account anytime, anywhere with the **Money Network® Mobile App**[1], set balance or purchase alerts, or visit **moneynetwork.com**.

MORE SAVINGS. Access your money in a variety of ways at no cost[2] – make purchases, use or cash Money Network Checks and access thousands of surcharge-free in-network ATMs.

MORE PROTECTION. Access your FDIC-insured[3] wages on payday without the worry of a lost or stolen paycheck, stay protected against unauthorized purchases with the Visa® Zero Liability Policy[4] or access bilingual customer service 24 hours a day, seven days a week.

[1] Standard Message and Data Rates may apply.
[2] Other fees may apply. See the Fee and Transaction Limit Schedule for the Money Network® Service for more details.
[3] Card funds will be FDIC insured provided the Card is registered to the name of the primary cardholder.
[4] The Visa Zero Liability policy covers U.S.-issued cards only and does not apply to ATM transactions, PIN transactions not processed by Visa, or certain commercial card transactions. Cardholder must notify issuer promptly of any unauthorized use. Consult issuer for additional details or visit www.visa.com/security.

Talk to your HR representative to see how easy it is to get started today!