# Employee Benefits Guide

## November 1, 2026 through October 31, 2027

**Benefits Advocacy Team**
(855) 860-8679
jonescompaniesbenefits@sullicurt.com
7:30am to 5:00pm PST
M-F, excluding holidays

**Benefits Website**
www.jonescompanies.benefitsmap.com
username: **jones**
password: **benefits**



JONES LUMBER

JONES WHOLESALE LUMBER



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*The information contained within is a summary of plan options. All employee benefit premium contributions outlined in this guide are deducted on a post-tax basis. For further details, please refer to the governing plan documents.*

# Contact Information

## Member Service Numbers

**Blue Shield (Group#: W3002601)**

Trio HMO Medical Plan ..... (855) 829-3566
All Other Medical Plans ..... (888) 256-1915
Dental ..... (888) 702-4171
Vision ..... (877) 601-9083

**MetLife**

Basic Life and AD&D ..... (800) 438-6388
Employee Assistance program (EAP) ..... (888) 319-7819

## Helpful Websites/Emails

Blue Shield Website ..... www.bscaplan.com/as3bxz
MetLife ..... www.metlife.com
MetLife EAP Website ..... one.telushealth.com
*(Username: metlifeeap Password: eap)*

**If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 11 for more details.**

## Benefits Advocacy Team

Jones Companies employees can call a convenient, toll-free number to reach experienced benefits administrators and licensed insurance professionals for information on benefits, eligibility, claims assistance and how to enroll in the online enrollment system.

Jones Companies employees have access to the Benefits Advocacy Team from 7:30 am to 5:00 pm Pacific Time, Monday through Friday (excluding holidays). Spanish speaking representatives are available.

**Toll Free: (855) 860-8679**
**Email: jonescompaniesbenefits@sullicurt.com**

# Open Enrollment

Open Enrollment occurs one time each year. During this time, you may add or remove dependents from your coverage, enroll for the first time, change your coverage level, or change your benefit elections, without experiencing a qualifying event. All benefit enrollments and elections made during this time will be effective November 1, 2026, and will remain in effect throughout the plan year, until October 31, 2027. Employees can call the Benefits Advocacy Team for help or assistance and contact our Human Resources department with any questions.

## 2026-27 Highlights

An overview of the benefit plan offerings available to you are as follows:

- **NEW!** Medical through Blue Shield
- **NEW!** Dental through Blue Shield
- **NEW!** Vision through Blue Shield
- Basic Life/AD&D through MetLife
- Employee Assistance Program through MetLife

## Eligibility

**New Hires:** Newly hired full time employees are eligible to participate in the plan after the new hire waiting period.

**Dependents:** You may cover your spouse or domestic partner and children. Children can be up to age 26 regardless of student status.

## Payroll Contributions

**Premiums for all benefits elected are deducted from your paycheck on a post-tax basis.** This means your contributions toward insurance premiums will be taken from your paycheck after taxes have been calculated and withheld. As a result, these premiums do not reduce your taxable income. If you have any questions about how this affects your paycheck or taxes, please contact Human Resources.

## Changing Benefits Mid-Year

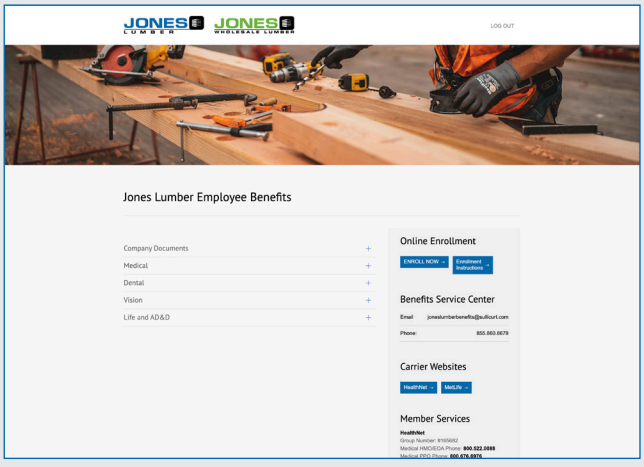
Because your benefit premiums are deducted on a post-tax basis, you may be eligible to make changes to your coverage during the year.

Mid-year changes are permitted in accordance with plan rules and may require carrier approval. Please contact Human Resources for more details.

## Benefits Website

Visit our employee benefit website, an online destination where you can find all of your benefit information, carrier forms, educational resources and enrollment information. This site will allow you to quickly access the information you need to make an informed decision about choosing your benefit plans.

**www.jonescompanies.benefitsmap.com**
username: **jones**
password: **benefits**





# Medical

Jones Companies offers four choices of medical insurance plans: three HMO plans and a PPO plan. Each of our medical insurance plans offer different levels of deductibles, copayments, and out-of-pocket maximums.

## Blue Shield Medical HMO's

If you elect coverage in any of the HMO plans you are required to choose a Primary Care Physician (PCP) who is part of the Blue Shield network as your primary doctor. Each family member covered through your plan can choose his or her own PCP and can change them at any time. All care must be provided by the primary physician. To search the provider list online, visit **www.blueshieldca.com**.

## Blue Shield PPO

When you enroll in the Blue Shield PPO plan, you have the freedom of choice! You can access Medical care from both In and out-of-network providers. There is also no requirement that you select a PCP or receive authorized referrals to specialists. In order to receive the highest level of coverage under the plan, simply obtain care from an in-network provider.

### Important Note

When choosing your Primary Care Physician on an HMO plan, please be sure to confirm they are within your chosen network. To find out if your doctor is in the network, or to find a new doctor in the network, go to www.blueshieldca.com and use the Find a Doctor tool (refer to page 5 for detailed instructions). You have the option of two Limited Networks (Trio/ Local Access+) or a Full Network (Access+). The PPO plan does not require a  PCP selection.

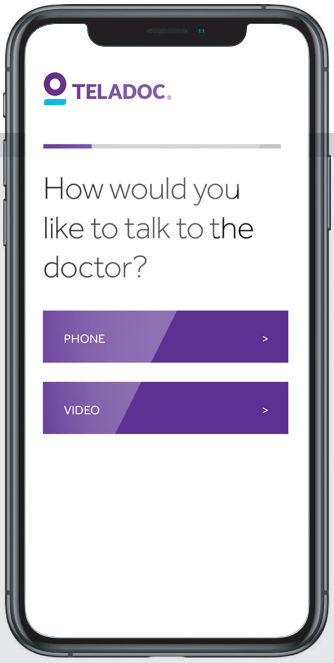
# Teladoc

Teladoc gives you 24/7 access to U.S. board-certified doctors through the convenience of web, phone or app. Get the care you need in minutes from the comfort of home, at work or while traveling. It's an affordable alternative to costly urgent care and ER visits when you need care now.

## When Should I Use Teladoc?

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- For short-term prescription refills

Access a doctor anytime, anywhere by going to teladoc.com to register online or calling **(800) 835-2362** You can also download the app for free on the App Store and Google Play.



# Medical HMO Plan Options

| Blue Shield | Trio HMO | Local Access+ HMO | Access+ HMO |
|---|---|---|---|
| **Network** | **Trio** | **Local Access+** | **Access+** |
| **Calendar year deductible** | None | None | None |
| **Calendar year out-of-pocket maximum** | $3,500 individual<br>$7,000 family | $3,500 individual<br>$7,000 family | $3,500 individual<br>$7,000 family |
| **Physician office visit** | $30 copay | $30 copay | $30 copay |
| **Specialist office visit** | $30 copay | Access+: $45 copay<br>Other: $30 copay | Access+: $45 copay<br>Other: $30 copay |
| **Preventive care** | No charge | No charge | No charge |
| **Lab/X-rays** | No charge | No charge | No charge |
| **Advanced Imaging** | No charge | No charge | No charge |
| **Inpatient hospital** | 30% coinsurance | 30% coinsurance | 30% coinsurance |
| **Outpatient Surgery** *(at Ambulatory Surgery Center)* | 15% coinsurance | 15% coinsurance | 15% coinsurance |
| **Emergency room (waived if admitted)** | $150 copay per visit<br>(waived if admitted) | $150 copay per visit<br>(waived if admitted) | $150 copay per visit<br>(waived if admitted) |
| **Chiropractic and Acupuncture Services**<br>Chiropractic<br>Acupuncture | *Up to 30 visits combined*<br>$10 per visit<br>$10 per visit | *Up to 30 visits combined*<br>$10 per visit<br>$10 per visit | *Up to 30 visits combined*<br>$10 per visit<br>$10 per visit |
| **Rx deductible** | None | None | None |
| **Retail prescriptions**<br>Tier 1: Generic<br>Tier 2: Brand<br>Tier 3: Non-Formulary<br>Specialty | *30-day supply*<br>$15<br>$30<br>$50<br>20% up to $250 | *30-day supply*<br>$15<br>$30<br>$50<br>20% up to $250 | *30-day supply*<br>$15<br>$30<br>$50<br>20% up to $250 |
| **Cost Per Week (52)**<br>Employee<br>Employee + 1<br>Employee + Spouse/DP + 1 or more children | <br>$0.00<br>$41.32<br>$56.70 | <br>$20.60<br>$85.60<br>$117.45 | <br>$36.87<br>$120.59<br>$165.46 |

Please refer to your carrier Summary(ies) of Benefits and Coverage (SBCs) for more detailed benefit information. Plan documents will govern.

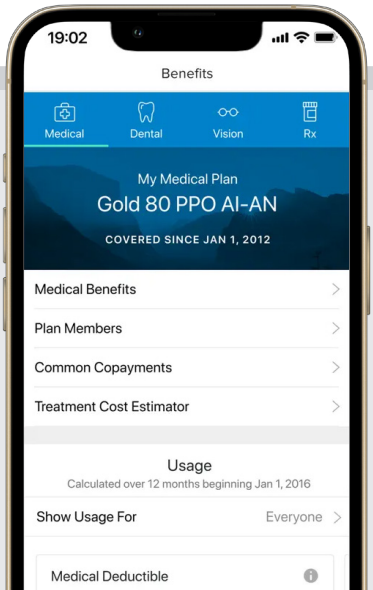
## Medical PPO Plan Option

| Blue Shield | Full PPO Combined Deductible | |
|---|---|---|
| **Network** | **In-Network** | **Out-of-Network** |
| **Calendar year deductible** | $250 individual $750 family | |
| **Calendar year out-of-pocket maximum** | $3,750 individual $7,500 family | $10,250 individual $20,500 family |
| **Physician / Specialist office visit** | $20 / $25 copay, deductible waived | 40% after deductible |
| **Preventive care** | No charge, deductible waived | 40% after deductible |
| **Lab/X-rays** | $20 copay, deductible waived | 40% after deductible |
| **Advanced Imaging** | 20% after deductible | 40% after deductible |
| **Inpatient hospital** | 20% after deductible | 40% after deductible; Max $600 per day |
| **Outpatient Surgery** *(at Ambulatory Surgery Center)* | 10% after deductible | 40% after deductible; Max $350 per day |
| **Emergency room (waived if admitted)** | $150 copay + 20% after deductible (copay waived if admitted) | |
| **Chiropractic and Acupuncture Services**<br>Chiropractic (Up to 20 visits)<br>Acupuncture (Up to 20 visits) | <br>$20 per visit<br>$20 per visit | <br>40% after deductible<br>40% after deductible |
| **Rx deductible** | None | |
| **Retail prescriptions**<br>Tier 1: Generic<br>Tier 2: Brand<br>Tier 3: Non-Formulary<br>Specialty | *30-day supply*<br>$10<br>$30<br>$50<br>30% up to $250 | *30-day supply*<br>25% + $10<br>25% + $30<br>25% + $50<br>30% up to $250 + 25% of purchase price |
| **Cost Per Week (52)**<br>Employee<br>Employee + 1<br>Employee + Spouse/DP + 1 or more children | <br>$98.89<br>$253.93<br>$348.42 | |

Please refer to your carrier Summary(ies) of Benefits and Coverage (SBCs) for more detailed benefit information. Plan documents will govern.

## Blue Shield App

With the Blue Shield mobile app, you can find everything you need to know about your Blue Shield benefits — personalized and all in one place, making it easier to get things done, so you can spend more time focused on your health. Use the Blue Shield app to manage and track claims, view, fax or email ID card information, find doctors, compare cost and quality information, review your coverage, track your account balances and deductibles, and more!



# Dental

## Dental Health Maintenance Organization (DHMO)

The DHMO features unlimited benefits but does require a copay for each covered procedure. Examples of some copays are provided in the chart below. If you elect coverage in this plan you must select a contracted dentist from the DHMO Provider list. All care must be provided by the primary care dentist in the DHMO Network. **The DHMO Schedule of Benefits can be found on the Jones Companies Benefits Website** at jonescompanies.benefitsmap.com (Username: jones, Password: benefits).

## Dental Preferred Provider Organization (DPPO)

The Dental PPO plans allow you to choose an in-network or out-of-network provider. When visiting an out-of-network dentist, please remember that you are responsible for amounts in excess of charges above the allowable amounts. Out-of-network dentists are not contracted with the carrier; therefore, members may expect to pay more for utilizing a dentist outside of the network.

| Blue Shield | DHMO | Low PPO | | High PPO | |
|---|---|---|---|---|---|
| | In-Network | In-Network | Out-of-Network | In-Network | Out-of-Network[2] |
| **Annual Deductible** | | | | | |
| Member | None | $50 | $75 | $50 | $75 |
| Family | None | $150 | $225 | $150 | $225 |
| **Annual Maximum Benefit** | None | $1,500 per person | $1,500 per person | $2,250 per person | $2,250 per person |
| **Preventive & Diagnostic Services** | $0 copay | No charge, deductible waived | No charge, deductible waived | No charge, deductible waived | No charge, deductible waived |
| **Basic Services** | Copays vary, see copay schedule | 20% after deductible | 20% after deductible | 10% after deductible | 20% after deductible |
| **Major Services** | Copays vary, see copay schedule | 50% after deductible | 50% after deductible | 40% after deductible | 50% after deductible |
| **Orthodontic Services** | | | | | |
| Child | $1,775 copay | 50% | 50% | 50% | 50% |
| Adult | $1,975 copay | 50% | 50% | 50% | 50% |
| Lifetime Maximum Benefit Per Person | N/A | $1,500 | $1,500 | $1,500 | $1,500 |
| **Cost Per Week (52)** | | | | | |
| Employee | $0.00 | $6.94 | | $12.73 | |
| Employee + Spouse/Domestic Partner (DP) | $1.38 | $15.54 | | $24.44 | |
| Employee + Child(ren) | $1.46 | $18.16 | | $30.15 | |
| Employee + Spouse/DP + 1 or more children | $1.79 | $29.11 | | $43.96 | |

Please refer to your carrier Summary(ies) of Benefits and Coverage (SBCs) for more detailed benefit information. Plan documents will govern.

# Vision

Vision examinations not only determine the need for corrective eyewear but also may help detect other general health problems such as glaucoma, cataracts, and diabetes. Plus, eye exams for children can help detect problems that can impact learning and development. You will get the best value from your vision care plan when you visit a **Blue Shield Vision** network provider. If you decide to see an out-of- network provider, the plan copays will still apply. The choice is yours — either way, your Blue Shield vision benefits are a tremendous part of your overall benefits package.

| Blue Shield | Vision Plan | |
|---|---|---|
| **Frequency limits**<br>Exam<br>Frames<br>Lenses | <br>Every 12 months<br>Every 24 months<br>Every 12 months | |
| | **In-Network** | **Out-of-Network Reimbursement** |
| **Exam** | $10 copay | Up to $60 |
| **Frames** | $25 copay + $130 allowance | Up to $85 |
| **Single vision lenses** | $25 copay | Up to $43 |
| **Bifocal lenses** | $25 copay | Up to $60 |
| **Trifocal lenses** | $25 copay | Up to $75 |
| **Elective contacts** | $25 copay + $130 allowance | Up to $85 |
| **Cost Per Week (52)**<br>Employee<br>Employee + Spouse/Domestic Partner (DP)<br>Employee + Child(ren)<br>Employee + Spouse/DP + 1 or more children | <br>$0.00<br>$0.57<br>$0.63<br>$1.02 | |

Please refer to your carrier Summary(ies) of Benefits and Coverage (SBCs) for more detailed benefit information. Plan documents will govern.





# Basic Life and AD&D

We provide full-time employees with Group Term Life and Accidental Death & Dismemberment (AD&D) insurance. **Please remember to update your beneficiary**. If you have any questions, please see Human Resources or contact the Benefits Service Center.

| MetLife | |
|---|---|
| **Life/AD&D Benefit** | $15,000 flat amount |
| **Benefit Reduction Formula** | At age 65 benefit reduces to 65%;<br>At age 70 benefit reduces to 50% |

# Employee Assistance Program (EAP)

As a Jones Lumber Company employee you can access your Employee Assistance Program at any time, 24/7/365, and speak with a professional, experienced counselor for help with:

- Balancing work and life
- Stress and anxiety
- Losing a loved one
- Legal issues
- Family, marital and relationship challenges
- And much more

Call (888) 319-7819 or visit one.telushealth.com *(Username: metlifeeap Password: eap)* to get started.



# How to Find a Provider

## Find a Medical Provider

**Trio HMO:** www.blueshieldca.com/networktriohmo
**Local Access+ HMO:** www.blueshieldca.com/networklocalaccess
**Access+ HMO:** www.blueshieldca.com/networkhmo
**Full PPO:** www.blueshieldca.com/pponetwork

1. Enter your address
2. Enter Doctor name, specialty, condition
3. Filter your results

## Find a Dental Provider

**Dental HMO:** www.blueshieldca.com/dentalhmo
**Dental PPO:** www.blueshieldca.com/dentalppo

1. Enter your address
2. Search by Specialty or Name
3. Filter your Results

## Find a Vision Provider

Vision: www.blueshieldca.com/fad/index.html?deeplinkID=VisionEYE2

1. Enter your address
2. Search by Specialty or Name
3. Filter your Results

# Notes

# Annual Notices & Disclosures

## The Women's Health and Cancer Rights Act of 1998—Important Notice

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

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

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas.

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

## HIPAA Privacy Notice—Important Notice about Your Health Information

The HIPAA Notice of Privacy Practices applies to Protected Health Information associated with the Group Health plan provided to our employees, employee's dependents and, as applicable, retired employees. The Notice describes that Jones Companies may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of the Notice so long as it remains in effect. We reserve the right to change the terms of the Notice as necessary and to make the new Notice effective for all Protected health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health plan. Copies of our current Notice may be obtained by contacting:

Silvia Mercado
Email: silviam@joneslumber.com

## Newborns' and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

## Patient Protection Disclosure

Blue Shield HMO health plan generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Shield designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Shield HMO at (888) 256-1915.

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

You do not need prior authorization from Blue Shield 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 Blue Shield HMO at (888) 256-1915.

## HIPAA Special Enrollment Rights

If you are declining for yourself or your dependent (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 towards you or your dependent's other coverage). However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing towards the other coverage). Note: if the change is due to Medicaid/CHIP eligibility, there is a 60 day window for Medicaid/CHIP eligibility changes only.

## Your Rights and Protections Against Surprise Medical Bills

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

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

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

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

**You're protected from balance billing for:**

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

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

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

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

**When balance billing isn't allowed, you also have these protections:**

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

## Medicare Notice of Creditable Coverage

**Important Notice from Jones Companies 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 Jones Companies and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Jones Companies has determined that the prescription drug coverage offered by the Blue Shield plans 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.

**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

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

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

**For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information.

Silvia Mercado
Email: silviam@joneslumber.com

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 Jones Companies changes. You also may request a copy of this notice at any time.

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

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

**For more information about Medicare prescription drug coverage:**

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

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

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

## 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, 2026. Contact your State for more information on eligibility –

**ALABAMA – Medicaid**

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

**ALASKA – Medicaid**

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

**ARKANSAS – Medicaid**

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

**CALIFORNIA – Medicaid**

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

**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**

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

**FLORIDA – Medicaid**

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

**GEORGIA – Medicaid**

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

**INDIANA – Medicaid**

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

**IOWA – Medicaid and CHIP (Hawki)**

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

**KANSAS – Medicaid**

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

**KENTUCKY – Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

**LOUISIANA – Medicaid**

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

**MAINE – Medicaid**

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

| MASSACHUSETTS – Medicaid and CHIP |
|---|
| Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840 TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** |
| Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 |
| **MISSOURI – Medicaid** |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov |
| **NEBRASKA – Medicaid** |
| Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 |
| **NEW HAMPSHIRE – Medicaid** |
| Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** |
| Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **NEW YORK – Medicaid** |
| Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **NORTH DAKOTA – Medicaid** |
| Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |
| **OREGON – Medicaid** |
| Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid** |
| Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) |
| **RHODE ISLAND – Medicaid and CHIP** |
| Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line) |
| **SOUTH CAROLINA – Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 |
| **SOUTH DAKOTA - Medicaid** |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 |
| **UTAH – Medicaid and CHIP** |
| Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT– Medicaid** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 |
| **VIRGINIA – Medicaid and CHIP** |
| Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select & https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 |
| **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://dhhr.wv.gov/bms/ & http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 |
| **WYOMING – Medicaid** |
| Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

## Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

This summary provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. If there is a disagreement between this summary and the plan documents, the documents will govern. In addition, the plans described in this summary are subject to change without notice. Continuation of any benefit plan or coverage is at the company's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact Human Resources at Jones Companies .