Jackson
FAMILY WINES

2026 Employee Benefits Guide

Contents

IMPORTANT NOTICE: READ CAREFULLY

This benefits guide briefly describes your benefits choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts.

The benefits described apply to benefits-eligible employees of Jackson Family Enterprises, Jackson Family Wines, Inc., Regal Wine Company, LLC., Jackson Family Investments, LLC and Hartford-Jackson, LLC, KJCB, Inc. (collectively referred to as “The Company”)

This guide is not intended to be a complete description of the benefits, and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this guide and the plan documents, the plan documents will govern. Information contained in this Health Benefits Guide is proprietary and confidential to Jackson Family Wines.

Jackson Family Wines reserves the right to modify or terminate any of the described benefits at any time and for any reason. This guide is not a guarantee of current or future employment or benefits. Some benefit programs require contributions from the employee. Refer to your benefits materials for additional details about any plan.

Getting Started

Benefits are a valuable addition to your overall compensation at Jackson Family Wines, Inc.* As an employee of Jackson Family Wines, you are provided a competitive package offering flexibility, financial protection and a foundation for future security. Our employees are of the utmost importance and our benefits are designed to create a healthy work-life balance that supports you and your family's needs. This benefits guide is here to help you better understand the plans offered and how to enroll in coverage. Please make sure you take full advantage of them by taking the time to understand your options and selecting the best coverage for you and your family.

This benefits guide briefly describes your benefits choices and options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. The benefits described apply to benefits-eligible employees at Jackson Family Wines.

This guide is not intended to be a complete description of the benefits, and it is not a summary plan description of plan document. In the event of any conflict between this guide and the official plan documents, the plan documents will govern. Jackson Family Wines reserves the rights to modify any or all components of the company's benefit plans at any time and for any reason This guide is not a guarantee of current of future employment or benefits.

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*The benefits described apply to benefits-eligible employees of Jackson Family Enterprises, Jackson Family Wines, Inc., Regal Wine Company, LLC., Jackson Family Investments, LLC and Hartford-Jackson, LLC, KJCB, Inc. (collectively referred to as "The Company"). Benefits described in this guide are effective January 1, 2026 – December 31, 2026.

Who is eligible for benefits?

Employees

You are eligible if you are actively working 30 or more hours per week and designated as a full-time employee.

Employees with variable hours and seasonal schedules may be considered eligible for benefits.

Eligible dependents

- Your spouse. The term “spouse” means the individual lawfully married to you.
- Your domestic partner must meet the criteria outlined below.
- Your qualified children under the age of 26 who is your: biological, step, adopted or placed for legal guardianship.
- Your unmarried child over the age of 26 who is disabled, living with you, dependent on you for support and unable to support himself/herself due to a mental or physical disability.

Domestic partner notice

Please note that domestic partner coverage can differ from spouse coverage when Medicare eligibility is a factor.

Medicare is the primary payer for domestic partners with large employer group health plan coverage if a domestic partner can get Medicare due to their age and has group health plan coverage through their partner's current employer.

Note: the value of health care coverage provided for a domestic partner, or any enrolled dependent children of your domestic partner is treated as income to you for federal tax purposes (and in most cases, state tax purposes). Jackson Family Wines will report the value of the coverage as income to you on your W-2 Form and will withhold applicable taxes. It is recommended you consult with your tax advisor for more information on how this affects you.

When you can enroll

New hires may elect benefits within 31 days of your date of hire and coverage will become effective first day of the month following date of hire. Existing employees can enroll during the annual open enrollment period which is typically held in November for January 1st effective date.

Outside of these periods, you can only make changes if you experience a qualifying life event which is described on the next page under “Making Changes Mid Year”.

What happens if you don’t enroll as a new hire?

As a newly eligible employee, if you do not log on and elect or waive coverage, you will be automatically enrolled in the Anthem Advantage Plus CDHP PPO-HSA medical plan for employee only coverage, effective the first day of the month following your date of hire. The biweekly employee contribution of $81.00 is deducted from the first pay period of the month in which your coverage is effective. However, you will not be automatically enrolled for dental, vision or voluntary life insurance.

You are also automatically enrolled in the company sponsored benefits: basic life insurance and AD&D, short-term and long-term disability, employee assistance program and Modern Health which are effective the first of the month following your date of hire.

Medicare Part D Notice

If you (and/or your dependents) 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 the Important Notices section for more details.

Making changes mid-year

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child

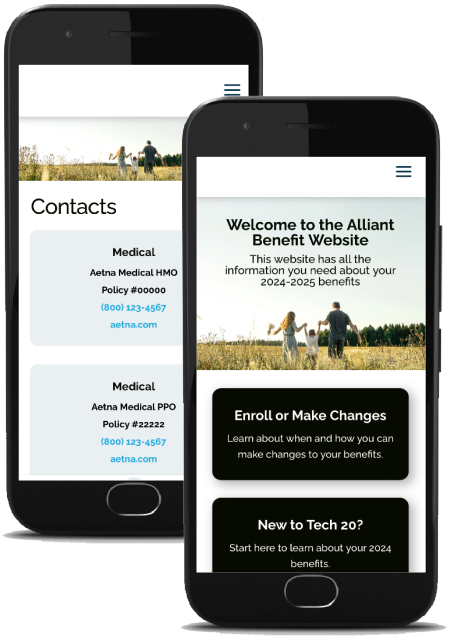
You must submit any changes within 31 days after the event.

Life happens

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

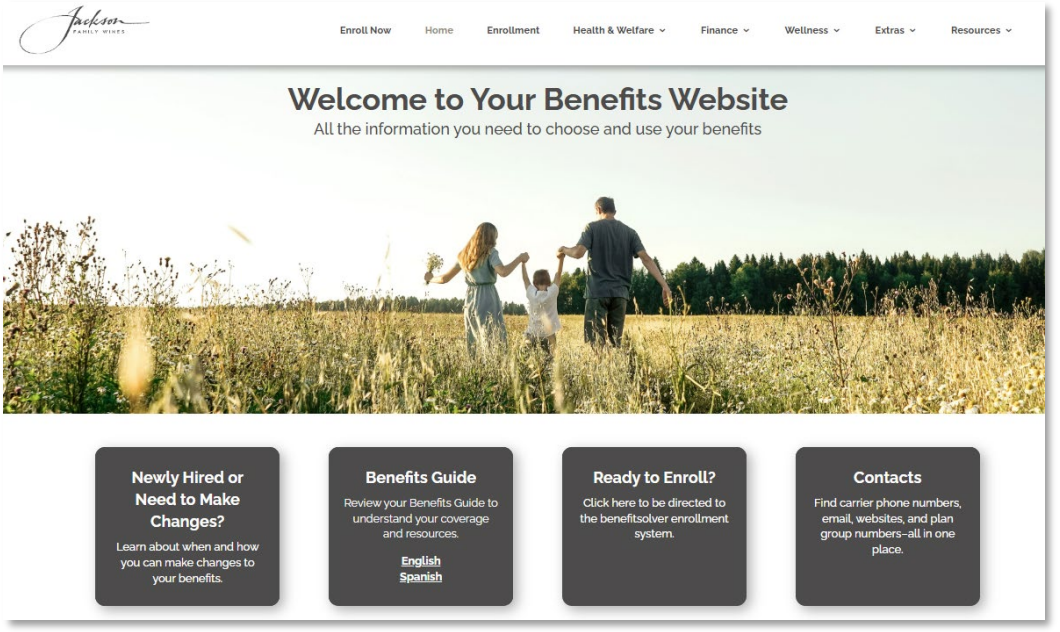
Click to play video

The easy way to get benefits info



Here's what you'll find on www.jfwbenefits.com

Benefits	See benefit details and costs for all plans you're eligible for.
Learn	View informative presentations about the benefits available.
Enroll	Easy SSO access to the enrollment system with your JFWNow credentials.
Documents	Read important benefit plan notices ("the fine print").
Contacts	Find HR, benefits, and carrier contacts.
Get help	Need help? Reach helpful resources.



Which plan is right for you?

All About Medical Plans

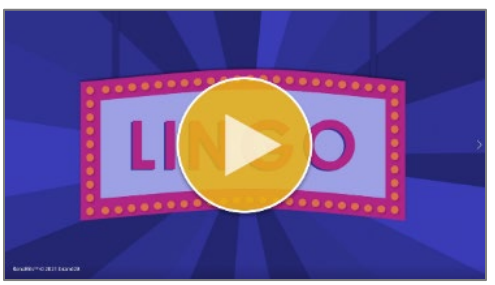
Plan type definitions

- **HMO:** health maintenance organization
- **PPO:** preferred provider organization
- **CDHP:** consumer driven health plan

When choosing a medical plan, it is important to look at your budget, your preferences, your age and health, as well as the age and health of your covered dependents. You should consider the key differences between plan types and choose one that best suits you and your family.

The plans differ in the following areas:

- Cost of coverage, including payroll contributions
- Deductible, co-payments, and coinsurance
- Out-of-pocket maximum
- Convenience, covered services, access to providers, ease of use



Play the Health Lingo Game!

Consider an HMO if:

- You want lower, predictable out-of-pocket costs.
- You like having one doctor to manage your care.
- You are happy with the selection of network providers.
- You don't see any doctors that are out-of-network.
- You have convenient access to Kaiser facilities.

Plans to consider

- Anthem Value HMO (CA only)
- Kaiser HMO (CA & OR only)

Consider a PPO if:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for out-of-network providers (at a higher cost).

Plans to consider

- Anthem Value PPO

Consider a CDHP (with Health Savings Account) if:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for out-of-network providers (at a higher cost).
- You want tax-free savings on your healthcare costs.
- You want to build a savings account for future healthcare. costs for you and your eligible family members.
- You want an extra way to add to your retirement savings.

Plans to consider

- Anthem Advantage Plus CDHP-HSA

In a CDHP you must first satisfy your deductible. Once your deductible is satisfied, you will pay a percentage of the cost (your coinsurance) until your annual out-of-pocket maximum is reached. Once your annual out-of-pocket maximum is reached, the plan will pay 100% of the cost of covered services for the remainder of the calendar year. Please note you will still be responsible for costs in excess of reasonable and customary limits (applies to non network providers only).

CDHP plan has a second component, Health Savings Account (HSA). The HSA allows you to fund a personal bank account to help offset future health care expenses and provides triple-tax savings.

Anthem Advantage Plus CDHP - HSA

Advantages of a Health Savings Account (HSA)

- Tax-free contributions when you or Jackson Family Wines contributes to the account
- Tax-free interest on your HSA balance and investment gains
- Tax-free withdrawals for qualified expenses
- Any unused funds rollover and all funds are yours to keep.*State payroll taxes apply in some states, please check with your tax professional.

About The Anthem Advantage Plus CDHP - HSA

A Consumer Driven Health Plan (CDHP) is a medical PPO plan. The unique part of being enrolled in a CDHP is that it allows you the opportunity to also open a Health Savings Account (HSA). This account allows you to set aside money on a pre-tax basis for eligible medical, dental and vision expenses.

The Anthem Advantage Plus CDHP - HSA plan is a special type of health plan that typically does not have copays; instead, you'll pay for all medical services and prescriptions up front until you meet your deductible. After meeting the deductible, most benefits are paid on a percentage basis rather than flat dollar copays.

Preventive care is 100% covered when you use in-network providers. Many preventive prescriptions are covered at 100% not subject to deductible or copay (refer to the reference center within the enrollment system for a listing of included medications). Enrolling in the Anthem Advantage CDHP PPO/HSA allows you to pay for eligible health care expenses using your own tax-free medical savings account called an HSA.

Health Savings Account

You must enroll in the Anthem Advantage Plus CDHP - HSA plan to be eligible to open an HSA. Contributions can be made to your HSA up to the limits set by the U.S. Treasury and the Internal Revenue Service (IRS). These limits include contributions from any source and the limits may be increased for inflation annually.

Jackson Family Wines will fund the following amounts to your HSA in 2026 (prorated based on date of hire):

- $500 for employee only coverage
- $1,000 for employee plus family coverage (enrolled with one or more family members on the medical plan

The 2026 maximum funding (combined employee and JFW contributions)

- $4,400 for employee only coverage
- $8,750 for employee plus family coverage (enrolled with one or more family members on the medical plan)
- $1,000 additional catch-up contribution for anyone age 55+ (catch up contributions can be made any time during the year in which the HSA participant turns 55)

Important components of a CDHP and HSA

Deductible

Your traditional health coverage begins after you meet the calendar year deductible ($1,700 if you enroll yourself only, or $3,600 if you enroll one or more family members). Your calendar year deductible resets every January. Remember you can use your HSA to pay for deductible and eligible expenses.

Out-of-pocket Maximum

Your calendar year deductible, non-preventive medical services and non-preventive prescription drug costs apply to the Anthem Advantage Plus CDHP - HSA calendar year out-of-pocket maximum. Once you have reached your calendar year out-of-pocket maximum, medical and prescription drug expenses are 100% covered (for covered services). Your out-of-pocket maximum resets every January.

Preventive Care

Preventive care for adults and children is 100% covered by the plan when you use PPO in-network providers (no charge to you). You do not need to meet any deductibles for preventive care visits as long as you use in-network providers. Additionally, there are certain maintenance/preventive drugs that are also 100% covered (no deductible). Please refer to the detailed list located in the reference center in the enrollment system.

Enrolling In A Health Care Flexible Spending Account (FSA)

Due to IRS regulations, if you contribute to an HSA, you may not contribute to a Health Care FSA. However, you are eligible to contribute towards a Limited Health Care FSA (LPFSA) and Dependent Care FSA. Learn more about FSAs, and how they differ from HSAs, on page 23.

Enrolling In Your HSA

JFW is working with HealthEquity to administer our HSA bank accounts. The first time you enroll in the CDHP plan, as part of the process, you will need to actively open your HSA account with HealthEquity. If you enroll in benefits online through the portal and you elect the CDHP plan, you may click to the link on the screen to open your HSA account at that time. If you do not open your HSA account at the time of enrollment, you may go to: www.healthequity.com anytime to open your account.

Making Changes To Your HSA

You may change your HSA contributions anytime through www.jfwbenefits.com by selecting “Enroll” to enter the enrollment system and log on. Select “Qualified Status Change” from the main page, then selecting “HSA Change” as the reason.

Health savings account (HSA)

Click to play videos

Are you eligible?

The HSA is not for everyone. You're eligible only if you are:

- Enrolled in the Anthem Advantage Plus CDHP-HSA medical plan.
- Not enrolled in other non-CDHP medical coverage, including Medicare, Medicaid, or Tricare.
- Not a tax dependent.
- Not enrolled in a healthcare flexible spending account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

Find out more

Eligible Expenses

Ineligible Expenses

A personal savings account for healthcare

A Consumer Driven Health Plan (CDHP) is a medical PPO plan. The unique part of being enrolled in a CDHP is that it allows you the opportunity to also open a Health Savings Account (HSA). This account allows you to set aside money on a pre-tax basis for eligible medical, dental, and vision expenses.

How the Anthem Advantage Plus CDHP-HSA plan works

- JFW is working with HealthEquity to administer our HSA bank accounts. The first time you enroll in the CDHP plan, as part of the process, you will need to actively open your HSA account with HealthEquity.
- If you enroll in benefits online through the portal and elect the CDHP plan, you may click the link on the screen to open your HSA account at that time. If you do not open your HSA account at the time of enrollment, you may go to www.healthequity.com anytime to open your account.
- To help you get started Jackson Family Wines will make a contribution to your HSA:

  Individual: $500
  Family: $1,000

- You can contribute up to the limit set by the IRS (includes Jackson Family Wine's contribution).

  Individual: $4,400 in 2026
  Family: $8,750 in 2026
  Age 55+: $1,000 extra per year

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save the money to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

Medical Plans

You pay the deductible and copayment ($) if applicable. The coinsurance (%) shows what you pay after the deductible.

	Anthem Advantage Plus CDHP-HSA**		Anthem Value PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$1,700 Individual $3,400 Member/$3,600 Family		$1,000 per member Max of 3 separate deductibles per family	$2,000 per member Max of 3 separate deductibles per family
Out-of-pocket maximum	$4,000 per member $8,000 Family ($4,000 embedded)*	$10,000 per member $20,000 Family	$4,000 per member $8,000 per family	$10,000 per member $20,000 per family
Member Coinsurance	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Exams				
PCP visit	20% after deductible	50% after deductible	$30 per visit (deductible waived)	50% after deductible
Specialist visit	20% after deductible	50% after deductible	$50 per visit (deductible waived)	50% after deductible
Preventive Care	No copay (deductible waived)	50% after deductible	No copay (deductible waived)	50% after deductible
Diagnostic services				
Labs and X-rays	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Facility services				
Urgent care	20% after deductible	50% after deductible	$30 per visit (deductible waived)	50% after deductible
Emergency room	20% after deductible	20% after deductible	20% after $150 deductible (deductible waived if admitted inpatient)	20% after $150 deductible (deductible waived if admitted inpatient)
Outpatient surgery	20% after deductible	50% after deductible	$50 per visit (deductible waived)	50% after deductible
Hospitalization	20% after deductible	50% after deductible	$50 per visit (deductible waived)	$250 deductible per admission + 50% after deductible
Prescription drugs				
Retail (30-day supply)	After plan deductible: $15/$50/$70/30% (max copay $250 per fill)	After plan deductible: 50% of Rx drug max allowed amount + costs in excess of the Rx drug max allowed amount	$15/$50/$70/30% (max copay $250 per fill)	Copay + 50% of Rx drug max allowed amount + costs in excess of the Rx drug max allowed amount
Mail Order (90-day supply)	After plan deductible: $30/$125/$175/30% (max copay $500 per fill)	Not Covered	$30/$125/$175/30% (max copay $500 per fill)	Not Covered

**If enrolling any dependents in the Anthem Advantage Plus CDHP - HSA, there are embedded individual out-of-pocket maximums within the family limits. A single member of a family would need to meet the embedded out-of-pocket amount rather than the full family out-of-pocket.*

***CDHP plan is eligible for JFW employer health savings account contribution: $500 individual coverage and $1,000 family coverage (prorated for mid year elections).*

This is intended to be a guide. For a complete description, refer to the summary plan documents. If there is a discrepancy, the plan documents govern.

Medical Plans

You pay the deductible and copayment ($) if applicable. The coinsurance (%) shows what you pay after the deductible.

	Anthem Value HMO In-Network only (CA only)	Kaiser HMO In-Network only (CA & OR only)**
Annual Deductible	None	None
Out-of-pocket maximum	$3,500 per member $7,000 per family	$3,000 per member $6,000 per family
Member Coinsurance	0% after copay	0% after copay
Exams		
PCP visit	$30 per visit	$30 per visit
Specialist visit	$50 per visit	$30 per visit
Preventive Care	No Charge	No Charge
Diagnostic services		
Labs and X-rays	No Charge $100 per test for Advanced Imaging	$10 per encounter
Facility services		
Urgent care	$50 copay per visit (Additional charges may apply depending on the care provided)	$30 per visit
Emergency room *(copay waived if admitted)*	$150 per visit	$150 per visit
Outpatient surgery	$400 per admission	$250 per procedure
Impatient Hospitalization	$750 per day, 3-day max	$500 per admission
Prescription drugs		
Retail (30-day supply)	After plan deductible: $15/$50/$70/30% (max copay $250 per fill)	Generic: $10 copay Brand: $30 copay Specialty: 20% (max copay $250 per fill)
Mail Order (90-day supply)	After plan deductible: $30/$125/$175/30% (max copay $500 per fill)	Generic: $20 copay Brand: $60 copay *100-day supply

**This is intended to be a guide. For a complete description, refer to the summary plan documents. If there is a discrepancy, the plan documents govern.*
***Some benefit coverages may differ between the California and Oregon plans.*

How to find a provider

Go to https://www.anthem.com/ca/find-care/

Log in to find in network providers or search as a guest following these steps:

Select the type of plan or network > "Medical Plan or Network"

Select the state where the plan or network is offered > "California"

Select how you get health insurance > "Medical (Employer-Sponsored)"

Select plan or network:

HMO members select > California Care HMO
or
Advantage Plus CDHP – HSA or Value PPO members select > Prudent Buyer PPO

Click > "continue"

Enter the location where you are searching for care and search by specific provider name or by provider type.

Go to www.kp.org

Select > "Doctors & Locations"
Select your applicable area > "California-Northern", "California-Southern" or "Oregon/Washington"

Enter the location where you are searching for care and search by specific provider name or by provider type.

Telemedicine

LiveHealth Online

At home or on the go, doctors and mental health professionals are here for you. You can meet with board certified doctors and psychiatrists using your smartphone, tablet or computer with LiveHealth Online!

- See a board-certified doctor 24/7. You don't need an appointment to see a doctor. They're always available to assess your condition and send a prescription to the pharmacy you choose, if needed. It's a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue. To schedule your appointment, call 1-888-548-3432 seven days a week.

- Visit a licensed therapist in four days or less. Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more. Schedule your appointment online or call 1-888-548-3432 seven days a week.

- Consult a board-certified psychiatrist within two weeks. If you're over 18 years old, you can get medication support to help you manage a mental health condition. To schedule your appointment, call 1-888-548-3432 seven days a week.

Kaiser Permanente Minute Clinic

Anytime, anywhere, Kaiser Permanente (KP) has you covered. Best options for Non-Emergency Urgent Care away from home:

Domestic Travel (USA) within a KP service area/region
- Nearest KP urgent care

Domestic Travel (USA) in states without KP
- Nearest MinuteClinic
- Nearest urgent care facility

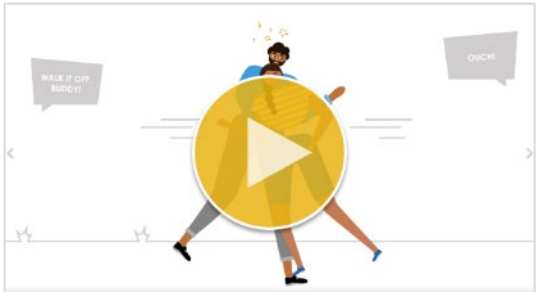
International Travel
- Nearest urgent care facility
- Nearest hospital

Know where to go

Where you get medical care can significantly affect the cost. Here's a quick guide to help you know where to go based on your condition, budget, and time.

Visit type	Use it for …
Nurse line ($) Often available 24/7 at no cost	• quick answers from a trained nurse: – to determine if immediate care is needed – for home treatment options & advice
Online visit ($) Often available 24/7	• non-emergency health issues: – cold, flu, allergies, headache, migraine – rashes, skin conditions – minor injuries – mental health concerns
Office visit ($$) Typically open during regular business hours	• routine medical care and management: – preventive care – illnesses and injuries – existing conditions
Urgent care ($$$) Typically open with extended evening and weekend hours	• urgent but not life-threatening conditions: – sprains or stitches – animal bites – high fever or respiratory infections
Emergency room ($$$$) Open 24/7	• life-threatening conditions requiring immediate care: – suspected heart attack or stroke – broken bones – excessive bleeding – severe pain – difficulty breathing

Click to play video



Urgent Care vs. ER

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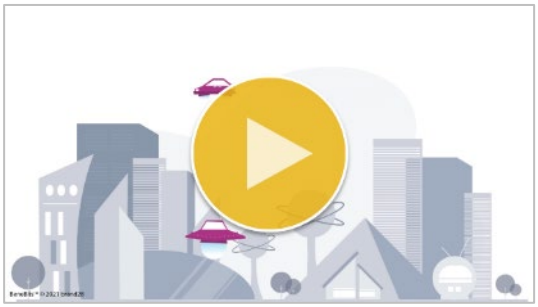


Virtual Healthcare

Alternative facilities

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Procedure	Alternative	Features	Savings*
Surgery	Ambulatory surgical center	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	Up to 50% vs. a hospital stay
Physical therapy	Outpatient facility	• Most cases are suited for outpatient physical therapy • Same types of treatments and similarly skilled therapists as inpatient facilities	40 to 60% vs. a hospital setting
Sleep study	Home testing	• Diagnoses obstructive sleep apnea • Cost is often covered by insurance if considered medically necessary	Up to $4,500 vs. a lab
Infusion therapy	Home or outpatient infusion	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% vs. a hospital stay

**Savings estimates are based on in-network facilities and providers*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital.

You can also search for surgical centers, physical therapy, and similar services on your plan's website, or call member services for assistance. Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings.

Some alternative facilities include a fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Prescriptions breaking your budget?

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

Other Prescription Drug Discount Options

In addition to checking with your insurance plan, you may find lower out-of-pocket costs through discount cards and coupon programs such as GoodRx, SingleCare, WellRx, Optum Perks, America's Pharmacy, and various county-sponsored discount cards.

Use the program to compare the cost at the pharmacy (with the discount) versus your insurance co-pay or your cash price — choose the lower out-of-pocket option.

Present the discount card or coupon at the pharmacy when filling the prescription. If the discount price is lower than your insured co-pay, you may save more by using the card.

Keep in mind: using these discount programs may mean you pay "cash" at the pharmacy (not submitting through your insurance). That may affect whether the amount counts toward your deductible or out-of-pocket maximum.

Click to play video

The formulary drug tiers determine your cost

$	Generic drugs
$$	Brand-name drugs
$$$	Specialty drugs

Nearing 65? Get to know Medicare

Important deadlines ahead

Most people become eligible for Medicare at age 65. At that time, you'll need to make some important decisions about your health insurance.

But the choice isn't always easy. Maybe you'll keep working after 65. Maybe you have dependents covered by your Jackson Family Wines sponsored insurance. Maybe you're just not sure which options could work best for your situation.

Medicare 101

Enrollment Concierge — McNally Insurance Services

Jackson Family Wines has partnered with McNally Insurance Services to assist you with your Health, Dental and Vision Insurance questions when you are coming off a group plan through your work. Here are some common scenarios when you may consider contacting McNally Insurance Services:

- Your dependent children have aged out of your group medical plan
- You turned 65 and are eligible for Medicare and still planning to work
- You're retiring or leaving your employment for other reasons

These have a great impact on our personal and family needs. McNally Insurance Services is available to Jackson Family Wines' employees free of charge to ensure that you are making the best possible choices for your needs.

For assistance, contact:

McNally Insurance Services: Toll Free (877) 490-2500
Maureen McNally: ext. 11, or maureen@mcnallyinsurance.com

Dental Coverage

You pay the deductible and copayment ($) if applicable. The coinsurance (%) shows what you pay after the deductible.

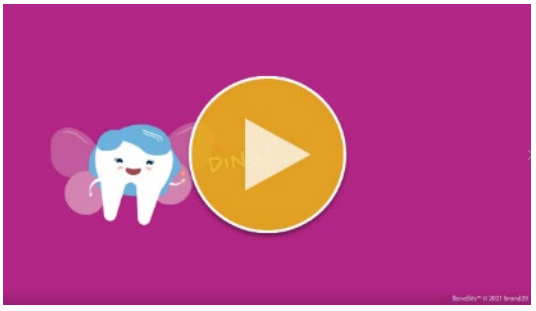
	Delta Dental PPO	
	Delta PPO Dentist	**Non-Delta Dentist**
Deductible	$50 per person / $150 per family	
Annual plan maximum	$2,000	$1,500
Dental Services		
Diagnostic & preventive	0% deductible waived	0% of UCR* deductible waived
Basic	10% after deductible	20% of UCR* after deductible
Major	40% after deductible	50% of UCR* after deductible
Endodontic	10% after deductible	20% of UCR* after deductible
Periodontic	10% after deductible	20% of UCR* after deductible
Implants	40% after deductible	50% of UCR* after deductible
Orthodontia		
Covered for	Adults and children	
Orthodontic Services	50% up to $2,000 lifetime maximum per person	

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile. Your provider will verify eligibility of dental benefits. Visit www.deltadental.com to find in network providers.

Find out how it works!

Click to play video



**Out-of-network providers will be paid at usual, customary and reasonable (UCR) limits. You will be responsible for any charges in excess of UCR.*

This is intended to be a guide. For a complete description, refer to the summary plan documents. If there is a discrepancy, the plan documents govern.

Vision Plan

You pay the copayment ($) if applicable and any costs above the plan allowance.

	In-Network	Out-of-Network
Exams		
Coverage	$25 copay	Up to $45* reimbursement
Frequency	Every Calendar Year	
Materials		
Coverage	$25 copay	See lens and frame allowance
Frames		
Coverage	Up to $200 allowance	Up to $70* reimbursement
Frequency	Every Other Calendar Year	
Lenses		
Single-vision	Covered in full	Up to $30*
Bifocal	Covered in full	Up to $50*
Trifocal	Covered in full	Up to $65*
Frequency	Every Calendar Year	
Contacts in lieu of glasses		
Elective	Up to $180 allowance	Up to $105* reimbursement
Fit and follow-up	Up to $60 copay	
Other Services		
Glasses and Sunglasses	20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last Well Vision Exam	
Laser vision correction	Average 15% off the regular price; discount available at contracted facilities.	

Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

Your provider will verify eligibility of vision benefits. VSP offers the largest network of vision care providers, visit www.vsp.com for details.

Click to play video

**This is intended to be a guide. For a complete description, refer to the summary plan documents. If there is a discrepancy, the plan documents govern.*

***Benefit Frequency is based on last date of service.*

Your bi-weekly benefit costs

The total amount you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis—before federal, state, and social security taxes are calculated—reducing your taxable income.

	Anthem Advantage Plus CDHP – HSA	Anthem Value PPO	Anthem HMO	Kaiser HMO
Employee Only	$81.00	$149.00	$129.00	$141.00
Employee + Spouse/DP	$181.00	$330.00	$286.00	$311.00
Employee + Children	$148.00	$270.00	$234.00	$255.00
Employee + Family	$255.00	$465.00	$404.00	$438.00

	Delta Dental	VSP Vision
Employee Only	$10.24	$1.22
Employee + Spouse/DP	$18.32	$1.71
Employee + Children	$17.91	$1.94
Employee + Family	$27.64	$3.10

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify JFW if your domestic partner is your tax dependent.

Healthcare flexible spending account (FSA)

Click to play video

Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan, like the Anthem Advantage Plus CDHP - HSA plan, you can only participate in the limited-purpose FSA for dental and vision expenses.

For employees enrolled in the Anthem Advantage Plus CDHP - HSA medical plan: You may only enroll in the Limited Health Care FSA. Only non-medical expenses (such as dental and vision) are eligible under a Limited Health Care FSA.

Set aside healthcare dollars for the year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the Flexible Spending Account works

- You estimate what your and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and certain drugstore items.
- You can contribute up to $3,400, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $680 to use the following year. Any additional remaining balance will be forfeited.

Potential tax savings

Because FSA contributions are pre-tax, they reduce the total amount of your income the government makes you pay taxes on.

Find out more

www.wexinc.com
Eligible Expenses
Ineligible Expenses

FSA vs. HSA comparison

REMINDER: YOU MUST RE-ENROLL IN FSA FOR 2026. YOUR PRIOR YEAR ELECTION DOES NOT ROLL OVER.

Flexible Spending Accounts are similar to HSAs in that you can use pre-tax dollars to pay for eligible medical, dental and vision expenses. Because an FSA can be used to pay for very similar expenses as an HSA, the IRS will not allow employees to have both types of accounts during the same plan year. This means that if you participate in a FSA plan, that is not considered a limited purpose FSA plan, you may not open and contribute funds to an HSA during the same plan year. However, this does NOT impact your ability to enroll in the Dependent Care portion of an FSA (just the Health Care).

	Healthcare Flexible Spending Account (FSA)	Health Savings Account (HSA)
Eligibility requirements	None	Must enroll in the Anthem Advantage Plus CDHP-HSA
2026 Contribution limits	$3,400 per employee	$4,400 individual $8,750 family
Catch-up contributions?	None	You may contribute and additional $1,000 if you are over age 55
Who owns the account?	Employer	Employee
Changes to contributions	Only for qualifying life events	Per paycheck
Debit card available?	Yes	Yes
Balance carry over/rollover	Plan has a 90-day run out period to submit claims for the prior plan year. You may roll over up to $680 unused 2026 funds into the next plan year.	Yes. Unused funds carry over from year to year
Portability or forfeiture	Not portable. When employment is terminated, any funds unspent are forfeited. Exception: if you're eligible for FSA continuation through COBRA	Yes. HSA balance is not forfeited when you change employers or health plans
Access to funds	Money can be accessed before it is paid into the account	Only funds paid into account can be accessed
Proof of expense required?	Yes	No; however, IRS may request you to substantiate any expense that has been incurred, the amount of expense, and its eligibility
Non-medical expenses	FSA funds cannot be used for non-medical expenses	HSA funds may be used for non-healthcare distributions but are included in gross income and subject to a 20% penalty if you are under age 65
Is interest earned on the account?	No	Yes; amount varies by HSA bank
Effect on taxes (varies by state)	Contributions are pretax and distributions are untaxed	Tax-free contributions when you contribute to the account, tax-free interest on your HSA balance and investment gains, and tax-free withdrawals for qualified medical expenses

Dependent care FSA (DCFSA)

Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Estimate carefully!

You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Dependent care FSA (DCFSA)—up to $7,500 tax-free

Learn more about the benefits of a DCFSA by clicking here.

Want to set up a recurring reimbursement? Click here to access the claim form.

Here's how the plan works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before- and after-school care programs, preschool, and summer day camp for children younger than 13.

The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $7,500 in 2026. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Commuter benefits

The Commuter Benefits are administered by Wex and is a pre-tax option available for eligible transit and parking costs. The Commuter Benefits allow employees to set aside pre-tax dollars each month to pay for qualified, work-related transit and parking expenses.

Mass Transit Account: If you ride public transportation to and from work such as the bus, rail, or qualified van pool, you may set aside up to $340 per month on a pre-tax basis to help you pay for tokens, fare cards, passes or other qualified transportation expenses.

Parking Account: If you pay to park your car at work or pay to park your car at a commuter terminal you may set aside up to $340 per month on a pre-tax basis to pay for qualified parking expenses.

How to use your Wex FSA debit card

You have a doctor office visit. Instead of paying the doctor in cash or a check, you use your FSA debit card (used like a credit card) to pay your office visit co-payment.

The doctor gives you a prescription to have filled. You go to the network pharmacy and use the FSA debit card to pay for your prescription co-pay.

You are hospitalized. After the insurance company has paid your share of the bill, there remains $1,200 in expenses you are responsible for. You pay the bill using your FSA debit card.

You go to the dentist to have a cavity filled. You use your FSA debit card to make your coinsurance payment.

Note: You can also choose to not use the debit card and pay your medical expenses out-of-pocket and then submit a claim for reimbursement. Click here to learn how to file a claim for reimbursement.

Jackson Family Wines provided life and AD&D insurance

Basic Life and AD&D

Basic life insurance pays your beneficiary a lump sum if you die. AD&D (accidental death & dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by Jackson Family Wine

Salary less than $175,000	Salary of $175,000 or more
$50,000 (flat amount)	1x annual compensation (maximum $600,000)

The benefit amounts above will be reduced if you are age 65 or older.

A note about taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Benefits reduced by:

- 65% at age 70
- 50% at age 75

Beneficiary – Important Information

You must name a beneficiary for your life and AD&D benefits. Beneficiary changes can be done at any time during the plan year.

Voluntary life and AD&D insurance

Voluntary life and AD&D insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or children if you purchase coverage for yourself.

Employee Voluntary Life and AD&D Coverage	• May purchase additional coverage in increments of $25,000 • Maximum coverage $1,050,000* • Request to add coverage subject to completion and approval of evidence of insurability form if election is not made when first eligible for coverage • Term life insurance policy • At ages 70 and 75, there are life insurance amount reductions • For AD&D benefit, the amount matches your voluntary life coverage election • Provides coverage in case of an accidental death or dismemberment • Benefits are payable in the event of loss of life, limb, sight, and speech or hearing
Spouse Voluntary Life and AD&D Coverage**	• Available when the employee enrolls in the Voluntary Life and AD&D Coverage • There are two coverage options for spouse/domestic partner coverage: 1.Flat $13,000 benefit amount 2.Units of $25,000 increments with a maximum of $525,000 (not to exceed 50% of the employee's elected amount) • Request to add coverage subject to completion and approval of evidence of insurability form if election not made when first eligible for coverage • Term life insurance policy • At ages 70 and 75, there are life insurance amount reductions • For AD&D benefit, the amount matches your optional life coverage election • Provides coverage in case of an accidental death or dismemberment • Benefits are payable in the event of loss of life, limb, sight, and speech or hearing
Child Voluntary Life and AD&D Coverage	• Available when the employee enrolls in the Voluntary Life and AD&D Coverage • Coverage amount of $5,000 available per eligible child • Term life insurance policy • Eligible until the child's 26th birthday • For AD&D benefit, the amount matches your optional life coverage election • Provides coverage in case of an accidental death or dismemberment • Benefits are payable in the event of loss of life, limb, sight, and speech or hearing
Guaranteed Issue***	• Voluntary Employee: $750,000 • Voluntary Spouse/Domestic Partner: $25,000 • Voluntary Child(-ren): $5,000

**The combined maximum of your basic and voluntary coverage is $1,200,000.*
***The cost of coverage is based on your spouse's age.*
****New hires and newly eligible employees may elect coverage up to Guarantee Issue without approval from the insurance company. If you apply for an amount of coverage for yourself or your spouse greater than the guaranteed coverage amount, coverage in excess of the guaranteed coverage amount will not be issued until the insurance company approves acceptable evidence of good health. Increases in coverage amounts take place the first day a person is active after the new coverage amount becomes effective.*

Guaranteed issue

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit evidence of insurability with additional information about your health for the insurance company to approve the amount of coverage.

Evidence of insurability

You may be asked to provide Evidence of Insurability (EOI) or proof of good health, if:

- You do not enroll for coverage when first available and choose to enroll later.
- You want to increase your coverage after your initial enrollment.

Disability insurance

All benefit-eligible employees with three or more months of service are covered by the Short-Term Disability plan. This plan provides salary replacement should you be unable to work due to injury or illness, including pregnancy disability. Benefits received under this plan will be offset by benefits you receive, or are entitled to receive, under any state or federal compulsory benefit act or law, such as state disability, workers' compensation and Social Security. Depending on your length of service, you may qualify to receive greater than 60% of your base weekly salary.

Jackson Family Wines provides all benefit-eligible employees with company-paid Long-Term Disability insurance through New York Life. If you are disabled for more than 90 days, you may be eligible to receive disability benefits under our Long-Term Disability (LTD) plan. You will continue to receive payments under the LTD plan as long as you are deemed "disabled" until you reach the latter of age 65 or Social Security Normal Retirement Age.

Plan	Benefit Amount and Timeline
Short-term disability (STD)	Regular Full Time with more than 1 year of service • 100% salary continuation* for up to 4 weeks • 60% salary continuation* up to 8 additional weeks Regular Full Time with less than 1 year of service • 60% Salary Continuation* for up to 12 weeks
Long-term disability (LTD)	• Provides coverage after a 90-day elimination period • Contact New York Life to file your LTD claim at 800-362-4462 • Replaces 66 2/3% of your monthly salary ($15,000 monthly maximum)* • Pre-existing conditions apply

*Benefits are reduced by any state disability, workers compensation, or social security benefits.

NOTE: If you become disabled during the first 12 months of coverage due to a pre-existing condition, the disability plans may not pay benefits. Your effective date of coverage is the first day of the month following 30 days of employment or the first day of the month following 30 days of transferring into a benefit eligible classification. For more detailed information, please see the summary plan descriptions available at: www.jfwbenefits.com

Paid Family Leave

The Company will provide 100% salary continuation for up to eight weeks for full-time benefit eligible employees with more than a year of service and up to 2 weeks for full time benefit eligible employees with less than a year of service who take family leave to bond with and care for a newborn (within 12 months of birth), care for a child following child's adoption or foster care placement (within months of adoption or placement), or care for a seriously ill parent, child, spouse or registered domestic partner. In order to be eligible, employees in states that offer Paid Family Leave are required to apply for and receive the benefits available through the state.

This benefit will allow for employees with more than 1 year of service to take eight weeks off for baby bonding or family leave with full pay. These benefits will run concurrently with any unpaid leave protection under the California Family Rights Act and/or the Family Medical Leave Act.

Pet benefits

Your pets are part of your family, and you'll do anything to keep them happy and healthy. But with the cost of pet care on the rise, it isn't always easy.

That's why we're offering Total Pet Plan, which makes pet care more affordable. Enroll in Total Pet and get the same high-quality products and services your pets are used to, just at a lower price!

Total Pet Plan from Pet Benefit Solutions is a pet care bundle is a discount plan which helps you save on everything your pet needs for one low price. There are no exclusions – even pets with pre-existing conditions are covered.

Combining the best in pet care, Total Pet Plan members get access to:

Discounts on products and Rx

- Up to 40% off on products like prescriptions, preventatives, food, toys and more
- Shipping is always free and same-day pickup is available for most human-grade prescriptions
- Discounts on veterinary care
- Instant 25% savings on your pet's in-house medical services at participating vets
- No exclusions due to age, health, pre-existing conditions or type of pet

24/7 pet telehealth

- Access real-time vet support, even when your vet's office is closed
- Unlimited support on your pet's health, wellness, behavior and more

Lost pet recovery service

- Durable ID tag helps lost pets return home quicker than a microchip
- Easily update your information online with no need to request a new tag

Exclusive member discounts

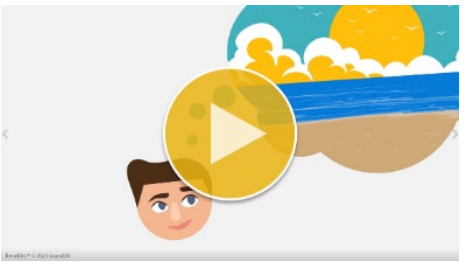
- Special deals and promotions from national pet retailers and service providers
- Easy access directly from your online member account

Visit www.petbenefits.com
to locate participating vets and product discounts

1 Pet	Multi Pet (2+)
$11.75 per month	$18.50 per month

Save now, enjoy later

Click to play video



What are your plans?

Many of us can't plan past the weekend, never mind thinking about a retirement nest egg. Our 401(k) retirement plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if you think it's too small an amount.

Maximum 2026 contribution

(IRS limits are evaluated annually)

- Up to $24,500
- If you're 50-59 years old, you can contribute an extra $7,500*
- And if you're 60-63, you can contribute an extra $11,250*

*If you are age 50 or older and earned more than **$145,000 in FICA wages** last year, any **catch-up contributions** you make must be designated as **Roth contributions**. If you currently make catch-up contributions and earn more than $145,000 in 2025, your contributions will automatically switch to **Roth Catch-Up**.

*Those who earned **$145,000 or less** in FICA wages last year may continue making **pretax catch-up contributions** and are not required to use Roth.

401(k) retirement savings plan—up to $24,500 per year (or more)

Our 401(k) retirement savings plan helps you save for retirement. The plan offers tax savings through pre-tax contributions. All regular full-time employees 18 years of age and older are eligible to participate on the first of the month following their hire date.

All other employees are eligible to participate upon completion of 1,000 hours in a consecutive 12-month period or two consecutive years with 500+ hours of service and are 18 years of age or older. The plan allows employee contributions up to 50% of pay on a pre-tax basis, limited to $23,000 per calendar year (or $30,500 if you are age 50 or older). You may rollover money from a prior employer's tax-qualified plan into the Jackson Family Enterprises 401(k) Plan.

Automatic Enrollment: Three percent (3%) of your pre-tax pay is automatically contributed to the plan 30 days following your date of eligibility, unless you elect not to contribute. The 3% contribution is automatically invested in a Target Date Fund selected using your estimated retirement year based on your date of birth. If you would like to change or waive the automatic deduction or make elections regarding how you would like your contributions invested, you can contact Vanguard at 1-800-523-1188 or visit www.ownyourfuture.vanguard.com

Automatic Savings Increase: To make things even easier, the plan offers automatic savings increases to help you set aside more money. Your savings rate will increase 1% every January until you reach 6%. (For employees hired during the last three months of the year, the increase will take effect in the following January.) You can opt out of the automatic savings increase by contacting Vanguard at 1-800-523-1188 or visiting www.ownyourfuture.vanguard.com

Company Match: Biweekly, the company may make a discretionary match of up to 100% of the first 3% and 50% of the next 2% of eligible compensation you defer into the plan during the pay period, up to a maximum of $5,200 per calendar year. You will be eligible for the discretionary company match if you are actively deferring compensation into the plan during the pay period. You are 100% vested in the company match and your deferrals immediately.

Cheers to you!/Salud

Our Rewards & Recognition Program

Cheers to You!/Salud

It is important to **give your colleagues kudos and recognize their hard work** with a personal shout-out. By taking a few minutes to recognize people on the **'Cheers to You!/Salud'** online platform, we can **celebrate** the effort and the wins, and show how much we **value** one another. **Recognize your team!** The people you work with and rely on to make it happen. Or your cross-functional partner who helped you finish a project. Or **that person who made a real difference in your day.**

More Info:

Recognize your colleagues with reward points that can be used to purchase merchandise such as:

JFW Merch
Gift cards
Experiences
Charitable donations & more!

Earn additional points for completing certain tasks such as:

Learning Courses
Festive Activities
Company-related participation

Build community -Get involved and show support for colleagues!

How to Access:

Go to JFWnow > My Favorites >CTY/Salud

App:

When accessing Cheer to You via the web, login should happen automatically with your company login/ Single Sign On (SSO). The mobile app is also SSO, but may require you to login and go through two factor authentication, depending if you are connected to company Wi-Fi or not.

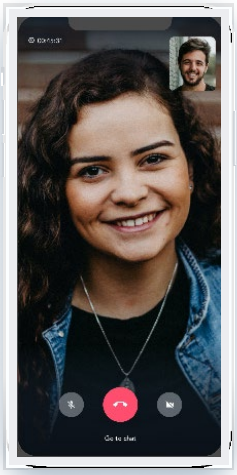
Link: https://jfw.awardco.com

Scan the QR code below: use the camera on your smartphone or device to **access website**.

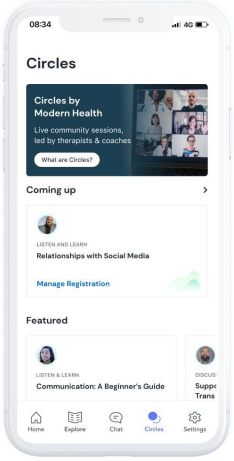
Wellbeing resources

Modern Health

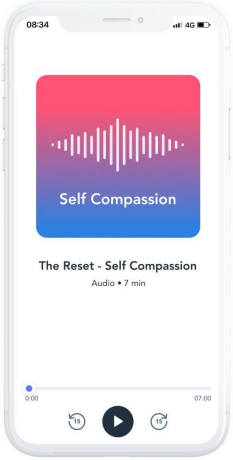
Welcome to Modern Health, your resource for mental wellness benefits so you can be the best version of yourself, at home and at work. Modern Health is provided by JFW at no cost to you and provides you and your eligible family members access to personalizes 1:1 counseling and coaching, group and self serve resources to support your well-being. Accessing care is easy and always completely confidential.



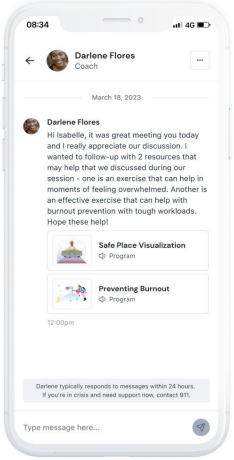
One-on-one coaching & therapy



Live and on-demand group sessions



Meditations & programs



Unlimited texting with providers

Modern Health provides support for all aspects of life:

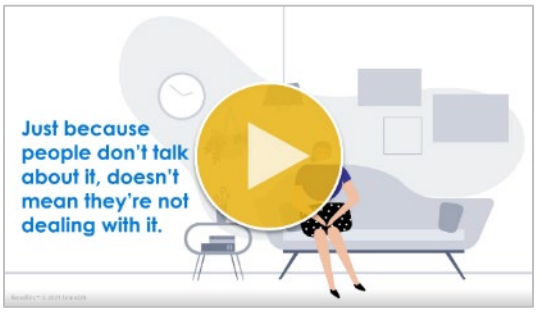
- Emotional Health
- Professional Health
- Social Health
- Physical Health
- Financial Health

Take the first step
toward prioritizing you:

Scan this QR code or visit my.modernhealth.com to get started.
Questions? Email us at help@modernhealth.com.

Employee assistance program (EAP)

Click to play video



Help for you and your household

There are times when everyone needs a little help or advice, or assistance with a serious concern. The Work-Life Services EAP can help you handle a wide variety of personal issues, such as emotional health, substance use disorder, parenting and childcare needs, financial coaching, legal consultation, and elder care resources.

Best of all, contacting the EAP is completely confidential and free for any member of your immediate household.

No-cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- Unlimited web access to helpful articles, resources, and self-assessment tools.

Contact the EAP

Phone: (866) 535-6463

Website:
modernhealth.helpwhereyouare.com

Counseling

- Relationship challenges
- Emotional distress
- Job stress
- Communication issues
- Interpersonal conflict
- Alcohol or drug use
- Loss and grief

Elder care

- Help finding care resources for elderly or disabled relatives

Financial

- Money/debt management
- Identity theft resolution
- Tax issues
- Bankruptcy

Parenting & childcare

- Quality referrals
- Family day care centers
- Infant centers and preschools
- Before- and after-school care
- 24-hour care

Online resources

- Self-help tools to enhance resilience and well-being
- Information and links to various services and topics

Convenience Services

- Pet sitting
- Moving support
- Travel information
- Cleaners and more

Active&Fit DIRECT™

Anthem

Everything You Need to Get Moving This Fall

$0 Enrollment Fee with Code: FITFOCUS[1]

- **Top-brand gym options** for just $28/mo.[2]
- **Premium boutique exercise studios** at 20%-70% off[2]
- **No long-term contracts**—switch gyms or cancel with ease
- **Create a free account** to get 15,000+ at-home workout videos
- **Personalized well-being coaching**[3] for nutrition, stress, sleep, and now GLP-1 assisted weight loss (***New!***)

12,700+ Standard Gyms

LA Fitness · Crunch · 24 Hour Fitness · Eos Fitness · Anytime Fitness · snap fitness 24/7

+ More

9,800+ Premium Gyms

STRETCH LAB · FIT4MOM · CLUB PILATES · F45 TRAINING · pure barre

+ More

STANDARD FITNESS MEMBERSHIP

$28/mo.

12,700+ FITNESS CENTERS

Active&Fit DIRECT™ ™

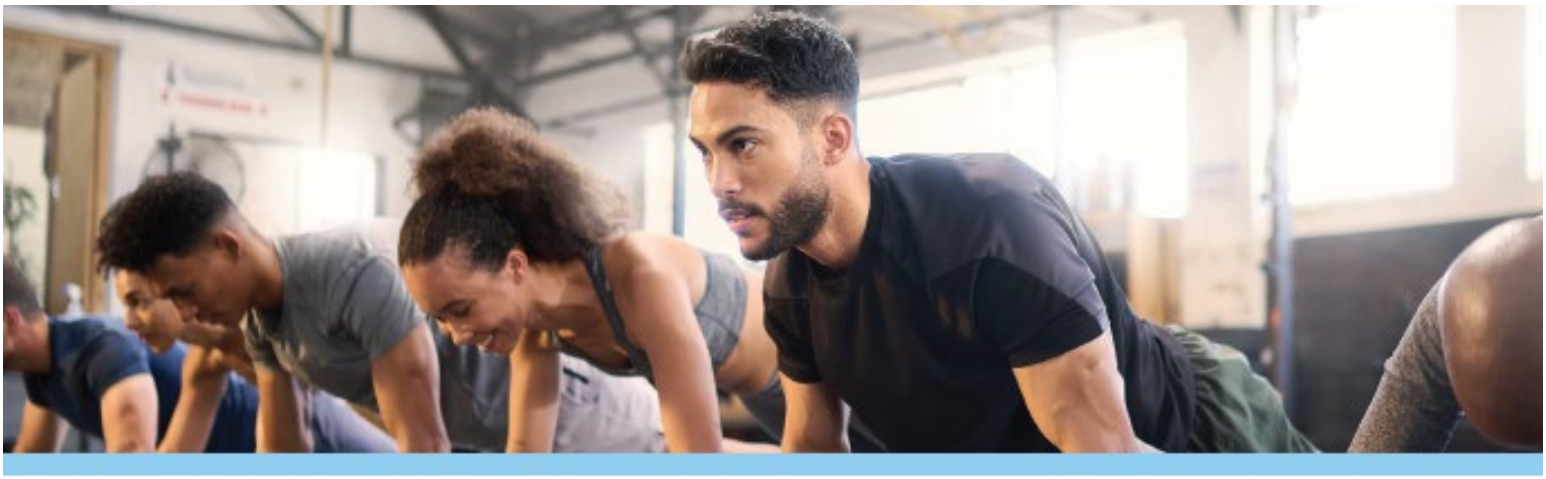
Learn More:

By logging in to your member website and clicking on the link for Discounts found under the Care menu.

[1] $28 enrollment fees waived for standard and premium gyms 9/1/25 12:01 a.m. - 11/30/25 11:59 p.m. PT.

[2] Plus applicable enrollment fees and taxes. Costs for premium exercise studios exceed $28/mo. plus applicable enrollment fees and taxes. Fees vary based on premium exercise studios selected.

[3] The Active&Fit Direct℠ program is not a medical provider or pharmacist, and its coaches do not offer medical or pharmaceutical advice. They cannot and do not diagnose or treat medical, mental health, or other health conditions. Coaches provide general information for educational purposes only. For any medical or health concerns, consult a qualified healthcare professional.



Whole-body health made easier

Get help reaching your wellness goals

Choose a One Pass Select Affinity fitness plan that fits your lifestyle

Make a commitment to your overall well-being by joining One Pass Select Affinity from Optum.[1] Choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources.

- 5 membership tiers with different monthly fees[2]
- 19,000 gym locations and boutique studios
- 23,000+ on-demand and livestreamed classes
- Digital tools to track progress and an AI workout builder
- 10% off memberships for family and friends
- No contracts – change tiers monthly or cancel within 30 days
- Groceries and household essentials delivered with Walmart+ and Shipt

Save on wellness services

All members who sign up for One Pass Select Affinity can access Optum's affinity musculoskeletal program.

Get 20% off chiropractors, acupuncturists, and massage therapists when you visit a participating provider.[3]

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1. The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. **2.** In Colorado, eligible employees who have the One Pass Select program have access to the classic tier after paying a $100 annual fee. Employees with the classic tier may access other tiers within the gym network after paying an additional fee. In Hawaii, members pay a $200 annual fee to access the classic tier (aka Fit Rewards program). Members who work out for 45 days for at least 30 minutes each session over the year will earn a $200 reward. Only 1 training session per day counts toward the 45-day total. **3.** See note 1.

Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 2715 Naches Ave. SW, Renton, WA 98057

Learn more at **kp.org/exercise**

KAISER PERMANENTE®

YOURWINESTORE

WELCOME TO JACKSON FAMILY WINES

FROM OUR VINEYARDS TO YOUR DOORSTEP

YourWineStore is the place to find the most comprehensive collection of Jackson Family Wines at employee prices. **Shop wines from our 30+ brands, most at 50% off retail.** Also, included: Employee Exclusives, Last Call and Featured Winery selections throughout the year.

Orders may be placed at yourwinestore.com for will-call pick-up or shipping.

Will- call delivery is free and available at seven locations in California and McMinnville, Oregon. **Orders submitted by Monday, 9am PT will be delivered to the will-call location and available by Friday of each week**.

Visit JFWNOW for more details on will-call delivery, shipping, and frequently asked questions.

TO GET STARTED

Create a YourWineStore account using your company email address at yourwinestore.com, and email info@yourwinestore.com once completed. Upon confirmation of your hire by Human Resources, the YourWineStore team will mark you as an employee for your discount.

Reminder: Employees must log-in at yourwinestore.com to view employee prices.

YourWineStore
info@yourwinestore.com 707-535-8477

Plan contacts and resources

General

Benefits Website
Website: jfwbenefits.com

Benefit Support
jfwbenefits@alliant.com
Phone: (888) 907-1391

Human Resources
Email: hrdirect@jfwmail.com
Email: kristy.vanlare@jfwmail.com
Phone: (707) 525-6213

Medical

Anthem Blue Cross
Policy No. L00837
CDHP Phone: (866) 207-9878
PPO Phone: (800) 888-8288
HMO Phone: (833) 913-2236
Website: anthem.com/ca

Kaiser
NCal/SCal Policy No.
38765/229286
Phone: (800) 464-4000
Oregon Policy No. 19769
Phone: (800) 813-2000
Website: kp.org

Dental

Delta Dental
Policy No. 01633
Phone: (800_ 765-6003
Website: deltadental.com

Vision

VSP
Policy No. 12146160
Phone: (800) 877-7195
Website: vsp.com

HSA

HealthEquity
Phone: (866) 735-8195
Website: healthequity.com

Life & Disability

New York Life
Life Policy No. FLX-964763
AD&D Policy No. OK-966373
LTD Policy No. LK-963332
Phone: (800) 362-4462
Website: newyorklife.com

Wellbeing Support

Modern Health
Website: modernhealth.com

EAP

Modern Health
Company Key:
Jackson Family Wines
Phone: (866) 535-6463

FSA

Wex
Policy No. 16125
Phone: (866) 451-3399
Website: wexinc.com

401(k)

Vanguard
Policy No. 095683
Phone: (800) 523-1188
Website:
ownyourfuture.vanguard.com

Business Travel

The Hartford
Policy No. ETB-112402
Phone: (800) 243-6108
Website: thehartford.com

Pet Benefits

Pet Benefit Solutions
Policy No. 9327
Phone: (800) 891-2565
Website: petbenefits.com

Glossary

Accumulation Period
The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible
A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Max
A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount
The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center
A healthcare facility that specializes in same-day surgical procedures.

Annual Limit
The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing
Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges $100 but the plan's allowed amount is only $70, an out-of-network provider can bill you for the $30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary
The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

Claim
A request for payment that you or your provider submits to your insurance plan after you receive services.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Coinsurance
The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)
A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible
The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services
Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Eligible Expense
Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible
A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Max
A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Excluded Service
A service for which your insurance will not pay any portion of the cost. These services may also be referred to as "ineligible," "not covered," or "not allowed."

Glossary

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

Generic Drug
A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In Network
Also known as participating providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order
A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out of Network
Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan's allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs
Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or from a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum
The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital or clinic that doesn't require you to stay overnight.

Participating Pharmacy
Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a "formulary," is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care
Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)
Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider
A doctor, dentist, physician's assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine
A virtual visit with a provider using video chat on a computer, tablet or smartphone.

Usual, Customary, and Reasonable (UCR)
The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care
Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations
Also known as "immunizations," vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit
An optional benefit offered by your employer for which you pay the entire premium, usually through payroll deduction.

Plan documents

Important documents for our health plan and retirement plan are available online by going to www.jfwbenefits.com and accessing the enrollment system reference center, or by contacting Human Resources. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Summary plan descriptions (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Jackson Family Enterprises Health Care Plan

Summary of benefits and coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available online by going to www.jfwbenefits.com and accessing the enrollment system reference center, or by contacting Human Resources.

- Anthem Advantage Plus CDHP - HSA
- Anthem Premium PPO
- Anthem Value PPO
- Anthem HMO
- Kaiser HMO

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Jackson Family Enterprises Health Care Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Important plan information

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, visit www.jfwbenefits.com and navigate to the enrollment system reference center for all plan documents.

- **Domestic Partner Coverage (see page 4 of this guide)**
- **Anthem Plan Arbitration Agreement**
- **Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement**
- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **ACA Disclaimer:** Advises you may not qualify for government subsidies
- **Termination of Coverage for Ineligible Dependents: Knowingly e**nrolling ineligible dependents will result in retroactively termination of coverage and any previously paid claims making them payable by the individual. Employer may explore disciplinary action up to and including termination of employment.
- **Marketplace Notice:** Describes Marketplace plan availability
- **Illinois Consumer Coverage Disclosure Act:** Provides to Illinois employees a list that compares the essential health insurance benefits offered by the employer's group health plan with the essential health benefits regulated by the State of Illinois.

COBRA continuation coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

2026 Legal Notices

ANTHEM PLAN ARBITRATION AGREEMENT

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

KAISER FOUNDATION HEALTH PLAN, INC., AND KAISER PERMANENTE INSURANCE COMPANY ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage and in the Certificate of Insurance.

Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2) the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3) the KPIC Dental plans.

Medicare Part D Notice

Important Notice from Jackson Family Enterprises 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 Jackson Family Enterprises 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. Jackson Family Enterprises has determined that the prescription drug coverage offered by the group health plan, 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 Jackson Family Enterprises coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Jackson Family Enterprises group coverage is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Jackson Family Enterprises prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Jackson Family Enterprises 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 or call the benefit service center at (888) 907-1391. 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 Jackson Family Enterprises 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 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 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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

Date: 01/01/2026
Name of Entity/Sender: Jackson Family Enterprises
Contact-Position/Office: Kristy Van Lare, Director, Benefits and HR Operations
Address: 420 Aviation Blvd, Santa Rosa, CA 95403
Phone Number: (707) 525-6213

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance shown in the medical section of the benefit guide will apply. If you would like more information on WHCRA benefits, call your plan administrator Krisy Van Lare, Director, Benefits and HR Operations at kristy.vanlare@jfwmail.com or (707) 525-6213.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator Krisy Van Lare, Director, Benefits and HR Operations at kristy.vanlare@jfwmail.com or (707) 525-6213.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Jackson Family Enterprises health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Jackson Family Enterprises health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Jackson Family Enterprises health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Jackson Family Enterprises describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Krisy Van Lare, Director, Benefits and HR Operations at kristy.vanlare@jfwmail.com or (707) 525-6213 A copy of our notices are also available on the web at www.jfwbenefits.com

Notice of Choice of Providers

The Anthem HMO generally requires 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, Anthem Blue Cross HMO 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 Anthem at (833) 913-2236.

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

You do not need prior authorization from Anthem Blue Cross HMO 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 Krisy Van Lare, Director, Benefits and HR Operations at kristy.vanlare@jfwmail.com or (707) 525-6213

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, 2025. 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

Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program

Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare | Phone: 1-866-614-6005

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

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

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov | Phone: 1-888-222-2542 |
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

Termination of coverage for ineligible dependents

Knowingly enrolling an ineligible dependent or intentionally keeping a dependent on the plan when they have lost eligibility constitutes insurance fraud and is a material misrepresentation of fact. When the plan discovers any such ineligible dependent it will terminate coverage retroactively and reprocess any claims, making them payable by such an individual. The employer plan sponsor will also explore disciplinary action against any employee who engages in this misconduct including but not limited to termination of employment.

Health Insurance Marketplace Coverage Notice

Part A: general information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by Jackson Family Enterprises.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the annual cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kristy Van Lare, Director, Benefits & HR Operations, at kristy.vanlare@jfwmail.com or 707-525-6213.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: General Information About Health Coverage Offered by Your Employer

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

3. Employer Name	**4. Employer Identification Number (EIN)**	
Jackson Family Wines Jackson Family Enterprises Regal III, LLC Jackson Family Investments Hartford-Jackson, LLC KJCB, Inc	94-3040414 20-5780901 27-4098644 94-3304190 68-0371964 83-2545193	
5. Employer Address 425 Aviation Blvd	**6. Employer phone number** 707-525-6212	
7. City Santa Rosa	**8. State** CA	**9. Zip Code** 95403
10. Who can we contact about employee health coverage at this job? Kristy Van Lare, Director, Benefits & HR Operations		
11. Phone number (if different from above) (707) 525-6213	**11. Email address** kristy.vanlare@jfwmail.com	

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

As your employer, we offer a health plan to:

☐ All employees.

☒ Regular full-time employees who regularly work more than 30 hours per week. Temporary full-time employees scheduled to work more than 30 hours per week, and variable hour employees who have worked more than 30 hours per week over their one-year measurement period.

With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

- Spouse, same-sex or opposite sex domestic partner (see Benefits Guide for specifics)
- Unmarried, dependent children under the age 26 provided that the child is not offered group insurance through their own employer
- Dependent child with a physical or mental disability as defined by the Social Security Administration

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.*

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the Access to Care and Treatment Benchmark Plan and the Pediatric Dental Plan to reference the pages listed below.

Employer Name:	Jackson Family Enterprises
Employer State of Situs:	CA
Name of Issuer:	Anthem Blue Cross
Plan Marketing Name:	Anthem Value PPO Anthem Premium PPO Anthem Advantage Plus CDHP - HSA
Plan Year:	2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				**Employer Plan Covered Benefit?**
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes

8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	Yes
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Jackson
FAMILY WINES

Alliant