National Beverage Corp.

2019

Team Member Benefits Guide

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare D notice in this benefits guide for more details.

OVERVIEW

Introduction

National Beverage Corp. understands that your benefits are important to you and your family. Helping you understand the benefits available to you is essential. This Benefits Guide provides a description of our company's benefit program.

This guide is not a team member/employer contract. It is not intended to cover all provisions of all plans, but rather a quick reference to help answer most of your questions. Please see the carrier benefit summaries for more details.

Included in this guide are summary explanations of the benefits, as well as contact information for each provider. It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you.

We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable co-payments and deductibles, how to file claims, preauthorization requirements, participating networks and services that may be limited or not covered (exclusions). We hope this guide will give you an overview of your benefits and help you be better prepared for the enrollment process.

Benefits Eligibility

Team member Eligibility
Benefit eligible team members are provided an opportunity to participate in the National Beverage Corp. company sponsored benefits program upon initial hire and annually during Open Enrollment. You are eligible for benefits on the first day of the month following 60 days of employment if you are a full-time team member. Temporary to permanent members are eligible the first of the month following 30 days. Please refer to the following guidelines regarding eligibility and election changes.

Dependent Eligibility—*Medical, Dental and Vision*
A dependent is defined as a covered team member's legal spouse or a dependent child of the team member or team member's spouse. Dependent children may be covered up to age 26. A dependent child is defined as:

- A natural child
- A step-child
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the covered team member or the team member's spouse
- Unmarried children of any age who become mentally or physically disabled before reaching the age limit

FL Statute 627.6562 Dependent Coverage: Health insurance coverage may be available for dependents ages 26 to 30. Please contact your Human Resources Department for more information.

Spousal Exclusion

**Exclusion for Working Spouse: If either of the following apply, you may not enroll your spouse in the National Beverage Corp. medical plan:*

- Spouse has medical insurance available through his/her employer
- Spouse has medical insurance available due to his/her retirement (Note: this does not include Medicare eligibility)

If your spouse is working but is not eligible for coverage through his/her employer or no coverage is available through his/her employer, please obtain the necessary affidavit from Human Resources for completion.

Qualifying Event

Coverage elections made at Open Enrollment cannot be changed until the next annual Open Enrollment period. The only exception to this IRS Section 125 Rule is if you experience a "Qualifying Event." A Qualifying Event allows you to make a change to your benefit elections within 30 days of the event.

Examples of Qualifying Events include, but are not limited to:

- Marriage
- Divorce
- Birth, adoption, or legal custody of a dependent child
- Involuntary loss of other group insurance coverage
- Death
- Spouse's Open Enrollment

If you experience a Qualifying Event, contact the Benefits Department or go online to www.explainmybenefits.biz/nbc-benefits/ to process the event and submit all required documents within 30 days of the qualifying event.

Your Responsibility

Before you enroll, make sure you understand the plans and ask questions if you do not. After you enroll, you should always check your first paycheck stub to make sure that the correct amount is being deducted and all of the benefits you elected are included.

Any corrections must be made within the first 30 days of enrollment. You should also verify that all beneficiary information is up to date.

Medical Insurance Plan Comparison

National Beverage Corp. is providing three (3) plan options through BCBS. The plans offered are the HDHP w/ HSA Plan, the PPO Plan, and the PPO Copay Plan.

Plan Name	**HDHP w/ HSA**		**PPO Plan**	
Network Access	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Calendar Year Deductibles (CYD)	**Your Responsibility**		**Your Responsibility**	
Individual	$3,000	$4,000	$1,500	$5,000
Family	$6,000	$8,000	$3,000	$10,000
Your Benefit Plan Details	**Your Responsibility**		**Your Responsibility**	
Coinsurance (when applicable)	20%	40%	20%	40%
Individual Out-Of-Pocket Maximum	$6,500	$12,900	$6,500	$12,900
Family Out-Of-Pocket Maximum	$13,000	$25,600	$13,000	$25,600
Professional Services				
TelaDoc Visit	$45 and then 20% after CYD	N/A	$10 Copay	N/A
Primary Care Physician (PCP) Office Visits	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Specialist Office Visits	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Preventive Care Visits	No charge	Limited benefits	No charge	Limited benefits
Hospital Services				
In-patient Hospitalization	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Outpatient Hospitalization	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Urgent Care Center	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Emergency Room (waived if admitted)	20% after CYD		20% after CYD	
Pharmacy				
Tier 1	20% after CYD	Not Covered	20% from first dollar	Not Covered
Tier 2				
Tier 3				
Mail Order Pharmacy				

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.
*Balance billing will apply when utilizing out-of-network providers

Medical Insurance Plan Comparison

You can locate a physician by contacting BCBS Member Services, or visit the website at www.myhealthtoolkitfl.com.

Plan Name	PPO Copay Plan	
Network Access	**In-Network**	**Out-of-Network***
Calendar Year Deductibles (CYD)	**Your Responsibility**	
Individual	$750	$2,400
Family	$2,000	$6,000
Your Benefit Plan Details	**Your Responsibility**	
Coinsurance (when applicable)	20%	40%
Individual Out-Of-Pocket Maximum	$6,500	$12,900
Family Out-Of-Pocket Maximum	$13,000	$25,600
Professional Services		
TelaDoc Visit	$10 Copay	40% after CYD
Primary Care Physician (PCP) Office Visits	$25 Copay	40% after CYD
Specialist Office Visits	$50 Copay	40% after CYD
Preventive Care Visits	No charge	Limited benefits
Hospital Services		
In-patient Hospitalization	20% after CYD	40% after CYD
Outpatient Hospitalization	20% after CYD	40% after CYD
Urgent Care Center	$75 Copay	40% after CYD
Emergency Room (waived if admitted)	$400 Copay	
Pharmacy		
Tier 1	$10	Not Covered
Tier 2	$40	
Tier 3	$60	
Mail Order Pharmacy	$25/$100/$150	

Explanation of Calendar Year Deductible and Calendar Year Out-of-Pocket Maximum

Calendar Year Deductible

The Calendar Year Deductible is a specified dollar amount that you must pay for certain covered services per calendar year. There are individual and family deductibles. Once an individual or a family deductible has been satisfied, then coinsurance applies, if applicable. Coinsurance is your share of the costs of a health care service. It is the amount a member pays after the deductible has been met.

Calendar Year Out-of-Pocket Maximum

The Calendar Year Out-of-Pocket Maximum is the amount of covered expenses, (including deductible, coinsurance, and copayments) that must be paid by you, either individually or combined as a covered family. After the individual/family out-of-pocket maximum has been satisfied in a calendar year, payment for in-network covered services requiring copayment and coinsurance for that covered individual/family will be payable by BCBS at the rate of 100% for the remainder of the calendar year, subject to any other terms, limitation, and exclusions.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

*Balance billing will apply when utilizing out-of-network providers

TELADOC

National Beverage continues to provide members with access to Teladoc services giving you 24/7 access to board certified physicians. Teladoc allows you to resolve your routine medical issues any time you need care from wherever you happen to be. It's healthcare made simple!

WHAT IS TELADOC?

Teladoc is a national network of board-certified physicians who provide quality healthcare through the convenience of phone or online video consultations for members of any age. Teladoc physicians can diagnose, treat, and write prescriptions, when necessary for routine medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory Infection
- Sinus problems
- And more!

WHEN SHOULD YOU USE IT?

- If you're considering the ER or urgent care center
- When you can't reach your primary care physician due to time, weather, remote location, or a disability
- When you're on vacation or a business trip
- For short-term prescription refills

The cost of Teladoc services for the HDHP HSA Plan will be $45 per call until your deductible is met; 20% coinsurance applies for any future calls. The cost for the PPO Plan will be $10 per call. Payment will be collected at the time of the call.

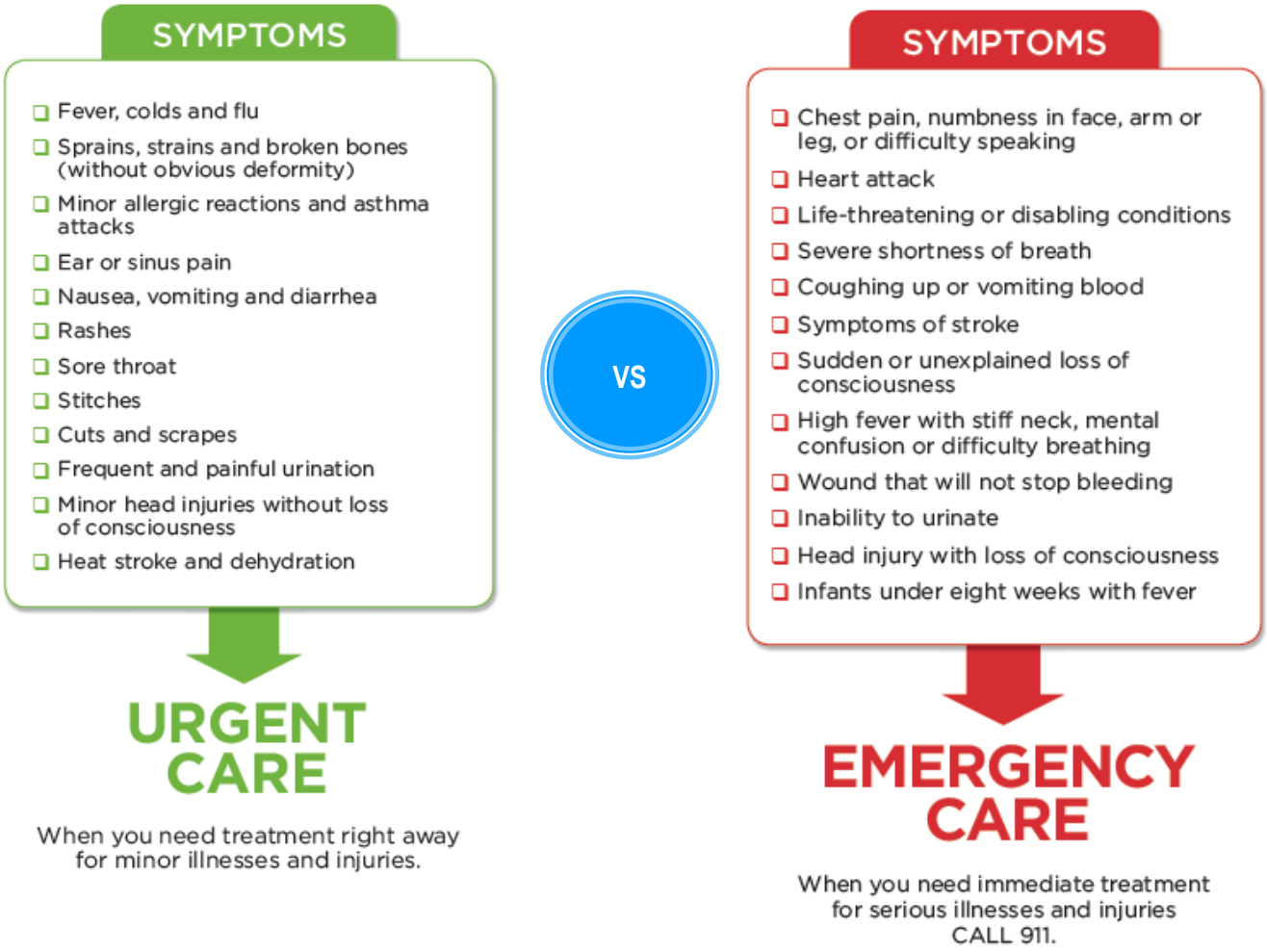
TELADOC

Urgent Care vs Emergency Care

Choosing the Right Health Care Setting - Emergency Room and Urgent Care

When an emergency strikes, you know you need medical care fast. But what if you're not sure if it's a true emergency?

While the answer is not always simple, knowing the difference between urgent care and emergency care and where to seek treatment could save you time and money.



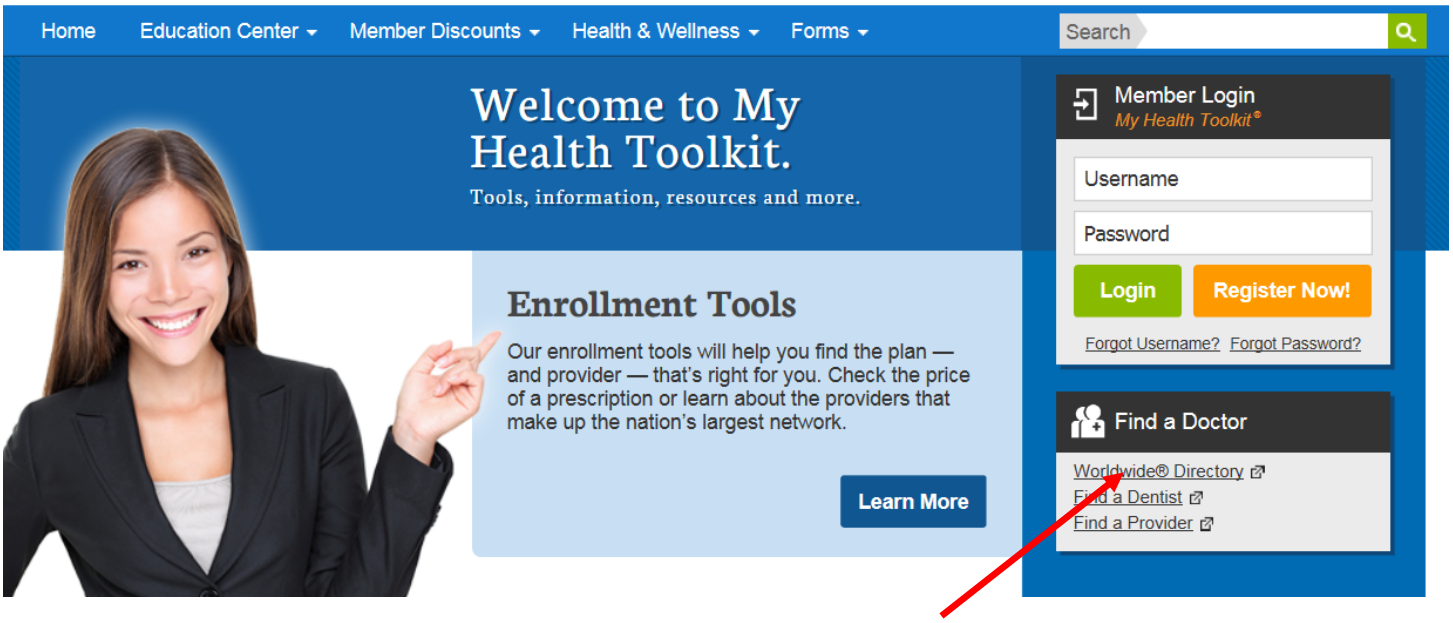
Be prepared for medical care

Whether you're going to urgent care or the ER, take with you a list of all current prescription medications including dosages and any over-the-counter medications and vitamins. Many medications and even vitamins, can interact with the treatment options your physician recommends.

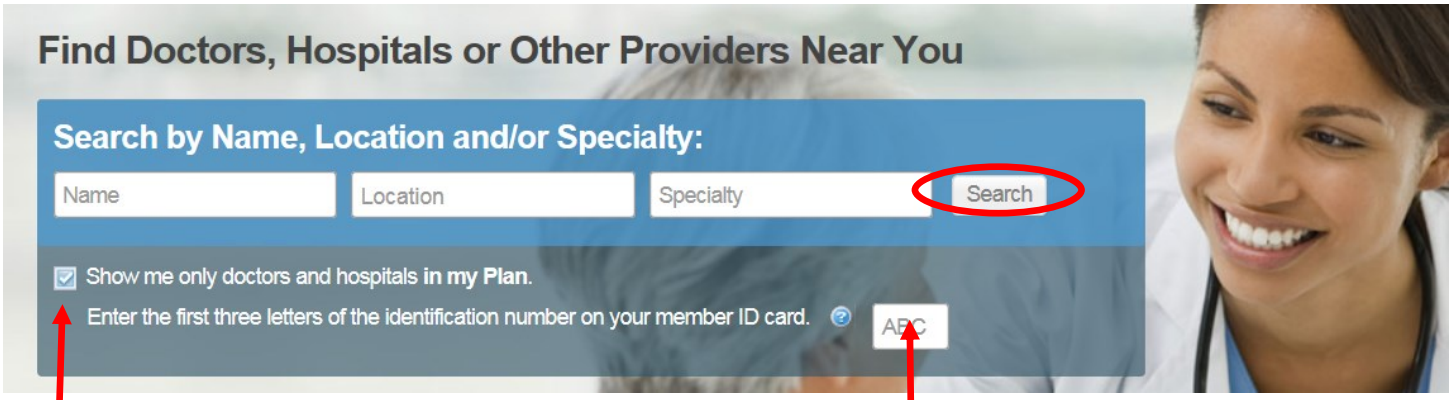
Also, take with you a list of any known allergies especially to medications. The list should include any previous invasive medical procedures and surgeries, the dates they were done and the names of the physicians or surgeons who treated you.

How to look up a participating (In-Network) provider or hospital.

To find participating providers, laboratories or facilities (In-Network), please visit www.myhealthtoolkitfl.com.



Find a Network Doctor or Hospital



Check this box

Insert National Beverage Pre-Fix: "NIU"

Additional Services / Programs through BCBS

My Health Toolkit

My Health Toolkit is the one-stop shop for answers about your health care, filled with resources that are customized just for you! It has everything you need to understand your health plan coverage and manage your benefits. All members ages 16 and older, including spouses and dependents, should sign up for an account. It's easy to register and its free.

Register in just a few clicks:

1. Go to www.myhealthtoolkitfl.com
2. Click the **Register Now** button on the right-hand side of the page.
3. Enter the Member ID located on your membership card.
4. Follow the instructions to Create Your Profile

Care Disease Management Program

Have you been diagnosed with asthma, COPD, diabetes, high cholesterol, high blood pressure, heart failure or heart disease? This program can help you take charge of your health. You will receive a comprehensive disease management guide as well as tips, tools and strategies to learn more about managing your condition. You will also have access to a health coach who can help you answer any of your health questions.

Blue 365

With Blue365, great deals are yours for every aspect of your life– like 20 percent off at Reebok.com, 20 percent off BodyMedia armbands to track your activity and calorie burn, or a gym membership for only $25 a month. Register at www.blue365deals.com to take advantage of Blue 365. Its an online destination featuring healthy deals and discounts exclusively for Blue Cross Blue Shield members. You can also call 855-511-2583 for any questions.

Discounts for you– just for being Blue

Improving health has many rewards! You have access to discounts on variety of products and services to enhance your quality of life. Think of them as special perks just for being Blue. Your regular health plan benefits generally will not cover these services. You are responsible for any costs of these services your health and save money.

Check out discounts on items such as:

- Hearing screenings
- Hearing aids
- Cosmetic surgery
- Cosmetic dentistry
- Hair restoration
- Eye Care
- Eyewear
- Lasik services
- Weight loss programs

- Acupuncture
- Massage therapy
- Chiropractic services
- Fitness centers
- Diets and supplement advisers

Health Savings Account (HSA) administered by BCBS

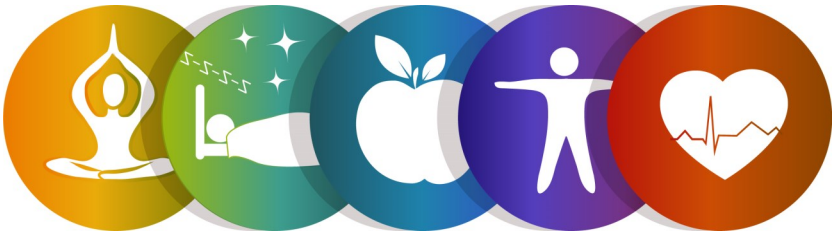
When you enroll in the BCBS HDHP HSA Plan, you can choose to fund a Health Savings Account (HSA). The money you contribute to the HSA is deducted on a pre-tax basis. Therefore, you lower your current tax bill. You can use money in the account to pay for eligible health care expenses, including medical , dental, vision and other qualified expenses.

NEW! National Beverage Corp. will be contributing funds to your HSA:

- $500 for employee only ($125 in Apr, July, Oct & Jan)
- $750 for employee with dependents ($187.50 in Apr, July, Oct & Jan)

An HSA is a great way to set aside tax-free money for your healthcare expenses. Because you have an HSA qualified plan you have to pay a certain amount out of your own pocket before your health plan covers your expenses. With an HSA, you can set aside money from each paycheck to cover your deductible and other out-of-pocket expenses. Besides paying for your healthcare, an HSA has other advantages you will want to consider:

- **Reduces your taxable.** You pay no federal taxes on the money you put into your HSA, so you keep more of your paycheck.
- **The money always belongs to you.** Any money you put into an HSA, belongs to you– even if you leave the National Beverage.
- **Your money earns interest tax-free.** Money you put into an HSA earns interest– a lot of a little, depending on the type of account y our employer chooses, the investments you choose, and your balance. All the interest earned is tax-free, too.
- **You control the money.** You decide how to invest the funds.
- **You can save the money for future needs.** Even if you don't use a lot of healthcare services now, your HSA funds will be there if you need them in the future– even after retirement. If you never need the money, it goes to your heirs.
- **It's easy to use the funds.** You will receive a debit card that lets you take money out of your HSA for eligible expenses without the hassle of reimbursement forms.
- **How much can I contribute to an HSA?** The maximum amount you, your employer, and anyone else can contribute to your HSA in any year is the amount established by the IRS. The IRS amounts for 2019 are $3,500 for Individual and $7,000 for Family.
- **When can I make "catch-up" contributions to an HSA?** If you are 55 or older, or turning 55 during the calendar year, you can make additional "catch-up" contributions to your HSA.
- **Does all the money I contribute need to be in my HSA before I can use it?** You don't have to wait until all the money is deposited, but you can only withdraw funds that have accrued in the account.
- **What qualifies as an HSA expense?** Some IRS-approved expenses are; diabetic supplies, eye exams, eyeglasses, contact lenses and solution, hearing aids, orthodontia, dental cleanings and fillings, physical therapy, speech therapy and chiropractic expenses. *Over the counter medications such as pain relievers, cough syrup, and allergy medications require a prescription to be eligible for reimbursement.* Be sure to keep all receipts and prescriptions for your tax records.



Dental Benefits

Cigna is our exclusive carrier for the 2019 dental plan. You have the option of a DPPO Plan. The DPPO plan provides coverage for both In-Network (contracted PPO dentist) and Out-of-Network (non-contracted dentist) coverage. You will maximize your benefits and minimize your out-of-pocket expenses when you seek care from a contracted dentist.

When you choose a dentist outside of Cigna network, your out-of-pocket costs will be higher and you may be subject to "balance billing" for provider fees that exceed the contracted amount allowed by Cigna contract. You can locate participating (In-Network) dental providers by calling (800) 244-6224 or by visiting Cigna website at www.mycigna.com.

1. Register
2. Once logged in, click on “Find a Doctor”
3. Click on “Dentist” under the “Find a Person” heading and double-click a specialty dentist by grouping

Plan Name	**Cigna Total DPPO**	
Network Access	**In-Network**	**Out-of-Network***
Calendar Year Maximum	$ 1,500	
	Your Responsibility	**Your Responsibility**
Individual Deductible	$100	
Family Deductible		
Dental Description		
Preventive-Class I	No Charge	No Charge
Basic-Class II	20% after CYD	20% after CYD
Major-Class III	50% after CYD	50% after CYD
Routine Exams	No Charge	No Charge
Teeth Cleaning	No Charge	No Charge
Bitewings / Panoramic X-rays	No Charge	No Charge
Amalgam Fillings	20% after CYD	20% after CYD
Simple Extraction	20% after CYD	20% after CYD
Root Canal / Endodontics	50% after CYD	50% after CYD
Periodontal scaling	50% after CYD	50% after CYD
Full or partial dentures	50% after CYD	50% after CYD
Crowns	50% after CYD	50% after CYD
Child and Adult Orthodontia		
Benefit	50% after CYD	
Lifetime Maximum	$1,000	

*Balance billing will apply when utilizing out-of-network providers

Vision Program

Cigna is our exclusive carrier for the 2019 vision plan. Your vision coverage includes a routine eye exam, frames, and either eyeglass lenses or contact lenses. Eye exams, lenses, and contacts are allowed on an annual basis, however you are only eligible for frames every two years. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. When you receive care from a Cigna vision participating provider, you can maximize your benefits and money-saving discounts. To find a participating provider visit www.mycigna.com.

If you choose to, you may receive covered benefits outside of the Cigna vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.

Plan Name	**C1 PPO**	
Network Access	**In-Network**	**Out-of-Network**
Eye Exam Office Visit	$15 Copay	Reimbursement up to $45
Frequency	12 Months	
Materials ($30 hardware)		
Lenses (Standard plastic)		
Single Vision	No Charge after Copay	Reimbursement up to $40
Bifocals	No Charge after Copay	Reimbursement up to $65
Trifocals	No Charge after Copay	Reimbursement up to $75
Frequency	12 Months	
Frames		
Selected Frames	Up to $130 + 20% off balance	Reimbursement up to $78
Frequency	24 Months	
Contacts	In lieu of eyeglasses	
Elective	Up to $130	Reimbursement up to $115
Medically Necessary Contacts	No Charge	Reimbursement up to $250
Frequency	12 Months	

Flexible Spending Account (FSA) administered by Discovery

**If you elect the HDHP HSA Plan, you are not permitted to enroll into the health care FSA Plan.*

Flexible Spending Accounts (FSAs) are designed to save you money on your taxes. They work in a similar way to a savings account. Each pay period, funds are deducted from your pay on a pre-tax basis and are deposited to your Health Care and/or Dependent Care FSA. You then use your funds to pay for eligible health care or dependent care expenses.

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over the counter medications)	Maximum Contribution is $2,650 per year	Saves on eligible expenses not covered by insurance; reduces your taxable income
Dependent Care	Care for your child, disabled spouse, elderly parent, or other dependent who is physically or mentally incapable of self-care	Maximum Contribution is $5,000 per year	

"Use it or lose it"

Your FSA elections will be in effect from January 1st through December 31st. Claims for reimbursement must be submitted by March 15 of the following year. Please plan your contributions carefully. Any money remaining in your account after March 31st will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year. The chart below is an example of how much you can save when you use the FSAs to pay for your predictable health care and dependent care expenses.

	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pre-tax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$11,701	$12,355
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses	$36,299	$35,645
Tax savings with the Medical and Dependent Care FSA	$654	N/A

Save on your taxes with an FSA

**This is an example only, and may not reflect your actual experience. It assumes a 25% federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will also save on any state and local taxes as well.*

Basic Life Insurance and AD&D Administered by Unum

National Beverage Corp. provides all eligible team members with Basic Life Insurance and Accidental Death & Dismemberment (AD&D). National Beverage Corp. offers you $25,000 of coverage provided by Unum at no cost. Please refer to the certificate for complete plan description.

While the company has automatically enrolled you in the Life Insurance plan, please make sure that Human Resources has an updated Beneficiary Designation Form. You may obtain a Beneficiary Designation Form directly from Human Resources.

Voluntary Life Insurance and AD&D Administered by Unum

For you: You can elect up to $500,000 for yourself– in $25,000 increments.

For your spouse: You can elect Voluntary Life and AD&D for your spouse at a flat $10,000.

For your child(ren): You can elect Voluntary Life and AD&D for your dependents. You can purchase $5,000 in coverage for each child, all children are covered for a single cost. (Benefit for child birth to 6 months is $1,000).

Late entrants will require an Evidence of Insurability (EOI) Form to be completed for review and approval.

Disability Benefits Administered by Unum

When you are healthy it is hard to imagine not being able to work because of a serious illness or injury. But a disability that keeps you out of work could have a devastating impact on your income, jeopardizing your ability to cover normal household expenses. You have the option to elect Short Term Disability (STD) with Long Term Disability (LTD), or (LTD) only.

If you elect both STD and LTD a discount of 25% will be applied to your LTD rate.

Short Term Disability: Covers 60% of your weekly pre-disability earnings, up to a $2,500 weekly maximum. Benefits begin on the thirtieth day of injury or illness and continues to the earlier of recovery or ninety days.

Long Term Disability: Covers 60% of your weekly pre-disability earnings, up to a $10,000 maximum. Benefits begin after 90 days of disability or illness and continues to retirement age.

Unum Option Benefits Rates	
Team member Life	$0.423 per $1,000 of coverage
Team member AD&D	$0.020 per $1,000 of coverage
Spouse Life/AD&D	$0.263 per $1,000 of coverage
Dependent Life/AD&D	$0.163 per $1,000 of coverage; includes one or more children
LTD*	$0.447 per $100 of monthly covered payroll
STD	$0.257 per $10 of weekly benefit

Late entrants will require an Evidence of Insurability (EOI) Form to be completed for review and approval.

**For team members who elect the combined LTD/STD option, NBC will pay 25% of the LTD premium. For team members who elect LTD only, the team member will pay 100% of the LTD premium.*

Voluntary Worksite Benefits Administered by Chubb

Group Accident Insurance

Accident Insurance can pay you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious, like an injury from a car accident. Your plan can pay you a cash benefit for an emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. You can also purchase coverage for your spouse and dependent children. The plan included a $75 wellness benefit and is portable at the same rate. Monthly Premium starting at $13.16 for individual coverage.

Most utilized reimbursement services with the Accident are shown below.

Hospital Admission	$1,000
Hospital ICU Admission	$2,000
Hospital Confinement Per Day	$200 (Up to 365 Days)
Hospital ICU Confinement Per Day	$400 (Up to 30 Days)
Emergency Room	$150
Non-Emergency Room Care	$75 Physician's Office/Urgent Care
Ambulance Ground/Air	$200/$2,000
Physical Therapy	$50 (Up to 10 Visits)
Fractures/Dislocations	Up to $7,000 / Up to $4,800
Lacerations	Up to $500
Accidental Death/Dismemberment	Up to $50,000 / Up to $20,000
Wellness	$75 per person per year

Please refer to the plan brochure for all covered services.

Group Critical Illness Insurance

What's a Critical Illness? Some common examples are heart attack, stroke and cancer. The medical treatment for these conditions can be very expensive. Critical Illness insurance can help by paying a lump sum payment directly to you at the first diagnosis of a covered condition. This plan will pay multiple times for either the same diagnosis or different diagnosis. But they must be separated by 6 months. The plan included a $50 wellness benefit and is portable at the same rate. Available with monthly premiums starting at $13.18 for individual coverage.

Continued on next page

Group Critical Illness Insurance– continued

Guaranteed Issue Maximum	Employee: Up to $30,000 Spouse: 50% of Employee Coverage Amount Child: 25% of Employee Coverage Amount
Pre-Existing Condition Limitations	None
Covered Critical Illnesses	Cancer, Benign Brain Tumor, Heart Attack, Stroke, Major Organ Failure, Kidney Failure, Coma
Other Covered Critical Illnesses	Covered at 25%: Carcinoma In Situ, Coronary Artery Obstruction Miscellaneous conditions covered at 100%: (Alzheimer's Disease, Parkinson's Disease, Multiple Sclerosis, Paralysis or Dismemberment) Childhood Conditions: Cerebral Palsy, Congenital Birth Defects, Heart, Lung, Cleft Lip, Palate, etc., Cystic Fibrosis, Down Syndrome, Muscular Dystrophy, Type 1 Diabetes, Skin Cancer $250)
Wellness	$50 (Per covered person per calendar year)
Portability	Fully Portable

Please refer to the plan brochure for all covered services.

Group Permanent Life Insurance

Is Permanent Life Insurance needed? It's important to make sure your family is covered in the event of an unforeseen loss of life. Creating financial security for your loved ones can be very difficult. With the group permanent life insurance you can provide financial protection for you and your family under the benefits of a large group plan. This additional permanent life insurance has guarantee issue amounts of $100,000 for our team members, $75,000 for your spouse and $25,000 for your children. Additional benefits offered is an accelerated death benefit rider option and is fully portable.

Group Hospital Indemnity Insurance

An unexpected hospital stay, even for a routine procedure, could force you to dip into your hard-earned savings. Hospital indemnity insurance can pay you a benefit to help you cover the costs associated with a hospital stay. It can complement your health plan to help with the out-of-pocket expenses medical insurance may not cover, such as co-insurance, co-pays and deductibles. You decide how to spend the money. Coverage is also available for your spouse and children. Monthly Premium starting at $24.80 for individual coverage.

Guaranteed Issue	Yes
Pre-Existing Condition Limitations	None 9 month wait on pregnancy
Initial Hospital Admission	$1500 (Once per calendar year)
Daily Hospital	$200 up to 10 days
Daily ICU Hospital	$200 up to 10 days
Pregnancy	Covered

Please refer to the plan brochure for all covered services.

Team member Assistance Program (EAP) administered by Unum

When you find yourself in need of some professional support to deal with personal, work, financial or family issues, your Team member Assistance Program (EAP) can assist. You and your immediate family (spouse or domestic partner, dependent children, parents and parents-in-law) can use this program for a variety of issues, including:

- Marital and family conflicts
- Job related difficulties
- Stress, anxiety, and depression
- Parent and child relationships
- Legal and financial counseling
- Financial planning
- Various other related issues

All services provided are confidential and will not be shared with us. To access this service, please call 800-854-1446 or visit www.lifebalance.net and enter the User ID and Password: **lifebalance**

PayActiv

PayActiv partners with employers to deliver comprehensive, turnkey financial wellness services. These life-changing HR benefits empower workers to free themselves from accruing debt and revitalize employee engagement, achieving measurable gains in the workplace.

The Solution: MyMoNow Service– PayActiv's financial wellness solution is unlike anything the marketplace has seen.

- MyMoNow (short for "MyMoneyNow")- the service is offered by employers as a voluntary team member membership program.
- App gives employees secure, one-click access to earned wages– their own money– without waiting for the next payday.
- Once you enroll in the program, you use your mobile devices to manage financial transactions, including immediate access to cash, free bill pay, bank transfers, automatic savings plans, and more.
- Enrollment is simple– enrollment is via text message
- Text "Enroll Me" to 1-877-937-6966
- Respond to the text asking for your first name (only enter your first name)
- Respond to the text asking for your last name (only enter your last name)
- Finally, respond to the text asking for your employee identification number– It's that simple!

Explain My Benefits (EMB) Login Instructions

ACCESSING EMB eNROLL

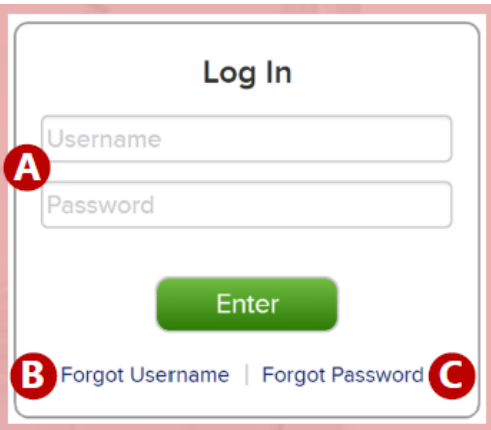
GETTING STARTED

Access National Beverage Corp.'s ***Benefits Resource Website*** and select "**Log into Your Benefit System**".

A **Access** the system using your Username and Password

B **Forgot username**
- Enter your 9-digit ID (SSN without dashes)
- Answer your three security questions
- Your username will be emailed to your email address on file (watch for an email from autobenestatus@autobene.com)

C **Forgot password**
- Enter your username
- Answer your three security questions
- Enter and confirm your new password
- Confirm your email address; you will receive a confirmation of the change



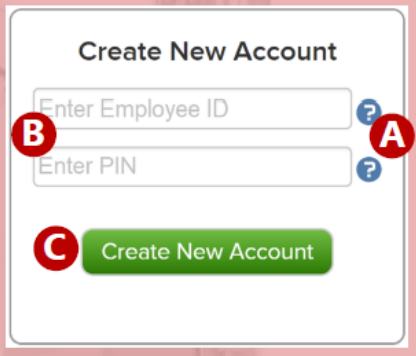
PROCESS FOR NEW USERS AND PRIOR USERS THAT HAVE NOT ACCESSED EMB ENROLL SINCE MARCH 1, 2018

CREATE NEW ACCOUNT

All users who have not accessed EMB Enroll since March 1, 2018 should start by creating a new account in the Create New Account section.

- **A** **Hover** over the question mark next to each field for specific instructions
- **B** **Enter** the required Employee ID and PIN as instructed
- **C** Click ***"Create New Account"***

*In the event the system advises that an account already exists, return to the **"Log In"** steps above.*



Explain My Benefits (EMB) Login Instructions continued

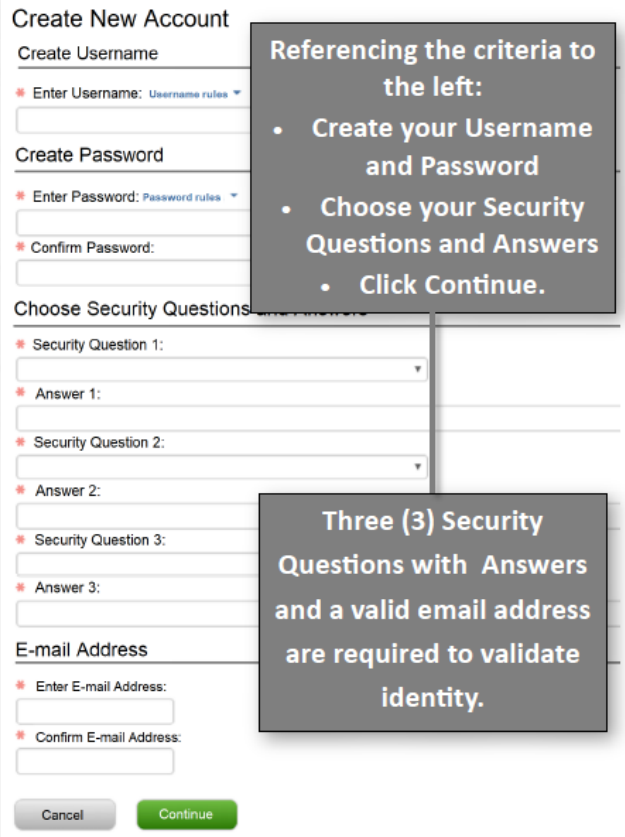
USERNAME AND PASSWORD CRITERIA

Username:

- At least one (1) letter and one (1) number
- Between 8 - 32 characters
- Not the same as your password
- No more than three sequential characters *(abc, cba, 123, 321)*
- No more than three repeating characters *(aaa, 111)*
- Permitted special characters: @ . - _ *
- Your username must be unique

Password:

- At least one (1) uppercase letter and one (1) lowercase letter
- At least one (1) number
- Between 8 - 20 characters
- Not the same as your username
- No more than three sequential characters *(abc, cba, 123, 321)*
- No more than three repeating characters *(aaa, 111)*
- Permitted special characters: @ . - _ *
- Password cannot be the same as your previous 10 passwords on this system



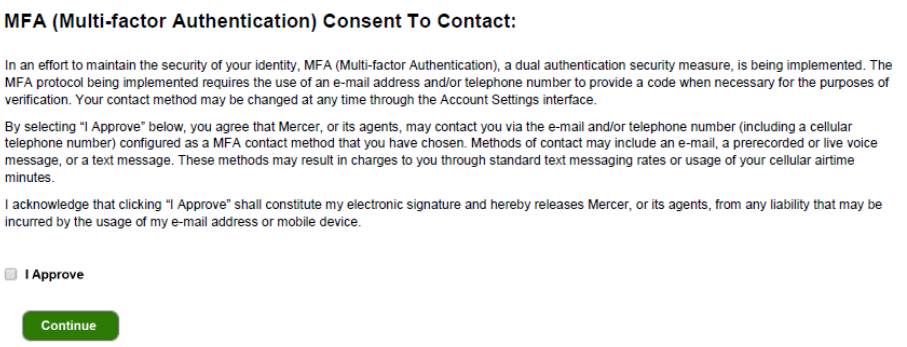
MFA

MULTI-FACTOR AUTHENTICATION

In order to protect your and your dependents' personal information, the **EMB eNROLL** system has implemented enhanced security features. At your first log in and at random intervals, the system will require use of a verification code. This code can be emailed or sent via text message to a mobile device. Please review the steps below for instructions on setting up your verification contact methods.

STEP 1: CONSENT TO CONTACT

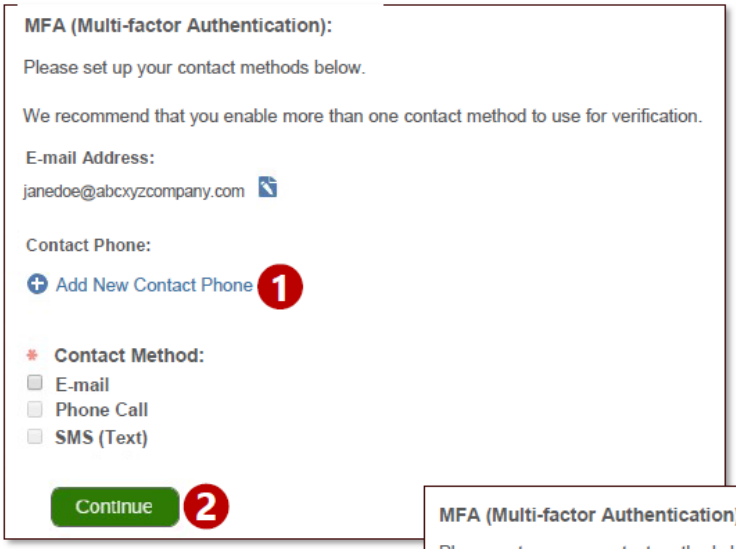
Fully read the consent statement, check off the "I Approve" Checkbox and click Continue



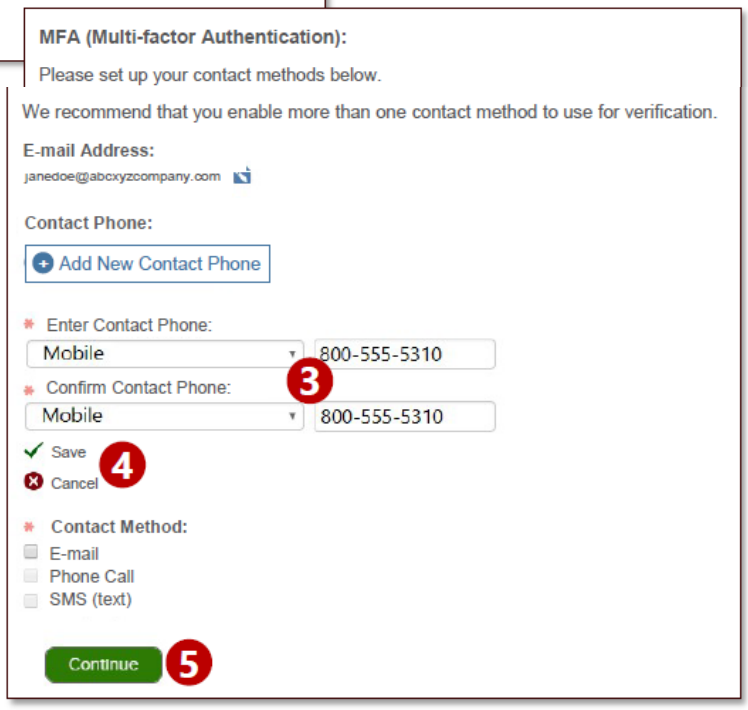
Explain My Benefits (EMB) Login Instructions continued

STEP 2: SETUP YOUR CONTACT METHODS

Multi-factor Authentication recommends the use of an email address and contact number for use when sending a verification code upon login. *The simplest and preferred contact method is SMS (TEXT) Message.*



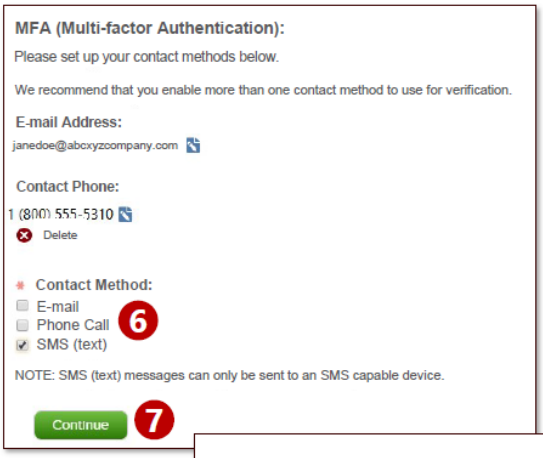
1. If setting up a phone number for receiving a verification phone call or text message, click "Add New Contact Phone"
2. Click "Continue"



3. Enter and confirm your phone type and phone number
4. Click Save to continue
5. Click "Continue"

Explain My Benefits (EMB) Login Instructions continued

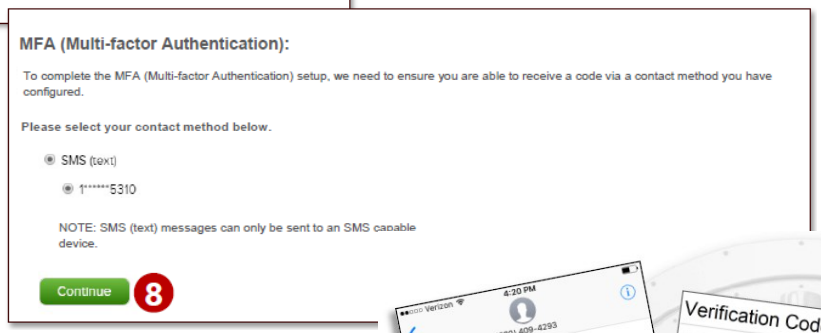
STEP 2: SETUP YOUR CONTACT METHODS (CONT')

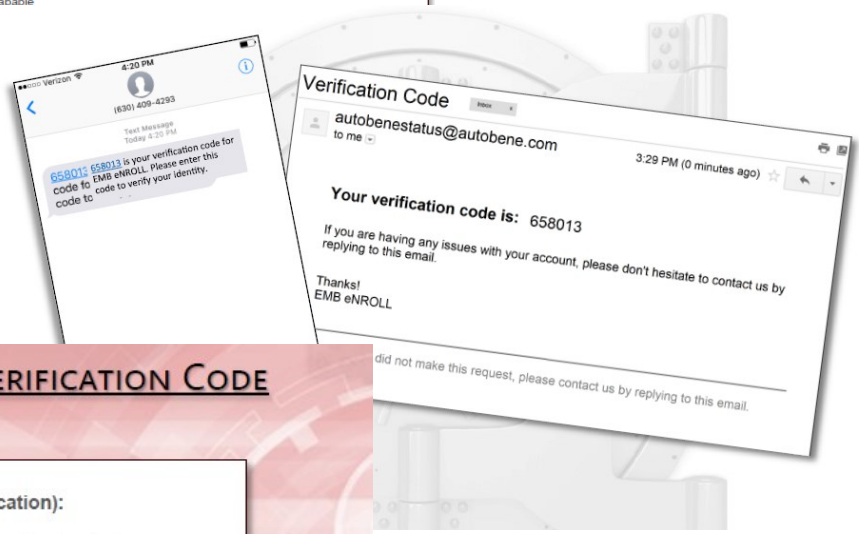


6 Select your preferred contact method by checking the appropriate box.

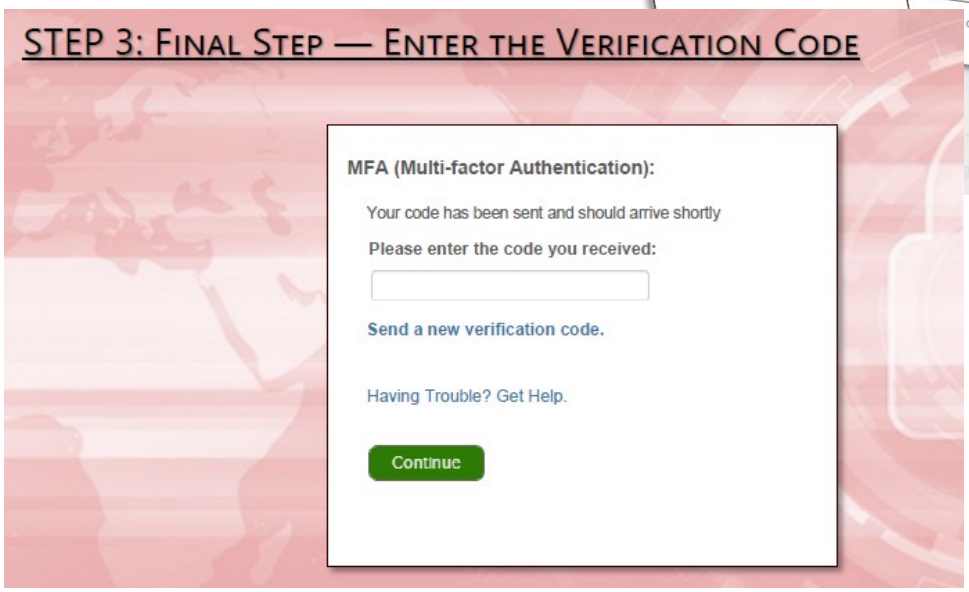
7 Click "Continue"

8 Click "Continue" To complete setup





STEP 3: FINAL STEP — ENTER THE VERIFICATION CODE



PAYROLL DEDUCTIONS

2019 Payroll Deductions Weekly

BCBS Medical Coverage (Weekly)	HDHP w/ HSA Plan		
	Wellness Rates	Non-Wellness Rates (EE or Spouse)	Non-Wellness Rates (EE + Spouse)
Team Member Only	$16.38	$33.68	$33.68
Team Member + Spouse	$56.51	$73.82	$91.13
Team Member + Child(ren)	$48.17	$65.48	$65.48
Team Member + Family	$87.07	$104.38	$121.69

BCBS Medical Coverage (Weekly)	PPO Plan		
	Wellness Rates	Non-Wellness Rates (EE or Spouse)	Non-Wellness Rates (EE + Spouse)
Team Member Only	$31.93	$49.23	$49.23
Team Member + Spouse	$101.14	$118.44	$135.75
Team Member + Child(ren)	$87.59	$104.89	$104.89
Team Member + Family	$155.43	$172.74	$190.05

BCBS Medical Coverage (Weekly)	PPO Copay Plan		
	Wellness Rates	Non-Wellness Rates (EE or Spouse)	Non-Wellness Rates (EE + Spouse)
Team Member Only	$34.43	$51.74	$51.74
Team Member + Spouse	$114.03	$131.34	$148.64
Team Member + Child(ren)	$98.75	$116.06	$116.06
Team Member + Family	$175.24	$192.55	$209.86

Wellness premium based on participants completing the following by December 15, 2018:

- Be a non-smoker / non-tobacco user / non-e-cigarette user (vape)
- Has had a wellness physical in 2018
- Has completed his/her health risk assessment on BCBS website
- Has registered for Teladoc

Cigna Dental Coverage (Weekly)	Cigna Total DPPO
Team Member Only	$11.46
Team Member + Spouse	$16.78
Team Member + Child(ren)	$15.54
Team Member + Family	$20.05

Cigna Vision Coverage (Weekly)	Vision Plan
Team Member Only	$1.18
Team Member + Spouse	$2.17
Team Member + Child(ren)	$2.28
Team Member + Family	$3.41

2019 Payroll Deductions Bi-Weekly

BCBS Medical Coverage (Bi-Weekly)	HDHP w/ HSA Plan		
	Wellness Rates	Non-Wellness Rates (EE or Spouse)	Non-Wellness Rates (EE + Spouse)
Team Member Only	$32.75	$67.37	$67.37
Team Member + Spouse	$113.03	$147.64	$182.26
Team Member + Child(ren)	$96.34	$130.96	$130.96
Team Member + Family	$174.14	$208.76	$243.37

BCBS Medical Coverage (Bi-Weekly)	PPO Plan		
	Wellness Rates	Non-Wellness Rates (EE or Spouse)	Non-Wellness Rates (EE + Spouse)
Team Member Only	$63.85	$98.47	$98.47
Team Member + Spouse	$202.27	$236.89	$271.50
Team Member + Child(ren)	$175.17	$209.79	$209.79
Team Member + Family	$310.86	$345.48	$380.10

BCBS Medical Coverage (Bi-Weekly)	PPO Copay Plan		
	Wellness Rates	Non-Wellness Rates (EE or Spouse)	Non-Wellness Rates (EE + Spouse)
Team Member Only	$68.87	$103.48	$103.48
Team Member + Spouse	$228.06	$262.67	$297.29
Team Member + Child(ren)	$197.50	$232.12	$232.12
Team Member + Family	$350.48	$385.10	$419.71

Wellness premium based on participants completing the following by December 15, 2018:

- Be a non-smoker / non-tobacco user / non-e-cigarette user (vape)
- Has had a wellness physical in 2018
- Has completed his/her health risk assessment on BCBS website

Cigna Dental Coverage (Bi-Weekly)	Cigna Total DPPO
Team Member Only	$22.92
Team Member + Spouse	$33.55
Team Member + Child(ren)	$31.08
Team Member + Family	$40.09

Cigna Vision Coverage (Bi-Weekly)	Vision Plan
Team Member Only	$2.35
Team Member + Spouse	$4.34
Team Member + Child(ren)	$4.55
Team Member + Family	$6.82

Glossary of Medical Plan Terms

Brand Name Drugs– Drugs that have trade names and are protected by patents. Brand name drugs are generally the **most costly choice.**

Coinsurance– The percentage of a covered charge paid by the plan.

Consumer Driven Health Plan (CDHP)- A medical plan used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

Copayment (Copay)- A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible– The annual amount you and your family must pay each year before the plan pays benefits.

Generic Drugs– Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

Health Savings Account (HSA)- A Fund you can use to help pay for eligible medical costs not covered by your medical plan. Both employers and employees may contribute to this fund; employees do so through pre-tax payroll deductions.

HSA Qualified Plan—A Medical plan that may be used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

In-Network– Use of a health care provider that participates in the plans network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Inpatient– Services provided to individual during an overnight hospital stay.

Mail Order Pharmacy– Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Out-of-Network– Use of a health care provider that does not participate in a plan's network.

Out-of-Pocket Maximum– The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year, except for prescriptions under all medical plans.

Outpatient– Services provided to an individual at a hospital facility without an overnight hospital stay.

Primary Care Physician (PCP)- physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Specialist– A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).

Specialty Drugs– Are high cost prescription medications used to treat complex, chronic conditions like cancer rheumatoid arthritis and multiple sclerosis.

CONTACT INFORMATION

Resource / Service Provider	Contact Source	Details
BCBS (Medical Insurance)	Member Services Website	(800) 830-1501 www.myhealthtoolkitfl.com
HSA Bank (Health Savings Account)	Member Services Website	(866) 357-5232 www.hsabank.com
Cigna (Dental Insurance)	Member Services Website	(800) 244-6224 www.mycigna.com
Cigna (Vision Insurance)	Member Services Website	(800) 244-6224 www.mycigna.com
Discovery Benefits (Flexible Spending Account)	Member Services Website	(866) 451-3399 www.discoverybenefits.com/team members
Unum (Basic Life / AD&D and Voluntary Life / AD&D Insurance)	Member Services Website	(866) 679-3054 www.unum.com
Unum (Short Term Disability and Long Term Disability)	Member Services Website	(866) 679-3054 www.unum.com
Chubb (Voluntary Worksite Benefits)	Member Services Website	(855) 241-9891 (permanent life) (866) 445-8874 (all other products) www.chubbworkplacebenefits.com
Unum (Team member Assistance Program)	Member Services Website	(800) 854-1446 www.lifebalance.net **Username & Password: lifebalance**
Teladoc (Telemedicine)	Member Services Website	(800) 835-2362 www.teladoc.com

ANNUAL DISCLOSURES

HIPAA Special Enrollment Rights – If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the health coverage).

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

To request special enrollment or obtain more information, contact Human Resources.

Michelle's Law – The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. This law applies to medically necessary leaves of absence that begin on or after January 1, 2010.

If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).

Your employer will require a written certification from the child's physician that states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

Section 111 – Effective January 1, 2009 Group Health Plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help establish who pays first. The mandate requires Group Health Plans to collect additional information, more specifically Social Security Numbers for all enrollees, including dependents six months of age or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

Women's Health and Cancer Rights Act of 1998 – 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
- 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.

The Newborn's and Mother's 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 insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

Patient Protection: If the Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier 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 the 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, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

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, 2018. Contact your State for more information on eligibility.

ANNUAL DISCLOSURES

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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS - Medicaid

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

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+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

FLORIDA - Medicaid

Website: http://flmedicaidtplrecovery.com/hipp
Phone: 1-877-357-3268

GEORGIA - Medicaid

Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

INDIANA - Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA - Medicaid

Website: http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

KANSAS - Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY - Medicaid

Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA - Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE - Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS - Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA - Medicaid

Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

NEBRASKA - Medicaid

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

NEVADA - Medicaid

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

NEW HAMPSHIRE - Medicaid

Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY - Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid

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

NORTH CAROLINA - Medicaid

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

NORTH DAKOTA - Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP

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

OREGON - Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND- Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

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: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH - Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT - Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP

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

WASHINGTON - Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA - Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING - Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, 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

MEDICARE D NOTICE

Important Notice from National Beverage Corp. About Your Prescription Drug Coverage and Medicare

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

There are 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. **National Beverage Corp. has determined that the prescription drug coverage offered by BCBS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current National Beverage Corp. coverage will not be affected.

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

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

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

Important Notice from National Beverage Corp. About Your Prescription Drug Coverage and Medicare (continued)

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

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

Contact the person listed below for further information.

NOTE: You will 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 National Beverage Corp. changes. You may also request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2019
Name of Entity /Sender: National Beverage Corp.
Contact: Florence Almarales
Address: 8100 SW 10th S, Suite 4000
Fort Lauderdale, FL 33324
Phone Number: (954) 581-0922

The information in this guide is a summary of the benefits available to you and should not be intended to take the place of the official carriers' Member Certificates or our plan's Summary Plan Description (SPD). This guide contains a general description of the benefits to which you and your eligible dependents may be entitled as a full-time employee. This guide does not change or otherwise interpret the terms of the official plan documents. To the extent that any of the information contained in this guide is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases and the plan documents and carrier certificates will prevail.

This guide highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept with your most recent Summary Plan Description.

National Beverage Corp. reserves the right, in its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the benefit plans.

This Benefits Guide is a Presentation Prepared by

Gallagher

Insurance | Risk Management | Consulting