Required Annual Enrollment Legal Notices

This document includes the following important Annual Enrollment legal notices for Bimbo Bakeries USA and Bimbo Quick Service Restaurants (the "Company"):

- Medicare Part D Creditable Coverage
- Summary Annual Report
- HIPAA Privacy Notice Reminder
- HIPAA Special Enrollment Rights
- Women's Health and Cancer Rights Act of 1998
- Newborns' & Mothers Health Protection Act
- Your Rights Under USERRA - The Uniformed Services Employment and Reemployment Rights Act
- COBRA Rights
- Notice Regarding Wellness Program
- Medicaid and the Children's Health Insurance Program (CHIP)

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 page 2 for more details.

If you have questions about these notices, please contact the **Benefits Center** at **1-888-60-myBBU** (1-888-606-9228), Monday to Friday, 9:00 a.m. to 7:00 p.m., Eastern Time.

For additional information on Medicare, please contact **HTA** at **1-610-430-6650, Option 1** to schedule a Medicare consultation or visit **www.hta-insurance.com**.

Important Notice 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 the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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 is available 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. **The Company has determined that the prescription drug coverage offered by the Company is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays for 2024 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.**

If you or your family members are not currently covered by Medicare and will not become covered by Medicare in the next 12 months, this notice does not apply to you.

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 and you are an active associate or family member of an active associate, your current Company prescription drug coverage will not be affected.

You may enroll in a Medicare prescription drug plan and if you are an active associate or family member of an active associate, you may also continue your employer coverage and retain your current coverage under the BBU Health and Welfare Plan. However, you will be required to pay premiums for both and the Medicare prescription drug plan will generally pay benefits after the Company plan. If you enroll in Medicare, you may also elect to drop your prescription drug coverage with the Company. However, please note, if you drop your Company prescription drug coverage you will also be required to drop your Company coverage for other medical services. Because your Company prescription drug coverage is linked to your Company medical coverage, you will be able to drop your Company prescription drug coverage only by dropping your entire medical plan.

If you waive or drop coverage under the BBU Health and Welfare Plan and enroll in Medicare prescription drug coverage, Medicare will be your only payer. You will be able to re-enroll in the BBU Health and Welfare Plan, assuming you remain eligible, during the Company's annual enrollment period, due to certain life events, or if you become eligible for a special enrollment right under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You should compare your current prescription drug coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area before making your decision.

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 the Company and do not 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) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information

For more information about this notice or your current prescription drug coverage, contact the **Benefits Center** at **1-888-60-myBBU** (1-888-606-9228), Monday to Friday, 9:00 a.m. to 7:00 p.m., Eastern Time.

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 the Company changes. You also may request a copy of this notice at any time.

More information about your options under Medicare 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 (phone numbers are located on the inside back cover of your copy of the *Medicare & You* handbook) 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. Go to **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778) for information.

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 you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

SUMMARY ANNUAL REPORT FOR THE BBU HEALTH AND WELFARE PLAN

This is a summary of the annual report of the Bimbo Bakeries USA Health & Welfare Plan, Employer Identification Number 75-2491201, Plan Number 532, for the plan year January 1, 2022, through December 31, 2022. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Uninsured Components

The Plan Sponsor, BBU Inc., has committed to pay certain medical and prescription drug claims (including all flexible spending account expenses) and all dental claims, short-term disability claims and severance plan benefits incurred under the terms of the plan.

Insurance Information

The Plan had contracts with insurance carriers to pay certain claims incurred under the terms of the Plan. The type of benefit provided, name of the insurer, and premiums paid for each component are set forth in the table below. The total amount of non-experience-rated premiums paid for contract years that ended during the 2022 plan year was $12,337,088.

Type of Benefit	Name of Insurer	Premiums Paid
Business Travel Accident	Zurich American Insurance Company #GTU 3031921	$14,868
Medical and Evacuation	Cigna Health and Life Insurance Company 04979B	$68,957
Legal Services	MetLife Legal Plans #100895	$267,259
Long-Term Disability	Life Insurance Company of North America #FLK980131	$3,715,651
Basic/Supplemental Life and AD&D Insurance	Securian Life Insurance Company #70009	$5,359,800
Critical Illness	Securian Life Insurance Company #76002	$1,457,125
Vision	UnitedHealthcare Insurance Company #0754195	$522,462
	Vision Service Plan #12134660	$930,966

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, upon request. The insurance information, including sales commissions paid by insurance carriers, is included in that report.

To obtain a copy of the full annual report, or any part thereof, write or call BBU, Inc., 255 Business Center Drive, Horsham, PA 19044, 1-215-672-8010. The charge to cover copying costs will be the actual reproduction costs, but in no event, more than 25 cents per page.

You also have the legally protected right to examine the annual report at the main office of the plan (BBU, Inc., 255 Business Center Drive, Horsham, PA 19044), at the U.S. Department of Labor in Washington, D.C., or you may obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

HIPAA Privacy Notice Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Bimbo Bakeries USA Health & Welfare Plan (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice contact Kelly McCann, Bimbo Bakeries USA Benefits Manager, at 255 Business Center Drive, Horsham, PA 19044. You may also view the Privacy Notice online at **GB-on**.

You may also contact the Plan's Privacy Official, Kelly McCann at 1-215-957-4446 for more information on the Plan's privacy policies or your rights under HIPAA.

HIPAA Special Enrollment Rights

If you declined enrollment for yourself or your dependents (including your spouse) in the Bimbo Bakeries USA health plan because of other health insurance or group health plan coverage, later you may be able to enroll yourself and your dependents in this Plan without waiting for the next open enrollment period, 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 you or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage) Additionally, you and/or your dependent(s) may be able to enroll in a Company-sponsored medical plan if you and/or your dependent(s) became eligible for state premium assistance under Medicaid or Children's Health Insurance Program (CHIP) or lose Medicaid or CHIP coverage because you are no longer eligible.

Note that you must request enrollment within 60 days of an event that involves loss of Medicaid or CHIP coverage or eligibility for state premium assistance. Also, note that this 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

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. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective on 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.

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.

To request special enrollment or to obtain more information, please contact the **Benefits Center** at **1-888-60-myBBU** (1-888-606-9228), Monday to Friday, 9:00 a.m. to 7:00 p.m., Eastern Time.

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 any person receiving plan benefits in connection with a mastectomy, 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 a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications, including lymphedema, at all stages of the mastectomy

This coverage will be provided subject to the same annual deductibles and coinsurance provisions that apply for other medical and surgical benefit provided under this plan. If you would like more information on WHCRA benefits, please contact your plan vendor directly.

Newborns' & Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

Your Rights Under USERRA - The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service;

then an employer may not deny you:

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed on the internet at **http://www.dol.gov/vets/programs/userra/poster.htm.** Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

For additional information on military leaves, such as how to request a leave and other rights and obligations, as well as their impact on benefits, please contact the Benefits Center at **1-888-60-myBBU** (1-888-606-9228), Monday to Friday, 9:00 a.m. to 7:00 p.m., Eastern Time.

General Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you are participating or have recently become eligible for benefits under the Bimbo Bakeries USA Health and Welfare Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, as well as other health coverage alternatives that may be available to you through the Health Care Exchange.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.**

For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact your Company representative.

You may have other options available to you when you lose group health coverage.
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through Marketplace, you may qualify for lower cost on your monthly premiums and lower out –of-pocket costs. Additionally, you may qualify for a special enrollment period for another group

health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for this coverage.

If you are an associate, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events happen:
1. Your hours of employment are reduced.
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an associate, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:
1. Your spouse dies.
2. Your spouse's hours of employment are reduced.
3. Your spouse's employment ends for any reason other than his or her gross misconduct.
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both) and is not an active associate.
5. You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happen:
1. The parent-associate dies.
2. The parent-associate's hours of employment are reduced.
3. The parent-associate's employment ends for any reason other than his or her gross misconduct.
4. The parent-associate becomes divorced.
5. The child stops being eligible for coverage as a "dependent child" under the Plan.

Newly Eligible Child: If you, elect COBRA coverage and then have a child (either by birth, adoption or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage, with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary and birth certificate or adoption decree.

If you fail to notify the Plan Administrator as described in this notice, you will not be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired Dependent Child(ren) (other than children born to, adopted by or placed for adoption with the associate) will not be considered qualified beneficiaries, but may be added to the associate's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

QMCSO: A child of the covered associate who is receiving benefits under the Plan pursuant to a QMCSO received by the Plan Administrator during the covered associate's period of employment is entitled to the same rights to elect COBRA as an eligible Dependent Child of the covered associate.

When Is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Company has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction in hours of employment, death of the associate, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the associate in Medicare (Part A, Part B or both) if the associate is not an active associate, the Company will automatically notify the COBRA Administrator.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce or legal separation of the associate and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Company within 60 days after the qualifying event occurs. This notice must be provided in writing to your Company contact and must include the following information:

- The name of the associate who is covered under the plan,
- The names and address(es) of the qualified beneficiary(ies) who will receive COBRA coverage, and the qualifying event that gave rise to COBRA coverage,
- The date of the qualifying event,
- The signature, name and contact information of the individual sending the notice.

Depending upon the qualifying event, your Company contact may request supporting documentation.

How Is COBRA Continuation Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the associate, enrollment of the associate in Medicare (Part A, Part B, or both) if the associate is not an active associate, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the associate's hours of employment, and the associate became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the associate can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered associates become entitled to Medicare within 18 months BEFORE termination or reduction of hours. For example, if a covered associate becomes entitled to Medicare eight months before the date on which his employment terminated, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely manner, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some point before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60 days of the determination and before the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage for a maximum of 36 months. This extension may be available to the spouse and dependent children receiving COBRA continuation coverage if the associate or former associate dies, enrolls in Medicare (Part A, Part B or both), if the associate is not an active associate, or gets. The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent child. In each case, however, the extension of COBRA continuation coverage will apply only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all these cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

Special Rule for the Health Care FSA

Extension of coverage for the Health Care FSA is limited to the end of the year in which the qualifying event occurs. However, an individual who is covered under COBRA continuation coverage on December 31 of any Plan year can submit claims for expenses incurred during the Grace Period (the period from January 1 through March 15) following the Plan year.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as spouse's plan) through what is call a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage after my Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified in Chart One under Plan Contact Information below.

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[1] **https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**.

For more information about your rights under ERISA, including COBRA, the Patient Protection Affordable Care Act, Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at **www.dol.gov/ebsa** or call their toll-free number at 1-888-444-3272. For more information about health insurance options available through a Health Care Exchange, visit **www.healthcare.gov**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your Company contact (see Chart One under Plan Contact Information below) informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or COBRA Administrator.

Plan Contact Information

If you have any questions about the plan or COBRA continuation coverage, please contact the following departments:

CHART ONE – COMPANY CONTACT INFORMATION		
Contact Name	**Address**	**Phone Number**
Benefits Department	255 Business Center Dr. Horsham, PA 19044	1-888-60-myBBU (1-888-606-9228)
CHART TWO – COBRA ADMINISTRATOR		
Contact Name	**Address**	**Phone Number**
WageWorks, Inc.	P.O. Box 650407 Dallas, TX 75265-0407	1-877-630-7215

Notice Regarding Wellness Program

The Company's wellness program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve associate health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. Salaried and non-union hourly associates and enrolled spouses will be asked to complete a biometric screening, which will include a blood test for cotinine to test for tobacco use. You are not required to complete the blood test or other medical examinations. The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Salaried and non-union hourly associates and enrolled spouses will receive an incentive of medical plan premium discounts for:

- Completing the biometric screening
- Being tobacco-free
- Demonstrating a BMI under 30 or a waist circumference of 35" or less for women, or 40" or less for men.

Although you are not required to complete the biometric screening, only associates and enrolled spouses who do so will receive medical plan premium discounts.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn the incentive, you may be entitled to a reasonable accommodation or an alternative standard. Please check GB-On to access the Healthy Standard Appeals Form. You will need to have the form completed by your physician and submit it to **HRBenefitSolutions@grupobimbo.com** or to the Benefits Department at 255 Business Center Drive, Horsham, PA, 19044 for processing by September 30, 2023.

If you are not tobacco-free, the Pelago tobacco cessation program is the reasonable alternative standard to allow you to earn the incentive. You can learn more about the Program and enroll by calling 1-877-349-

7755. Once you have enrolled and completed the Pelago tobacco cessation program, you will earn the “being tobacco-free” incentive.

If you have any questions about the reasonable accommodation or alternative standard processes, you can contact the Benefits Department at 1-877-524-5218, option 5.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the Company may use aggregate information it collects to design a program based on identified health risks in the workplace, it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach involving information you provide in connection with the wellness program occurs, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Benefits Department at 255 Business Center Dr., Horsham, PA 19044.

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, 2023. Contact your State for more information on eligibility:

State	Service	Website	Phone Number
Alabama	Medicaid	http:// myalhipp.com	1-855-692-5447
Alaska	Medicaid	http://myakhipp.com/ https://health.alaska.gov/dpa/Pages/default.aspx	1-866-251-4861
Arkansas	Medicaid	http://myarhipp.com/	1-855-692-7447
California	Medicaid	http://dhcs.ca.gov/hipp	1-916-445-8322
Colorado	Medicaid	https://www.healthfirstcolorado.com/	1-800-221-3943
	CHP+	https://hcpf.colorado.gov/child-health-plan-plus	1-800-359-1991
	HIBI	https://www.mycohibi.com/	1-855-692-6442
Florida	Medicaid	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia	Medicaid (HIPP)	https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp	1-678-564-1162, Press 1
	Medicaid (CHIPRA)	https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra	1-678-564-1162, Press 2
Indiana	Medicaid	http://www.in.gov/fssa/hip/ (low-income adults 19-64) https://www.in.gov/medicaid/ (all others)	1-877-438-4479 1-800-457-4584
Iowa	Medicaid	https://dhs.iowa.gov/ime/members	1-800-338-8366
	CHIP	http://dhs.iowa.gov/Hawki	1-800-257-8563
	HIPP	https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-888-346-9562
Kansas	Medicaid	https://www.kancare.ks.gov/	1-800-792-4884
Kentucky	Medicaid	https://chfs.ky.gov/agencies/dms	
	CHIP	https://kidshealth.ky.gov/Pages/index.aspx	1-877-524-4718
	KI-HIPP	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx	1-855-459-6328
Louisiana	Medicaid	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488
Maine	Medicaid	https://www.mymaineconnection.gov/benefits/s/?language=en_US https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 or 1-800-977-6740

State	Service	Website	Phone Number
Massachusetts	Medicaid and CHIP	https://www.mass.gov/info-details/masshealth-premium-assistance-pa	1-800-862-4840
Minnesota	Medicaid	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri	Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	1-573-751-2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	Medicaid	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 1-402-473-7000 (Lincoln) 1-402-595-1178 (Omaha)
Nevada	Medicaid	http://dhcfp.nv.gov	1-800-992-0900
New Hampshire	Medicaid	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	1-603-271-5218 1-800-852-3345 (ext 5218)
New Jersey	Medicaid	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/	1-609-631-2392
	CHIP	http://www.njfamilycare.org/index.html	1-800-701-0710
New York	Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	Medicaid	https://medicaid.ncdhhs.gov/	1-919-855-4100
North Dakota	Medicaid	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma	Medicaid and CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon	Medicaid	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania	Medicaid	https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx	1-800-692-7462
	CHIP	https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	1-800-986-5437
Rhode Island	Medicaid and CHIP	http://www.eohhs.ri.gov/	1-855-697-4347 1-401-462-0311
South Carolina	Medicaid	https://www.scdhhs.gov	1-888-549-0820
South Dakota	Medicaid	http://dss.sd.gov	1-888-828-0059
Texas	Medicaid	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah	Medicaid	https://medicaid.utah.gov/	1-877-543-7669
	CHIP	http://health.utah.gov/chip	
Vermont	Medicaid	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia	Medicaid and CHIP	https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington	Medicaid	https://www.hca.wa.gov/	1-800-562-3022
West Virginia	Medicaid	https://dhhr.wv.gov/bms/	1-304-558-1700
	CHIP	http://mywvhipp.com/	1-855-699-8447
Wisconsin	Medicaid and CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming	Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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