



Employee Benefit Guide

Management & Full-Time Supervisors
January 1, 2026 - December 31, 2026

Medicare Part D

If you have Medicare or will become eligible for Medicare in the next 12 months, it is important to understand your rights and penalties about your prescription drug coverage before electing an employer plan. Please see Thrive Benefit Team for more information.



This brochure summarizes the benefit plans that are available to Thrive Restaurant Group eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the People Experience Team – Benefits Department. Information provided in this brochure is not a guarantee of benefits.

Table of Contents

Welcome	1
A Message From Thrive	1
Enrollment	2
The Essentials	3
Benefits for You & Your Family	4
Thrive Benefit Eligibility	5
Missed Insurance Premiums	6
Life Events	7
Impact of Role Changes on Your Benefits	7
What Plan Do I Choose?	8
Out-of-Pocket Costs	9
Preventive Care	9
Where to Go for Care	10
Assistance & Contacts	12
Benefit Plan Pricing	13
What Your Benefits Will Cost	14
What Your Ancillary Benefits Will Cost	15
Health Coverage	16
Medical Insurance	17
GOLD PPO Plan	17
Coupe Health - Kansas Only	18
SILVER HDHP Plan	19
BRONZE HDHP Plan	20
Allied Benefit	21
Minimum Essential Coverage Care Plus Plan	21
See a Doctor at Home with Virtual Health	22
Care That Works Around Your Schedule	24
Pharmacy Benefit Manager – Ventegra	25
International Drug Program – Rescrysbe	26
Discount Prescription Programs	27
Online Resources	28
Links and Mobile Apps	29
Dental & Vision	30
Dental Insurance	31
Management	31
Vision Insurance	32
Health Savings & Spending Accounts	33
Health Savings Account (HSA)	34
Flexible Spending Accounts (FSA)	35
HSA vs. FSA	36
Supplementary Health Benefits	37
Life and Accidental Death & Dismemberment Insurance	38
Voluntary Life Insurance	38
Short- and Long- Term Disability Insurance	39
Accident & Injury	40
Critical Illness	40
Hospital Indemnity	41
Additional Support for You & Your Family	42
Mental Health Access	43
Thrive Family Fund	44
Pet Insurance	45
401(k) Retirement Savings Plan	46
Common Questions & Legal Notices	48
Frequently Asked Questions	49
Important Legal Notices	51

Section 1

Welcome

A Message from Thrive | Enrollment



A Message from Thrive Restaurant Group



We're excited to present your Thrive Restaurant Group Benefit Guide! Whether you're enrolling for the first time or updating your current choices, this guide is here to help you make informed decisions for you and your family. At Thrive, we understand how important your health and well-being are—because they're just as important to us.

Through our benefits programs, we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access, and affordable for all our employees.



Here's what you'll find inside:

- Steps to prepare for enrollment so you can make confident decisions for the upcoming plan year.
- An overview of benefit options with clear explanations of coverage.
- Costs associated with each benefit option.
- Thrive's benefit eligibility breakdown, so you'll know exactly what you qualify for.
- Enrollment timelines and instructions.
- Contact details for all benefit vendors.

This benefit guide will help you choose the type of plan and level of coverage that is right for you. You can also view overviews of our benefit plans by accessing your payroll portal, [WorkforceNow.adp.com](https://workforcenow.adp.com).

Take a moment to explore—your benefits are designed to help you and your family thrive!

If you have questions, don't hesitate to reach out to your Benefits Team at Benefits@thriveg.com. You can also contact the Benefits Resource Center at **(855) 874-0742**. We're all here to help you make the best decision for the upcoming plan year.

Ready for Enrollment?

**Open Enrollment Starts
November 5, 2025**

Here are five simple steps to prepare.

1

Gather Personal Info

Federal regulations require Thrive to collect Social Security or Tax ID numbers, birthdates, and your relationship to dependents covered by the medical plan during enrollment.

2

Pick a Plan

Think about your expected medical needs for the upcoming year, your overall health, and any medications you're currently using.

3

Explore an HSA

An HSA helps pay for healthcare costs, including dental, vision, and prescriptions. It also offers advantages to support your financial goals

4

Review Plan Deductibles

Expect high medical needs this year? Consider a lower deductible. If not, a higher deductible plan could save you on premiums.

5

Network Check

Sticking with in-network providers saves money. Review plan changes to ensure your preferred providers and pharmacy are still covered.

Section 2

The Essentials

Benefits for You & Your Family | Thrive Benefit Eligibility | Missed Insurance Premiums | Life Events | Impact of Role Changes on Your Benefits | What Plan Do I Choose? | Out-of-Pocket Costs | Preventive Care | Where to Go for Care | Assistance & Contacts





Benefits for You & Your Family

Who is eligible?

All Thrive team members and their eligible dependents can participate in the Thrive Restaurant Group benefits program. Plans offered will vary depending on position and hours worked. See the Thrive Benefit Eligibility page in this guide for details.

Generally, for the Thrive Restaurant Group benefits program, dependents are defined as:

- Your spouse and domestic partner (certain requirements must be met for domestic partner coverage, and tax implications may result. Contact Benefits@Thriverg.com with questions.)
- Dependent children up to age 26

When is my coverage effective?

The effective dates for the benefits described in this guide is a 12 month plan year beginning January 1st and will remain in effect until the end of the year December 31st.

New employees are eligible on the first of the month following 30 days from hire date.

When and how do I enroll?

All newly eligible employees are required to complete the enrollment process within 30 days of your hire date or your change in employment status.

To enroll in Thrive Restaurant Group Employee Benefits, login to ADP Workforce Now using the website, workforcenow.adp.com, or ADP Mobile App.

Every year there will be an open enrollment conducted to allow benefit eligible employees to join the plan.

Thrive Benefit Eligibility

What am I eligible to enroll in?

Full-Time

Full-time is defined as Salary Managers, FT Supervisors, & FT Hourly Team Members with 30+ hours.

Medical

- ✓ Gold PPO Plan
- ✓ Silver HDHP Plan
- ✓ Bronze HDHP Plan
- ✓ MEC Care Plus Plan
- ✓ Coupe Health Plan - Kansas Only

Supplemental Benefits

- ✓ Health Savings Account (HDHP Req.)
- ✓ Teladoc (PPO or HDHP Req.)
- ✓ First Stop Health (MEC+ & Coupe Req.)
- ✓ Critical Illness
- ✓ Accident
- ✓ Hospital Indemnity
- ✓ Pet Assure / Pet Plus
- ✓ Employee Assistance Program

Dental & Vision

- ✓ Management Dental Plan (Mgmt & FT Sups)
- ✓ Hourly Dental Plan
- ✓ Vision Plan

Mgmt & FT Sups ONLY

- ✓ FSA Medical (PPO Req.)
- ✓ Dependent Care (PPO Req.)
- ✓ Voluntary Life & AD&D
- ✓ Spouse Life
- ✓ Dependent Life
- ✓ Employer Paid Basic Life
- ✓ Employer Paid AD&D
- ✓ Employer Paid Short-Term Disability
- ✓ Employer Paid Long-Term Disability

Thrive Family Fund



At Thrive we are dedicated to supporting team members in crisis. Through payroll contributions, **everyone** can support other team members in their time of need.

Questions?

Contact the Benefits Team at
benefits@thriverg.com
or 316-871-6871

Part-Time

Part-time is defined as hourly new hires and PT hourly team members with 29 hours or less.

Dental & Vision

- ✓ Hourly Dental Plan
- ✓ Vision Plan

Supplemental Benefits

- ✓ Critical Illness
- ✓ Accident
- ✓ Hospital Indemnity
- ✓ Pet Assure / Pet Plus
- ✓ Employee Assistance Program

To Enroll

Log in to ADP (website or mobile app) and go to Benefits > Enrollments. New team members have 30 days to enroll. Plans are effective the first of the month following 30 days of employment.

Missed Insurance Premiums Process

We're proud to provide insurance benefits for all team members. However, sometimes your paycheck may not quite cover your insurance premiums for whatever reason. In these cases, we'll send you an invoice to ensure your coverage stays intact. Don't worry, we've made the process simple and straightforward!

Missed Premiums

These are insurance premiums that could not be deducted from payroll. Thrive will invoice employees for missed premiums monthly. The amount may vary depending on the number of pay periods in the month.

Invoices

- Sent via email to the address listed in ADP Workforce Now.
- Payment is due within 30 days.

Invoicing Timeline Example



March

Missed March premium invoices will cover all pay dates in March.



April

The invoice will be emailed the first week in April, with payment due by April 30.



May

Termination notices for non-payment will be sent during the first week of May.

Payment Process

- **Method:** Payments are made via PayPal using a PayPal account or debit/credit card (no PayPal account required).
- **Confirmation:** Employees will receive an email confirming successful payment. If no confirmation is received, contact Benefits@thriverg.com.

Important Notes

- Insurance will be terminated retroactively if payment is not received by the due date. Any claims after the termination date will be the employee's responsibility.
- COBRA coverage is not available for missed premium non-payments. COBRA is only offered for active plans at the time of employment termination.
- Re-enrollment in terminated plans is only allowed during open enrollment.

Questions?

Contact Benefits@thriverg.com for assistance.



Life Events

We know that life happens, and sometimes it brings big changes. When you experience a qualified life event, you have the chance to update your insurance coverage outside of the annual Open Enrollment period. Just be sure to submit your request within 30 days of the event date.

What counts as a life event?

- Getting married or divorced
- Welcoming a new child through birth, adoption, or placement for adoption
- Gaining or losing other coverage

Your coverage updates need to match the type of life event. Check out the Life Event section for more details.

How do I report a life event?

- Log in to ADP Workforce Now (online or mobile app)
- Go to Benefits > Enrollments > Report a Life Change
- Upload proof of your life event. If you're adding a dependent, you'll need to include verification documents for approval

Heads up: The event date should reflect when your coverage was gained or lost. Remember, you've got 30 days to report the change to the Thrive Benefits Team to keep everything running smoothly.

Impact of Role Changes on Your Benefits

Career growth and changes in responsibilities are part of your journey with us. Whether you're promoted to a new role or experience a change in your position, it's important to understand how this can impact your benefits.



Promotions and Demotions: How They Affect Your Benefits

When your role changes, your eligibility for certain benefits may also change. For example, moving from a part-time to a full-time role may open new benefit options, while a reduction in hours could affect your eligibility for existing benefits. Some of these changes may require you to re-enroll in your benefits to ensure continued coverage or to select new options that better align with your updated role.



Why Benefits Matter

Your benefits are a critical part of your overall compensation package, providing financial protection, health and wellness support, and security for you and your family. Staying up to date on your benefits ensures you're making the most of what Thrive offers, especially as your role and needs evolve.



Updating Your Enrollment in ADP Workforce Now

All benefit enrollment changes, whether due to a promotion, demotion, or other qualifying life events, are managed through ADP Workforce Now. If your role change affects your eligibility, you will receive guidance on how to access ADP to review and update your benefits. It's important to act promptly to avoid any gaps in coverage or missed opportunities for new benefits.

What Plan Do I Choose?

There are 5 medical plans to choose from, but essentially, 3 plan types are offered. Below is a side-by-side comparison of the plan types offered.

	PPO	HDHP	MEC	Coupe - Kansas Management & Above Only
Would you rather pay more money as you incur services or pay more each pay period?	Most money out of your paycheck – set copays for many services.	Less money out of your paycheck – you will pay more when you incur services.	Least amount of money out of your paycheck – limited coverage.	More money out of your paycheck – all services have set copays
Is this plan eligible for an HSA?	✗	✓	✗	✗
Is this plan eligible for an FSA?	✓	✗	✓	✓
Is preventative care covered? (age and gender-appropriate screenings)	✓	✓ Deductible waived	✓ Medicare rate	✓
Is there coverage for doctor's office visits (including mental health visits)?	✓	✓ You pay network cost until deductible is met, then you pay 0-10%	✓ Limited number of office visits paid at the Medicare rate	✓
Is there prescription drugs coverage?	✓	✓ You pay network cost until deductible is met, then you pay 0-10%	✓ Limited to 12 generic prescriptions per year	✓
Is there coverage for a hospital stay?	✓ You pay network cost until deductible is met, then you pay 20%	✓ You pay network cost until deductible is met, then you pay 0-10%	✓ Limited number of visits paid at the Medicare rate	✓ You pay copays until out of pocket met, then plan pays 100%
Which plan is better?	It just depends on your financial point of view, medical needs and long-term financial goals and objectives. PPO, Coupe and HDHP plans provide comprehensive coverage. The MEC Plus Plan has limited coverage at a discounted rate. The MEC Plus plan is not a major medical plan and will not cover major medical conditions such as maternity, diabetic care, cancer and on-going health condition care.			

Out-of-Pocket Costs

These are the types of payments you're responsible for:



Copay

A fixed fee you pay at the time of receiving healthcare services.



Deductible

The amount you need to pay for covered healthcare services before your insurance starts contributing.



Coinsurance

The percentage of a covered service's cost that you pay. For example, if a visit costs \$100 and your coinsurance rate is 20% (after meeting your deductible but not your out-of-pocket maximum), you would pay \$20.



Out-of-Pocket Maximum

The highest amount you'll pay in a plan year before your insurance covers 100% of allowed costs.

Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance. Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protections and Affordable Care Act (PPACA), some common covered services include:



Wellness visits, physicals, and standard immunizations



Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women



Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes



Iron supplements (for children ages 6 to 12 months at risk for anemia)



Pediatric screenings for hearing, vision, obesity, and developmental disorders

Don't miss out on these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options:



Telemedicine



When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).



Types of Care*

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems



Costs and Time Considerations**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Usually immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states



Primary Care Center



When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.



Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- General health management



Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

**This is a sample list of services and may not be all inclusive.*

***Costs and time information represent averages only and are not tied to a specific condition or treatment.*

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options:



Urgent Care Center



When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.



Types of Care*

- Strains, sprains
- Minor broken bones (e.g. finger), infections, and burns
- X-rays



Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)



Emergency Room



When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.



Types of Care*

- Heavy bleeding
- Chest pain
- Major burns and head injuries
- Spinal injuries
- Broken bones



Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7 but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

Do your homework. What may seem like an urgent care center could actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

**This is a sample list of services and may not be all inclusive.*

***Costs and time information represent averages only and are not tied to a specific condition or treatment.*

Assistance & Contacts

Have Questions? Need Help?

Thrive Restaurant Group is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals whose primary responsibility is to assist you.

The Specialists in the BRC are available Monday through Friday 8:00 am to 5:00 pm at 855-874-0742 or via e-mail at BRCMT@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

	Carrier	Phone Number	Website/Email
Thrive Benefits	Thrive Restaurant Group	(316) 871-6871	Thrivegr.hrbenefits.net
Benefit Resource Center	USI	(855) 874-0742	BRCMT@usi.com
Medical	Blue Cross Blue Shield of Kansas*	(855) 263-0677	www.myhealthtoolkit.com
Medical (MEC)	Allied Benefit*	(800) 288-2078	www.alliedbenefit.com
Prescriptions	Ventegra	(877) 867-0943	Ventegra.com
Specialty Prescriptions (Eligibility req.)	Rescrybe	(866) 401-1883	www.rescrybe.com
FREE Telemedicine	Teladoc	(800) 835-2362	Teladoc.com
Telemedicine (Coupe & MEC+ Plans Only)	First Stop Health	(888) 691-7867	firststophealth.com
Dental	Guardian	(888) 618-2016	Guardiananytime.com
Vision (VSP)	Guardian	(877) 814-8970	Guardiananytime.com
HSA & FSA	Equity Bank	(833) 654-3075	equitybank.com/healthcare
Short Term Disability	Guardian	(800) 268-2525	Guardiananytime.com
Long Term Disability	Guardian	(800) 538-4583	Guardiananytime.com
Voluntary Life	Guardian	(800) 525-4542	Guardiananytime.com
Critical Illness & Accident	Guardian	(800) 541-7846	Guardiananytime.com
Pet Insurance	Pet Benefit Solutions	(800) 891-2565	www.petbenefits.com
ADP Customer Service	ADP	(866) 695-7526	workforcenow.adp.com
Medicare Specialist	Allan Booth	(385) 464-4001	allan@reviveinsurance.com
Financial Advisor for 401(k)	David Brand	(813) 227-2183	David.F.Brand@morganstanley.com
Employee Assistance Program (EAP)	ComPsych	(855) 239-0743	GuidanceResources.com

Sign up for Thrive text messages for company updates and information sent via text. Text the word "START" to 46659.

* All states outside Kansas, including the Kansas City Metro Area, qualify for Blue Cross Blue Shield. Kansas, excluding the Kansas City Metro Area qualifies for Allied.

Section 3

Benefit Plan Pricing

What Your Benefits Will Cost | What Your Ancillary Benefits Will Cost



What Your Benefits Will Cost

Medical, dental and vision benefits are deducted from payroll pre-tax (26 paychecks annually).

Medical - GOLD PPO Plan		
	Employee Monthly Rate	Employee Per Pay Rate
Employee	\$195.75	\$90.35
Employee + Spouse	\$386.41	\$178.34
Employee + Child(ren)	\$366.07	\$168.96
Family	\$571.99	\$264.00
Medical - SILVER HDHP Plan		
Employee	\$113.93	\$52.58
Employee + Spouse	\$312.62	\$144.29
Employee + Child(ren)	\$286.19	\$132.09
Family	\$456.64	\$210.76
Medical - BRONZE HDHP Plan		
Employee	\$76.53	\$35.32
Employee + Spouse	\$271.44	\$125.28
Employee + Child(ren)	\$244.63	\$112.91
Family	\$382.31	\$176.45
Medical - COUPE Health Plan		
Employee	\$185.96	\$85.83
Employee + Spouse	\$367.09	\$169.43
Employee + Child(ren)	\$347.77	\$160.51
Family	\$543.39	\$250.80
Medical - MEC Care PLUS Plan		
Employee	\$41.44	\$19.13
Employee + Spouse	\$168.32	\$77.69
Employee + Child(ren)	\$178.51	\$82.39
Family	\$272.65	\$125.84
Dental - Guardian		
Employee	\$12.96	\$5.98
Family	\$27.16	\$12.54
Vision - Guardian		
Employee	\$7.36	\$3.40
Family	\$15.83	\$7.31

These premiums are deducted from your paycheck on a pre-tax basis through a Premium-Only Section 125 Plan. Due to IRS Regulations, the premiums you pay for non-tax dependent domestic partner coverage are not eligible for Section 125 tax savings.

What Your Ancillary Benefits Will Cost

Ancillary benefits are deducted from payroll post-tax (26 paychecks annually).

Pet Insurance						
		Employee Monthly Rate			Employee Per Pay Rate	
Pet Assure – 1 Pet		\$8.00			\$3.69	
Pet Assure – 1+ Pets		\$11.00			\$5.08	
Pet Plus – 1 Pet		\$3.75			\$1.73	
Pet Plus – 1+ Pets		\$7.50			\$3.46	
Accident Plan						
Employee		\$9.57			\$4.42	
Employee + Spouse		\$14.54			\$6.71	
Employee + Child(ren)		\$16.41			\$7.57	
Family		\$21.38			\$9.87	
Critical Illness Plan						
	\$10,000	\$20,000	\$30,000	\$10,000 Per Pay Rate	\$20,000 Per Pay Rate	\$30,000 Per Pay Rate
<29	\$5.50	\$11.00	\$16.50	\$2.54	\$5.08	\$7.62
30 - 39	\$6.70	\$13.40	\$20.10	\$3.09	\$6.18	\$9.28
40 - 49	\$10.20	\$20.40	\$30.60	\$4.71	\$9.42	\$14.12
50 - 59	\$17.80	\$35.60	\$53.40	\$8.22	\$16.43	\$24.65
60 - 69	\$30.00	\$60.00	\$90.00	\$13.85	\$27.69	\$41.54
70+	\$28.60	\$57.20	\$85.80	\$13.20	\$26.40	\$39.60
Hospital Indemnity						
		Employee Monthly Rate			Employee Per Pay Rate	
Employee		\$23.56			\$10.87	
Employee + Spouse		\$45.66			\$21.07	
Employee + Child(ren)		\$39.24			\$18.11	
Family		\$61.34			\$28.31	
Voluntary Employee Life & AD&D Plan						
Per \$10,000, purchased in \$10,000 increments. Rates are the same regardless of age or gender. Accidental Death & Dismemberment (AD&D) rate added to Life rate.						
Life and AD&D			Per \$1000			
Employee	\$0.225					
Voluntary Spouse and Child Life and AD&D (Vol. Emp. Life Enrollment Req.)						
Rates are the same regardless of age or gender. Accidental Death & Dismemberment (AD&D) rate added to Life rate.						
Child (up to age 26)			\$0.165 per \$1,000 up to \$5,000			
Spouse			\$0.165 per \$1,000 up to \$10,000			

Thrive Restaurant Group provides a \$50,000 Life and AD&D policy for all full-time employees at no cost. Eligible employees have the opportunity to purchase additional Voluntary Life insurance for themselves, spouse and dependents at their own cost. Rates are based upon age and will be calculated within ADP. Voluntary Life premiums are deducted from payroll post-tax (26 paychecks annually).

Section 4

Health Coverage

Medical Insurance | Allied Benefit | See a Doctor at Home with Virtual Health |

Pharmacy Benefit Manager - Ventegra | International Drug Program – Rescrybe | Discount Prescription Programs



Medical Insurance – GOLD PPO Plan

Thrive Restaurant Group will continue to offer medical coverage. The following chart is a brief, in-network only, overview of coverage. Please refer to the summary plan description for complete plan details.

A **deductible** is the amount of money you or your dependents must pay toward a health claim before your insurance company makes any payments for healthcare services rendered outside a provider's office.

Coinsurance is the amount expressed as a percentage of covered health services that you must pay after you have satisfied your plan deductible. The plan pays 80% of the costs of care after the deductible has been met.

The **maximum amount** (deductible and coinsurance) that an insured will have to pay for covered expenses under your plan. Once the out-of-pocket limit is reached, the plan will cover eligible expenses at 100%.

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations & wellness exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early. Remember all preventive care benefits are covered 100% under all medical plan options, that includes x-ray & lab tests that are part of your age-appropriate screenings.

Urgent Care should be used for minor emergencies (fever, cough, pain, etc.) when your physician's office is closed and your symptoms are too severe to wait until the office reopens or when you are out-of-town. The cost will be less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for emergencies such as broken bones, vigorous bleeding or severe pain. In an emergency, seek the appropriate care without delay.

Inpatient services are provided to an individual during an overnight hospital stay. Outpatient services are provided to an individual at a hospital or outpatient facility without an overnight stay.

In-Network	
Annual Deductible (Re-starts January 1st)	
Individual / Family	\$1,000 / \$2,000
Coinsurance	After the deductible is met you pay 20% of the cost
Maximum Out-of-Pocket	
Individual / Family	\$3,650 / \$7,300
Physician Office Visit	
Primary Care	\$30 copay
Specialty Care	\$50 copay
Teladoc (general medicine)	\$0 copay
Preventive Care	100% deductible waived
Facility Services	
Urgent Care	\$75 copay
Emergency Room	\$250 copay, subject to deductible & coinsurance
Complex Radiology (MRI, PET, CT Scans)	After deductible you pay 20%
Inpatient & Outpatient Facility	After deductible you pay 20%
Mental Health & Substance Abuse	
Inpatient	After deductible you pay 20%
Outpatient	\$30 copay for office visits
Prescription (No deductible applied)	
Generic	\$10 copay
Brand	\$40 copay
Brand (non-preferred)	\$80 copay
Specialty Prescriptions	Not covered - Call Ventegra (877) 867-0943 for assistance

Medical Insurance – Coupe Health Plan

New for 2026 (Kansas Salaried Manager and above Only): BCBS Coupe Health Plan

The Coupe plan makes healthcare simple—no deductibles, no co-insurance, no surprise bills. Shop online to see costs upfront and choose Tier 1 doctors, recognized for quality care and value. A great option if you want clarity on both care and cost before your visit.

The **maximum amount** that an insured will have to pay for covered expenses under the Coupe plan will be the tier copay amount for the service. Once the the Max Out-of-Pocket limit is reached the plan pays 100%. *Please note, Out-of-Network copays do not apply to the out-of-pocket max.*

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations & wellness exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early. Remember all preventive care benefits are covered 100% under all medical plan options, that includes x-ray & lab tests that are part of your age-appropriate screenings.

Urgent Care should be used for minor emergencies (fever, cough, pain, etc.) when your physician's office is closed and your symptoms are too severe to wait until the office reopens or when you are out-of-town. The cost will be less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for emergencies such as broken bones, vigorous bleeding or severe pain. In an emergency, seek the appropriate care without delay.

Inpatient services are provided to an individual during an overnight hospital stay. Outpatient services are provided to an individual at a hospital or outpatient facility without an overnight stay.

Annual Deductible (Re-starts January 1st)				
Individual / Family		\$0		
Coinsurance	N/A			
Maximum Out-of-Pocket				
Individual / Family	\$3,650 / \$7,300			
Physician Office Visit				
Service Description	Tier 1	Tier 2	Tier 3	Out-of-Network*
Preventative Care	100% covered	100% covered	100% covered	100% covered
Primary Care	\$20	\$25	\$40	\$50
Specialty Care	\$35	\$50	\$80	\$100
First Stop Health (Telemedicine)	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Routine Labs	\$20	\$25	\$40	\$50
Advance Labs	\$60	\$80	\$130	\$155
Routine Radiology	\$80	\$100	\$160	\$190
Complex Radiology (MRI, PET, CT Scans)	\$230	\$310	\$520	\$630
Outpatient (PT, OT, ST)	\$35	\$50	\$80	\$100
Urgent Care	\$45			
Emergency Room/ Abulance	\$200/\$200			
Outpatient Facility	\$810	\$1,080	\$1,820	\$2,180
Inpatient Facility	\$2,000	\$2,600	\$4,400	\$5,280
Durable Medical Equipment	\$115	\$155	\$160	\$320
Chiropractic Care / Acupuncture	\$35	\$50	\$80	\$100
Prescription				
Generic	\$10	\$10	\$10	40% of cost
Brand	\$40	\$40	\$40	40% of cost
Brand (non-preferred)	\$80	\$80	\$80	40% of cost
Specialty Prescriptions	Not covered – Call Ventegra (877) 867-0943 for assistance			

*Out-of-network copays do not apply to out-of-pocket maximums

Medical Insurance – SILVER HDHP Plan

Thrive Restaurant Group will continue to offer medical coverage. The following chart is a brief, in-network only, overview of coverage. Please refer to the summary plan description for complete plan details.

A **deductible** is the amount of money you or your dependents must pay toward a health claim before your insurance company makes any payments for healthcare services rendered outside a provider's office.

Coinsurance is the amount expressed as a percentage of covered health services that you must pay after you have satisfied your plan deductible. The plan pays 90% of the costs of care after the deductible has been met.

The **maximum amount** (deductible and coinsurance) that an insured will have to pay for covered expenses under your plan. Once the out-of-pocket limit is reached, the plan will cover eligible expenses at 100%.

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations & wellness exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early. Remember all preventive care benefits are covered 100% under all medical plan options, that includes x-ray & lab tests that are part of your age-appropriate screenings.

Urgent Care should be used for minor emergencies (fever, cough, pain, etc.) when your physician's office is closed and your symptoms are too severe to wait until the office reopens or when you are out-of-town. The cost will be less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for emergencies such as broken bones, vigorous bleeding or severe pain. In an emergency, seek the appropriate care without delay.

Inpatient services are provided to an individual during an overnight hospital stay. Outpatient services are provided to an individual at a hospital or outpatient facility without an overnight stay.

In-Network	
Annual Deductible (Re-starts January 1st)	
Individual / Family	\$3,400 / \$6,800
Coinsurance	After the deductible is met you pay 10% of the cost
Maximum Out-of-Pocket	
Individual / Family	\$6,800 / \$13,600
Physician Office Visit	
Primary Care	After deductible you pay 10%
Specialty Care	After deductible you pay 10%
Teladoc (general medicine)	\$0 copay
Preventive Care	100% deductible waived
Facility Services	
Urgent Care	After deductible you pay 10%
Emergency Room	After deductible you pay 10%
Complex Radiology (MRI, PET, CT Scans)	After deductible you pay 10%
Inpatient & Outpatient Facility	After deductible you pay 10%
Mental Health & Substance Abuse	
Inpatient	After deductible you pay 10%
Outpatient	After deductible you pay 10%
Prescription (No deductible applied)	
Generic	After deductible you pay 10%
Brand	After deductible you pay 10%
Brand (non-preferred)	After deductible you pay 10%
Specialty Prescriptions	Not covered - Call Ventegra (877) 867-0943 for assistance

Medical Insurance – BRONZE HDHP Plan

Thrive Restaurant Group will continue to offer medical coverage. The following chart is a brief, in-network only, overview of coverage. Please refer to the summary plan description for complete plan details.

A **deductible** is the amount of money you or your dependents must pay toward a health claim before your insurance company makes any payments for healthcare services rendered outside a provider's office.

Coinsurance is the amount expressed as a percentage of covered health services that you must pay after you have satisfied your plan deductible. The plan pays 100% of the costs of care after the deductible has been met.

The **maximum amount** (deductible and coinsurance) that an insured will have to pay for covered expenses under your plan. Once the out-of-pocket limit is reached, the plan will cover eligible expenses at 100%.

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations & wellness exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early. Remember all preventive care benefits are covered 100% under all medical plan options, that includes x-ray & lab tests that are part of your age-appropriate screenings.

Urgent Care should be used for minor emergencies (fever, cough, pain, etc.) when your physician's office is closed and your symptoms are too severe to wait until the office reopens or when you are out-of-town. The cost will be less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for emergencies such as broken bones, vigorous bleeding or severe pain. In an emergency, seek the appropriate care without delay.

Inpatient services are provided to an individual during an overnight hospital stay. Outpatient services are provided to an individual at a hospital or outpatient facility without an overnight stay.

In-Network	
Annual Deductible (Re-starts January 1st)	
Individual / Family	\$5,000 / \$10,000
Coinsurance	After the deductible is met you pay 0% of the cost
Maximum Out-of-Pocket	
Individual / Family	\$5,000 / \$10,000
Physician Office Visit	
Primary Care	After deductible you pay 10%
Specialty Care	After deductible you pay 10%
Teladoc (general medicine)	\$0 copay
Preventive Care	100% deductible waived
Facility Services	
Urgent Care	After deductible you pay 0%
Emergency Room	After deductible you pay 0%
Complex Radiology (MRI, PET, CT Scans)	After deductible you pay 0%
Inpatient & Outpatient Facility	After deductible you pay 0%
Mental Health & Substance Abuse	
Inpatient	After deductible you pay 0%
Outpatient	After deductible you pay 0%
Prescription (No deductible applied)	
Generic	After deductible you pay 0%
Brand	After deductible you pay 0%
Brand (non-preferred)	After deductible you pay 0%
Specialty Prescriptions	Not covered - Call Ventegra (877) 867-0943 for assistance

Allied Benefit – Minimum Essential Coverage Care Plus Plan

This is a limited benefit plan and may not cover certain medical services. Certain covered services have a maximum allowed number of visits per year, per participant. This plan does not utilize a provider network. Instead, doctors and hospitals are reimbursed based on pricing set by the federal government, known as the Medicare Fee Schedule. Healthcare professionals have the right to decide whether or not to accept this amount for individuals covered under a non-Medicare health plan as payment in full. As a result, **you may be subject to a balance bill. This is not a major medical plan and will not cover all medical services.**

This plan does not have an **annual deductible or an out-of-pocket maximum**. Instead the plan pays a fixed cost for care based on Medicare Rates. Services have limits imposed for the plan year by participant on the plan.

This plan pays a fixed cost for **physician services** based on Medicare rates. Healthcare professionals have the right to decide whether or not to accept this amount for individuals covered under a non-Medicare health plan as payment in full. As a result, you may be subject to a balance bill.

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations & wellness exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early. This plan pays a fixed cost for preventative services.

Urgent Care should be used for minor emergencies (fever, cough, pain, etc.) when your physician's office is closed and your symptoms are too severe to wait until the office reopens or when you are out-of-town. The cost will be less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for emergencies such as broken bones, vigorous bleeding or severe pain. In an emergency, seek the appropriate care without delay. The plan pays a fixed cost for services and participants may be subject to a balance bill.

Inpatient services are provided to an individual during an overnight hospital stay (includes mental health & substance abuse inpatient care). Outpatient services are provided to an individual at a hospital or outpatient facility without an overnight stay. This plan pays a fixed cost for these services with a limit to the number of services charged each plan year. Not all services within inpatient and outpatient service will be covered by this plan.

Allied Benefit – MEC Care Non-Network		
Annual Deductible & Out-of-Pocket Max		
Individual / Family	N/A	
Physician Office Visit		
Primary Care, Specialty Care, or Mental Health	Plan pays 100% of Medicare Rate, limit to 6 office visits per plan year	
X-ray and Lab Tests	Plan pays 100% of the Medicare Rate, limit to 5 per plan year	
First Stop Health (Telemedicine)	\$0 copay	
Chiropractic or Physical Therapy	Not covered	
Preventive Care		
Adult Periodic Exams	Plan pays 100% of the Medicare Rate	
Well-Child Care	Plan pays 100% of the Medicare Rate	
Facility Services		
Complex Radiology (include MRI, PET or CT scans)	Not covered	
Urgent Care or Emergency Room Facility	Plan pays 100% of the Medicare Rate, limit 5 visits per plan year	
Inpatient Facility	Plan pays 100% of the Medicare Rate, limit 5 days per plan year	
Outpatient	Plan pays 100% of the Medicare Rate, limit 3 visits per plan year	
Prescription	Retail Pharmacy (30 day)	Mail-Order (90 day)
Generic (Tier 1)	You pay \$5 copay, limited to 12 prescriptions per plan year	Not covered
All Other RX	Not covered	Not covered
Prescription Drug Benefit is administered by Caremark. Call (877) 860-6415 or visit www.caremark.com		

See a Doctor at Home with Virtual Health

Only available on PPO and HDHP Health Plans. Must be 18 years of age or older for Mental Health Teladoc Services (fees apply).



Praise for Teladoc

"The convenience of Teladoc is amazing! I have used this service multiple times in the past. The first time was when my daughter was sick on the weekend.

Within 20 minutes, we downloaded the app, set up an appt, had a call from a doctor, and were on our way to the pharmacy to pick up the prescription! And get this... we were still in our pajamas!!!!

You can't even get dressed and registered at Urgent Care in that amount of time!"

— Keith Vedral, Applebee's Market President

Teladoc provides you with 24/7 online medical consultations with licensed professionals. Be seen virtually for things like:

- Bronchitis
- Rash & other dermatology needs
- Sinus infection
- Sore throats
- Mental Health*
- And more!

How it Works

- Download the app, visit online or call to set up your account
- Complete or update your medical history
- Request a visit and speak to a provider within minutes

See a Doctor at Home with Virtual Health



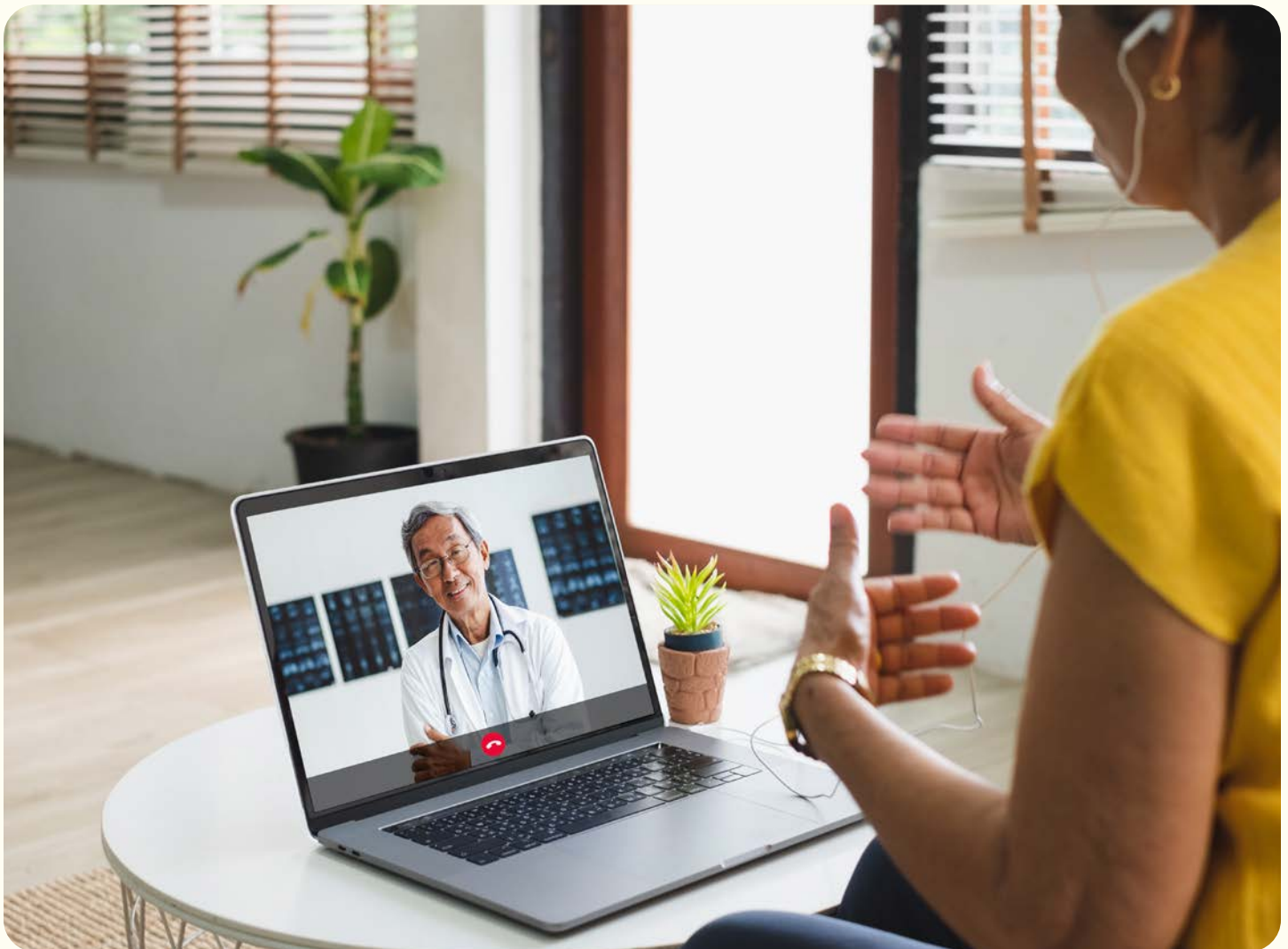
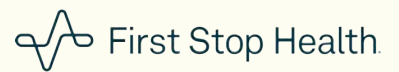
Download the App, Visit [Teladoc.com](https://www.teladoc.com), Call 800-Teladoc

*Only available on PPO and HDHP Health Plans. Must be 18 years of age or older for Mental Health Teladoc Services. (fees apply)

Teladoc Fees				
National Alliance	Plan Cost	PPO Cost	\$3400 HDHP Cost*	\$5000 HDHP Cost
General Visits	\$65	\$0	\$0	\$0
Psychiatrists (Initial)	\$260	\$30	Deductible then 10%	Deductible then 0%
Psychiatrists (On-going)	\$105	\$30	Deductible then 10%	Deductible then 0%
Dermatology	\$90	\$30	Deductible then 10%	Deductible then 0%

Care That Works Around Your Schedule

Available for Coupe Health and MEC+ plans only.



Heal faster and get back to life.

When your body is telling you that something is wrong, don't wait for care. Use 24/7 virtual urgent care.

- Available 24/7 via phone or video
- No appointment needed
- Skip the paperwork, we're a tap away
- Quick, professional care
- ¡El español está disponible!

For emergency situations, always dial 911. Available for Coupe Health and MEC Plus plans only.



Scan to download the app.

Use First Stop Health Virtual Urgent Care when you need care — it's fast, easy, and always open. We're here for you!

Reasons to Use

- Skin Rash
- Cold & Flu
- Sinus Issues
- Fever
- Mental Health
- Allergies
- Stomach Issues
- Minor Injury
- And much more!

Contact

- firststophealth.com
- (888) 691-7867



Do you need a prescription?

Picking up your prescription from a pharmacy is easy with your Ventegra Prescription coverage.

Ventegra is your Pharmacy Benefit Manager (PBM) for the PPO, HDHP and Coupe Health medical plans. They process and pay your pharmacy cost. Present your Ventegra information from your ID Card to the pharmacy when picking up your prescription.

Having trouble picking up your prescription from the pharmacy?

Call Ventegra at (877) 867-0943 while you are at the pharmacy. They can offer real-time assistance to help you. Some prescriptions require additional information from your provider before they are released to the patient. Ventegra can help answer any questions you have about your prescriptions.

What pharmacy can you use your Ventegra coverage at?

Ventegra is accepted at thousands of pharmacies, including CVS, Costco, Dillons, Amazon Pharmacy and most likely your local pharmacy.

Ever wonder what tier your drug is on?

Knowing what tier your drug is on will help you determine what your copay will be before you head to the pharmacy. Ventegra maintains a list of prescriptions on their website which is updated twice annually. Visit [Ventegra.com](https://www.ventegra.com) to view the “Ventegra Premium Formulary” list of prescriptions (found at the bottom of the website). The list will show what is covered, what requires a prior authorization or step therapy and what tier the prescription is listed under.

Need a specialty medication?

Thrive's benefit plans offer no coverage for specialty prescriptions (tier 4), such as Stelara and Skyrizi. Ventegra can assist you in obtaining these uncovered specialty prescriptions by using various assistance programs, including international sourcing.

Ventegra's Benefit Preservation Program (BPP) can help you obtain a specialty prescription at a **steep discount or at no cost to you!** Contact Ventegra directly for assistance with your specialty drug prescription at **(877) 867-0943**.

Be advised that set-up will take time as Ventegra searches for the best assistance program to obtain your specialty prescriptions at a discount or at no cost to you. Do not delay, call them today.

International Drug Program – Rescrybe

Eligibility Required



Rescrybe – International Drug Program

Thrive partners with Rescrybe, in coordination with Ventegra, to help reduce out-of-pocket costs for high-cost brand and specialty medications. When you become eligible for the program, Rescrybe will reach out to you directly to guide you through next steps. Through safe and licensed international pharmacies, eligible prescriptions are delivered right to your home—often at \$0 out of pocket. This program offers:

- Savings of hundreds to thousands of dollars annually.
- Medications from trusted countries like Canada, the UK, and Australia
- Refill reminders and exceptional member service
- Easy setup with minimal paperwork

Team Members on HSA plans may need to meet their deductible before receiving medications at no cost.

How will I know if I am eligible?

A representative from Rescrybe will reach out directly to you via telephone and email when you become eligible.

What do I need to do to get my medication through Rescrybe?

A Rescrybe pharmacy advocate will walk you through the process which will include the following:

- A photo of your driver's license (or government issued photo)
- A short medical questionnaire and consent form
- A prescription from your provider to Rescrybe for a 3 month supply with 3 refills

Are these medications from this program safe?

Rescrybe only works with pharmacies in countries with the highest tier of quality assurance in their supply chain (Tier 1 Countries). The vast majority of medications are from the same manufacturers and the same distributors as you get in the US. All medications are dispensed by a licensed pharmacy and pharmacists.

Praise for Rescrybe

"They contacted me about a prescription that was costing me \$100 for a 3 month period under my current prescription plan. After filling out a few forms and having my doctor send my prescription to them, they were able to fill it at no charge and shipped it directly to my house. It was a really easy process.

- Ed Parker, Applebee's Full Time Supervisor

Discount Prescription Programs

Looking for a cheaper way to obtain your prescriptions?

There are alternative programs to assist patients when purchasing prescriptions. These discount programs do not use your insurance and will not apply to your deductible or out-of-pocket.

The logo for GoodRx, featuring the text "GoodRx" in a bold, black, sans-serif font centered on a bright yellow square background.

GoodRx

Head to [GoodRx.com](https://www.goodrx.com) and put in your prescription name into their search function. OR download their free app for prescriptions assistance at your fingertips.

- **Find free coupons.** Coupons work at virtually every US pharmacy. Prices may even beat your insurance
- **Show coupon to your pharmacy.** Text, email, or print your coupon. No approvals or paperwork needed.
- **Save up to 80%.** Save on all your family's prescriptions. Coupons work for refills, too!



Costplusdrugs.com

Cost Plus Drugs is a drug wholesaler that offers huge drug savings on mail-order drugs that do not run through your medical plan. Which means you do not have a deductible to satisfy. Not all medications are found through their pharmacy partner, but many maintenance medications are offered at a steep discount without having to leave your home.

How it works:

- Visit [costplusdrugs.com](https://www.costplusdrugs.com) and find your prescription
- Ask your doctor to send the prescription to their pharmacy partner
- Receive your medications in the mail



Costco Mail-Order Pharmacy

While Costco Mail-Order is not a discount program it is a cost-effective and convenient way to have your prescriptions mailed to your home. Purchasing your prescriptions through Costco will run through your Ventegra coverage. Visit [pharmacy.costco.com](https://www.pharmacy.costco.com) and get started by setting up an account online. You may also use traditional mail-order forms completed and sent into Costco Pharmacy. Once Costco Pharmacy has your prescription on file, you will be able to easily request refills from your account online. **Contact Costco Mail-Order Pharmacy at (800) 607-6861 for additional information.**

[Click here for the Costco Mail-Order Brochure](#)

Section 5

Online Resources

Links & Mobile Apps



Links & Mobile Apps

Benefit Microsite



www.Thriverg.hrbenefits.net

Major Medical Plans



Blue Cross Blue Shield* - My Health Toolkit App

SSN & DOB required for registration
www.MyHealthtoolkitKS.com

MEC Plus Plan



Allied Member Portal**

SSN & DOB required for registration
<https://member.alliedbenefit.com/login>

Dental, Vision, Accident, Critical Illness, Life, STD & LTD Plans



Guardian Anytime Portal

Name, DOB & zip code required for registration
<http://guardianlife.com/>

Prescription Coverage



Ventegra Member Portal

Member ID, name and DOB required for registration (Member IDs: KS ONLY - VRX0039, ALL OTHERS -VRX0135)
myventegra.com

FSA, HSA Dependent FSA



Equity Bank

Name, SSN & zip code required for registration
<https://www.equitybank.com/healthcare>

Telehealth Services (PPO & HDHP Only)



Teladoc

SSN & DOB required for registration
<https://www.teladochealth.com>

Benefit Enrollment System



ADP

Name, registration code required
WorkforceNow.ADP.com

Telehealth Services (MEC+ & Coupe Only)



First Stop Health

<https://www.firststophealth.com/>

*All locations except Kansas (including KC Metro)

**Kansas Only Locations (excludes KC Metro)

Section 6

Dental & Vision

Dental Insurance | Vision Insurance



Dental Insurance (Management)



Thrive Restaurant Group will continue to offer a dental program through Guardian. Regular dental exams can help you and your dentist detect problems in the early stages when treatment is more basic and costs are much lower. Remember to get your annual cleanings and check-ups. The chart to the right is a brief outline of the benefits of the dental plan. Please refer to the summary plan description for complete plan details.

Maximum Rollover Benefit

With Maximum Rollover, Guardian will roll over a portion of your unused annual maximum to be used in future years. To qualify, a member must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. For example, those with \$700 remaining in their \$1,500 annual maximum will rollover \$350 to use in future years.

Find a dental provider within the Guardian Dental Guard Network

With Guardian Dental, you can choose from thousands of dentists. You can find the names, addresses, and phone numbers of providers by searching Guardian online "Find a Dental Provider" directory.

Guardian Dental Guard Network Dental - Management		
	In-Network	Out-of-Network*
Annual Deductible		
Individual	\$25	\$50
Family	\$75	\$150
Annual Maximum		
Per Person / Family	\$1,500	\$1,500
Preventive <i>Oral exams twice a year, Bitewing x-rays (2 sets a year), Panoramic x-rays (every 24 months), and fluoride treatment for child under age 21 (once a year).</i>	100%, deductible waived	Pays 100% of the usual and customary cost for your area
Basic <i>Fillings, simple extractions, problem focused exams, root canal and injection of therapeutic drugs.</i>	90%	60%*
Major <i>Initial installation of full or partial dentures, relining and rebasing of existing removable dentures.</i>	60%	40%*
Orthodontia		
Benefit <i>Coverage for covered participants, children up to age 26.</i>	\$1,500 lifetime max	\$1,500 lifetime max

*Your annual maximum may not cover as much of your dental cost when going out-of-network. Out-of-network dentist may not accept contract discounts in place at in-network dentist. (Texas employee's out-of-network coverage will match in-network coverage.)

*Texas Locations Only - There is no Out-of-Network costs. See SBC for more details.

Thrive Restaurant Group offers vision insurance through Guardian. Sight, it's a beautiful thing and not to be taken for granted. Whether you want to be incognito and wear contact lenses or stand out in the crowd with the latest stylish frames, this vision plan has you covered.

The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Find a vision provider within the VSP Vision Network

With Guardian Vision, you can choose from thousands of ophthalmologists, optometrists and opticians at private practices or at popular retail locations like Costco Optical, Visionworks and more. You can find the names, addresses, and phone numbers of providers by searching Guardian online "Find a Vision Provider" directory.

	Guardian Vision
	In-Network (VSP)
Copay	
Routine Exams (Annually)	\$10 copay
Vision Materials	
Materials Copay	\$15 copay
Lenses	Benefit varies by type of lens. Covered every 12 months
Contacts <i>Covered in lieu of frames.</i>	Elective contacts covered \$130 allowance Covered every 12 months (Medically necessary contacts may be covered at a higher benefit level)
Frames	Covered at \$130 \$70 at Costco, Walmart, or Sam's Club every 24 months

Section 7

Health Savings & Spending Accounts

Health Savings Account (HSA) | Flexible Spending Accounts (FSA) | HSA vs. FSA



ONLY when you are enrolled in the High Deductible Health Plan (HDHP, also referred to as an HSA medical plan) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.



What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible healthcare expenses for you and/or your eligible dependents for current or future healthcare expenses. **The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” rule; your balance carries over year to year.**

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax-free; and
- You don’t pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

2026 Maximum HSA Contributions	
Individual	\$4,400
Family (2 or more)	\$8,750
Age 55+ catch-up	Additional \$1,000

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP), also referred to as an HSA health plan.
- You must not be covered by another non-QHDHP health plan, such as a spouse’s PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person’s tax return.
- You are not covered by a traditional healthcare flexible spending account (FSA). This includes your spouse’s FSA. (Enrollment in a limited-purpose healthcare FSA is allowed).

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. Equity Bank provides helpful information about your HSA, please go online at equitybank.com/healthcare or call Equity Bank at (833) 654-3075.



The Flexible Spending Account (FSA) plan with Equity Bank allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a healthcare spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How FSA & Dependent Care FSA plans work:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Differences between FSA & Dependent Care FSA:

- Dependent Care FSA can be used for childcare expenses ONLY while an FSA can be used for medical-related expenses.
- Dependent Care FSA will not have a debit card; daycare claims will need to be submitted manually.
- Your FSA will be pre-loaded beginning March 1 with your elected funds to cover expenses prior to your payroll deductions.
- Unlike the FSA, Dependent Care FSA will only reimburse you funds that have been deducted from your paycheck.

Runout Period

Participants have until March 31, 2026, to file a 2025 claim with Equity Bank FSA for reimbursement, with receipts. Once the runout period ends, any amounts that have not been used will be forfeited over the allowed carryover amount of \$660.

Important rules to keep in mind:

- The IRS has a strict “use it or lose it” rule. If you do not use the funds in your FSA, you will lose any remaining funds, except for the allowed roll over amount*.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.
- Claims must incur in the plan year in which you submit for reimbursement. 2026 FSA funds cannot be used to pay medical expenses for the prior year, except for orthodontia.
- There is a 90-day run-out period after the end of the plan year to give participants time to submit their plan year claims for reimbursement.

2026 Maximum FSA Election

Healthcare FSA	\$3,400
Dependent Care FSA	\$7,500

**Participants may roll over up to \$660 of unused 2025 funds into a 2026 FSA that will begin January 1, 2026. All other unused funds will be forfeited at the end of the 2025 plan year's run-out.*

How do I get reimbursed for my eligible expenses?

The easiest way to use your FSA dollars is by using your FSA Debit Card at the time you incur an eligible expense. Dependent Care Reimbursements can be submitted online. Contact Equity Bank online at equitybank.com/healthcare or call Equity Bank at (833) 654-3075 for additional assistance.

HSA vs. FSA

Below is a comparison of the 2 types of pre-tax spending accounts offered.

	HSA	FSA	DCA
Requires enrollment in a qualified high-deductible health plan (HDHP) to make contributions	✓	✗	✗
Pre-tax savings for eligible healthcare expenses	✓	✓	✓
Ownership	Employee	Employer	Employer
Rollover funds*	Full account balance	Limit \$680	No rollover
Account earns interest	✓	✗	✗
Contribution locked in the plan year from paycheck to paycheck	✗	✓	✓
Must be used on expenses incurred in the same plan year in which funds were deducted	✗	✓ (except ortho)	✓
Full election available on day 1 while the contributions are deducted from your paycheck	✗	✓	✗

Section 8

Supplementary Health Benefits

Life and Accidental Death & Dismemberment Insurance | Voluntary Life Insurance | Short- and Long-Term Disability Insurance |
Accident & Injury | Critical Illness | Hospital Indemnity



Life and Accidental Death & Dismemberment Insurance

Thrive Restaurant Group provides Basic Life benefits to employees (eligible upon hire) at no cost to you! The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The below benefits will begin to decrease at age 65. Contact Guardian directly for conversion and/or portability options.

Guardian Basic Life Insurance	
Employee Life	\$50,000
Employee AD&D	\$50,000

Voluntary Life Insurance

Thrive Restaurant Group offers Voluntary Life insurance to employees (eligible upon hire). The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. Evidence of Insurability (EOI) is required for any election or increase made after initial offering of benefit, as well as any amount over the GI. The below benefits will begin to decrease at age 65. Contact Guardian directly for conversion and/or portability options.

Guardian Supplemental Life Insurance			
	Employee	Spouse	Child(ren)
Maximum Amount	\$500,000	Not to exceed 50% of employee election to the maximum of \$10,000	\$5,000
Guarantee Issue Amount (GI)	\$150,000	\$10,000	\$5,000
Purchase Increments	\$10,000	\$1,000	\$1,000
Accidental Death & Dismemberment			
	Employee	Spouse	Child(ren)
	100% life benefit up to \$500,000	100% life benefit	100% life benefit

Evidence of Insurability (EOI) is required for any election or increase made after initial offering of benefit, as well as any amount over the GI. Once the election request is complete, an EOI is sent via email to the employee to complete. Coverage will not begin until EOI has been reviewed and approved by Guardian.

Short-Term Disability Insurance



Thrive Restaurant Group provides short-term disability through Guardian. This benefit covers 60% of your weekly base salary up to \$2,000/week at **no cost to you!** The benefit begins after 14 days of injury or illness and lasts up to 24 weeks. Please see the summary plan description for complete plan details.

Short-Term Disability	
Benefits Begin	Income Replacement
14th day illness/accident	60% of basic weekly income
Benefits Payable	Maximum Weekly Benefit
Up to 24 weeks	\$2,000

Long-Term Disability Insurance

Thrive Restaurant Group provides long-term income protection through Guardian in the event you become unable to work due to a non-work-related illness or injury at **no cost to you!** This benefit covers 60% of your monthly base salary up to 10,000. Benefit payments begin after 180 days of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details.

Long-Term Disability	
Benefits Begin	Income Replacement
180th day illness/accident	60% of basic weekly income
Benefits Payable	Maximum Weekly Benefit
Up to Social Security Retirement Age	\$10,000



No one plans to have an accident. It can happen at any moment throughout the day, whether at work or at play. Most major medical insurance plans only pay a portion of the bills. Guardian can help pick up where other insurance leaves off and provide cash to cover the expenses. Their accident coverage helps offer peace of mind when an accidental injury occurs. To the right is a sample of the cash payment Guardian will provide directly to you in the event you experience an accident or injury.

2nd Degree Burns	\$400 - \$2,000
Ground Ambulance	\$300
Closed Fractures	\$100 - \$4,000
Outpatient Surgical Expenses	\$300
Broken Tooth	\$125 - \$400
Emergency Room Visit	\$200

Critical Illness

The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed. Guardian's group voluntary critical illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness.

Sample Illnesses Covered	Sample Screenings and Biopsies Covered
Skin cancer	Cancer biopsies
Cardiovascular diseases	EKG & EEG
Heart attack & Stroke	Mammogram
Tuberculosis	Colonoscopy
Kidney failure	Chest X-ray
Multiple Sclerosis	Lipid panel

Rates are found in ADP and are based on age.

Hospital Indemnity helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth* (elective surgeries excluded).

Guardian - Hospital Indemnity	
Hospital / ICU Admission	\$1,500, max of 2 admissions per year, per insured
Hospital Daily Stay	\$200, max of 15 days per year, per insured
ICU Daily Stay	\$400, max of 15 days per year, per insured

**Guardian will pay benefits due to Childbirth for any Insured within the first nine months after the Insured's Coverage Effective Date. Childbirth or Complications of Pregnancy will be covered to the same extent as any other Covered Sickness. Newborn hospital stays are not payable unless admitted to Neonatal ICU.*

Who can get coverage?	
You	If you're actively at work
Your spouse	Can get coverage as long as you have purchased coverage for yourself
Your children	Dependent children & newborn until their 26th birthday

Important: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

For a list of benefits, including exclusions and limitations, see the Hospital Indemnity Summary of Benefits.

Section 9

Additional Support for You & Your Family

Mental Health Access | Thrive Family Fund | Pet Insurance | 401(k) Retirement Savings Plan





Mental Health Access

Flourishing starts with feeling your best—mind and body. Mental health is an essential part of overall well-being, and because our minds and bodies are connected, caring for one supports the other. That's why our benefits include robust options for mental healthcare, whether in-person or online, access to necessary medications, and other resources to help you feel whole and healthy. We're here to help you because when you thrive, we all thrive.

Medical Insurance Coverage

If you choose a PPO or HDHP plan, mental health services are covered for both in-person and online visits. Check your plan details to understand coverage, as PPO and HDHP plans differ.

Employee Assistance Program (EAP)

The EAP is available at no cost to you, even if you don't have company-sponsored medical insurance. The EAP supports your total wellbeing. It offers mental health resources, legal and financial assistance, and 24/7 support. You also receive three face-to-face visits per situation with a licensed professional, all confidential and not shared with Thrive. Access the EAP by phone at (855) 239-0743, online at [GuidanceResources.com](https://www.guidanceresources.com), or via the GuidanceNow app. Use the Organization Web ID: Guardian.

The EAP provides referrals to help with:

- Emotional health and wellbeing
- Alcohol or drug dependency
- Marriage or family problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Additional Mental Health Resources

Whatever challenge you're facing, don't be afraid to ask for help. There are resources available 24/7.

- **988 Suicide & Crisis Lifeline:** Call 988 for free, confidential 24/7 crisis support.
- **Crisis Text Line:** Text "HELLO" to 741741 to connect with a counselor anytime (standard text rates apply).
- **War Vet Call Center:** Veterans and families can call 877-WAR-VETS (877-927-8387) for support.
- **Emergency:** Call 911 or go to the nearest emergency room if you or someone you know is in immediate danger.

Thrive Restaurant Group is committed to helping you and your family access the support you need, with many services available at little or no cost.

Teladoc Services

Available to PPO and HDHP participants only. Your plan will pay for mental health professionals at the same rate as you see your primary care providers (PCP). However, if accessibility to a network mental health provider is an issue in your area, Teladoc services are provided at the PCP copay (HDHP deductible will apply first). It provides access to mental healthcare from anywhere you are. Talk to a therapist or psychologist by phone, video, web or app. (Must be 18 years old or older to use Mental Health services with Teladoc.) See the Teladoc page in this guide for more details.



Thrive Family Fund:

Join Us in Making a Difference

At Thrive, we're more than a team—we're family. Families take care of each other, especially during life's toughest moments. That's why we created the Thrive Family Fund, an employee-led 501(c)(3) nonprofit dedicated to supporting team members in crisis. What makes the Thrive Family Fund unique is that it's built by us, for us. Through team member contributions, we've given almost a million dollars to support folks in crisis—proof of what happens when we show up for each other.

This isn't just about charity; it's about changing lives. The fund has helped teammates move from homelessness into stable housing, provided critical support for women escaping unsafe situations, and bridged financial gaps during emergencies or natural disasters. These are stories of resilience, hope, and the incredible power of a supportive community.

Every contribution matters. By donating a small amount each paycheck, you help keep this vital support system strong. Joining is easy: login to ADP Workforce Now or the ADP Mobile app, go to **Myself > Benefits > Enrollments**, and select the Family Fund tile to start or adjust your contribution anytime.

Together, we're not just building restaurants—we're building a family that truly cares. Thank you for considering this mission of compassion. Every dollar makes a difference.



Pet Assure Veterinary Discount Plan

Established in 1995, Pet Assure is America's Veterinary Discount Plan. As an alternative or addition to pet insurance, Pet Assure helps pet owners like you save on veterinary care. Pet Assure members save 25% at participating veterinarians on all in-house medical services, including:

- Office Visits
- Vaccinations
- X-Rays
- Dental Work
- Spay & Neuter
- Emergency Visits
- Surgeries
- Hospitalization

It's as simple as that: since Pet Assure is not insurance, there are no forms to fill out, no waiting for reimbursements and no denials of coverage – even pets with pre-existing conditions are accepted.

Pet Assure has participating veterinarians in all 50 states and Puerto Rico. Search for a veterinarian at www.petbenefits.com/search.

Pet Assure also includes a 24/7 Lost Pet Recovery Service.

PetPlus Product and Rx Discount Plan

With PetPlus, you receive members-only pricing on prescriptions and everything else your pet needs. View available products and pricing at www.petplusbenefit.com. PetPlus members save up to 40% on:

- Prescription Medications
- Flea & Tick Products
- Vitamins & Supplements
- Heartworm Preventatives
- Food (Rx & Non-Rx)
- Treats & Supplies

It's easy to shop at your members-only pricing at www.petcarerx.com. Get free shipping on all online orders and same-day pickup is available for most prescriptions at any Caremark pharmacy nationwide, including Walgreens, Target, CVS and other local pharmacies.

401(k) Retirement Savings Plan

No matter what point of your career you're in, it's never a bad time to think about your future and save for retirement. Contributing to a 401(k) account now can help keep you financially secure later in life. The Thrive Together, LLC 401(k) Profit Sharing Plan provides eligible team members with the tools you'll need to prepare.

Plan at a Glance	
Plan Name	Thrive Together, LLC 401(k) Profit Sharing Plan
Record Keeper	ADP
Website	www.mykplan.com
Eligibility	Eligible Team Members can begin contributions immediately. FT Supervisors, Management & Home Office (Excluding Highly Compensated)
Company Match	50% up to \$2,000 (Match is deposited to accounts once per year)

Contributing to the Plan

The deferred contribution limit is set annually by the IRS. You have the option of electing a flat dollar amount to contribute each pay period. The total maximum amount you may contribute to the Plan is 75%. If you're 50 years of age or older, you may also make a catch-up contribution more than IRS code or plan limits.

Vesting

Your contributions and any amounts you rolled into the plan, adjusted for gains and losses, are always 100% yours. Thrive's company contribution account vests according to the following schedule:

Years of Service	0	1	2	3	4	5	6
Employer Match w/Vesting	Immediately vested						
Employer NEC	0%	0%	0%	100%			

Consolidating your Retirement Savings:

Retirement savings from previous plans or a Rollover IRA can be transferred into the Plan, even if you haven't met age or service requirements. Consolidating accounts can simplify tracking and help with long-term retirement planning. These assets will also be part of your overall balance if needed. To start, click the Consolidate Accounts tile after logging into your account or using the ADP Mobile Solutions App, and follow the steps.

Changing or Stopping Your Contributions:

You may change the amount of your contributions at any time. You may also discontinue your contributions and start them again at any time. Changes are effective the pay period following the change request is entered in the 401K portal.

401(k) Retirement Savings Plan

Distribution Options

Planning for your retirement is a long-term commitment and the money you have saved should be considered “untouchable” and used only as income in retirement. In the event of a financial need, you have the following distribution options available to you:

Loans

- Number of outstanding loans allowed at any one time: 1
- Minimum loan amount: \$500.00
- Maximum repayment period: Generally, 5 years, unless for the purchase of a primary residence.
- Loan interest rate information can be obtained by logging into your account > Loans & Withdrawals > View or Request a Loan.
- A fee may apply if you take a loan from your retirement plan account. Fee information can be obtained by logging into your account > Plan Information > Participant Fee Disclosure > Individual

Expenses

- Withdrawals while employed.
- Rollover: Age 59½

Withdrawals after employments

You may receive a distribution of the vested portion of some, or all of your retirement account balances in the Plan for the following reasons:

- Termination of employment
- Normal Retirement
- Disability
- Death

Account Resources

You can access your retirement account at any time through:

- ADP Mobile App
- www.mykplan.com
- 1-866-695-7526

Questions?

ADP 401K Representatives are available Mon-Fri, 8AM – 9PM ET.

Ready to Enroll?

Text Enroll 401k to 72408 or login to ADP Workforce Now and navigate to Myself > Benefits > Retirement Account.



Special rules exist for each type of withdrawal. You may be subject to a 10% penalty in addition to federal and state taxes if you withdraw money before age 59½. For more information, review the Special Tax Notice located in the retirement plan website.

ADP Mobile App

The ADP Mobile App and MyKPlan website allows you to:

- Check account balances
- Enroll and make account changes
- Research plan investments & request investment changes
- Access retirement planning tools & calculators
- Get prospectuses

Section 10

Common Questions & Legal Notices

Frequently Asked Questions | Important Legal Notices



Frequently Asked Questions

✓ What is the Medicare Rate?

Pricing set by the federal government, known as the Medicare Fee Schedule. A fixed cost is paid to the provider or facility for your services based on this pricing. This pricing is paid to medical professionals to perform certain procedures for people covered under Medicare.

✓ What is an Explanation of Benefits?

An EOB is a description the insurance company sends to you explaining the healthcare charges that you incurred and the services for which your doctor has requested payment. You should compare your EOB to the bill you receive from the doctor. All data on your EOB should match the information that appears on the statements you receive from your doctor. If it doesn't, contact the doctor's office immediately.

✓ What is the difference between generic and brand name drugs?

The difference between generic and brand name medications lies in the name of the drug and the cost. Generic drugs cost much less than brand name drugs, save you and your employer money, and provide the same health benefits as brand name drugs.

✓ What is the benefit of Mail-Order Drugs?

Mail-order drugs are perfect for patients who take medication on an ongoing basis. Examples are high blood pressure medication, high cholesterol medication, insulin and birth control. Mail-order drugs are convenient because they are delivered to your doorstep, which relieves the stress of standing in line at the pharmacy.

✓ What should I ask my doctor?

Amazingly, many patients do not ask their doctor basic questions. "How much will my treatment cost?" "Can I be treated another way that is equally effective but less costly?" "What are the risks?" "What are the side effects?" Having a dialogue with your physician can help you better understand how his or her care decisions affect your health plan costs. It will also help your doctor get to know you better and consequently prescribe treatment that is more effective.



Frequently Asked Questions



✓ What is the difference between a Primary Care Physician (PCP) and a Specialist?

PCP are generally family practitioners, internists or pediatricians who provide ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists as necessary. A specialist physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).

✓ What is the difference between Inpatient and Outpatient Services?

Inpatient services are provided to an individual during an overnight hospital stay. Outpatient services are provided to an individual at a hospital or outpatient facility without an overnight stay.

✓ What is the difference between In-Network and Out of Network?

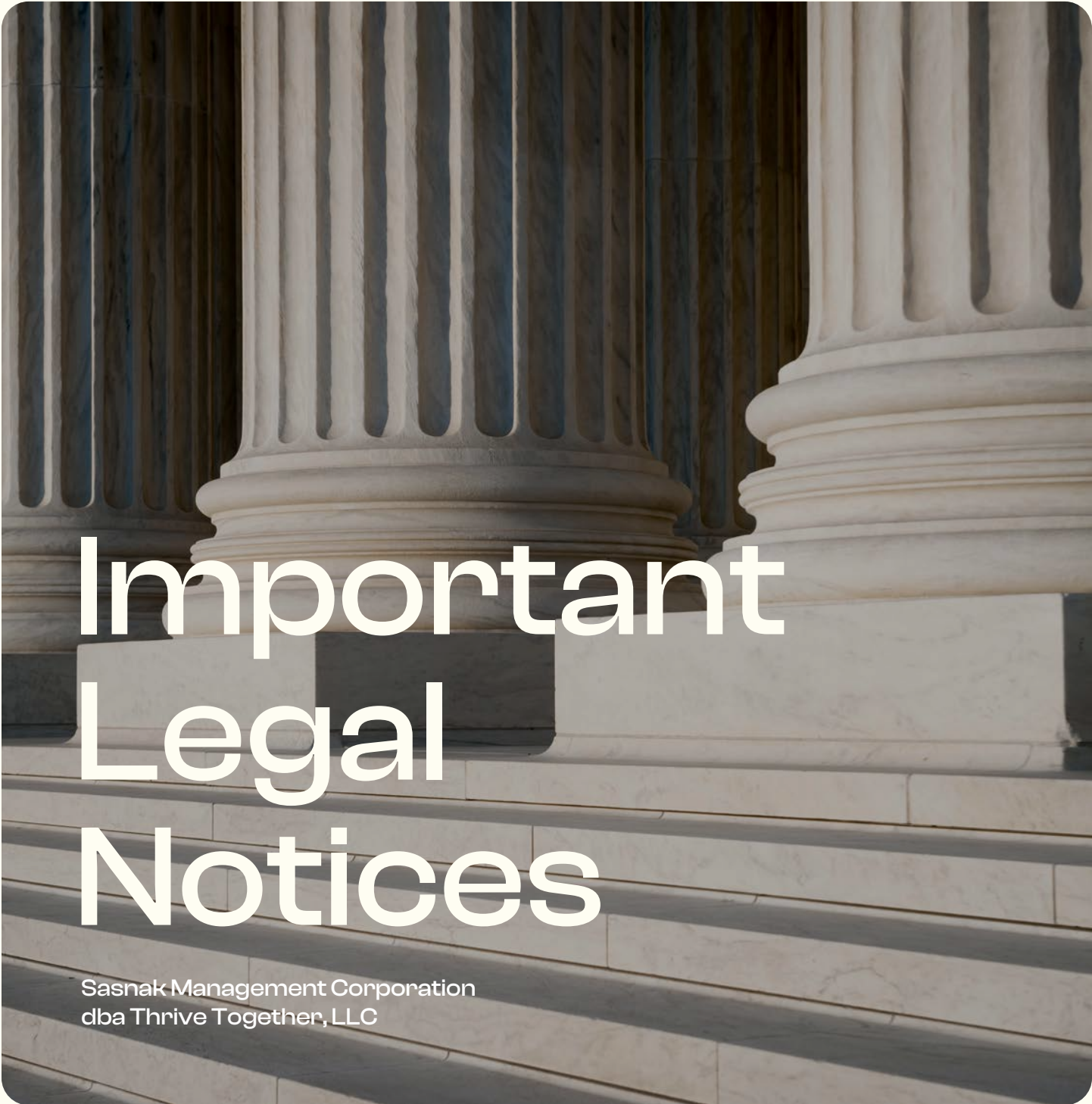
In-Network use of a healthcare provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses. Out-of-Network use of a healthcare provider that does not participate in a plan's network and thus may increase your overall out-of-pocket expenses.

✓ What is a balance bill?

A provider or facility contracts with networks and carriers for services at an agreed-upon cost. Outside these agreements, a provider or facility is not obligated to discount their services. Participants may receive a balance bill in situations where they have sought services outside a network agreement. Other situations that can cause a balance bill would be the plan pays a set price for each healthcare service instead of negotiating prices with providers. If the plan has a limit to reimbursement, the remaining portion of the bill is left to the provider or facilities discretion for balance bill or discount.

CONFIDENTIAL AND PROPRIETARY: This document and the information contained herein is confidential and proprietary information of USI Insurance Services, LLC ("USI"). Recipient agrees not to copy, reproduce or distribute this document, in whole or in part, without the prior written consent of USI. Estimates are illustrative given data limitation, may not be cumulative and are subject to change based on carrier underwriting.

© 2025 USI Insurance Services. All rights reserved.

The background of the top half of the page is a photograph of classical stone columns, likely from a government building or courthouse, with strong shadows and highlights. Overlaid on this image is the title "Important Legal Notices" in a large, white, sans-serif font.

Important Legal Notices

Sasnak Management Corporation
dba Thrive Together, LLC

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 9 for more details.

IMPORTANT NOTICE

This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

Important Legal Notices Affecting Your Health Plan Coverage

Fixed Indemnity Notice

(In regards to the newly offered Guardian Hospital Indemnity Plan) **IMPORTANT: This is a fixed indemnity policy, NOT health insurance.** This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

The Women's Health Cancer Rights Act of 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: GOLD Deductible \$1000/\$2000 coinsurance 80/20; SILVER Deductible \$3200/\$6400 coinsurance 90/10; BRONZE Deductible \$5000/\$10000 coinsurance 100/0; MEC plans offer limited coverage and are not considered an ACA qualified plan. If you have this policy through your job, or a family member's job, contact the employer.

Newborns Act Disclosure - Federal

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

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

Patient Protection Model Disclosure

Thrive Together, LLC generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Allied Benefit* at 800-288-2078 in Kansas or Blue Cross Blue Shield* at 855-263-0677 for outside Kansas.

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

You do not need prior authorization from Allied Benefit* or Blue Cross Blue Shield* or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact Allied Benefit* at 800-288-2078 in Kansas or Blue Cross Blue Shield* at 855-263-0677 for outside Kansas.

**All states outside Kansas, including the Kansas City Metro Area, qualify for Blue Cross Blue Shield. Kansas, excluding the Kansas City Metro Area qualifies for Allied.*

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state

or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Contact Information

Questions regarding any of this information can be directed to:

Renee Chaloupka

1877 North Rock Road, Wichita, KS 67206

316-978-9505

rchaloupka@thriverg.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.** Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the healthcare treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request.
- We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission: marketing purposes, sale of your information.

Other Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the healthcare treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
- Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

For certain health information, you can tell us your choices about what we share.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Our Responsibilities

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- January 1, 2026
- Renee Chaloupka, 316-978-9505 or rchaloupka@thriverg.com, 1877 North Rock Road, Wichita, KS 67206

Model Individual Creditable Coverage Disclosure Notice Language for Use On or After April 1, 2011

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

Important Notice From Thrive Restaurant Group 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 Thrive Restaurant Group 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. Thrive Restaurant Group has determined that the prescription drug coverage offered by the Thrive Restaurant Group Medical Plan for the plan year 2026 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 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, the following options may apply:

- You may stay in the Thrive Restaurant Group Medical Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose Thrive Restaurant Group Medical Plan creditable coverage.
- You may stay in the Thrive Restaurant Group Medical Plan and also enroll in a Medicare prescription drug plan. The Thrive Restaurant Group Medical Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Thrive Restaurant Group Medical Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Thrive Restaurant Group Medical Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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

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

Contact the person listed below for the further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Thrive Restaurant Group changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

Remember:

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

Date: January 1, 2026

Name of Entity/Sender: Thrive Restaurant Group

Contact Position/Office: Renee Chaloupka

Address: 1877 North Rock Road, Wichita, KS 67206

Phone Number: 316-978-9505

Model Individual Non-Creditable Coverage Disclosure Notice Language for Use On or After April 1, 2011

Applies to Allied MEC Care PLUS plan only. If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

Important Notice From Thrive Restaurant Group 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 Thrive Restaurant Group 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Thrive Restaurant Group has determined that the prescription drug coverage offered by Thrive Restaurant Group Medical Plan for the plan year 2026 is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug

1. plan, than if you only have prescription drug coverage from Thrive Restaurant Group Medical Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
2. You can keep your current coverage from Thrive Restaurant Group Medical Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

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 decide to drop your current coverage with Thrive Restaurant Group, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Thrive Restaurant Group Medical 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, the following options may apply:

- You may stay in Thrive Restaurant Group Medical Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date but you will have to pay a higher premium (penalty) because you did not have creditable coverage.
- You may stay in Thrive Restaurant Group Medical Plan and also enroll in the Medicare prescription drug plan. Thrive Restaurant Group Medical Plan will be a primary payer for prescription drugs and Medicare Part D will be a secondary payer.
- You may decline coverage in Thrive Restaurant Group Medical Plan and choose to enroll in Medicare as the only payer for all medical and prescription drug expenses. If you do not enroll in Thrive Restaurant Group Medical Plan, you are not able to receive coverage through the plan unless and until you are eligible to re-enroll in the plan at the next open enrollment period or due to status change under the cafeteria plan or a special enrollment event.

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

Since the coverage under Thrive Restaurant Group Medical Plan, is not creditable for the plan year 2026, and depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Thrive Restaurant Group changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

Date: January 1, 2026

Name of Entity/Sender: Thrive Restaurant Group

Contact Position/Office: Renee Chaloupka

Address: 1877 North Rock Road, Wichita, KS 67206

Phone Number: 316-978-9505

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, 2024. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: <http://myalhipp.com/>

Phone: 1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

Arkansas – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

California – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: <http://dhcs.ca.gov/hipp>

Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

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

Health First Colorado Website: <https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>

HIBI Customer Service: 1-855-692-6442

Florida – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

Georgia – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, Press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: 678-564-1162, Press 2

Indiana – Medicaid

Health Insurance Premium Payment Program

All other Medicaid

Website: <https://www.in.gov/medicaid/>

<http://www.in.gov/fssa/dfr/>

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid Website: [Iowa Medicaid | Health & Human Services](#)

Medicaid Phone: 1-800-338-8366

Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#)

Hawki Phone: 1-800-257-8563

HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)

HIPP Phone: 1-888-346-9562

Kansas – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

Louisiana – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Massachusetts – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840 TTY: 711

Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3739

Missouri – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.html>

Phone: 573-751-2005

Montana – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

Nevada – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

New Hampshire – Medicaid

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

Phone: 603-271-5218

Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 1-800-356-1561

Medicaid Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

North Carolina – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

Oklahoma – Medicaid

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

Oregon – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

Pennsylvania – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>

Phone: 1-800-692-7462

CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://www.pa.gov/en/services/dhs/childrens-health-insurance-program-chip)

CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

South Carolina – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

South Dakota – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

Texas – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](#)

Phone: 1-800-440-0493

Utah – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

Vermont – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)

Phone: 1-800-250-8427

Virginia – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

Washington – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

West Virginia – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/>

<http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

Wyoming – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 1-800-251-1269

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

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Benefits@ThriveRG.com.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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 period¹ 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 below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Benefits@thriverg.com

OMB Control Number 1210-0137 (expires 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%² of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.³

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

² Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

³ An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:

Thrive Together, LLC

Contact--Position/Office:

Renee Chaloupka

Address:

1877 North Rock Road, Wichita, KS 67206

Phone Number:

316-978-9505

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Sasnak Management Corporation dba Thrive Together, LLC	4. Employer Identification Number (EIN) 48-0851041	
5. Employer Address 1877 N Rock Road		6. Employer Phone Number
7. City Wichita	8. State KS	9. ZIP Code 67206
10. Who can we contact about employee health coverage at this job? Renee Chaloupka		
11. Phone Number (if different from above) 316-978-9505	12. Email Address rchaloupka@thriverg.com	

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

- As your employer, we offer a health plan to all employees. Eligible employees are: Full-time employees who work 30+ hours per week
- With respect to dependents: we do offer coverage. Eligible dependents are: spouse, domestic partner, disabled adult dependents and dependents to age 26

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.



THRIVE
RESTAURANT group