FABIANO BROTHERS – NON-UNION EMPLOYEES

EMPLOYEE BENEFIT ENROLLMENT GUIDE

EFFECTIVE January 1, 2026 – December 31, 2026

MICHIGAN BEVERAGE COLLECTIVE®

Claims Questions or Issues about Medical, Vision, or Dental Coverage?
Contact MBC
Phone (517) 482-5555 x 221

Blue Cross Blue Shield of Michigan

VSP®

Ulliance

44NORTH
ACRISURE® PARTNER

Claim Questions or Issues about Disability, FSA, or Life Insurance?
Contact 44N at 855-306-1099

DELTA DENTAL

MetLife

FLEX ADMINISTRATORS

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"Click on the page you want to view to navigate to that page!"

All benefits in this booklet are subject to change. This is only intended to be an Employee Benefits Highlights summary and not a contract. All benefits are subject to provisions and exclusions of the master contracts and plan documents.

Benefit Options
Provider Contact Information

The Effective Date for insurance is 90 days after full-time employment begins.

Fabiano Brothers HR is also available to assist with any benefit inquiries
Submit questions via Paycom's Ask Here or hr4u@fabianobrothers.com

BENEFITS ADMINISTERED BY MICHIGAN BEVERAGE COLLECTIVE (MBC)
CONTACT NUMBER | 517-482-555 x221

Medical Insurance - BCBSM & Prescription

GROUP: #71502

BCBS Phone: 877-790-2583

Member Portal: https://www.bcbsm.com/login/

Available Plan Options:

All medical plans include prescription drug coverage

PLAN A PPO SB 1000

PLAN B PPO SB 1500

PLAN C PPO 2000 + HSA
HSA requires separate election
HSA Provider: Health Equity

PLAN D HMO 2000 + HSA
HSA requires separate election
HSA Provider: Health Equity

Vision Insurance - VSP

GROUP: #71502

VSP Phone: 877-790-2583

Member Portal: https://www.vsp.com/

Virtual membership cards only - no physical cards will be issued

Dental Insurance - Delta Dental of Michigan

GROUP: #12160

DELTA Phone: 877-790-2583

Member Portal: https://www.deltadentalmi.com

Virtual membership cards only - no physical cards will be issued

Available Plan Options:

STANDARD PLAN

PREMIUM PLAN
Includes Orthodontia

ENHANCED PLAN
Includes Orthodontia

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Benefit Options
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BENEFITS ADMINISTERED BY ACRISURE (44N)
CONTACT NUMBER | 855-306-1099

Disability & Life Insurance - METLIFE

Metlife Phone: 877-790-2583

Member Portal: https://www.metlife.com/

Company-Paid Plans (No Employee Cost)

- ✓ **Short-Term Disability** up-to $500 week
- ✓ **Long-Term Disability** up-to $1000 month
- ✓ **Group Life Insurance** $15,000
- ✓ **Dependent Life Insurance** $2,000

Buy-Up options available for all Metlife insurance products

Telemedicine - MDLIVE

NO COST virtual medical care!

Company-Paid Plan (No Employee Cost)

MDLIVE Phone: 888-548-4251

Member Portal: www.mdlive.com/44n

Flexible Spending Accounts (FSA) - Flex Admin

Flex Phone: 800-437-3539

Member Portal: https://flex-admin.com/participants

Available Plan Options:

- **Medical FSA**
- **Dependent FSA**

Important: *FSA is a "use it or lose it" plan. Unused funds do not roll over. FSA is not the same as an HSA plan.*

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INSURANCE ELIGIBILITY

Effective Date is 90 days after Full-Time Employment.

Employee Eligibility

Full-time employees are eligible to participate in the company's insurance plans after 90 days of full-time employment.

Using Paycom, employees can enroll in the benefits they wish to participate in and waive those they do not need. Enrollment must be completed at least **14 days prior** to the effective date. Employees who do not enroll on time will have to wait until the next annual open enrollment period, unless a qualifying life event occurs.

Dependent Eligibility

A dependent is defined as the employee's legal spouse and/or dependent child(ren). The term child refers to natural child or stepchild; legally adopted child; or any child for whom the employee has permanent legal custody
To add dependents, employees must provide supporting documentation:

- **Marriage license – for a spouse**
- **Birth certificate – for a child**

Dependent children are eligible for medical, dental, and vision coverage through the end of the calendar month in which they turn 26. For voluntary dependent life and accidental death and dismemberment (AD&D) coverage, dependent children are eligible up to age 23, or up to age 25 if they are full-time students.

Separation from Employment

If employment ends, all coverage will end on the date of separation. Continuation of coverage under COBRA may be available as required by law, and details will be provided at the time of separation.

Direct any questions to Human Resources through Paycom's Ask Here or at hr4u@fabianobrothers.com.

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Qualifying Life Events
Special Enrollment Periods

Under certain circumstances, you are permitted to make a new election mid-year. You may only change your choices, including if you choose to decline coverage:

It is your responsibility to notify Human Resources of any status changes.
If you experience a Qualifying Life Event, act quickly by notifying HR through Paycom Ask Here and submitting a "New Message" under the Benefits category.

Important: Any cost-sharing changes are due on the effective date, even if notification of the life event occurs 30 or 60 days after the event. Cost-sharing adjustments will be made retroactively to align with the effective date after HR is notified.

When You Can Make Changes for Medical, Dental, or Vision Coverage

During the Open Enrollment Period with an Effective Date of January 1
Within 30 days of family or employment status change. *Effective the date of the event.*
Within 30 days (or 60 days*) of a qualifying event. *Effective the date of the event.*

Qualifying Events for Medical, Dental, or Vision Coverage

Change in marital status (provide marriage certificate or divorce decree)
Change in number of dependents such as a birth (provide verification)
Change in employment status including reduction in hours of service
Change in dependent status (must provide verification) Judgment, decree, or Court order
Entitlement to Medicare or Medicaid or Exchange enrollment*
Significant changes in cost of employee's or spouse's coverage
Family or medical leave under the Family Medical Leave Act (FMLA)
Loss of coverage under CHIP, Medicaid, or any other qualified health plan*
If a special enrollment event occurs as provided under HIPPA

When Your Benefits Are Effective Due to a Qualifying Event

Annual Enrollment: Changes made during the annual enrollment period are effective on the first day of the following year (January 1).

Qualifying Life Events: The effective date for benefit changes due to a qualifying life event aligns with the event date itself. For example, if you marry on June 1, your benefit update effective date is June 1, even if you notify HR later.

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Special Enrollment Rights

IMPORTANT

If you are declining enrollment in the group health plan 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 experience a Qualified Event.

If you experience a qualifying event, you must contact Human Resources within 30 days of the qualifying event to make the appropriate changes to your coverage. If the Qualifying Event is a divorce or dependent ages out of eligibility, you are allowed 30 days to notify Human Resources. Beyond 30 days, requests will be denied, and your may be responsible both legally and financially for any claims and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place on the date of the qualifying event. You will be required to furnish valid documentation supporting a change in status or "Qualifying Event".

If you or your eligible dependents are eligible for, but not enrolled in, the group health plan and your coverage or the coverage of your spouse or other eligible dependent under a Medicaid plan or state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, you must notify Human Resources no later than 60 days after the date the Medicaid or CHIP coverage terminates. If you, your spouse or other eligible dependent become eligible for a premium subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) you must contact Human Resources to request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance. Your enrollment will take effect no later than the first of the month following your loss of coverage and the date the company receives your request for enrollment, as long as your request to enroll on or before the date that is 60 days after the lost of coverage.

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

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Medical Insurance options:

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Group 71502 see Benefits at a Glance for exact details	PLAN A: BCBS PPO SB 1000	PLAN B: BCBS PPO 1500	PLAN C: BCBS PPO 2000 With HSA	PLAN D: BCBS HMO 2000 With HSA
Preventive Services	Covered at 100% - Copays & Deductible Do Not Apply			
Plan Year Deductible				
Individual	$1,000	$1,500	$2,000	$2,000
Family	$2,000	$3,000	$4,000	$4,000
Deductible Reset	Calendar Year	Calendar Year	Calendar Year	Calendar Year
Coinsurance Maximums				
Individual	$2,500	$2,500	$1,250	$2,000
Family	$5,000	$5,000	$2,450	$4,000
Member Responsibility	20% after deductible	20% after deductible	10% after deductible	10% after deductible
Annual Out-of-Pocket Maximum Deductible & Coinsurance, DOES NOT INCLUDE Copays & Prescription Drug Copays or Plan A or B. Plan C DOES include copays.				
Individual	$3,500	$4,000	$3,250	$4,000
Family	$7,000	$8,000	$6,450	$8,000
Provider Copays				
Primary Care	$30	$30	10% after Deductible	
Specialist	$30	$50	10% after Deductible	
Urgent Care Facility	$30	$60	10% after Deductible	
Emergency Room	$150	$150	10% after Deductible	
Prescription Drugs – 30 Day Supply				
Generic	$15	$15	10% after Deductible	$6, $25 After deductible
Preferred Brand	$50	$50	10% after Deductible	$50 After Deductible
Non-preferred Brand	50% ($70 min/$100 max)	50% ($70 min/ $100 max)	10% after Deductible	$80, 20% After Deductible

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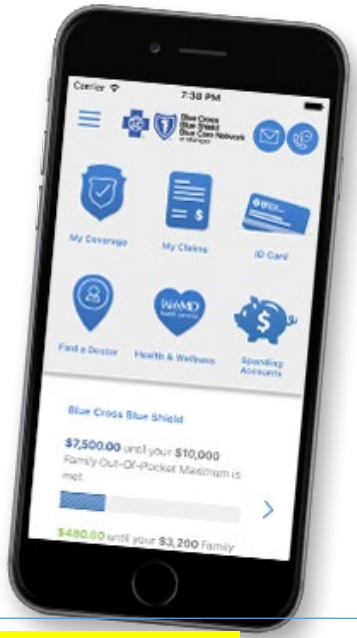
BCBSM Online Account Registration

EASILY manage your health care with 24/7 online access to your account using a computer or any mobile device. You can select a primary care provider, find in-network specialists and providers, set your communication preferences, Access Blue Cross Health & Well–Being Resources, take advantage of Blue 365 Member Discounts, and more!

Log in today as a **Member** at https://www.bcbsm.com/login/ or register for an online account following these simple instructions –

1. Click REGISTER YOUR ONLINE ACCOUNT on the right-hand side
2. Fill in the requested information and press CONTINUE
3. Follow the setup instructions



Logging into the BCBSM site also allows you to download a digital membership card, view your claims, view your explanation of benefits, access resources such as forms or documents you need for your vehicle insurance, pharmacy coverage and Mail-Order Service through Optum Rx, reimbursement forms, and even access your Health Savings Account if set up with Health Equity.

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Dental Insurance

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DELTA DENTAL Group 12160 (new group number)

Deductible	Premium Plan	Standard Plan	Enhanced Plan (new)
	PPO Dentist OR Premier Dentist	PPO Dentist OR Premier Dentist	PPO Dentist OR Premier Dentist
Individual	$25	None	$25
Family	$75	None	$75
Deductible Reset	Calendar Year	Calendar Year	Calendar Year
Maximum Benefit			
Per Member	$1,000	$1,000	$1,500
Diagnostic & Preventative Services			
Routine Oral Exam	100%	100%	100%
Routine Cleanings			
X-Rays			
Basic Services			
Fillings	80%	50%	80%
Endodontics (Root Canals)			
Periodontics (Surgical & Non-Surgical)			
Recementing Bridges			
Oral Surgery			
Repair & Adjustments of Dentures			
Major Restorative			
Bridges	50%	50%	50%
Removable Dentures			
Orthodontia- Dependent Children up to age 19			
Benefit	50%	N/A	50%
Lifetime Maximum	$1,000	N/A	$1,500

Delta Customer Service – 800-524-0149.

https://www.deltadentalmi.com/Extranets/Michigan-Beverage-Collective

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Vision Insurance:

VISION

Plan Overview

Your vision coverage provides comprehensive eye care benefits through the VSP Choice network, including routine eye exams, prescription eyewear, and contact lenses.

Covered Benefits

Provider Network: VSP Choice

Benefit	Coverage Details	Copay
WellVision Exam	Comprehensive eye exam Routine retinal screening Available every 12 months	$20
Prescription Glasses	Frames and lenses Available every 24 months	$20
Frame Allowance	$180 standard frame allowance 20% savings on amount over allowance Available every 24 months	Included in prescription glasses
Lenses	Single vision, bifocal, or trifocal Impact-resistant for children Available every 12 months	Included in prescription glasses
Contact Lenses	$150 allowance (instead of glasses) Contact lens exam and evaluation Available every 12 months	Up to $60 for exam

Click here for a complete listing of benefits

Enhancements Available: Progressive lenses, lens coatings, and other upgrades are available at discounted rates.
Network Access: Visit vsp.com or call 800.877.7195 to locate a VSP provider near you.
Member Resources: Create an account at vsp.com to access your benefits, find providers, and explore additional savings.
Questions? Call VSP Member Services at 800-877-7195

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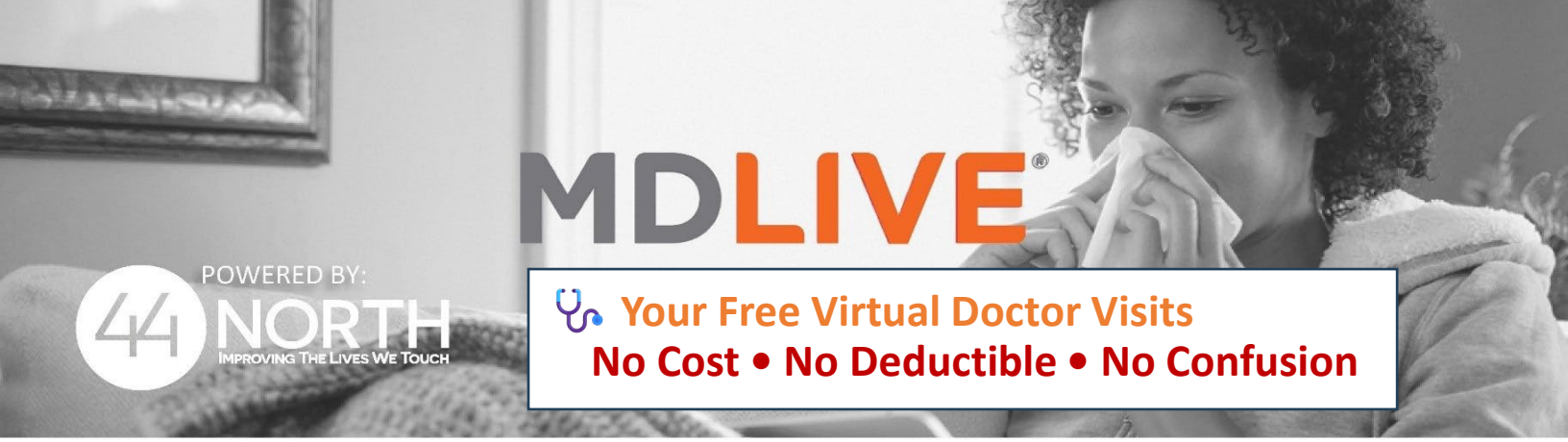

MDLIVE gives you 24/7 access to board-certified doctors by phone, video, or app — at **no cost** to you or your covered dependents. This service is **available to all Fabiano Brothers employees enrolled in our health insurance** and is **not part of your BCBS medical plan**, so your **deductible does not apply**.

MDLive Phone: 888-548-4251

When to Use MDLIVE

- Cold, flu, sore throat, sinus infections
- Allergies or skin conditions
- Minor injuries or urgent care needs

💡 **Tip:**

If you use **Teladoc through BCBS**, your visit goes toward your **deductible**. Use **MDLIVE instead** — it's **free, fast, and always available.**

How to Get Started - Visit www.mdlive.com/44n

Click **"Activate Now"** or download the **MDLIVE app**

Register once — be ready when you need care

⚖️ MDLIVE vs. Teladoc — Know the Difference

	MDLIVE (stand-alone service)	Teladoc (within BCBS plan)
Cost to You	✅ Free — no deductible	💰 Deductible applies
Plan Connection	❌ Separate from BCBS	✔ Part of BCBS plan
Access	24/7 phone or video visits	24/7 phone or video visits
Best Option	⭐ Use MDLIVE for free care	💡 Teladoc bills to insurance

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HEALTH SAVINGS ACCOUNT (HSA)

Take control of your healthcare spending.

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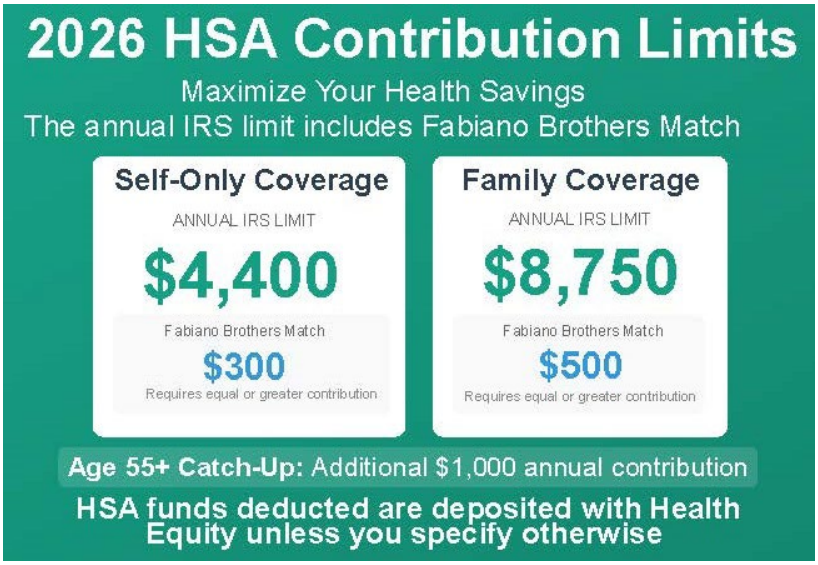
A **Health Savings Account (HSA)** is a **tax-free savings account** that helps you pay for eligible medical, dental, and vision expenses for yourself, your spouse, and your dependents. It pairs with the **Fabiano Brothers Medical Plan (2000/4000) – HDHP** to give you **flexibility and control** over your healthcare dollars.

Know the Facts

- **Not "use it or lose it."** Your HSA balance rolls over each year and continues to grow with interest — it's yours to keep, even if you leave the company.
- **More transparency, more choice.** HSAs help you make informed healthcare decisions by showing the real cost of care and letting you shop around.
- **Spending flexibility.** Use funds as you go or save receipts and reimburse yourself later — all **federally tax-free** when used for qualified expenses.

Enrollment Reminder- to participate, you must:

- **Elect** your HSA in Paycom each year during open enrollment, and
- **Enter the amount** you want to contribute to the HSA per paycheck. Remember that your HSA contribution is in addition to the medical cost-sharing you pay from each paycheck.



Watch a short video at HSA Video
Learn More at
https://www.healthequity.com/learn/hsa

"Stretch your dollars further and put more money in your pocket. Health Savings Accounts empower you to save more, spend smarter, and invest in your healthcare." – Health Equity, HSA like a pro

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Flexible Spending Account

Medical Flexible Spending Account

A Flexible Spending Account is a special account you put money into that you use to pay for certain out-of-pocket health care costs. You don't pay taxes on this money, meaning you'll save an amount equal to the taxes you would have paid on the money you set aside.

FSA's are NOT the same as an HSA, and you cannot have both an HSA and FSA at the same time for medical expenses. FSA's do not have an employer contribution.

In 2026 the maximum contribution to an FSA is $3,400. These funds are subject to a use-it-or-lose-it rule, which means you lose your remaining money if you miss the deadline for spending it all, so always keep track. Fabiano Brothers does roll over up to $610 of unused funds each year.

Medical FSA accounts are an option for Plans A, B, and C only.

Dependent Care Flexible Spending Account

Dependent Care Accounts reimburse dependent child expenses up to the age of 13. Once your child reaches age 13, they are no longer eligible. This account is used to reimburse you for dependent care expenses, such as child daycare, elder care, etc. The contribution limits for 2026 are $7,500 per household per year.

RESOURCES

To learn more about Flexible Spending Accounts go to https://flexadministrators.com/ To calculate your options go to https://flexadministrators.com/participants/benefit-calculators/

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FLEX ADMINISTRATORS

FLEX ADMINISTRATORS handles both the Medical FSA and the Dependent FSA.

Life Insurance & AD&D Coverage

Protecting Your Financial Security When You Need It Most

Fabiano Brothers provides core life insurance and AD&D coverage to all eligible employees at no cost. Life insurance provides financial benefits to your beneficiaries in the event of your death. AD&D offers additional protection for accidental death or serious injury, such as loss of a limb, sight, or hearing.

You may purchase additional voluntary coverage for yourself, your spouse, and your children through MetLife. The following page details available coverage levels and enrollment opportunities.
Please keep your beneficiary information updated in Paycom.

Employee Life Insurance

Core Coverage: $15,000 - EMPLOYER PAID

Voluntary Buy-Up Options:

Add $10,000	**Total: $25,000**
Add $40,000	**Total: $55,000**
Add $90,000	**Total: $105,000**
Add $140,000	**Total: $155,000**

If you currently have Voluntary Employee Life or Dependent Life and wish to increase to a higher coverage level, you must complete a Statement of Health (SOH) for MetLife. Your new coverage amount will not take effect until MetLife reviews and approves the SOH.

If you already have voluntary employee life insurance in 2025, your coverage will automatically adjust to the next closest coverage tier without requiring an SOH—provided you elect that tier for 2026.

Spouse Life Insurance

Core Coverage: $2,000 - EMPLOYER PAID

Voluntary Buy-Up Options:

Requires $10,000+ employee voluntary coverage

Add $5.000	**Total: $7,000**
Add $10,000	**Total: $12,000**
Add $20,000*	**Total: $22,000**

Requires $40,000+ voluntary employee coverage

Child Life Insurance

Core Coverage: $1,000 - EMPLOYER PAID

Voluntary Buy-Up Options:

Requires $10,000+ employee voluntary coverage

Add $2,000	**Total: $3,000**
Add $4,000	**Total: $5,000**
Add $10,000	**Total: $11,000**

Direct any questions to Human Resources through Paycom's Ask Here or at hr4u@fabianobrothers.com.

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DISABILITY BENEFITS

MetLife

Protecting Your Financial Security When You Need It Most

Illness or injury can interrupt your ability to work and cause financial stress. Disability coverage helps protect your income when you're unable to perform your job due to a medical condition. Short-Term Disability replaces part of your pay during brief recovery periods, while Long-Term Disability provides ongoing income support for more serious or lasting conditions—helping you maintain financial stability and focus on your health.

Short-Term Disability (STD)

EMPLOYER FUNDED

Base Coverage: 60% of base weekly earnings (max benefit $500/week)
Waiting Period: 1st day (accident) | 8th day (illness)
Duration: 26 weeks

STD Buy-Up Option

EMPLOYEE FUNDED

Base Coverage: 60% of base weekly earnings (max benefit $750/week)

Eligibility: Base wages must exceed $833 per week

Long-Term Disability (LTD)

EMPLOYER FUNDED

Base Coverage: 50% of base monthly earnings (max benefit $1000/month)
Elimination Period: 180 days
Duration: Up to Social Security Normal Retirement Age

Voluntary LTD Buy-Up

EMPLOYEE FUNDED

Base Coverage: 60% of base monthly earnings (max benefit $3000/month)

NOTE: Must elect during initial enrollment OR complete Evidence of Insurability during open enrollment

Direct any questions to Human Resources through Paycom's Ask Here or at hr4u@fabianobrothers.com.

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A Partnership in Support.
A Commitment to You.

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We're pleased to continue partnering with **Ulliance** to offer the **Life Advisor Employee Assistance Program (EAP)**—a free, confidential resource for you and your family. At **Fabiano Brothers, Inc.**, we believe that caring for our employees is the best investment we can make.

As part of our **Safety & Wellness Program**, Ulliance provides expert support and guidance to help you thrive personally and professionally. Watch this short **2-minute video** to discover how **Ulliance** can support your well-being. https://www.youtube.com/watch?v=g1pCP_0wFQo

Fabiano Brothers

Ulliance

Life can be hard. Ulliance helps.

Your Life Advisor Employee Assistance Program!

800.448.8326 **LifeAdvisor.com**

Login: Box 1 = Fabiano Brothers Box 2 = Michigan or Wisconsin

100% CONFIDENTIAL. Only you and Ulliance knows you contacted them

Federal mandated notices

The following are Federal or State laws and/or plan notices that apply to your health benefits coverage and are found in appropriate sections of your Summary Plan Descriptions. You may access your plan document by contacting your Human Resources department.

HIPAA Special Enrollment Notice
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 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, court-appointed guardianship, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 supplements the HIPAA special enrollment notice by allowing eligible employees and dependents to enroll under the Plan under the following circumstances:

- The employee's spouse or dependent's Medicaid or CHIP coverage terminates as a result of loss of eligibility, or
- The employee, spouse, or dependent becomes eligible for a premium assistance subsidy or Medicaid coverage under Medicaid or Children's Health Insurance Program (CHIP).

Employees and dependents must request special enrollment under this provision within 60 days of the loss of Medicaid or CHIP coverage or within 60 days after the employee or dependent is determined to be eligible for a Medicaid or CHIP subsidy. To request special enrollment or to obtain more information, contact your Human Resources department for more information.

HIPAA Notice of Privacy Practices Reminder
Protecting your Health Information Privacy Rights – The administrators of the Plan use strict privacy standards to protect your health information from unauthorized use or disclosure. The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Blue Cross Blue Shield of Michigan.

Genetic Information Non-Discrimination Act of 2008 (H.R. 493 [110th])
Benefit provisions will comply with the Genetic Information Non-Discrimination Act of 2008 therefore, employees and dependents will not be discriminated against on the basis on genetic information.

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Federal mandated notices

Uniformed Services Employment and Reemployment Rights Act (USERRA)
Coverage will terminate if you are called to active duty by any of the armed forces of the United States of America. However, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest if you request to continue coverage and pay any required contributions toward the cost of the coverage during the leave. If the leave is less than 30 days, the contribution rate will be the same as active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. If you do not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave, and your coverage had been continuous under this Plan. Contact your employer for complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act.

WHCRA Full Annual Notice
The Women's Health and Cancer Rights Act of 1998 requires notification to you, as a participant or beneficiary, of your rights related to benefits provided through the plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the plan's regular deductible and co-pays/coinsurance. See SUMMARY OF BENEFITS for details. Keep this notice for your records and call your designated Human Resources department for more information.

The Newborns' and Mothers' Health Protection Act of 1996
Under federal law, this Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery (less than 96 hours following a caesarean section) or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. 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).

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Federal mandated notices

Patient Protections Notice (PPACA, 2010)

Your employer generally does not require the designation of a primary care provider. You have the right to designate any primary care provider available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the carrier or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact **Blue Cross Blue Shield** (888) 605-2564, or www.bcbsm.com

Continue group health plan coverage

You may continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the plan due to a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage if applicable.

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 1/31/2023)

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Important Notice About Your Prescription Drug Coverage and Medicare (Creditable Coverage Notice)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with MB&WWA and prescription drug coverage available for people with Medicare. It also explains your options under Medicare prescription drug coverage and can help you decide if you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. 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 through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. MB&WWA has determined that your current prescription drug coverage offered by the MBWWA Employee Benefit Trust is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay and ***is considered Creditable Coverage***. Because your existing coverage is on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage (if you cancel your MB&WWA coverage).

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a (2) month Special Enrollment Period (SEP) to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you do decide to enroll in a Medicare prescription drug plan and drop your MB&WWA prescription drug coverage, be aware that you and your dependents *may not* be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

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 coverage with MB&WWA and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

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For more information about this notice or your current prescription drug coverage…
Contact the MB&WWA office for further information1-800-456-2992. NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage through MB&WWA changes. You also may request a copy 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 prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: October 2025
Name of Entity/Sender: Michigan Beverage Collective
Contact--Position/Office: Tonya Davis, Benefits Manager
1-800-456-2992 ext. 221
Address: 332 Townsend, Lansing, MI 48933

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General Notice of COBRA Continuation Coverage Rights
** 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 [*choose and enter appropriate information:* must pay *or* aren't required to 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.

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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; or
- 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: Wendy Yelsik, HR Director, Fabiano Brothers.

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.

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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. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

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 period 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.

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

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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:

Michigan Collective Beverage; Tonya Davis; Benefits Manager; 1-800-456-2992 ext. 221
Fabiano Brothers, Wendy Yelsik, HR Director; 989-509-0282 or Paycom Ask Here

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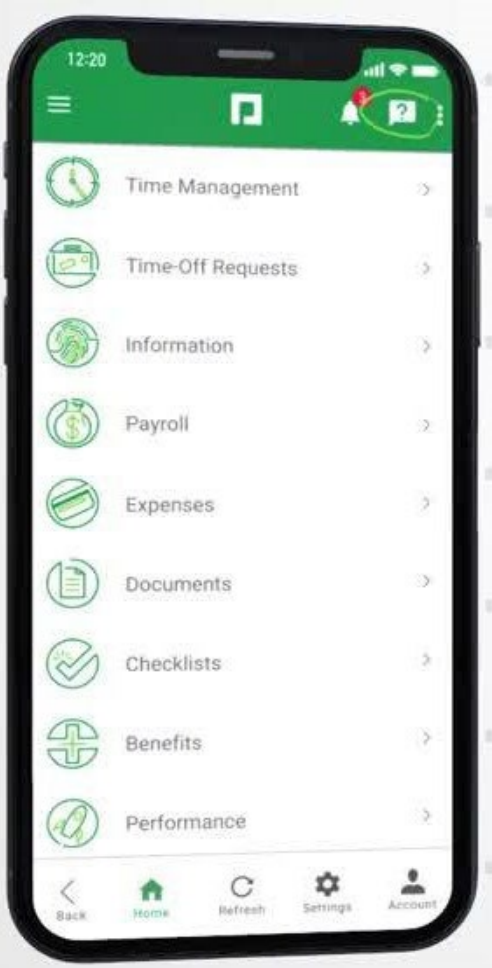
ASK HERE™



PRESS "?" ON THE UPPER RIGHT-HAND CORNER TO SELECT A CATEGORY AND THEN START A "NEW MESSAGE" TO CONTACT HUMAN RESOURCES, INCLUDING PAYROLL

COMPLETE BENEFIT ENROLLMENT IN PAYCOM

Fabiano Brothers

NON-Union Employees

MICHIGAN BEVERAGE COLLECTIVE®

Claims Questions or Issues about Medical, Vision, or Dental Coverage?
Contact MBC
Phone (517) 482-5555 x 221

Blue Cross Blue Shield of Michigan

VSP®

Ulliance

44NORTH
ACRISURE® PARTNER

Claim Questions or Issues about Disability, FSA, or Life Insurance?
Contact 44N at 855-306-1099

DELTA DENTAL

MetLife

FLEX ADMINISTRATORS

Fabiano Brothers
Established 1885

2026 ELECTION WORKSHEET
NON-UNION BAY CITY

Weekly Deduction

This information is for viewing only. Health Insurance Elections are done using paycom

1 MEDICAL INSURANCE INCLUDING RX. BCBSM	SINGLE	DOUBLE	FAMILY	WEEKLY COST
PLAN A | PPO $1000/$2000 deductible; $15/$50/ 50% Rx	$ 67.50	$ 150.31	$ 192.40	
PLAN B | PPO $1500/$3000 deductible; $15/$50/ 50% Rx	$ 61.00	$ 135.19	$ 173.39	
PLAN C | PPO $2000/$4000 deductible; + Health Savings Account	$ 52.44	$ 107.50	$ 141.58	
PLAN D | HMO $2000/$4000 deductible; + Health Savings Account	$ 50.56	$ 103.67	$ 136.54	

HSA contributions for Plans C and D increase weekly costs. Limits are $4,100 individual, $8,250 family, plus $1,000 if age 55+, with employer matches of $300 single and $500 family. Elections are separate from medical plans.

2 DENTAL INSURANCE - DELTA DENTAL	SINGLE	DOUBLE	FAMILY	
STANDARD PLAN | $1000 yr / 100% / 50% / $50% / NO ORTHO	$ 2.56	$ 4.41	$ 7.71	
PREMIUM PLAN | $1000 yr / 100% / 80% / 50% / WITH ORTHO	$ 4.12	$ 7.42	$ 13.74	
ENHANCED PLAN | $1500 yr / 100% / 80% / 50% / WITH ORTHO	$ 4.84	$ 8.79	$ 16.47	

3 VISION INSURANCE - VSP	SINGLE	DOUBLE	FAMILY	
STANDARD PLAN | **$20 / 12 / 12 / 12**	$ 0.51	$ 0.97	$ 1.43	

4 LIFE INSURANCE	COMPANY PAID	Buy Up	Buy Up	Buy Up	Buy Up	
BUY-UP OPTIONS (added to company-paid amount) ***MetLife requires a SOH to move to Buy Up option***	**$15,000**	**$10,000** $ 0.89	**$40,000** $ 3.10	**$90,000** $ 7.56	**$140,000** $ 12.02	

5 SHORT-TERM DISABILITY	BUY UP	
STANDARD PLAN (COMPANY PAID) | 60% of base wages up-to $500 weekly	-0-	
BUY-UP PLAN | 60% of base wages up-to $750 weekly. Eligible for buy-up STD if base pay exceeds $833/week.	$ 2.50	

6 LONG-TERM DISABILITY	BUY UP	
STANDARD PLAN (COMPANY PAID) | 60% of base wages up-to $1,000 weekly	-0-	
BUY-UP PLAN | 60% of base wages up-to $3,000 monthly. ***MetLife requires a Statement of Health (SOH) to move to Buy Up option***	$ 5.00	

7 DEPENDENT LIFE INSURANCE	COMPANY PAID	Buy Up	Buy Up	Buy Up	
SPOUSE: BUY-UP OPTIONS (added to the company-paid amount) ***MetLife requires a SOH to move to Buy Up option***	**$2,000**	**$5,000** $ .50	**$10,000** $ .75	**$20,000** $ 1.25	
CHILD: BUY-UP OPTIONS (added to the company-paid amount) ***MetLife requires a SOH to move to Buy Up option***	**$1,000**	**$2,000** $ .50	**$ 4,000** $ .75	**$ 10,000** $ 1.25	

TOTAL WEEKLY COST:

This worksheet is for information only. To choose your 2026 benefits, log in to Paycom and go to your Benefits Section. For questions, contact HR via Paycom's Ask Here or email hr4u@fabianobrothers.com.

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Revised 11/22/25

Fabiano Brothers
Established 1885

2026 ELECTION WORKSHEET
NON-UNION DETROIT

Weekly Deduction

This information is for viewing only. Health Insurance Elections are done using paycom

1 MEDICAL INSURANCE INCLUDING RX. BCBSM	SINGLE	DOUBLE	FAMILY	WEEKLY COST
PLAN A | PPO $1000/$2000 deductible; $15/$50/ 50% Rx	$ 67.50	$ 150.31	$ 192.40	
PLAN B | PPO $1500/$3000 deductible; $15/$50/ 50% Rx	$ 61.00	$ 135.19	$ 173.39	
PLAN C | PPO $2000/$4000 deductible; + Health Savings Account	$ 52.44	$ 107.50	$ 141.58	
PLAN D | HMO $2000/$4000 deductible; + Health Savings Account	$ 47.89	$ 98.17	$ 129.30	

HSA contributions for Plans C and D increase weekly costs. Limits are $4,100 individual, $8,250 family, plus $1,000 if age 55+, with employer matches of $300 single and $500 family. Elections are separate from medical plans.

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4 LIFE INSURANCE	COMPANY PAID	Buy Up	Buy Up	Buy Up	Buy Up	
BUY-UP OPTIONS (added to company-paid amount) ***MetLife requires a SOH to move to Buy Up option***	**$15,000**	**$10,000** $ 0.89	**$40,000** $ 3.10	**$90,000** $ 7.56	**$140,000** $ 12.02	

5 SHORT-TERM DISABILITY	BUY UP	
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BUY-UP PLAN | 60% of base wages up-to $750 weekly. Eligible for buy-up STD if base pay exceeds $833/week.	$ 2.50	

6 LONG-TERM DISABILITY	BUY UP	
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BUY-UP PLAN | 60% of base wages up-to $3,000 monthly. ***MetLife requires a SOH to move to Buy Up option***	$ 5.00	

7 DEPENDENT LIFE INSURANCE	COMPANY PAID	Buy Up	Buy Up	Buy Up	
SPOUSE: BUY-UP OPTIONS (added to the company-paid amount) ***MetLife requires a SOH to move to Buy Up option***	**$2,000**	**$5,000** $ .50	**$10,000** $ .75	**$20,000** $ 1.25	
CHILD: BUY-UP OPTIONS (added to the company-paid amount) ***MetLife requires a SOH to move to Buy Up option***	**$1,000**	**$2,000** $ .50	**$ 4,000** $ .75	**$ 10,000** $ 1.25	

TOTAL WEEKLY COST:

This worksheet is for information only. To choose your 2026 benefits, log in to Paycom and go to your Benefits Section. For questions, contact HR via Paycom's Ask Here or email hr4u@fabianobrothers.com.

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Revised 11/22/25