BENEFITS

INFORMATION GUIDE

2024 / 2025

FOR WEEKLY PAID PARTNERS

BENEFITS

INFORMATION GUIDE

2024 / 2025

This Benefits Information Guide is a comprehensive tool designed to help familiarize you with the plans and programs you and your family can enroll in for the plan year. Now, more than ever, it is important to have the flexibility to use your health plans. With this in mind, our plans are cost-effective to visit your doctors, get your prescriptions and utilize virtual visits. If you have any questions regarding your benefits, please contact your Benefits Department at **(949) 453-4498** or **benefits@bootbarn.com**. Please visit the benefits website at **bootbarnbenefits.com** for plan information, webinars, workshops and more!

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

ELIGIBILITY & ENROLLMENT

WHO CAN ENROLL?

If you are a partner regularly working a minimum of 30 hours per week and have completed the benefit waiting period, you are eligible to participate in the benefits program. Eligible partners may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law hereinafter referred to as "registered domestic partner") and/or eligible children up to the age of 26.

A partner may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of a partner's state-registered domestic partner that does not meet the definition of the partner's tax dependent under IRC Section 152.

WHEN DOES COVERAGE BEGIN?

Elections made during Open Enrollment will be effective October 1, 2024.

HOW DO I ENROLL?

Enrollment is made easy with **ADP Lyric!** You will need your credentials (created by you during the new hire process) to access the benefits enrollment portal.

To enroll, simply follow these steps:

1. Go to **lyric.adp.com**
2. Once you are logged into the system, mouse over your initials in the top right corner of your screen, select "**Your Profile**", "**Benefits**" and "**ADP Benefits Dashboard**"
3. Select the "**New Hire Enrollment**" button

For step by step instructions on how to enroll visit:
bootbarnbenefits.com/how-to-enroll-in-adp

> **TIP:** If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a qualified change in status during the plan year. Please review details on IRS qualified change on page 4 of the benefits guide.

ELIGIBILITY & ENROLLMENT

WHAT IF MY NEEDS CHANGE DURING THE YEAR?

You are only able to make changes to your benefits outside of the open enrollment period if you have experienced a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event.

Change in status examples include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Death of a dependent
- You or your spouse's/registered domestic partner's loss or gain of coverage through our organization or another employer

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" at the end of this guide.

HAVE BENEFIT QUESTIONS?

For all Boot Barn Plans, Member Advocates are available to help. From clearing up provider billing to researching the finer details of your benefits coverage, their experts can get you what you need.

Member Advocates help with:

- Understanding your plan benefits
- Navigating the Collective Health Portal
- Claims, billing and benefit questions
- Finding in-network providers
- Anything that can make the healthcare process easier for you

Call **(855) 672-2692** or visit **join.collectivehealth.com/bootbarn**

ELIGIBILITY & ENROLLMENT

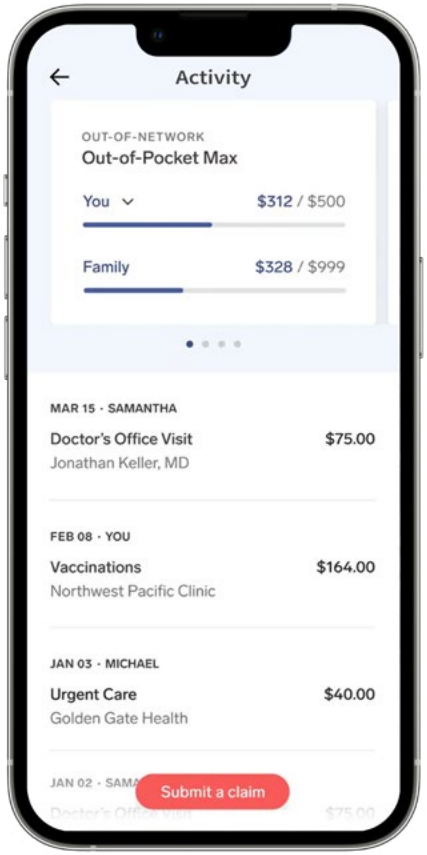
MEMBER ADVOCATES ARE MOBILE!

Download the Collective Health mobile app that lets you:

- Find in-network providers
- Access your ID card
- Check plan benefits
- Review claim information
- Send a message or chat directly with a Member Advocate

Download on the App Store

GET IT ON Google Play



BENEFITS INFORMATION ON THE GO

COLLECTIVE HEALTH

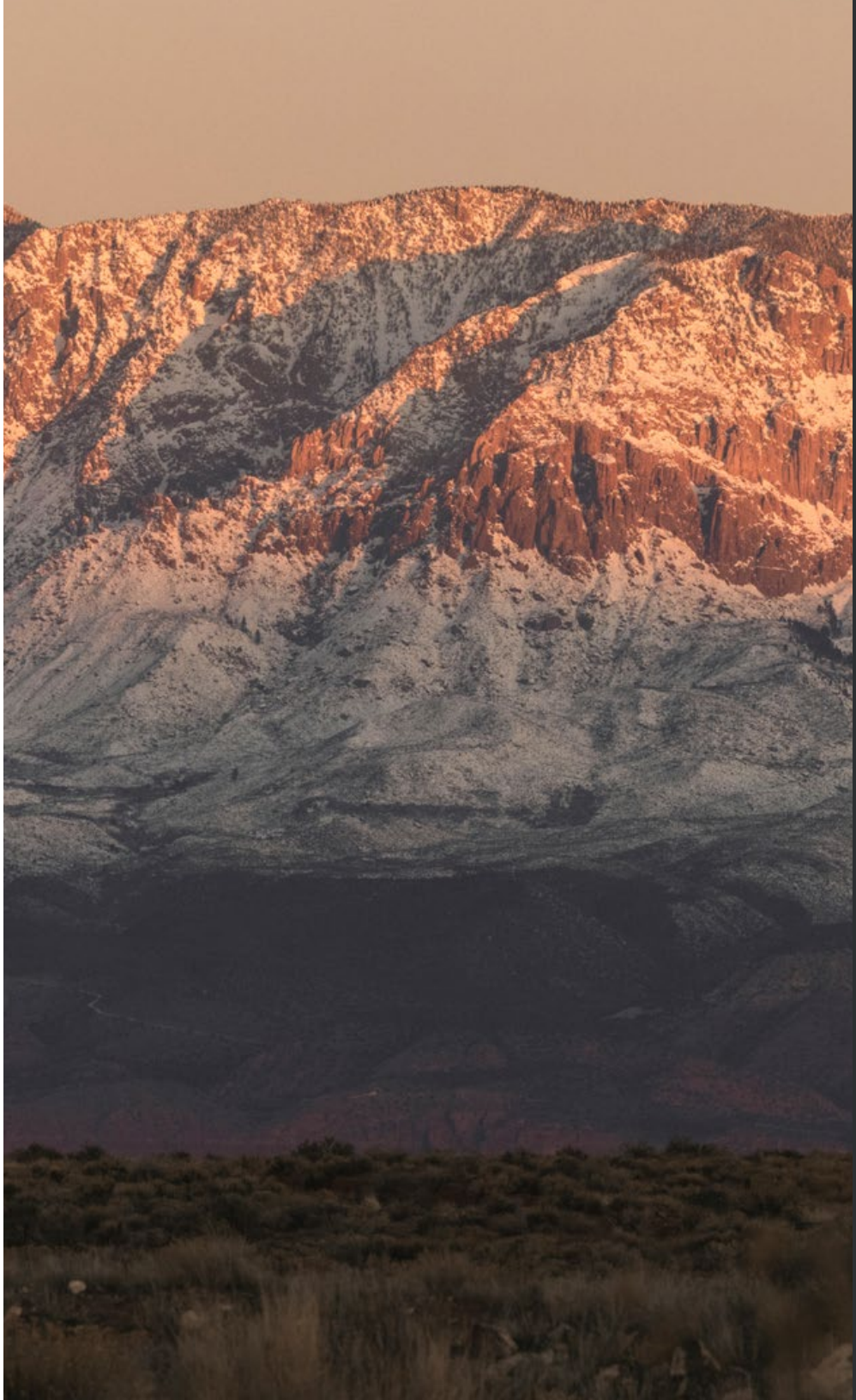
With Collective Health's mobile app, you can:

- Find in-network medical or dental providers
- Access your ID card
- Check plan benefits
- Review claim information
- Send a message or chat directly with a Member Advocate
- Research in-network providers near you

EYEMED – VISION INSURANCE

With EyeMed's mobile app, you can:

- Find additional savings for an exam or frames from top brands
- Check the status of your claim
- Download your ID card right to your phone



TELEHEALTH SERVICES

ANTHEM LIVEHEALTH ONLINE

With Anthem LiveHealth Online, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet or telephone. They are available 24/7/365 and treat illnesses such as the flu, sinus infection, rash, sore throat and more. By leveraging these virtual visits, you can avoid emergency rooms and urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

Telehealth services are offered through Anthem Blue Cross LiveHealth Online. PPO Classic members receive the service at no cost, and PPO Smart Saver and PPO Platinum Saver members will pay a $10 copay (deductible does not apply). Set up your account today by calling **(888) 548-3432** or downloading the app.

In addition, you can use Anthem's 24/7 NurseLine at no cost when you can't reach your primary care provider. They can assess your symptoms, determine when you should seek care, and help you find a provider near you. They can also answer questions about your prescriptions or over-the-counter medications, your or your child's health, immunizations, and getting relief from things like headaches, earaches, or allergies.

You can call 24/7 NurseLine at **(800) 700-9186**.

Download the app to talk to a doctor within an hour by phone or video.

1. DOWNLOAD THE APP
   Search "**LiveHealth Online**" in the App Store or on Google Play.
2. SET UP YOUR ACCOUNT
   Once you've downloaded the app, select "**Sign Up**".
3. ENTER BASIC CONTACT INFORMATION
   Enter a first and last name, date of birth, gender, email address, password, phone number, and agree to terms and conditions.

TIP: WHAT ARE QR CODES AND HOW TO USE THEM

QR Codes are a barcode, which allows your smartphones and tablets to recognize and decode the pattern to open a link or application. You can use the codes above to download helpful benefits apps! To do so, just follow these three easy steps:

1. Open your phone's camera, tap the camera app icon
2. Point the camera at the QR code, your phone should focus on the QR code after a brief moment
3. Open the QR code's content, tap the notification that appears on the screen to download the app

ADDITIONAL BENEFITS

RULA

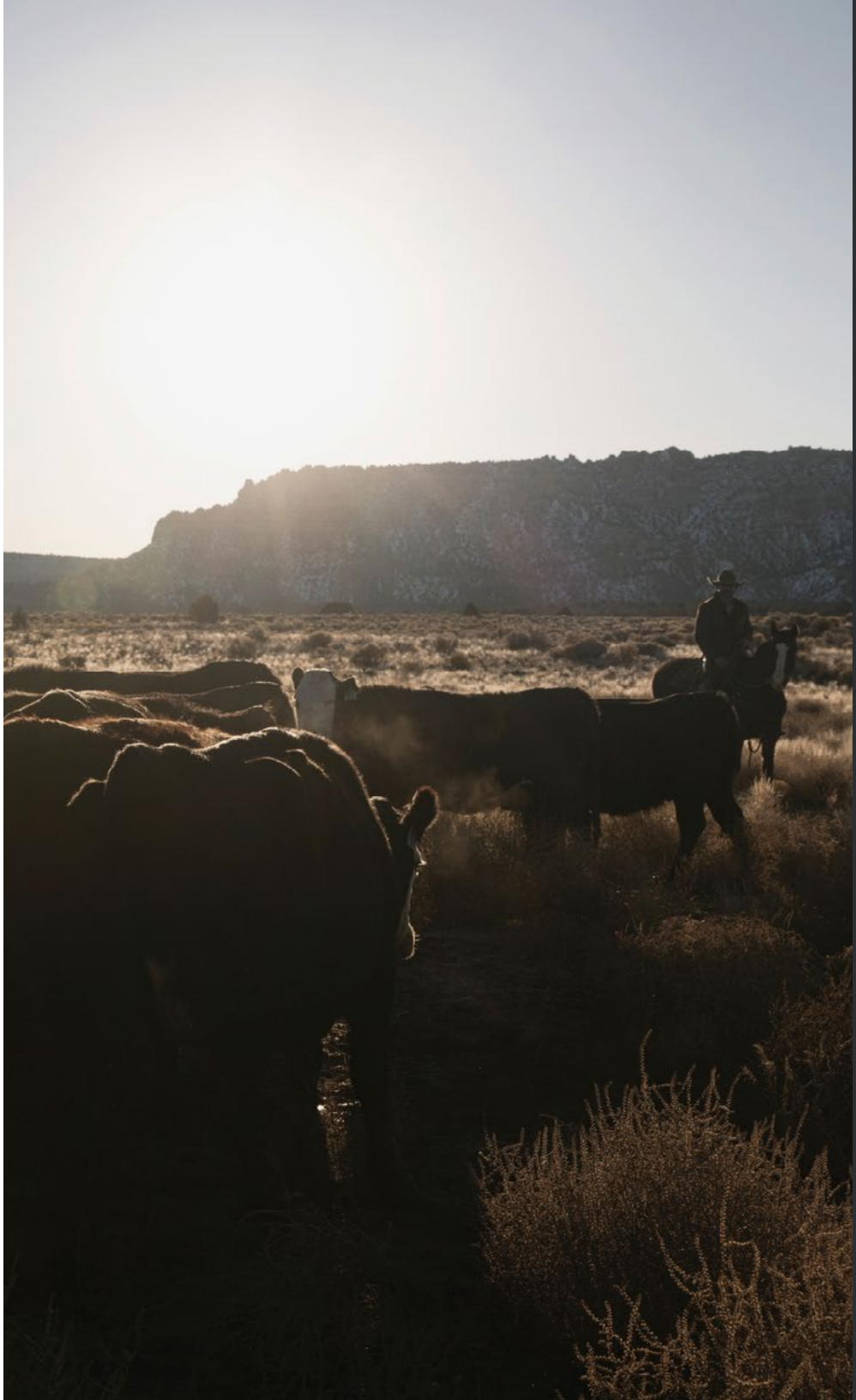
Rula is an online platform that connects individuals with licensed therapists, providing convenient and confidential access to high-quality mental health care. Whether you're seeking support for personal challenges, family issues, or simply want to prioritize your overall mental well-being, Rula is a great resource to utilize. You can meet with your preferred therapist in as soon as 2 days. Rula will also verify your out-of-pocket cost before your first session.

Get started today by visiting **rula.com/bootbarn** or call (**323) 205-7088**.

HINGE HEALTH

If you suffer from muscle and joint pain, you know that the freedom to move around can sometimes be an obstacle. Hinge Health can help you get a personalized workout plan, designed by certified physical therapists, to help with your pain management journey.

You can also get 1:1 support from a health coach. They can connect with you via text, email, phone call, or video chat. With the Hinge Health app, you can have the convenience of having access to exercises you can do from home or anywhere that is convenient for you. For more information on Hinge Health, please visit **hingehealth.com**



MEDICAL

YOUR MEDICAL PPO PLANS

You and your eligible dependents have the opportunity to enroll in medical plans. Boot Barn is currently offering three (3) plans:

- Anthem PPO Classic

High Deductible Health Plans (HDHP)

- Anthem PPO Platinum Saver – This plan qualifies and can be paired with a Health Savings Account
- Anthem PPO Smart Saver – This plan qualifies and can be paired with a Health Savings Account

We encourage you to review the coverage details in the next few pages and select the option that best suits your needs.

FINDING THE RIGHT MEDICAL PROVIDER

Finding the right medical doctor or specialty doctor is important. You can use the below instructions in addition to the Member Advocates to help you find the right care you need.

1. To find an in-network provider, go to the Collective Health website **join.collectivehealth.com/bootbarn**
2. Click on the "**Find in-Network Doctors**" link, or contact the Member Advocate team at **(855) 672-2692** or by signing into Collective Health to send a Message.

For a step-by-step guide with pictures please visit: **bootbarnbenefits.com**

MEDICAL

ANTHEM PPO CLASSIC

PLAN HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
ANNUAL CALENDAR YEAR DEDUCTIBLE [1] Individual / Individual in a Family / Family	$3,500 / $3,500 / $7,000	$6,000 / $6,000 / $12,000
MAXIMUM CALENDAR YEAR OUT-OF-POCKET [1] Individual / Individual in a Family / Family	$7,000 / $7,000 / $14,000	$10,000 / $10,000 / $20,000
PROFESSIONAL SERVICES		
Primary Care Physician (PCP)	$20 Copay	50% after Deductible
Telemedicine (LiveHealth Online)	Free	Not Covered
Specialist	$30 Copay	50% after Deductible
Preventive Care Exam	100% Covered (Deductible waived)	50% after Deductible
Diagnostic X-Ray and Lab	20% after Deductible	50% after Deductible
Complex Diagnostics (MRI/CT Scan)	20% after Deductible (Hospital Setting)	Not Covered
Complex Diagnostics (MRI/CT Scan)	10% after Deductible (Free Standing Facility)	Not Covered
Chiropractor	$30 Copay (30 visit max)	50% after Deductible (30 visit max)
Infertility Dx and Treatment	$2,000 Medical / $2,000 Prescription Drug Benefit	Not Covered
HOSPITAL SERVICES		
Inpatient	20% after Deductible	50% after Deductible
Outpatient Surgery	20% after Deductible (Hospital Setting)	50% after Deductible
Outpatient Surgery	10% after Deductible (Free Standing Facility)	50% after Deductible
Emergency Room	$300 Copay + 20% after Deductible (Copay waived if admitted)	
Urgent Care	$50 Copay Deductible Waived	50% after Deductible
PRESCRIPTION DRUGS		
Retail Prescription Drugs (30-Day Supply) Tier 1 Tier 2 Tier 3 Tier 4	 $20 Copay / $0 Costco $50 Copay $100 Copay 25% ($350 Max.)	 Not Covered Not Covered Not Covered Not Covered
MEDICAL RATES PER PAY PERIOD (52)		
Partner Only	$49.94	
Partner & Spouse	$157.52	
Partner & Child(ren)	$106.20	
Partner & Family	$181.16	

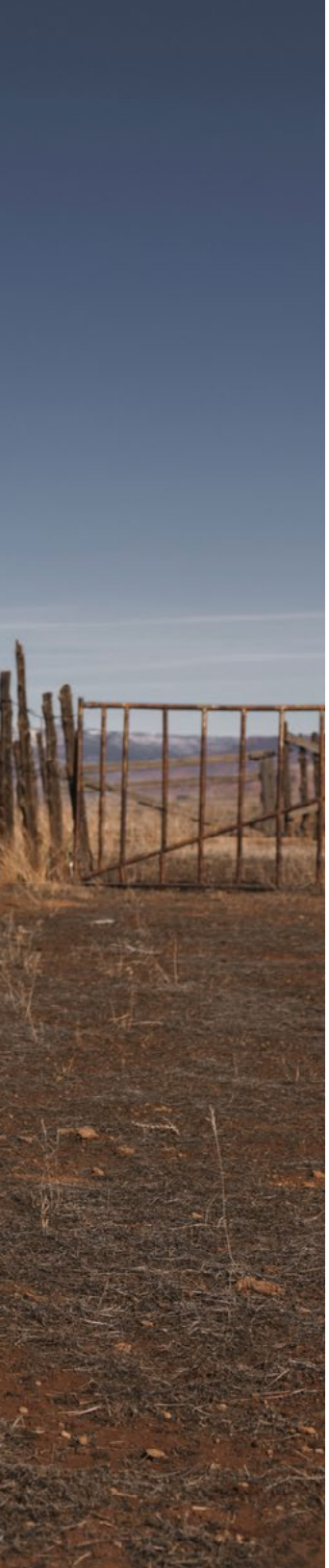
1) Resets effective January 1, 2025

MEDICAL

ANTHEM PPO PLATINUM SAVER

PLAN HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
ANNUAL CALENDAR YEAR DEDUCTIBLE [1] Individual / Individual in a Family / Family	$1,600 / $3,200 / $3,200	$3,000 / $6,000 / $6,000
MAXIMUM CALENDAR YEAR OUT-OF-POCKET [1] Individual / Individual in a Family / Family	$3,500 / $3,500 / $7,000	$7,000 / $7,000 / $14,000
PROFESSIONAL SERVICES		
Primary Care Physician (PCP)	20% after Deductible	50% after Deductible
Telemedicine (LiveHealth Online)	$10 copay (Deductible does not apply)	Not Covered
Specialist	20% after Deductible	50% after Deductible
Preventive Care Exam	100% Covered (Deductible waived)	50% after Deductible
Diagnostic X-Ray and Lab	20% after Deductible	50% after Deductible
Complex Diagnostics (MRI/CT Scan)	20% after Deductible (Hospital Setting)	Not Covered
Complex Diagnostics (MRI/CT Scan)	10% after Deductible (Free Standing Facility)	Not Covered
Chiropractor	20% after Deductible (30 visit max)	50% after Deductible (30 visit max)
Infertility Dx and Treatment	$2,000 Medical / $2,000 Prescription Drug Benefit	Not Covered
HOSPITAL SERVICES		
Inpatient	20% after Deductible	50% after Deductible
Outpatient Surgery	20% after Deductible (Hospital Setting)	50% after Deductible
Outpatient Surgery	10% after Deductible (Free Standing Facility)	50% after Deductible
Emergency Room	20% after Deductible	
Urgent Care	20% after Deductible	50% after Deductible
PRESCRIPTION DRUGS		
Retail Prescription Drugs (30-Day Supply) Tier 1 Tier 2 Tier 3 Tier 4	 $10 Copay / $0 Costco $25 Copay $40 Copay 20%	 Not Covered Not Covered Not Covered Not Covered
	Medical Deductible Applies	
MEDICAL RATES PER PAY PERIOD (52)		
Partner Only	$32.50	
Partner & Spouse	$126.16	
Partner & Child(ren)	$84.61	
Partner & Family	$157.99	

1) Resets effective January 1, 2025



MEDICAL

ANTHEM PPO SMART SAVER

PLAN HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
ANNUAL CALENDAR YEAR DEDUCTIBLE [1] Individual / Individual in a Family / Family	$3,200 / $3,200 / $6,400	$6,400 / $6,400 / $12,800
MAXIMUM CALENDAR YEAR OUT-OF-POCKET [1] Individual / Individual in a Family / Family	$8,000 / $8,000 / $16,000	$16,000 / $16,000 / $32,000
PROFESSIONAL SERVICES		
Primary Care Physician (PCP)	20% after Deductible	50% after Deductible
Telemedicine (LiveHealth Online)	$10 copay (Deductible does not apply)	Not Covered
Specialist	20% after Deductible	50% after Deductible
Preventive Care Exam	100% Covered (Deductible waived)	50% after Deductible
Diagnostic X-Ray and Lab	20% after Deductible	50% after Deductible
Complex Diagnostics (MRI/CT Scan)	20% after Deductible (Hospital Setting)	Not Covered
Complex Diagnostics (MRI/CT Scan)	10% after Deductible (Free Standing Facility)	Not Covered
Chiropractor	20% after Deductible (30 visit max)	50% after Deductible (30 visit max)
Infertility Dx and Treatment	$2,000 Medical / $2,000 Prescription Drug Benefit	Not Covered
HOSPITAL SERVICES		
Inpatient	20% after Deductible	50% after Deductible
Outpatient Surgery	20% after Deductible (Hospital Setting)	50% after Deductible
Outpatient Surgery	10% after Deductible (Free Standing Facility)	50% after Deductible
Emergency Room	20% after Deductible	
Urgent Care	20% after Deductible	50% after Deductible
PRESCRIPTION DRUGS		
Retail Prescription Drugs (30-Day Supply) Tier 1 Tier 2 Tier 3 Tier 4	 $10 Copay / $0 Costco $25 Copay $40 Copay 20%	 Not Covered Not Covered Not Covered Not Covered
	Medical Deductible Applies	
MEDICAL RATES PER PAY PERIOD (52)		
Partner Only	$28.62	
Partner & Spouse	$110.58	
Partner & Child(ren)	$74.16	
Partner & Family	$138.88	

1) Resets effective January 1, 2025

HEALTH SAVINGS ACCOUNT (HSA)

YOUR MEDICAL PPO PLANS

A Health Savings Account (HSA) is your own personal savings account created to use for your out-of-pocket healthcare expenses and is an investment into your future. By enrolling in the Anthem PPO Smart Saver Plan or the Anthem PPO Platinum Saver Plan, you will have access to a Health Savings Account (HSA).

WHAT ARE THE BENEFITS?

The savings account is yours – the funds in your HSA account stay with you, even if you change jobs. If you're no longer covered by an HSA qualified plan, your account stays active and you can use the remaining funds for IRS qualified expenses.

- Lower monthly premiums – allows you to put the difference in cost into your own savings account to keep.
- Triple Tax Advantaged – The money going into the HSA is tax-free, investment gains are tax-free and funds spent on qualified medical expenses are taken out tax-free. State Tax subject to state law.[1]
- It grows – If you maintain a balance of $2,000, your additional funds may be invested in mutual funds yielding tax-free earnings.
- Future planning – Until you turn 65, only withdrawals used for eligible expenses are tax-free. After you turn 65, or if you become disabled, your HSA account becomes similar to a regular IRA. Withdrawals you use for non-eligible expenses will be taxed at your regular income tax rate but won't incur additional penalties.[1]
- The funds can be assigned to a beneficiary or left to your estate.[1]

1) Please consult your tax advisor for applicable tax laws in your state.

WHAT TO KNOW ABOUT YOUR HEALTH SAVINGS ACCOUNT

- You own your HSA
- Your money rolls over year after year
- You choose how much to contribute (limits apply)
- Paired with a high-deductible health plan
- You receive a triple tax advantage

HEALTH SAVINGS ACCOUNT (HSA)

WHAT DOES IT COVER?

HSA funds can be used to cover a wide range of medically necessary expenses including, but not limited to:

- Co-Pays, Deductibles
- Dental expenses
- Orthodontia payments
- Prescriptions
- Vision expenses
- Over-the-Counter medications, vitamins or creams
- First aid expenses such as Band-Aids, aspirin, back brace
- Durable medical equipment
- Childbirth classes
- Counseling
- Massage therapy (with a letter of medical necessity – not for spas)

For a full list of Qualified Medical Expenses please visit: **hsastore.com**

HOW DO I QUALIFY TO OPEN AND CONTRIBUTE INTO AN HSA BANK ACCOUNT?

The IRS has guidelines regarding who can open or contribute into an HSA. Here are the guidelines:

In order to open & contribute to a Health Savings Account:

- You must first be enrolled in a qualified HSA medical plan such as the Anthem PPO Smart Saver or Anthem PPO Platinum Saver Plan
- You cannot be enrolled in a secondary medical health plan
- You cannot be claimed as a dependent on someone else's tax return (excluding spouse)

Once you have established a Health Savings Account the funds remain yours and you will continue to have access to the funds regardless of the aforementioned qualifications to enroll or contribute to the plan.

HEALTH SAVINGS ACCOUNT (HSA)

WAYS TO MAXIMIZE YOUR HSA

There are several ways to maximize your HSA. HealthEquity has provided tools and resources in the resource library link: **healthequity.com/learn**

- The most convenient way to pay for qualified expenses is to utilize the debit card
- You can also use your own cash or a personal credit card and reimburse yourself through your online HSA Bank account
- It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS
- View the status of your claims and check your HSA balance at **healthequity.com**
- HSA Calculator: **healthequity.com/calculator/hsa-contribution**

2024 AND 2025 HSA CONTRIBUTION LIMITS

The IRS regulates how much can be contributed to the HSA plan per year. Below are the limits for 2024 and 2025.

CALENDAR YEAR MAXIMUM CONTRIBUTION RATES	2024	2025
Partner Only	$4,150	$4,300
Partner & Dependent(s)	$8,300	$8,550
Additional “Catch-up” if 55 or older	$1,000	$1,000

PRESCRIPTION DRUG COVERAGE

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- Your medical plans cover generic formulary, brand-name formulary, non-formulary brand, and specialty drugs
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list
- Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring

For a current version of the prescription drug list(s), contact your Member Advocates at **(855) 672-2692**.

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

MAIL ORDER

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk -in pharmacy.

SHOP AROUND

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

EXPLORE OVER-THE-COUNTER OPTIONS

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

FLEXIBLE SPENDING ACCOUNT (FSA)

A flexible spending account is a special account that lets you use pre-tax dollars to cover eligible health care and dependent care, expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

HEALTH CARE FSA

- Can use funds for eligible health care expenses not covered by your medical, dental, vision insurance
- Maximum contribution for January 1 through December 31, 2025 is $3,200*
- Note – Plan year is changing to January 1 through December 31
- * This may change due to IRS announcement

DEPENDENT CARE FSA

- Can be used to pay for childcare expenses for children up to the age of 13 and/or care for a disabled family member in the household, who is unable to care for themselves
- Maximum contribution for January 1 through December 31, 2025 is $5,000

COMMUTER SPENDING ACCOUNT

- Can be used to cover qualified transit passes, vanpooling, payments for transportation in a commuter highway vehicle, and qualified parking costs.
- Parking maximum contribution for 2024 is $315 per month.
- Transit maximum contribution for 2024 is $315 per month.
- Cash reimbursement is not allowed. You must use the FSA Debit card for all parking and transit purchases.

WHAT ARE THE BENEFITS?

- Your taxable income is reduced and your spendable income increases
- Save money while keeping you and your family healthy

HOW DO I USE IT?

To utilize your FSA Health Care account:

- You can use the debit card you receive from Flex Facts at the time of purchase of an eligible expense and the amount will deduct from your FSA account directly
- You can also submit a proof of an eligible expense to Flex Facts via the website **flexfacts.wealthcareportal.com/page/home**

To utilize your FSA Dependent Care account:

- You will pay out of pocket for the eligible dependent care expense and then submit a proof to Flex Facts via the website **flexfacts.wealthcareportal.com/page/home**

A few rules you need to know:

- The 2023 - 2024 FSA plan year will end on 9/30/2024 with a 2.5 month grace period to submit your expenses for your health care FSA. There will not be a carryover amount into the 2025 FSA plan year.
- The 2025 FSA plan year will begin on January 1, 2025. A separate open enrollment for the FSA plan will be held in November 2024.
- You must enroll in the FSA program within 30 days of your hire date or during open enrollment. At that time, you will establish an annual contribution amount within the maximum limit
- Once enrolled, you will have online access at **flexfacts.wealthcareportal.com/page/home** to view your FSA balance, check on a reimbursement and more

Contact your Benefits Department Team with any questions regarding FSA enrollments.

DENTAL PLAN

YOUR DENTAL PPO PLAN

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental. We encourage you to review the coverage details and select the option that best suits your needs.

USING THE PLAN

The Dental PPO plans are designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

> **TIP: FIND A DENTIST**
> The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. To determine whether your dentist is in or out of your insurance network, use the Collective Health mobile app or call Delta Dental at **(800) 765-6003**.

DENTAL PLAN

	DELTA DENTAL HIGH PPO		DELTA DENTAL LOW PPO	
PLAN HIGHLIGHTS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL CALENDAR YEAR DEDUCTIBLE Individual / Family	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Calendar Year Maximum	$2,000 per member		$1,500 per member	
PREVENTIVE				
Office Visit	No Copay		No Copay	
Cleanings / X-ray	No Copay		No Copay	
BASIC				
Amalgam Fillings	90% Covered	90% Covered	90% Covered	90% Covered
MAJOR				
Crowns (porcelain fused to noble metal)	60% Covered	60% Covered	60% Covered	60% Covered
Dentures	60% Covered	60% Covered	60% Covered	60% Covered
ORTHODONTIA				
Adult	50% Covered $2,000 Life Max	50% Covered $2,000 Life Max	50% Covered $1,500 Life Max	50% Covered $1,500 Life Max
Child	50% Covered $2,000 Life Max	50% Covered $2,000 Life Max	50% Covered $1,500 Life Max	50% Covered $1,500 Life Max
DENTAL RATES PER PAY PERIOD (52)				
Partner Only	$6.22		$4.40	
Partner & Spouse	$16.74		$11.82	
Partner & Child(ren)	$15.38		$10.86	
Partner & Family	$25.40		$17.93	

VISION PLAN

YOUR VISION PLAN

Vision coverage is offered by EyeMed as a Preferred Provider Organization (PPO) plan.

USING THE PLAN

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You will be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

TIP: FOR GREAT VISION

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- Eat lots of leafy greens and dark berries
- Get regular eye exams

EYEMED VISION PPO

PLAN HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
EXAM - *Every 12 Months*	$20 Copay	Up to $30
LENSES - *Every 12 Months* Single Bifocal Trifocal	 No Copay No Copay No Copay	 Up to $25 Up to $40 Up to $63
FRAMES - *Every 12 Months*	Up to $160 allowance, 20% off balance over $160 40% off any additional pairs of glasses	Up to $80
CONTACTS - *Every 12 Months* Medically necessary (In lieu of lenses & frames)	Up to $160 allowance, 15% off balance over $160	Up to $128
EYE360 Services through a Plus Network provider	$0 Exam and $50 additional frame allowance, bringing it to $210	N/A
VISION RATES PER PAY PERIOD (52)		
Partner Only	$1.28	
Partner & Spouse	$2.17	
Partner & Child(ren)	$2.30	
Partner & Family	$3.45	

COMPANY PROVIDED BENEFITS

COMPANY PROVIDED BASIC LIFE AND AD&D

In the event of your death, Life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply. Boot Barn provides Basic Life and AD&D coverage through Reliance Standard. All full-time partners working 30 or more hours per week receive the benefit amount of $25,000. Please note, benefits will reduce when you reach age 70.

COMPANY PROVIDED SHORT TERM DISABILITY (STD) AND LONG TERM DISABILITY (LTD)

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

- Company sponsored Short Term Disability (STD) - Boot Barn offers a STD plan through Reliance Standard to provide 66.67% of your weekly income. The plan begins paying these benefits at the time of disability after you have been absent from work for 7 consecutive days. This plan may coordinate with states that offer disability income programs.
- Company sponsored Long Term Disability (LTD) - Boot Barn offers a LTD plan through Reliance Standard. If your disability extends beyond 90 days, LTD coverage can replace 60% of your earnings, up to maximum of $6,000 per month. Your benefits may continue to be paid as long as you meet the definition of disability.

Kindly contact your Benefits Team at **benefits@bootbarn.com** for eligibility and additional information.

REQUIRED! ARE YOUR BENEFICIARIES UP TO DATE?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated
- To select or change your beneficiary, log into ADP or contact your Benefits Team at **(949) 453-4498**

LIFE INSURANCE & DISABILITY

VOLUNTARY TERM LIFE AND AD&D INSURANCE

Voluntary Term Life and AD&D coverage is available to partners wishing to purchase additional life coverage.

Partner	Increments of $10,000 to a maximum of $250,000 or 5 times your basic annual earnings, whichever is less
Spouse	Increments of $5,000 to a maximum of $125,000, but not to exceed 50% of the partner's coverage amount
Child(ren)	Increments of $5,000 to a maximum of $25,000, but not to exceed 50% of the partner's coverage amount

PLEASE NOTE: Evidence of Insurability (EOI) may be required prior to approval. Partners must elect coverage first, before their spouse and child(ren) may elect coverage!

VOLUNTARY SHORT TERM DISABILITY (STD)

Disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings should you have a non-work related illness or injury. You can buy additional Short Term Disability (STD) coverage through Reliance Standard. This plan varies on partner-specific age and wage. Please see ADP for your specific rate.

STATE DISABILITY INSURANCE

- The state you reside in may provide a partial wage-replacement disability insurance plan
- For more information regarding statutory disability programs, contact your Benefits Team at **(949) 453-4498**

VOLUNTARY COVERAGE

CRITICAL ILLNESS COVERAGE

Critical Illness coverage offered on a voluntary basis through Reliance Standard pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

WHAT CAN CRITICAL ILLNESS COVERAGE PAY FOR?

- Medical expenses, such as copays, deductibles or co-insurance
- Lost income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to a specialist

WHAT ARE EXAMPLES OF COVERED ILLNESSES OR CONDITIONS?

- Heart attack
- Major organ failure
- Benign brain tumor
- Blindness
- End-stage renal (kidney) failure
- Coronary artery bypass surgery; pays 25% of lump-sum amount

HERE'S AN EXAMPLE OF HOW CRITICAL ILLNESS COVERAGE CAN HELP SUPPORT YOU

Denise is 45 years old and had a heart attack. She was out of work for a couple of months recovering and although she had disability insurance, it didn't cover all of her lost income and medical bills.

Thankfully, Denise had a $10,000 Critical Illness policy. She filed her claim and received her cash benefit so that she could pay her bills and medical expenses. With her Critical Illness policy, Denise had peace of mind and was able to focus on improving her health.

WANT TO LEARN MORE?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits, contact your Benefits Team at **(949) 453-4498**.

VOLUNTARY COVERAGE

HOSPITAL INDEMNITY COVERAGE

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital insurance offered on a voluntary basis through Reliance Standard pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

HOW CAN HOSPITAL INSURANCE HELP?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them.

Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Child care
- Lodging expenses for a companion
- Lost income

WEEKLY RATES	
Partner Only	$3.80
Partner & Spouse	$5.57
Partner & Child(ren)	$6.70
Partner & Family	$8.39

WANT TO LEARN MORE ABOUT HOSPITAL INDEMNITY OR ACCIDENT COVERAGE?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period.

To learn more or to obtain a full schedule of benefits, contact your Benefits Team at **(949) 453-4498**.

ACCIDENT COVERAGE

Accident insurance offered on a voluntary basis through Reliance Standard provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

HOW CAN ACCIDENT INSURANCE HELP?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

Examples of Covered Injuries:

- Broken bones
- Lacerations
- Burns
- Concussion
- Torn ligaments
- Eye injuries

COVERED EVENT/INJURY	BENEFIT AMOUNT
Ambulance (ground)	$100
Emergency room care	$101
Physician follow-up ($75 x 2)	$100
X-ray	$25
Concussion	$100
Broken tooth (repaired by crown)	$150

VOLUNTARY COVERAGE

LIFELOCK ID

In today's world of online shopping, using Wi-Fi and giving out Social Security numbers as a form of ID, our personal information can be exposed. If you do have an identity theft problem, LifeLock can help fix it. Contact your Benefits Team at **(949) 453-4498** for additional information.

When a threat is detected, LifeLock notifies members by:

- Phone
- Text
- Email

WEEKLY PLAN OPTIONS	LIFELOCK BENEFIT
Partner Only (18 and over)	$1.96
Partner & Family	$3.92

CANCER GUARDIAN

Through affordable payroll deductions, enrollment in Cancer Guardian can help you prevent and fight cancer more effectively. Cancer Guardian solves the problem of awareness, access, and affordability to services that can help improve prevention and survival. Please review eligibility and program pricing through your online enrollment portal, ADP. Contact your Benefits Team at **(949) 453-4498** for additional information.

The program includes these valuable benefits and features:

- Advanced DNA Testing
- Cancer Support Specialists
- Medical Records Platform

WEEKLY RATES	
Partner Only	$3.69
Partner & Spouse	$7.38
Partner & Child(ren)	$3.69
Partner & Family	$7.38

RETIREMENT OPTIONS

YOUR 401(K) PLAN OPTION

Administered by Fidelity Investment, the 401(k) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 401(k) account, subject to federal law and plan guidelines. Contact your Benefits Team at **benefits@bootbarn.com** to confirm eligibility and enrollment dates.

ENROLLMENT & ACCOUNT ACCESS

To enroll in the 401(k) plan, please visit **netbenefits.com** to enroll online or contact Fidelity by phone at **(800) 835-5097**. Fidelity Investment Specialists are available Monday through Friday, 8:30 am to 8:30 pm (ET). Check your 401(k) account balance, view your contributions, change your investments and more by visiting **netbenefits.com**.

EMPLOYER MATCH

Full-Time and Part-Time Partners are able to start contributing to their 401(k) after 30 days of employment. Eligible partners can enroll at any time! Boot Barn will match partners' contributions after they've been with the company for 1 year. The match is 100% for the first 3% and 50% for the next 2% contributed.

ADDITIONAL 401(K) INFORMATION

CONTRIBUTION LIMITS

For 2025, the IRS annual contribution limit is $23,000 for everyone under age 50. Partners aged 50 to 59 or 64 or older can contribute an additional $7,500. Partners aged 60 to 63 can contribute an additional $11,250, which is known as a "super-catch-up" contribution. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

CONTRIBUTION CHANGES

Contact your Benefits Team at **(949) 453-4498** for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to your Benefits Team.

EMPLOYER CONTRIBUTIONS

Contact your Benefits Team at **(949) 453-4498** for the current status of any employer contributions to the plan.

ROLLOVER CONTRIBUTIONS

If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact Fidelity Investments or your Benefits Team at **(949) 453-4498** for additional information.

BOOT STRAPS FUND

The Boot Straps Fund is a partner-operated, partner-supported charity where every dollar donated will go to a partner in need. It was created for our fellow colleagues, teammates, and coworkers to provide short-term financial assistance in the event of an unforeseen qualified personal hardship.

AM I ELIGIBLE?

To be eligible for assistance, you must meet all of the following requirements:

- You must be a Part-Time or Full-Time partner, in good standing, with a minimum of 6 months continuous employment. Seasonal partners are not eligible to apply to the Boot Straps Fund
- You must not have received financial assistance from the Boot Straps Fund within the past 12 months
- Your situation must meet the fund guidelines and definition of an emergency or personal financial hardship resulting from natural disaster, illness, accident, or any other family emergency that is unforeseen and beyond your control

PLEASE NOTE: Only Boot Barn partners can apply for assistance from the fund – not dependents. When reviewing your application, your number of eligible dependents will be considered. Eligible dependents include: spouse (unless legally separated), unmarried dependent children up to age 25 (child/ ren must be financially dependent on partner and be a full-time student), and legally recognized Domestic Partner.

HOW DO I APPLY?

1. Go to **bootbarnbenefits.com**
2. Click on the **Boot Straps Fund Tab** at the top of the screen
3. Click on the "**Apply**" link
4. Once your application is complete, click the "**Send**" button at the bottom of your screen

PLEASE NOTE: You may be asked to provide relevant supporting documentation as it pertains to the event. Questions regarding the process? Please contact **donate@bootbarn.com** or call the Benefits Team direct. Tel: **(949) 453-4498**.

HOW DO I DONATE?

1. Go to **bootbarnbenefits.com**
2. Click on the **Boot Straps Fund Tab** at the top of the screen
3. Click on the "**Donate**" link
4. You have the option of making a $5, $10, $15, $20, $25, $50 or $100 one-time donation
5. If you want to donate via payroll deductions, which is the preferred way, please click on "**Partner Payroll Deductions**" under the "**Donate**" tab
6. You will then be required to complete a Partner Donation Form
7. If you have any questions or need further information, please feel free to call our benefits hotline at **(949) 453-4498**, or send an email to **donate@bootbarn.com**

PET INSURANCE

HAVE A FURRY FRIEND?
For many of us, our pets are just as special and loved as our family members. That's why it's important we protect their health too!

ASPCA PET HEALTH INSURANCE
ASPCA Pet Health Insurance offers a traditional pet insurance and can help reimburse you for covered pet vet expenses.

GET ROUTINE WELLNESS COVERAGE
Help keep your pet safe and healthy with preventative care like X-rays and ultrasounds.

BE BETTER PREPARED FOR THE UNEXPECTED
A small monthly payment can help you prepare for accidents and injuries down the road.

HELP COVER UNPLANNED COSTS
When illness occurs, pet insurance can help to reimburse you for covered vet expenses.

Plus you'll receive the following benefits:
- Flexible product offerings with discounted group rates
- Quick online enrollment and hassle-free claims experience
- Multi-channel support options

To get a quote or enroll, visit **ASPCApetinsurance.com/BootBarn** or call **(877) 343-5314**.

NEED PET INSURANCE FOR YOUR HORSE?
ASPCA can help! Your horse is your companion. When it comes to their health, they deserve to get the care they need. ASPCA Pet Health Insurance plans can help with that as the first-ever insurance plans exclusively for the health of your horse – no mortality insurance required!

Companionship is priceless, and the amount you paid for your horse doesn't determine their eligibility for enrollment. With our customizable plan options, it's easy to find coverage that behooves your horse – and your life!

COLIC COVERAGE IN EVERY PLAN
Colic has many causes. We don't think you should have to choose which kinds of colic to cover your horse for. Both of the available equine plans have protection for colic caused by accidents or illnesses, so no matter which one you pick, your colic concerns are covered.

Horse insurance is currently available in CA, CO, CT, IL, KY, NJ, PA, OH, OK, TX, VA, WI, and WA.

To get a quote or enroll please visit: **ASPCApetinsurance.com/horse/?prioritycode=EB22BootBarn** or call **(877) 343-5314**.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Boot Barn understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you. This is a company-provided benefit.

PROGRAM COMPONENT	COVERAGE DETAILS
Who Can Utilize:	- All Boot Barn partners and their loved ones
Topics May Include:	- Childcare - Eldercare - Legal services - Identity theft - Marital, relationship or family problems - Bereavement or grief counseling - Substance abuse and recovery - Financial support - Educational materials
Number of Sessions:	- Unlimited telephonic clinical - Assessment and referral - Up to 3 sessions of professional Assessment for partners and family members - Unlimited child care and elder care referrals

HOW TO ACCESS

By Phone: **855-RSL-HELP (855) 775-4357**
Online: **rsli.acieap.com**
Email: **rsli@acieap.com**

DIRECTORY AND RESOURCES

BENEFIT	CONTACT	GROUP NUMBER	MEMBER SERVICES	WEBSITE / EMAIL ADDRESS
Enrollment & Eligibility	Benefits Department Team		(949) 453-4498	**bootbarnbenefits.com** **benefits@bootbarn.com**
Online Enrollment Vendor	ADP			**lyric.adp.com**
Medical Coverage	Collective Health	L06026	(855) 672-2692	**join.collectivehealth.com/bootbarn**
Dental	Delta Dental	21864	(800) 765-6003	**deltadentalins.com**
Vision	EyeMed	9820994	(866) 939-3633	**eyemed.com**
Basic Life/ AD&D and Voluntary Life	Reliance Standard	GL164597	(800) 351-7500	**reliancestandard.com**
Additional Resources	Rula	Boot Barn	(323) 205-7088	**rula.com/bootbarn**
Additional Resources	Hinge Health	Boot Barn	(855) 902-2777	**hingehealth.com**
Voluntary AD&D	Reliance Standard	VAR209745	(800) 351-7500	**reliancestandard.com**
Short Term Disability (STD)	Reliance Standard	STD168858	(800) 351-7500	**reliancestandard.com**
Long Term Disability (LTD)	Reliance Standard	LTD133150	(800) 351-7500	**reliancestandard.com**
Employee Assistance Plan (EAP)	Reliance Standard		(855) 775-4357	**rsli.acieap.com / rsli@acieap.com**
Accident Insurance	Reliance Standard	VAI854783	(800) 866-2301	**reliancestandard.com**
Critical Illness	Reliance Standard	VCI854622	(800) 866-2301	**reliancestandard.com**
Hospital Indemnity	Reliance Standard	VHI851313	(800) 866-2301	**reliancestandard.com**
Cancer Guardian	Genomic Life		(833) 248-2734	**genomiclife.com**
ID Theft Protection	LifeLock		(800) 866-2301	**lifelock.com**
Pet Insurance	ASPCA Pet Insurance		(877) 343-4314	**ASPCApetinsurance.com/BootBarn**
Flexible Spending Accounts	Flex Facts		(877) 943-2287	**flexfacts.wealthcareportal.com/page/home** **info@flexfacts.com**
Health Savings Account	HealthEquity		(866) 346-5800	**healthequity.com**
401(k)	Fidelity Investment		(800) 835-5097	**netbenefits.com**

NAME	CONTACT	PHONE NUMBER	EMAIL ADDRESS
Benefits Broker Marsh & McLennan Insurance Agency LLC 1 Polaris Way, Suite 300 Aliso Viejo, CA 92656	Marcy Vergara	(949) 540-6935	**Marcy.Vergara@MarshMMA.com**
	Kali Stover	(949) 353-4592	**Kali.Stover@MarshMMA.com**
	Kristen Forrand	(949) 544-8474	**Kristen.Forrand@MarshMMA.com**
	Patty Sanders	(949) 540-6957	**Patty.Sanders@MarshMMA.com**
	David Nava	(949) 544-8479	**David.Nava@MarshMMA.com**

IMPORTANT TO KNOW HSA RULES

- For 2024, the maximum contribution limit for partner and employer contributions in a partner's HSA Bank Account is $4,150 if you are enrolled in the PPO Smart Saver or Platinum Saver plan for partner-only coverage, and $8,300 for partners with dependent coverage
- For 2025, the maximum contribution limit for partner and employer contributions in a partner's HSA Bank Account is $4,300 if you are enrolled in the PPO Smart Saver or Platinum Saver plan for partner-only coverage, and $8,550 for partners with dependent coverage
- Remember to monitor your contributions to avoid going over the IRS limit, contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65
- You may not be able to contribute to your HSA bank account if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses
- You may not contribute to your HSA Bank Account if you are covered under any medical benefits plan which is not an HSA-qualified medical plan. However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your PPO Smart Saver deductible is met

Typically, the maximum amount a partner is eligible to contribute to an HSA per calendar year is based upon a pro-rated portion of the number of months a partner is eligible to contribute to an HSA. For example, a partner would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the partner first joins the HSA plan on September 1. However, under the full contribution rule, a partner is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year as long as he/she continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

GUIDELINES /EVIDENCE OF COVERAGE

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM BOOT BARN 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 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. Boot Barn has determined that the prescription drug coverage offered 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 PRESCRIPTION DRUG PLAN?

If you decide to join a Medicare drug plan while enrolled in Boot Barn coverage as an active employee, please note that your Boot Barn coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Boot Barn coverage as a former employee.

You may also choose to drop your Boot Barn coverage. If you do decide to join a Medicare drug plan and drop your current Boot Barn coverage, be aware that you and your dependents may not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Boot Barn 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 your Member Advocates at **(855) 672-2692**. 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 Boot Barn changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **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 **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:	October 1, 2024
Name of the Entity/Sender:	Boot Barn
Contact--Position/Office:	Jamey Booze, VP HR
Address:	15345 Barranca Pkwy, Irvine, CA 92618
Phone Number:	**(949) 453-4498**

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment in Boot Barn group health coverage 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA NOTICE OF PRIVACY PRACTICES

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.

Boot Barn sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Boot Barn, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:
1. your past, present or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present or future payment for the provision of health care to you.

NOTE: If you are covered by one or more fully-insured group health plans offered by Boot Barn, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

CONTACT INFORMATION
If you have any questions about this Notice or about our privacy practices, please contact the Boot Barn HIPAA Privacy Officer:

Boot Barn, Inc.
Attention: Jamey Booze Benefits Team
15345 Barranca Pkwy, Irvine, CA 92618
(949) 453-4400 ext. 615 (Office)
jbooze@bootbarn.com

Effective Date: This Notice as revised is effective October 1, 2024.

OUR RESPONSIBILITIES
We are required by law to:
- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment: We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment: We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations: We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates: We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law: We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety: We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors: For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation: If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority. Workers' Compensation: We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research: We may disclose your protected health information to researchers when:

1. the individual identifiers have been removed; or
2. when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

The following is a description of disclosures of your protected health information we are required to make.

Government Audits: We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You: When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach: We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

OTHER DISCLOSURES

Personal Representatives: We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- treating such person as your personal representative could endanger you; or
- in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members: With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations: Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Inspect and Copy: You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend: If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period Boot Barn has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see **Your Rights Under HIPAA**.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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 **hhs.gov/ocr/privacy/hipaa/complaints**.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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 **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 **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 **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 January 31, 2024.
Contact your State for more information on eligibility –

STATE	SERVICE	WEBSITE	PHONE
ALABAMA	Medicaid	http://www.myalhipp.com	1-855-692-5447
ALASKA	Medicaid	The AK Health Insurance Premium Payment Program: http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	1-866-251-4861 CustomerService@MyAKHIPP.com
ARKANSAS	Medicaid	http://myarhipp.com	1-855-MyARHIPP (855-692-7447)
CALIFORNIA	Medicaid	http://dhcs.ca.gov/hipp	916-445-8322 Fax: 916-440-5676 hipp@dhcs.ca.gov
COLORADO	Medicaid / CHIP+	Health First Colorado: https://www.healthfirstcolorado.com CHP+: https://hcpf.colorado.gov/child-health-plan-plus Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com	Health First Colorado: 1-800-221-3943 / State Relay 711 CHP+ Customer Service: 1-800-359-1991 / State Relay 711 HIBI Customer Service: 1-855-692-6442
FLORIDA	Medicaid	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
GEORGIA	Medicaid	HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	HIPP: 678-564-1162, Press 1 CHIPRA: 678-564-1162, Press 2
INDIANA	Medicaid	Healthy Indiana Plan for low-income adults19-64 Website: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid/	1-877-438-4479 1-800-457-4584
IOWA	Medicaid / CHIP	Medicaid: https://dhs.iowa.gov/ime/members Hawki: http://dhs.iowa.gov/Hawki	Medicaid: 1-800-338-8366 Hawki: 1-800-257-8563
KANSAS	Medicaid	http://www.kdheks.gov/hcf/default.htm	1-800-792-4884 HIPP: 1-800-766-9012
KENTUCKY	Medicaid	KI-HIPP: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KCHIP Website: https://kynect.ky.gov Medicaid Website: https://chfs.ky.gov	KI-HIPP: 1-855-459-6328 Email: kihipp.program@ky.gov KCHIP: 1-877-524-4718
LOUISIANA	Medicaid	www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid: 1-888-342-6207 or LaHIPP: 1-855-618-5488
MAINE	Medicaid	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en _US Private Health Insurance Premium Website: https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 TTY: Maine relay 711 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS	Medicaid / CHIP	https://www.mass.gov/masshealth/pa	1-800-862-4840 TTY: 617-886-8102
MINNESOTA	Medicaid	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
MISSOURI	Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
MONTANA	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084 HHSHIPPProgram@mt.gov
NEBRASKA	Medicaid	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA	Medicaid	http://dhcfp.nv.gov	1-800-992-0900
NEW HAMPSHIRE	Medicaid	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	603-271-5218 HIPP Program: 1-800-852-3345, ext 5218

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STATE	SERVICE	WEBSITE	PHONE
NEW JERSEY	Medicaid / CHIP	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710
NEW YORK	Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
NORTH CAROLINA	Medicaid	https://medicaid.ncdhhs.gov/	919-855-4100
NORTH DAKOTA	Medicaid	https://www.hhs.nd.gov/healthcare	1-844-854-4825
OKLAHOMA	Medicaid / CHIP	http://www.insureoklahoma.org	1-888-365-3742
OREGON	Medicaid / CHIP	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
PENNSYLVANIA	Medicaid / CHIP	Medicaid: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx CHIP: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
RHODE ISLAND	Medicaid / CHIP	http://www.eohhs.ri.gov	1-855-697-4347 or 401-462-0311
SOUTH CAROLINA	Medicaid	https://www.scdhhs.gov	1-888-549-0820
SOUTH DAKOTA	Medicaid	http://dss.sd.gov	1-888-828-0059
TEXAS	Medicaid	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
UTAH	Medicaid / CHIP	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
VERMONT	Medicaid	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
VIRGINIA	Medicaid / CHIP	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp	Medicaid: 1-800-432-5924 CHIP: 1-855-242-8282
WASHINGTON	Medicaid	https://www.hca.wa.gov/	1-800-562-3022
WEST VIRGINIA	Medicaid / CHIP	https://dhhr.wv.gov/bms http://mywvhipp.com	Medicaid: 304-558-1700 CHIP: 1-855-699-8447
WISCONSIN	Medicaid / CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
WYOMING	Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a 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. If you would like more information on WHCRA benefits, contact your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 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).

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS CONTINUATION COVERAGE RIGHTS UNDER COBRA

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; 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 Human Resources. You must provide this notice to any person covered under the plan who is a spouse, dependent child, or any other person eligible for COBRA continuation coverage under the plan.

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 **healthcare.gov**.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

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

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

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

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

For more information visit **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 **dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **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

Boot Barn Attention: Jamey Booze Benefits Team
(Office) (949) 453-4400 ext. 615
jbooze@bootbarn.com

HIPAA NOTICE OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

Boot Barn maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact your plan administrator.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance**, or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"**Out-of-network**" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"**Surprise billing**" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

1) **medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start**. These rules are different for people with End Stage Renal Disease (ESRD).

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services: If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center: When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at **(800) 985-3059** to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to **learn more about protections from surprise medical bills**.