CENTRAL
GARDEN & PET

2025 Benefits Guide

Welcome to Your Benefits

Central Garden & Pet (Central) is committed to providing comprehensive benefits that support your health, your income, and your family. Through our benefits program, you can choose and use the coverage that best fits your life.

BENEFITS CAN HELP WITH:

- Managing your health and ensuring you have access to great medical care when you need it
- Maximizing tax savings with a Health Savings Account (HSA) and Flexible Spending Accounts (FSAs)
- Protecting your income and reducing your financial exposure from a serious illness or injury

Please take a moment to explore this guide and get familiar with the benefits we offer.

This guide provides a summary of our benefits plans. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual Summary Plan Description (SPD), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

The benefits in this guide are effective from January 1, 2025 through December 31, 2025.

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QUESTIONS?

For more information,

Visit: centralbenefits.org

Email: hrben@central.com

Call: 925-948-4000, option 1, option 2

Enrollment

ELIGIBILITY & ENROLLMENT

WHO IS ELIGIBLE FOR BENEFITS?

Employees
Regular, full-time employees who work 30 hours per week or more are eligible to enroll in benefits on the first of the month following one calendar month of employment. Employees can also enroll eligible dependents in many of the same benefits.

Eligible dependents include:

- Legally married spouse or domestic partner
- Natural, adopted, step, and/or domestic partner's children up to age 26
- Unmarried children of any age who are disabled and depend on you for support
- Children named in a National Medical Support Notice

Dependent Eligibility Verification
If enrolling dependents (spouse, domestic partner, and/or children), you are required to provide Dependent Eligibility Verification (DEV).

WHEN CAN I ENROLL?

New Hires
New hires have 31 days from the hire date to enroll in benefits. Once you complete your elections online through Dayforce, your coverage becomes effective on the first of the month following one calendar month of employment.

Annual Benefits Open Enrollment
Once a year, you can select new benefits or change your current benefits. Benefits elected during Open Enrollment are effective January 1 through December 31 of the following year.

Qualifying Life Event
Once you make your elections, you won't be able to change them in the same year unless you have a Qualifying Life Event (QLE). A QLE is when you or your family experiences a life change that provides an extra opportunity to make changes to your benefits within 31 days of the event. These changes are effective on the first of the calendar month following or coinciding with the date of the event. QLEs include:

- Getting married or divorced
- Having a baby or adopting a child
- Enrolling in Medicare or Medicaid
- Receiving a court order to provide coverage for a child
- Gaining or losing other insurance coverage

Notify the Benefits Team by emailing **hrben@central.com** within 31 days if you have a QLE and need to make changes to your benefits outside of Open Enrollment.

HOW TO ENROLL

BEFORE YOU ENROLL

If you're eligible to enroll in or make changes to your benefits, you need to know the date of birth, Social Security number, and address for each dependent you plan to cover. Make sure you have reviewed this guide and know which medical plan and other benefits you want to choose.

To learn more about your benefits or for additional information, visit **centralbenefits.org**.

GETTING STARTED

Once you have the information you need to enroll and have chosen the benefits you want, you can enroll online through Dayforce.

Follow these steps to enroll:

1. Visit **dayforcehcm.com/mydayforce/login.aspx**
2. The company is "central"
3. Your username is the last six digits of the ID number on your Dayforce pay statement or the Employee Number from your Dayforce Earnings Statement
4. If you're logging in to Dayforce for the first time, your password is the last four digits of your Social Security number and the word "LoginCentral" (Example: ####LoginCentral)

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Health

MEDICAL PLAN OPTIONS

We offer three Anthem medical plan options and one Kaiser medical plan. All medical plans provide in-network preventive care at no cost to you. All of the Anthem plans give you access to the same network of high-quality medical providers. The difference is that each plan carries different premium and out-of-pocket costs.

ANTHEM HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

This plan offers the lowest premium (the amount deducted from your paycheck) and the highest deductible and out-of-pocket maximum. This plan is best if you are healthy, active, do not expect to use medical care frequently, and are looking for a way to save money for future medical expenses. If you choose this plan, it comes with a Health Savings Account (HSA) that allows you to make pre-tax contributions. You can use tax-free money from your HSA at any time to pay for eligible medical, prescription, dental, and/or vision expenses. Unused HSA money in your account is yours to use year after year. See the **HSA section** in this guide for more details.

ANTHEM CORE PLAN

This plan offers a balance between premium costs and out-of-pocket maximums. This plan is best if you are in good health but might need to seek more medical care throughout the year due to a medical condition and/or if you have a family.

ANTHEM BUY-UP PLAN

This plan has the highest premium but offers the lowest deductibles and out-of-pocket maximums. This is a good option if you expect substantial medical care in the coming year due to a chronic medical condition or are expecting a baby.

KAISER

The Kaiser plan is only available if you live in California or Georgia service areas. As a Health Maintenance Organization (HMO) plan, out-of-network coverage is not available.

Which plan should I choose?

All the medical plan options provide access to high-quality medical care. The difference is:

- How much you pay per paycheck (the **premium**) compared to how much you'll need to pay on your own before insurance begins to cover services (the **deductible**).
- The maximum amount of money you'll be responsible for paying in one plan year (**out-of-pocket maximum**).

The rising cost of health insurance is a concern for all of us. Consider choices you can make to minimize your cost of care (e.g., use network providers, request generic vs. brand-name drugs, get your annual physical, use the 24-hour NurseLine, contact several care providers and ask them what they charge, exercise, and maintain a proper diet).

Each person's health care needs are different. That's why we offer options so you can choose the coverage that best fits your needs.

MEDICAL PLAN COMPARISON

The table below features your coverage for certain services. Review the plan documents to view full coverage details and a list of included services. Remember, you'll save the most money by choosing in-network providers.

	ANTHEM HDHP***		ANTHEM CORE		ANTHEM BUY-UP		KAISER
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	CA & GA In-network only
Annual Deductible (Individual/Family)	$2,000/ $4,000	$4,000/ $8,000	$650/ $1,950	$850/ $2,550	$500/ $1,500	$650/ $2,100	N/A
Annual Out-of-Pocket Maximum (Individual/Family)	$6,000/ $12,000	$12,000/ $24,000	$5,000/ $10,000	$9,500/ $19,000	$4,000/ $8,000	$7,500/ $15,000	$1,500/ $3,000
Primary Provider Office Visit	Plan pays 80%*	Plan pays 60%*	Plan pays 80%*	Plan pays 60%*	$25 copay**	Plan pays 70%*	$25 per visit
Specialist Office Visit	Plan pays 80%*	Plan pays 60%*	Plan pays 80%*	Plan pays 60%*	$25 copay**	Plan pays 70%*	$25 per visit
Preventive Care	Plan pays 100%	Plan pays 60%*	Plan pays 100%	Plan pays 60%*	Plan pays 100%	Plan pays 70%*	Plan pays 100%
Diagnostic Lab and X-Ray	Plan pays 80%*	Plan pays 60%*	Plan pays 80%*	Plan pays 60%*	Plan pays 90%*	Plan pays 70%*	No charge
Imaging	Plan pays 80%*	Plan pays 60%*	Plan pays 80%*	Plan pays 80%*	Plan pays 90%*	Plan pays 70%*	No charge
Urgent Care	Plan pays 80%*	Plan pays 60%*	Plan pays 80%*	Plan pays 60%*	$25/visit	Plan pays 70%*	$25 copay
Emergency Room	$250/visit		$250/visit		$250/visit		$200 per visit
Hospitalization	Plan pays 80%*	Plan pays 60%*	$250/ admission	$500/ admission	$250/ admission	$300/ admission	$250/ admission
Outpatient Surgery	Plan pays 80%*	Plan pays 60%*	Plan pays 80%*	Plan pays 60%*	Plan pays 90%*	Plan pays 70%*	$25 copay

	ANTHEM HDHP	ANTHEM CORE	ANTHEM BUY-UP	KAISER HMO CA	KAISER HMO GA
Your Monthly Cost For Coverage					
Employee Only	$143.70	$194.71	$284.19	$182.94	$150.76
Employee + Spouse****	$501.82	$662.37	$845.64	$582.12	$479.70
Employee + Children	$361.36	$476.98	$612.47	$419.13	$345.38
Employee + Family	$621.96	$820.97	$1,064.52	$721.85	$594.85
Your Bi-Weekly Cost For Coverage					
Employee Only	$66.32	$89.87	$131.16	$84.43	$69.58
Employee + Spouse****	$231.61	$305.71	$390.30	$268.67	$221.40
Employee + Children	$166.78	$220.14	$282.68	$193.44	$159.41
Employee + Family	$287.06	$378.91	$491.32	$333.16	$274.55
Your Weekly Cost For Coverage					
Employee Only	$33.16	$44.93	$65.58	$42.22	$34.79
Employee + Spouse****	$115.80	$152.85	$195.15	$134.34	$110.70
Employee + Children	$83.39	$110.07	$141.34	$96.72	$79.70
Employee + Family	$143.53	$189.45	$245.66	$166.58	$137.27

*After deductible.

**The copay applies only to the office visit itself. An additional 10% coinsurance applies for any services performed in-office (i.e., X-ray, lab, surgery).

***The deductible under this plan is not embedded (i.e., if a member enrolls with one or more dependents, the family deductible must be met before benefits are paid).

****Premiums paid by Central for a domestic partner's benefits are taxable income to the employee, included in the employee's Form W-2. Any premiums paid by the employee on a domestic partner's benefits will be deducted on an after-tax basis.

PRESCRIPTION PLAN

All medical plan options include prescription drug coverage. Your prescription drug coverage and out-of-pocket costs are based on your medical plan selection. You can fill your prescription medications at the following:

Participating Retail (up to 30-day supply) or
Mail-Order (Anthem up to 90-day supply, Kaiser up to 100-day supply)

	ANTHEM HDHP*	ANTHEM CORE	ANTHEM BUY-UP	KAISER
Generic	$10 copay (retail) $25 copay (mail-order)			$10 copay (retail) $20 copay (mail-order)
Brand Name (Preferred)	You pay 30% of covered expense			$30 copay (retail) $60 copay (mail-order)
Brand Name (Non-Preferred)	You pay 50% of covered expense			$30 copay (retail)** $60 copay (mail-order)**
Specialty	You pay 30% of covered expense			You pay 20% of covered expense, not to exceed $150 for 30-day supply
Out-of-Pocket Maximum (Individual/Family)	Combined with medical OOP max	$2,000/$4,000 at participating pharmacies only		Combined with medical OOP max

*Medical deductible applies first
**Not covered in Georgia

SAVE ON YOUR PRESCRIPTIONS!

Use Generic: Save money on prescription medications by using generic options when possible. Generic drugs have the same active ingredients as their brand name counterparts but at a lower cost.

Mail-Order: If you're taking a medication for a chronic condition, you may also save money by using mail-order options, offering convenience and a larger supply.

KNOW WHERE TO GO FOR CARE

FIND A DOCTOR

Anthem Plans

To find an Anthem provider in your area, visit **anthem.com/ca**.

Under "Find Care," select "Basic search as a guest." The medical plans use the National PPO (BlueCard PPO) network in all states except those listed below, which use an alternate network:

- **Florida** – Network Blue
- **Georgia** – Blue Open Access POS
- **New Jersey** – Horizon Managed Care Network
- **Wisconsin** – Blue Preferred POS

You must use the appropriate network name, either National PPO (BlueCard PPO) or the network for your state if listed above, when searching for in-network providers.

Those who select an Anthem medical plan should fill their prescriptions through Anthem, a well-known, national prescription drug provider with high-quality customer service. You have access to four tiers of drugs:

- Generic
- Preferred brand-name drugs
- Non-preferred brand-name drugs
- Specialty drugs*

For a complete formulary list, visit **anthem.com/ca/pharmacyinformation**.

*To be covered under the plan, specialty medications must be filled through CarelonRx (formerly Ingenio Rx), Anthem's specialty pharmacy. If you are prescribed a specialty medication, you will be notified by CarelonRx via mail or phone, if necessary.

Kaiser Plan

To find a Kaiser provider in your area, visit **kp.org** and select "Doctors & Locations."

- Choose **CA** or **GA** to see listed facilities in your area

Kaiser coverage is provided at Kaiser facilities only. There is no health coverage outside of the Kaiser network.

Those who select a Kaiser medical plan fill their prescriptions through Kaiser pharmacies within most Kaiser medical offices and hospitals.

VIRTUAL CARE SERVICES

All medical plans have a virtual care option so you can see a doctor from your mobile device or computer for non-emergency health concerns. Virtual care is a good option for diagnosing and treating common medical problems such as colds, headache, minor rashes, allergies, digestive issues, and more.

URGENT CARE

Consider urgent care for symptoms, pain, or conditions that require quick medical attention but do not require hospital care, such as the flu, sprains, rashes, and minor injuries.

EMERGENCY ROOM

Go to the emergency room for serious or life-threatening conditions that require immediate treatment you can get only at a hospital, such as chest pain, trouble breathing, severe abdominal pain, loss of consciousness, and major injuries.

DENTAL

Regular dental exams are an important part of maintaining your oral health. We offer two Anthem dental plans; both plans allow you to see any dentist, but you will save money by selecting a dentist in the Anthem PPO network.

	CORE DENTAL PLAN	BUY-UP DENTAL PLAN
Calendar Year Deductible	$50 per individual Up to $150 per family	$25 per individual Up to $75 per family
Maximum Annual Benefits	$1,000 per person total	$1,500 per person total
Diagnostic and Preventive Services	Plan pays 100% with no deductible	
Basic Services Fillings, Root Canals, Periodontics, etc.	Plan pays 80% after deductible	
Major Services Bridges, Implants, Dentures	Plan pays 50% after deductible	Plan pays 70% after deductible
Orthodontic Services Braces	Not covered	Plan pays 50% up to the annual maximum of $750 with a lifetime maximum of $1,500
Your Monthly Cost For Coverage		
Employee Only	$7.13	$10.08
Employee + Spouse*	$16.94	$23.95
Employee + Children	$18.89	$26.72
Employee + Family	$26.74	$37.81
Your Bi-Weekly Cost For Coverage		
Employee Only	$3.29	$4.65
Employee + Spouse*	$7.82	$11.05
Employee + Children	$8.72	$12.33
Employee + Family	$12.34	$17.45
Your Weekly Cost For Coverage		
Employee Only	$1.65	$2.33
Employee + Spouse*	$3.91	$5.53
Employee + Children	$4.36	$6.17
Employee + Family	$6.17	$8.73

*Premiums paid by Central for a domestic partner's benefits are taxable income to the employee, included in the employee's Form W-2. Any premiums paid by the employee on a domestic partner's benefits will be deducted on an after-tax basis.

CHOOSING A DENTIST

Seeing an in-network dentist can help you save money. To make sure your dentist is in-network:

1. **Visit anthem.com/ca** and click "Find Care"
2. **Select** "Basic search as a guest" from the drop-down
3. **Select** "Dental Plan or Network" under type of plan or network
4. **Select** your state and "Anthem Dental" as your plan/network
5. **Pick** a special category (such as orthodontics or general dentistry)
6. **Fill** in the required information or contact a Customer Service Representative at **877-567-1804**, 7 days a week, from 7 a.m. – 7 p.m. PST

VISION

Annual eye exams check the health of your eyes and can detect other health issues even if you don't need glasses or contacts. There are two vision plan options through Vision Service Plan (VSP). Choose an in-network provider to save the most money. Visit **vsp.com** to view coverage and find an in-network doctor.

	CORE VISION PLAN	BUY-UP VISION PLAN
Frequency		
Examination	Once every calendar year	Once every calendar year
Lenses	Once every 2 calendar years	Once every calendar year
Frames*	Once every 2 calendar years	Once every calendar year
Contact Lenses (elective)	Once every 2 calendar years (instead of frames)	Once every calendar year (instead of frames)
Vision Care Services		
Examination	100% covered	
Lenses	Maximum benefits apply after $25 copay	
Frames*	Plan pays up to $200 (at Costco/Sam's Club/Walmart the plan pays up to $110) after $25 copay	
Contact Lenses (elective)	Plan pays up to $150; up to a $60 copay for the contact lens fitting and evaluation	
Medically Necessary Contact Lenses	Maximum benefits apply after $25 copay	
Hearing Aids	VSP provides free access to TruHearing MemberPlus Program for exams, fittings, up to 50% savings on hearing aids, and more. This is not insurance but provides discounts through contracted health plans. Includes covered dependents. Call **877-396-7194** and mention VSP.	
Your Monthly Cost For Coverage		
Employee Only	$4.64	$8.65
Employee + Spouse**	$11.60	$21.63
Employee + Children	$8.35	$15.58
Employee + Family	$14.39	$26.83
Your Bi-Weekly Cost For Coverage		
Employee Only	$2.14	$3.99
Employee + Spouse**	$5.35	$9.98
Employee + Children	$3.85	$7.19
Employee + Family	$6.64	$12.38
Your Weekly Cost For Coverage		
Employee Only	$1.07	$2.00
Employee + Spouse**	$2.68	$4.99
Employee + Children	$1.93	$3.60
Employee + Family	$3.32	$6.19

*If you purchase both frames and lenses together only one $25 copay applies. To find an in-network provider, search online at **vsp.com** or head to your local Costco/Sam's Club/Walmart.

**Premiums paid by Central for a domestic partner's benefits are taxable income to the employee, included in the employee's Form W-2. Any premiums paid by the employee on a domestic partner's benefits will be deducted on an after-tax basis.

Financial

401(K) RETIREMENT PLAN

Central's 401(k) helps you save money for retirement. The plan allows two types of contributions from your paycheck: traditional (pre-tax) and Roth (post-tax), available to eligible employees when hired. Employees of General Pet are eligible for a separate retirement plan.

PLAN FEATURES

Employer match – Central matches what you contribute to your account dollar for dollar up to the first 3%. The match is executed quarterly in a company stock fund. You're fully vested in matching contributions at five years of services (20% per year).

Rollover contributions – You may roll over contributions to the plan from eligible qualified plans or a rollover IRA.

Loans – You may request a loan from your account for any reason. The minimum amount is $500. The maximum loan amount is the lesser of 50% of your vested account balance or $50,000.

Withdrawals – Withdrawals from your account generally begin at normal retirement age, 65, although early retirement withdrawals can begin as early as 59 ½. You may also qualify for a hardship withdrawal after taking a loan.

QUESTIONS?

To manage your account or for additional information, visit **voya.com** or call **800-584-6001**.

IDENTITY THEFT PROTECTION

Everyday activities like online shopping, internet browsing, and banking can expose your personal information to potential thieves. Allstate Identity Protection includes credit monitoring, court records monitoring, fraudulent activity notifications, identity restoration services, and more. This benefit is paid by you through payroll deductions. For more information, call Allstate Identity Protection at **800-789-2720** or visit **myaip.com**.

ALLSTATE ID THEFT PROTECTION COST	MONTHLY	BI-WEEKLY	WEEKLY
Employee Only	$9.95	$4.59	$2.30
Family	$17.95	$8.28	$4.14

LEGAL SERVICES

Sometimes you need a trusted attorney on your side. Legal insurance provides access to a network of attorneys who can help with a variety of legal matters such as creating a will, buying a house, navigating a divorce, handling a speeding ticket, and more. For information call LegalEASE at **800-248-9000** or visit **legaleaseplan.com/central**.

LEGALEASE COST	MONTHLY	BI-WEEKLY	WEEKLY
Employee + Family	$15.97	$7.37	$3.69

HEALTH SAVINGS ACCOUNT (HSA) VS. FLEXIBLE SPENDING ACCOUNT (FSA)

HSAs and FSAs both offer tax advantages and a convenient way to pay for eligible healthcare costs. The chart below is a summary of the differences between the two.

	HEALTH SAVINGS ACCOUNT	HEALTH CARE FLEXIBLE SPENDING ACCOUNT
Am I Eligible?	You must be enrolled in the Anthem HDHP plan	Benefits-eligible employees not enrolled in the Anthem HDHP plan
Who Owns the Account?	You do! If you leave Central, the account and your balance go with you.	Central owns the account. If you leave, you have 90 days to submit any incurred claims eligible for reimbursement.
What Are the Tax Advantages?	Contributions are tax-free. Distributions made for qualified expenses are not subject to taxes.	
What Are the Annual Contribution Limits?	$4,300 for single coverage and $8,550 for family coverage (subject to change by IRS). Participants aged 55 and older can contribute an additional $1,000.	$3,200
Does Central Contribute to My Account?	Yes. Central makes quarterly contributions of $125 for individual coverage and $250 for family coverage.	No
Can My Funds Be Invested?	Yes. Funds are invested and gain interest tax-free.	No
What Can I Use the Funds For?	Out-of-pocket medical, dental, and vision expenses such as deductibles, copays, and coinsurance, other health-related items such as over-the-counter medications, and more.	
How Do I Pay for Expenses?	Pay with your account debit card or submit a claim for reimbursement online.	
Do Funds Expire?	No. Funds will accumulate for when you need them.	Yes. Funds must be used for qualified expenses within the plan year. If you elect to contribute the following plan year, you may roll over up to $640.

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in the Anthem HDHP plan, you are eligible to enroll in the Health Savings Account with HealthEquity. An HSA is a tax-advantaged savings account that you can use to pay for eligible healthcare expenses. HSA funds never expire, allowing you to save for future health needs, and if you leave Central, your HSA goes with you.

THE BENEFITS OF AN HSA

It's your account

Your HSA is a personal bank account that you own. It's up to you how much you contribute and when to use the money. HSA funds never expire, can be invested, and can even be used in retirement.

Get the triple tax advantage

Your HSA pre-tax contributions accrue interest, and qualified withdrawals are all tax-free, stretching your dollar while creating a reserve for future eligible out-of-pocket expenses.

Central contribution

When you choose the HDHP, Central makes quarterly contributions to your HSA account of $125 for individual medical coverage and $250 for family medical coverage. You must open your HSA with HealthEquity within the calendar year of the first contribution made by either you or Central to be eligible for the employer contribution.

A convenient way to pay

You will receive an HSA debit card, providing you extra convenience when paying for eligible expenses.

HSA FUNDING LIMITS

The IRS limits the total amount that can be contributed to an HSA annually. See the table for the current annual maximum.

COVERAGE TYPE	CURRENT ANNUAL TOTAL CONTRIBUTION IRS LIMIT	ANNUAL EMPLOYER CONTRIBUTION	YOUR MAXIMUM ANNUAL CONTRIBUTION
Employee Only*	$4,300	$500**	$3,800
Family	$8,550	$1,000**	$7,550

*Total IRS contribution limits for 2025 are cumulative of Central funding. Individuals aged 55 or older can make an additional $1,000 in "catch up" contributions.

**Employment and enrollment in the HDHP plan as of the first day of the calendar quarter is required to receive employer contribution.

GENERAL RULES AND RESTRICTIONS

- You must be enrolled in the Anthem HDHP medical plan.
- You cannot have both a Health Care FSA and HSA.
- Once you enroll in Medicare Part A and/or B, you are no longer eligible to contribute to an HSA.
- There may be a tax penalty on HSA contributions if made six months prior to Medicare enrollment.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts allow you to set aside pre-tax dollars from your paycheck to pay for eligible out-of-pocket healthcare or dependent care expenses.

HOW DOES AN FSA WORK?

You estimate how much you will spend on eligible expenses in the coming year and elect to have that amount deducted from your paycheck on a pre-tax basis. You don't pay taxes on your contributions or reimbursements. You will receive a debit card to pay for eligible expenses and can also submit online claims at **healthequity.com**.

CAUTION! When estimating your annual expenses, it is important to remember that FSA funds are "use it or lose it." You lose any money you do not spend and claim according to IRS rules and deadlines. Your annual contribution election cannot be changed during the year.

HOW MUCH MONEY CAN I CONTRIBUTE?

You can contribute **up to** the IRS annual maximum to your FSAs. In 2025, the limits are:

$3,200

Health Care/Limited Purpose FSA

$5,000

Dependent Care FSA

These limits are set by the IRS and are subject to change.

THE BENEFITS OF AN FSA

Lowers your taxable income
Enrolling in an FSA saves you money by lowering your overall taxable income which reduces your tax bill. For example, if you are in the 10% tax bracket and contribute $1,000, then you'll save the $100 that you otherwise would have paid in federal taxes.

A convenient way to pay
Contributing to an FSA creates a reserve of funds for your eligible healthcare and dependent care out-of-pocket expenses incurred within the plan year.

You choose your contribution amount
You elect the annual amount you want to contribute for the plan year, which will be deducted on a per paycheck basis.

TYPES OF FSAS

Health Care FSA
You can use the money in a Health Care FSA to pay for health-related expenses like copays, prescriptions, over-the-counter medicine, dental services, glasses, and more. Your entire annual contribution will be available for use at the start of the plan year.

Dependent Care FSA
The Dependent Care FSA allows you to set aside funds for eligible childcare or adult dependent care costs such as daycare, preschool, summer day camp, elder care, and in-home aides. Only the funds deducted from your paycheck will be available for use.

Limited Purpose FSA
The Limited Purpose FSA works like a traditional FSA, but you may only use the funds to pay for eligible vision and dental expenses. To be eligible for the Limited Purpose FSA, you must be enrolled in the Anthem HDHP and have an HSA.

IRS RULES TO KEEP IN MIND:

- Funds are considered "use it or lose it."
- The IRS limits contributions to $3,200 annually for the Health Care FSA and $5,000 for the Dependent Care FSA ($2,500 if married and filing separately).
- Dollars cannot be transferred between FSAs.
- Eligible expenses must be incurred by December 31 of the current policy year. Claims must be submitted by March 31 of the following policy year.
- You cannot change your FSA election in the middle of the plan year unless you experience a Qualifying Life Event. All changes must be consistent with your life event.
- Save your receipts! You may be required to submit a receipt as proof of expense eligibility.

For more information on your Flexible Spending Account visit **healthequity.com**.

Income Security

LIFE INSURANCE

Central provides Basic Life and Accidental Death & Dismemberment insurance (AD&D) through Reliance Standard at no cost to you, providing your loved ones financial security in the event of your death or serious injury.

CENTRAL PROVIDED INSURANCE

Basic Life and AD&D

Basic Life insurance pays a lump sum to a family member you choose (called a beneficiary) if you die. Accidental Death & Dismemberment (AD&D) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of Basic Life and AD&D is paid in full by Central and you are automatically enrolled (subject to imputed income tax liability).

Basic Life	1x annual salary up to $300,000
Basic AD&D	1x annual salary up to $300,000

Select a beneficiary

Your beneficiary is the person who will receive the cash benefit from your life insurance in the event of your death. When you enroll in benefits, make sure you choose a beneficiary.

SUPPLEMENTAL LIFE

You must purchase additional life insurance for yourself to be able to purchase spouse or child life insurance. If you enroll when you're first eligible, you may purchase coverage without submitting a proof of good health questionnaire, up to the guaranteed issue amount.

If you wait to enroll, you will be required to complete and submit a health questionnaire to be approved by Reliance Standard.

Employee	An amount you choose, not to exceed the lesser of 5× your annual salary or $1,000,000
Spouse	An amount you choose, not to exceed the lesser of 100% of your employee supplemental life amount or $100,000
Children	An amount you choose in increments of $5,000, not to exceed $20,000

Reliance Standard will allow you to increase your existing coverage up to the next $10,000 increment during benefits Open Enrollment ($5,000 increments for spouse and child coverage). Proof of good health is not required for this incremental increase in your coverage amount, up to the guaranteed issue amount (i.e., up to $200,000 for employee, $50,000 for spouse, $20,000 for children).

SUPPLEMENTAL AD&D INSURANCE

Accidental Death & Dismemberment (AD&D) insurance offers you financial protection in the form of a cash benefit should you experience a covered condition or injury. You can enroll in coverage at any time. You must be enrolled in employee Supplemental AD&D to elect this benefit for your spouse, domestic partner, and/or child(ren).

Employee	$25,000 increments up to $1,000,000 (not to exceed 10x your annual salary)
Spouse	If you do not have covered children, 60% of employee election; If you have covered children, 50% of employee election
Children	If you are not married, 15% of employee election; If you are married, 10% of employee election

DISABILITY INSURANCE

If you are unable to work due to an illness or injury, disability coverage will help replace part of your monthly income, so you and your family have financial security. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

SHORT-TERM DISABILITY

Central provides all eligible employees with Short-Term Disability (STD) benefits which will pay part of your income if you cannot work temporarily due to a covered injury, illness, or pregnancy.

Weekly Benefit Amount	60% of weekly earnings up to $1,750 per week
Benefits Begin	After 7 calendar days of disability
Maximum Payment Period	Recovery or 180 calendar days, whichever is earlier

VOLUNTARY LONG-TERM DISABILITY

You have the option to purchase and enroll in Long-Term Disability (LTD) benefits, which replaces part of your monthly income if your illness or injury causes you to be unable to work for more than 180 days. If you enroll when first eligible, you will not need to submit a proof of good health questionnaire.

Monthly Benefit Amount	60% of covered monthly earnings up to $15,000 per month
Benefits Begin	After 180 consecutive calendar days of disability
Maximum Payment Period	Recovery or Social Security normal retirement age, whichever is earlier

Note: An approved STD claim does not guarantee approval of an LTD claim. Eligible employees should expect an interruption in disability payments of at least 45 days when transitioning from an approved STD claim to an approved LTD claim.

Cost of Coverage

Rates for voluntary insurance products are based on age, salary, and selected level of coverage.

Additional Benefits

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP is available to every employee and their family members for free. Whenever you or your family members need support, you can call **888-881-5462** at any time, 24/7, 365 days a year and talk to a professional who can help or provide resources.

WHAT CAN THE EAP HELP ME WITH?

- Family issues
- Stress and anxiety
- Depression
- Marriage and relationships
- Grief and loss
- Substance use
- Anger management
- Work-related pressures
- Education guidance
- Childcare referrals
- Financial planning referrals
- Elder and adult care referrals

FREE COUNSELING SESSIONS

Your EAP provides up to five free counseling sessions for you and your family members per topic, per year.

VIRTUAL COUNSELING FROM ANYWHERE

You can connect with a licensed behavioral health professional for 25 or 50-minute video, phone, or web chat sessions through the mobile app, eConnect. Download eConnect from the **App Store** or **Google Play**.

GET SUPPORT

Call **888-881-5462** toll-free to connect with a licensed professional who can provide assistance. You can also register at **supportlinc.com** (code: central).

LEAVE OF ABSENCE

If you need to take extended time off work to care for yourself or a family member, you need to notify your manager first, and then contact Central's leave administrator (Matrix Absence Management) to file your claim. Matrix will work with you and your doctors to review your case, certify your claim, and manage your absence with Central. Contact the Central benefits team with questions about leave at **LOA@central.com**.

PAID PARENTAL LEAVE PROGRAM

Welcoming a new child into your home is a special time, filled with both excitement and adjustments. We provide paid parental leave to employees who become parents through birth or adoption.

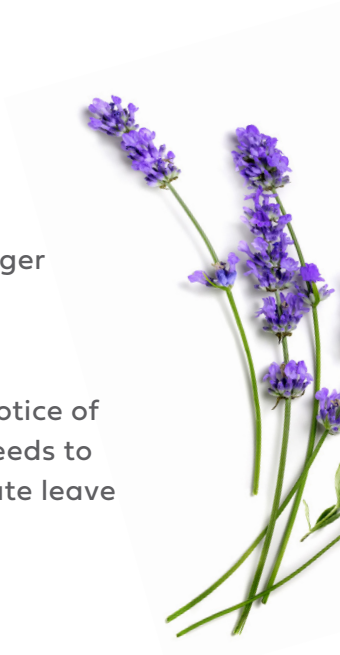
How does it work?

- Eligible pregnant employees will get a maximum of six weeks of paid medical leave to recover from the birth of a child/children (Childbirth-Related Medical Leave), which must begin no sooner than the due date and no later than the date of childbirth and be immediately followed by the two weeks of paid Bonding Leave.
- Eligible employees will receive a maximum of two weeks of paid leave to bond with their newborn or newly adopted child/children (Bonding Leave and, together with Childbirth-Related Medical Leave, Parental Leave). The two weeks of paid Bonding Leave must begin on the date of childbirth for the non-birthing parent.
- In the occurrence of a multiple birth or adoption (the birth of twins or adoption of siblings), the total amount of Childbirth-Related Medical Leave or Bonding Leave granted does not increase.
- Each week of paid Parental Leave is compensated at one hundred percent (100%) of the employee's regular, straight-time weekly pay, after deductions for any simultaneously applicable federal/state/local paid leave programs.
- Paid Parental Leave payments from Central will be executed on the same basis (for example weekly, bi-weekly, monthly) as the employee's regular scheduled pay dates.
- Paid Parental Leave must be taken in one continuous period. Any unused time will be forfeited upon returning to work.

Am I eligible?

To be eligible, employees must satisfy the following:

- Be a full-time, regular employee who works at least 30 or more hours per week (Temporary/seasonal employees, contractors, and interns are not eligible)
- Be actively employed with the company for a minimum of one calendar month
- Be the legal parent of the newborn child OR have adopted a child aged 17 or younger (The adoption of a family member or a spouse's child is excluded from this policy)



How do I request paid parental leave?

Employees must provide their supervisor and the Human Resource department with notice of the request for leave 30 days prior to the start date of the leave. The employee also needs to call Matrix Absence Management at **877-202-0055** or visit **matrixabsence.com** to initiate leave and provide requested documentation.

CRITICAL ILLNESS INSURANCE

The voluntary Critical Illness insurance plan through Reliance Standard offers valuable financial protection to you and your family*. The coverage will help pay the costs if you are diagnosed with a covered critical illness (pre-existing condition exclusions may apply). Once diagnosed with a covered critical illness, the plan pays a lump-sum benefit directly to you. You can then use the money to help pay the direct and indirect costs associated with a critical illness (for example, your rent or mortgage and other daily living expenses, as well as health-related expenses that aren't covered by major medical insurance).

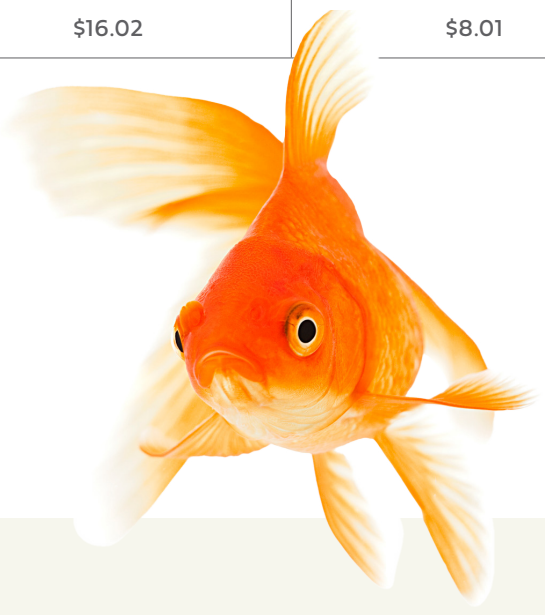
The benefit is paid in addition to any other insurance coverage you may have. You choose the benefit amount when you enroll, up to $40,000 (in $10,000 increments). Coverage is also available for your spouse ($10,000 increments up to 100% of employee coverage) and children (up to 25% of employee coverage, not to exceed $10,000). Coverage premiums are calculated based on age, tobacco use, amount of coverage elected, and other such factors provided at the time of enrollment. For more information about critical illness insurance, visit **centralbenefits.org/critical-illness**.

*Coverage is offered on a Guarantee Issue basis. No medical questions are asked and employees and their dependents will qualify regardless of medical history. The policy/certificate of coverage or its provisions, as well as covered illnesses, may vary or be unavailable in some states. In New York, a Specified Disease product is offered. The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.

ACCIDENT INSURANCE

Accident insurance from Reliance Standard provides financial peace of mind when the unexpected happens. The plan directly pays you a lump sum benefit based on expenses resulting from a covered accident. The plan covers a wide variety of injuries and accident-related expenses (e.g., hospitalization, fractures, burns, concussions, ligament surgery, physical therapy). The benefit amount is calculated based on the type of injury, its severity, and what medical services are required for treatment and recovery. For more information about accident insurance, visit **reliancematrix.com/individuals/product/employee-benefits/group-accident**.

RELIANCE STANDARD ACCIDENT INSURANCE	MONTHLY	BI-WEEKLY	WEEKLY
Employee Only	$11.74	$5.42	$2.71
Employee + Spouse	$19.59	$9.04	$4.52
Employee + Children	$26.69	$12.32	$6.16
Family	$34.71	$16.02	$8.01



ADOPTION REIMBURSEMENT

If you are seeking to grow your family through adoption, Central offers adoption reimbursement to help with the costs of adopting a child. All regular, full-time employees are eligible after 30 days of employment. Eligible adoption-related expenses (e.g., application fees, court/legal fees, placement/immigration fees) will be reimbursed up to a maximum of $2,000 per adopted child. Upon placement of the adopted child, submit receipts to Human Resources at **hrben@central.com**. Reimbursements will be made after the adoption is finalized and an adoption decree is provided.

EDUCATION ASSISTANCE PROGRAM

The Education Assistance Program is designed to encourage professional development through outside study. Financial assistance is available for educational-related expenses to all full-time, regular, salaried exempt and non-exempt employees. Our goal is to financially support your pursuit of the enhanced skills and knowledge necessary to succeed at Central in current and future roles.

This program applies to post-secondary education offered by accredited colleges, universities, and approved nationally recognized credentialing associations.

Courses can be reimbursed to the following annual maximums:

- Undergraduate level (associate or bachelor's), certifications, or individual courses: up to $7,500
- Graduate level (master's or doctorate): up to $15,000

Restrictions and successful course completion applies. Email Human Resources (**educationassistance@central.com**) for more information and instructions on how to apply. Green Garden employees are not eligible.

EMPLOYEE REFERRAL PROGRAM

The Employee Referral Program is designed to encourage employees to help us find the next talented member of our team! All full-time and part-time regular status employees are eligible to participate in the Employee Referral Program, except for Executive Leadership, Talent Acquisition, and Human Resources. Part-time, on-call, temporary, intern, seasonal, or contractor position referrals are not eligible under this program. Referral bonus amounts are determined per the position of the referred employee as outlined below:

- **$500 Award:** For regular, full-time hourly positions
- **$1,500 Award:** For regular, full-time salaried positions
- **$3,000 Award:** For senior management positions (Director-level positions and above)

Please be sure to direct the candidate to apply online at **central.com** and list you as the individual who referred them. Email the name of the referred candidate and the role they applied for to **employeereferral@central.com**. The referral award is included in the employee's regular paycheck following the referred employee's 90th day of employment with Central.

Green Garden and D&D employees are not eligible.

PET INSURANCE

Pets are family, too! When your pet gets sick or has an accident, vet bills add up fast. Pet insurance through Nationwide is a great way to take care of your pet's health and create a safety net for unexpected veterinary expenses. Services covered include treatments, surgeries, lab fees, X-rays, prescriptions, and more. Domestic pets and some exotic pets are eligible for coverage. Learn more about pet insurance from Nationwide at **benefits.petinsurance.com/central**.

Resources

If you need to get in touch with a plan provider, use the contact information provided below.

PLAN TYPE	PROVIDER	PHONE/EMAIL	WEBSITE
HEALTH			
Medical - Anthem	Anthem	877-800-3214	**anthem.com/ca**
Prescription Plan		877-800-3214	**anthem.com/ca**
ConditionCare: Health Improvement Program		800-621-2232	**anthem.com/ca**
24-Hour NurseLine		800-700-9184	**anthem.com/ca**
LiveHealth Online		N/A	**livehealthonline.com**
Medical - Kaiser CA	Kaiser	800-464-4000	**kp.org**
Medical - Kaiser GA		404-261-2590 Metro Atlanta: 888-865-5813	**kp.org**
Dental	Anthem	877-567-1804	**anthem.com/ca**
Vision	Vision Service Plan	800-877-7195	**vsp.com**
FINANCIAL			
401(k) Savings Plan	Voya	800-584-6001	**voya.com**
Legal Services	LegalEASE	800-248-9000	**legaleaseplan.com/central**
ID Theft Protection	Allstate ID Protection	800-789-2720	**myaip.com**
Health Savings Account (HSA)	HealthEquity	866-346-5800	**healthequity.com**
Flexible Spending Account (FSA)			
INCOME SECURITY			
Short-Term Disability & Leaves of Absence (LOA)	Matrix Absence Management	877-202-0055 (24/7 claims intake)	**matrixabsence.com**
Life/AD&D and Long-Term Disability	Reliance Standard	800-351-7500	**reliancestandard.com**
ADDITIONAL BENEFITS			
Employee Assistance Program (EAP)	CuraLinc Healthcare	888-881-5462	**supportlinc.com** (company code: central)
Accident & Critical Illness Insurance	Reliance Standard	800-351-7500	**reliancestandard.com**
Adoption Reimbursement Program	Central HR	**hrben@central.com**	**centralbenefits.org**
Education Assistance Program		**educationassistance@central.com**	
Employee Referral Program		**employeereferral@central.com**	
Pet Insurance	Nationwide	877-738-7874	**benefits.petinsurance.com/central**

Questions?

For more information, visit **centralbenefits.org**, email **hrben@central.com**, or call **925-948-4000** (option 1, option 2).

TERMS YOU SHOULD KNOW

Allowed amount
The maximum amount your plan will pay for a covered healthcare service.

Annual limit
A cap on the benefits your plan will pay in a year. Limits may be placed on services such as prescriptions or hospitalizations. After an annual limit is reached, you must pay all associated healthcare costs for the rest of the plan year.

Balance billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plan. You must name your beneficiary in advance.

Claim
A request for payment that you or your healthcare provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 80%, your coinsurance responsibility is 20% of the cost. If your plan has a deductible, you typically pay 100% until you meet your deductible amount.

Copay
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

Deductible
The amount of healthcare expenses you pay out-of-pocket before your health plan will pay.

Flexible Spending Account (FSA)
An arrangement through your employer that allows you to pay for eligible expenses with tax-free dollars. Eligible expenses are determined by the type of FSA you have.

In-network & out-of-network
In-network refers to the list of providers that have contracted rates with your chosen plan carrier, providing a lower overall cost. Out-of-network refers to providers outside your plan's network.

Out-of-pocket cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA, or HRA.

Out-of-pocket maximum
Protects you from big medical bills. Once costs (out of your own pocket) reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Preventive care services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, diseases, or other health problems. Many preventive care services are fully covered.

Primary care provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

Qualifying Life Event (QLE)
A change in your situation — like getting married, having a baby, or losing health coverage — that makes you eligible for a special open enrollment period allowing you to make changes to your benefits.

IMPORTANT NOTICES

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. Central Garden & Pet reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

REMINDER OF AVAILABILITY OF PRIVACY NOTICE

This is to remind plan participants and beneficiaries of the Central Garden & Pet Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and disclosed protected health information (PHI). You can obtain a copy of the Central Garden & Pet Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

Central Garden & Pet, Human Resources
1340 Treat Blvd., Suite 600
Walnut Creek, CA 94597

If you have any questions, please contact the Central Garden & Pet Human Resources Office at **(925) 948-4000** or **hrben@central.com**.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

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

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact the Central Garden & Pet Human Resources Administrator for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Your Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Central Garden & Pet 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. Central Garden & Pet has determined that the prescription drug coverage offered by the Core & Buy Up Medical Plans through Anthem is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Central Garden & Pet coverage WILL NOT be affected. If you do decide to join a Medicare drug plan and drop your current coverage you will not be allowed to re- enroll until the next open enrollment unless you have had a qualifying change in status.

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 Central Garden & Pet 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage: Contact the person listed below for further information. NOTE: You'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 Central Garden & Pet changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare Prescription Drug coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage visit **www.medicare.gov**.

Call your State Health Insurance Assistance Program for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.

Call **(800) MEDICARE** (**(800) 633-4227**)
TTY users should call **(877) 486-2048**.

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

Name of Entity/Sender: Central Garden & Pet Contact: Human Resources Admin.
Central Garden & Pet
Address: 1340 Treat Blvd., Suite 600, Walnut Creek, CA 94597
Phone Number: (925) 948-4000

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).

YOUR ERISA RIGHTS

As a participant in the Central Garden & Pet benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits
You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage
You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage;
  - You request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules. Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court.
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This should occur if the court finds your claim frivolous.

Assistance with Your Questions
If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining

documents from the plan administrator, you should contact the nearest office listed on EBSA's website:
www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor 200 Constitution Avenue, NW Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at **(866) 275-7922**. You may also visit the EBSA's web site on the Internet at: **www.dol.gov/ebsa**.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
You are receiving this notice because you have recently become covered under a group health plan (the Plan).

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happen:

- 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 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. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the 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:
Central Garden & Pet Human Resources or COBRA Administrator.

How is COBRA 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. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice will lose his or her right to elect COBRA.

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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

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

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

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension. You must provide the notice by Central Garden & Pet Human Resources or COBRA Administrator.

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

Other Coverage Options
Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
For further information regarding the plan and COBRA continuation, please contact:
Health Equity
(866) 346-5800
www.healthequity.com

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the next page, 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 **(877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **(866) 444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website:
https://www.myalhipp.com/
Phone: **1-855-692-5447**

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website:
https://www.myakhipp.com
Phone: **1-866-251-4861**
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility:
https://www.dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: **https://www.myarhipp.com/**
Phone: **1-855-MyARHIPP (855-692-7447)**

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: **http://dhcs.ca.gov/hipp**
Phone: **1-916-445-8322**
Fax: **1-916-440-5676**
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www. healthfirstcolorado.com
Health First Colorado Member Contact Center: **1-800-221-3943**/State Relay 711
CHP+:
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: **1-800-359-1991**/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: **1-855-692-6442**

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: **1-877-357-3268**

GEORGIA – Medicaid
GA HIPP Website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: **1-678-564-1162**, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance- program-reauthorization-act-2009-chipra
Phone: **1-678-564-1162**, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: **http://www.in.gov/fssa/hip/**
Phone: **1-877-438-4479**
All other Medicaid
Website: **https://www.in.gov/medicaid/**
Phone **1-800-457-4584**

IOWA –Medicaid and CHIP (Hawki)
Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: **1-800-338-8366**
Hawki Website: **http://dhs.iowa.gov/Hawki**
Hawki Phone: **1-800-257-8563**
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: **1-888-346-9562**

KANSAS – Medicaid
Website: **https://www.kancare.ks.gov/**
Phone: **1-800-792-4884**
HIPP Phone: **1-800-967-4660**

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: **1-855-459-6328**
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**
Phone: **1-877-524-4718**
Kentucky Medicaid Website: **https://chfs.ky.gov/agencies/dms**

LOUISIANA – Medicaid
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: **1-888-342-6207** (Medicaid hotline) or **1-855-618-5488** (LaHIPP)

MAINE – Medicaid
Enrollment Website: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: **1-800-442-6003**
TTY: Maine relay 711
Private Health Insurance Premium Website: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: **1-800-977-6740**
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: **https://www.mass.gov/masshealth/pa**
Phone: **1-800-862-4840**
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid
Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs- and-services/medical-assistance.jsp**
Phone: **1-800-657-3739**

MISSOURI – Medicaid
Website: **https://www.dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: **573-751-2005**

MONTANA – Medicaid
Website: **http://dphhs.mt.gov/**
MontanaHealthcarePrograms/HIPP Phone: **1-800-694-3084**
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid
Website:
https://www.ACCESSNebraska.ne.gov
Phone: **855-632-7633**
Lincoln: **402-473-7000**
Omaha: **402-595-1178**

NEVADA – Medicaid
Medicaid Website: **https://www.dhcfp.nv.gov**
Medicaid Phone: **1-800-992-0900**

NEW HAMPSHIRE – Medicaid
Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: **1-603-271-5218**
Toll free number for the HIPP program: **1-800-852-3345, ext 5218**

NEW JERSEY – Medicaid and CHIP
Medicaid Website: **https://www.state.nj.us/humanservices/dmahs/clients/medicaid/**
Medicaid Phone: **609-631-2392**
CHIP Website: **https://www.njfamilycare.org/index.html**
CHIP Phone: **1-800-701-0710**

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: **1-800-541-2831**

NORTH CAROLINA – Medicaid
Website: **https://medicaid.ncdhhs.gov/**
Phone: **919-855-4100**

NORTH DAKOTA – Medicaid
Website: **https://www.hhs.nd.gov/healthcare**
Phone: **1-844-854-4825**

OKLAHOMA – Medicaid and CHIP
Website: **https://www.insureoklahoma.org**
Phone: **1-888-365-3742**

OREGON – Medicaid
Website:
https://www.healthcare.oregon.gov/Pages/index.aspx
https://www.oregonhealthcare.gov/index-es.html
Phone: **1-800-699-9075**

PENNSYLVANIA – Medicaid
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**
CHIP Website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx**
CHIP Phone: **1-800-986-KIDS (5437)**

RHODE ISLAND – Medicaid and CHIP
Website: **https://www.eohhs.ri.gov/**
Phone: **855-697-4347**, or **401-462-0311** (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: **https://www.scdhhs.gov**
Phone: **1-888-549-0820**

SOUTH DAKOTA - Medicaid
Website: **https://www.dss.sd.gov**
Phone: **1-888-828-0059**

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: **1-800-440-0493**

UTAH – Medicaid and CHIP
Medicaid Website:
https://www.medicaid.utah.gov/
CHIP Website:
https://www.health.utah.gov/chip
Phone: **1-877-543-7669**

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: **1-800-250-8427**

VIRGINIA – Medicaid and CHIP
Website:
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp- programs
Medicaid Phone: **1-800-432-5924**
CHIP Phone: **1-800-432-5924**

WASHINGTON – Medicaid
Website: **https://www.hca.wa.gov/**
Phone: **1-800-562-3022**

WEST VIRGINIA – Medicaid
Website:
https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: **1-304-558-1700**
CHIP Toll-free phone: **1-855-MyWVHIPP** (**1-855-699-8447**)

WISCONSIN – Medicaid and CHIP
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: **1-800-362-3002**

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: **1-800-251-1269**

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor **Employee Benefits Security Administration**	**U.S. Department of Health and Human Services** **Centers for Medicare & Medicaid Services**
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	**1-877-267-2323**, Menu Option 4, **Ext. 61565**

CENTRAL
GARDEN & PET

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