IMPORTANT NOTICE FROM CRACKER BARREL OLD COUNTRY STORE (CBOCS) ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Your Prescription Drug Coverage in 2027 and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage and the prescription drug coverage for your dependents in 2027 under The Health and Welfare Plan for Store Hourly Employees of Cracker Barrel Old Country Store, Inc. (the "Plan") and about your options under Medicare's prescription drug coverage**. If you have Medicare-eligible dependents that you are enrolling in coverage under the Plan, you are responsible for sharing this notice with them as well.** This information can help you or your eligible dependents decide whether to join a Medicare drug plan. If you are considering joining a Medicare drug plan, you should compare the Plan coverage option in which you plan to enroll, 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 three important things you need to know about your coverage in 2027 and Medicare's prescription drug coverage as described below. Read this notice carefully — it explains your options, which differ based on whether you enroll in the Core Health option, the Traditional Health Care option or the In-Network option.

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. If you enroll in the Core Health Plan, Cracker Barrel has determined that the prescription drug coverage offered for this option is, on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Core Health Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

> **IMPORTANT NOTE**: You can enroll in the Core Health Plan. However, because that coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

3. If you enroll in the In-Network Plan or the Traditional Health Care Plan option, Cracker Barrel has determined that the prescription drug coverage offered for this option is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage. Because coverage under the In-Network Plan or the Traditional Health Care Plan option is Creditable Coverage, if you enroll in the In-Network Plan or the Traditional Health Care Plan option, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in Medicare prescription drug coverage.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you decide to drop your coverage under any of the options offered by Cracker Barrel, since it is employer-sponsored coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. However, if you were enrolled in the Core Health Plan option, you also may pay a higher premium (a penalty) because you did not have creditable coverage.

What happens to your current coverage if you decide to join a Medicare drug plan?

You should compare your current Cracker Barrel coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your current Cracker Barrel coverage pays for other health expenses, in addition to prescriptions. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits.

Note: If you decide to join a Medicare drug plan and drop your current Cracker Barrel coverage, be aware that you and your dependents will not be able to change your election with respect to Cracker Barrel coverage until the next annual enrollment period, unless you experience a change in status, as defined by the Internal Revenue Service, during the year.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

If you are enrolled in the Core Health Plan option, which is not creditable prescription drug coverage, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

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

If you are enrolled in the In-Network Plan or Traditional Health Care Plan option, which is creditable prescription drug coverage, and you drop or lose your current coverage 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 as described above.

For more information about this notice or your prescription drug coverage

Contact the Cracker Barrel Benefits Department at myhr.crackerbarrel.com. You may receive this notice at other times in the future, such as before the next period you can enroll in a Medicare prescription drug plan, and if your Cracker Barrel coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare

The "Medicare & You" handbook contains more detailed information about Medicare plans that offer prescription drug coverage. If you're eligible for Medicare coverage, you'll receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about extra help is available from the Social Security Administration online at **www.socialsecurity.gov** or by calling **1-800-772-1213** (TTY 1-800-325-0778).

Remember: If you are enrolled in the In-Network or Traditional Health Care option, keep this notice. If you or one of your eligible dependents decides to enroll in 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 or your eligible dependents have maintained creditable coverage and, therefore, whether or not a higher premium (a penalty) is required. Please also ensure that you share this notice with your eligible dependents.

Patient Protection & Affordable Care Act (i.e., "ACA" or Health Care Reform)

The Plan changes described in the Enrollment Guide and/or previously made in accordance with the ACA may not be permanent. They may be reversed or modified by future agency action, judicial decision, or legislation. If changes are necessary, the Plan(s) will be changed as soon as practicable or as required by law.

Marketplace Coverage Options and Your Health Coverage

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2026 for coverage starting as early as January 1, 2027.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if Cracker Barrel does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you may be eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from Cracker Barrel that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, through the Marketplace and may wish to enroll in the Cracker Barrel Plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing if Cracker Barrel does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If the cost of the Cracker Barrel Plan that would cover you (and not any other members of your family) is more than 9.96% of your household income for the 2026 calendar year (10.22% in 2027), or if the Cracker Barrel Plan's share of the total allowed benefit costs covered by the Plan is 60% or less of such costs, you may be eligible for a tax credit and advance payment of the credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by Cracker Barrel, then you may lose the employer contribution (if any) to the Cracker Barrel-offered coverage. Also, the Cracker Barrel contribution – as well as your employee contribution to the Cracker Barrel coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on

an after-tax basis. In addition, note that if the health coverage offered through Cracker Barrel does not meet the affordability or minimum value standards, but you accept the coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

How Can You Get More Information?
For more information about your coverage offered by Cracker Barrel, please check your Summary Plan Description or contact Cracker Barrel Benefits Department at myhr.crackerbarrel.com.

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

If you would like assistance with navigating healthcare.gov and your Marketplace options, you can also reach out to HealthSherpa at 855-772-2663 or online at www.healthsherpa.com/shopping.

Massachusetts Residents – Notice of MA Minimum Creditable Coverage (MCC) Health Plan Status

Massachusetts Health Care Reform Law requires most residents over 18 who can afford health insurance to have coverage that meets the MA Minimum Creditable Coverage (MCC) requirements or pay a penalty through their tax returns. The Massachusetts MCC standards are higher than the MCC requirements defined in the Federal Affordable Care Act.

- The following Cracker Barrel health plans meet the Federal Affordable Care Act MCC requirements, but do NOT meet the MA MCC requirements: The In-Network Plan and The Core Health Plan
- The following Cracker Barrel health plan meets the Federal Affordable Care Act MCC requirements, and it also meets the MA MCC requirements: The Traditional Health Care Plan

If you are not offered a health plan that meets the MA MCC requirements, you may be eligible for subsidized coverage through the health insurance marketplace for Massachusetts residents, referred to as Massachusetts Health Connector, by logging on to https://www.mahealthconnector.org or by calling 1-877-623-6765 Monday - Friday: 8:00AM - 6:00PM EST.

MEDICAL PLAN POST-MASTECTOMY BENEFITS –WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The U.S. Congress passed the Women's Health and Cancer Rights Act of 1998 providing coverage for reconstructive surgery and related services following a mastectomy. This act affects group and individual health plans that provide medical/surgical coverage for mastectomy.

- Coverage will be provided for reconstructive surgery of the breast on which a mastectomy has been performed.
- Coverage will be provided for surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage will be provided for prosthesis and physical complication through all stages of a mastectomy, including swelling associated with the removal of lymph nodes.
- Coverage will be in a manner that is determined in consultation with the attending physician and patient.

These services are subject to the applicable calendar year deductible, co-insurance, and/or co-payment amounts as outlined in your Benefits Enrollment Guide. All other terms and conditions of your health benefit plans will apply to this coverage. If you have any questions, or concerns about how this legislation affects you and your health benefit plan, please call the BlueCross BlueShield of Tennessee Customer Services Department at 1-844-383-2275.

Newborns' and Mothers' Health Protection Act

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

Cracker Barrel Old Country Store, Inc. HIPAA Notice of Privacy Practices for Protected Health Information

Revised effective January 1, 2026

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.

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") requires health plans to notify plan participants about their policies and practices to protect the confidentiality of participant health information. This document is intended to satisfy the HIPAA notice requirement for all individually identifiable health information created, received, or maintained by the Health Plans (as defined below) sponsored by Cracker Barrel Old Country Store, Inc. (the "**Company**").

This HIPAA Notice of Privacy Practices for Protected Health Information ("**Notice**") describes how protected health information may be used or disclosed by The Health and Welfare Plan for Store Hourly Employees of Cracker Barrel Old Country Store, Inc.* and The Health and Welfare Plan for Home Office and Field Management Employees of Cracker Barrel Old Country Store, Inc.* (collectively referred to herein as the "**Health Plans**") to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out the Health Plans' legal obligation concerning your protected health information, and describes your rights to access and control your protected health information.

Protected health information ("**PHI**") is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition in the past, present or future.

The Health Plans are required by law to protect and maintain the privacy of your PHI as set forth in this Notice and to provide to you and other individuals this Notice of their legal duties and privacy practices regarding PHI. The Health Plans are required to abide by the terms of the Notice currently in effect. The Health Plans are also required to notify affected individuals in the event of a breach involving unsecured protected health information.

The Health Plans reserve the right to change the terms of this Notice at any time. The Health Plans reserve the right to make the revised or changed Notice effective for PHI that the Health Plans already have about you, as well as any information the Health Plans receive in the future. If the Health Plans make a material change to the Notice, they will post

the revised Notice on the website and will provide a copy to you. A copy of the current Notice is available on the Internet at employees.crackerbarrel.com, click on the "My Benefits" link.

**This Notice of Privacy Practices applies only to the health care components (e.g., the medical coverage (including prescription drug and vision care) and the Health Care Reimbursement Account) offered by the Health Plans. Where a coverage is fully insured, the insurance carrier will provide its own HIPAA Notice of Privacy Practices.*

HOW THE HEALTH PLANS USE AND DISCLOSE YOUR PHI

The Health Plans may use and disclose your PHI as described below. The Health Plans are required to comply with any state or federal laws that impose stricter standards than the uses and disclosures described in this Notice. Your PHI may be stored and disclosed electronically.

For Purposes of Treatment: The Health Plans may use or disclose your PHI for treatment purposes. "Treatment" is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Health Plans may disclose your PHI to a health care provider when needed by the provider to treat you.

To Make or Obtain Payment: The Health Plans may use or disclose your PHI to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Health Plans may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits. Further, the Health Plans may disclose your PHI when a provider requests information regarding your eligibility for coverage, or the Health Plans may use your PHI to determine if a treatment that you received was medically necessary.

To Conduct Health Care Operations: The Health Plans may use or disclose PHI for their own operations to facilitate the administration of the Health Plans and as necessary to provide coverage and services to all of the Health Plans' participants. "Health care operations" includes quality assessment and improvement activities, activities designed to improve health or reduce health care costs; case management and care coordination; contacting participants with information about treatment alternatives and other related functions, and business management and general administrative activities of the Health Plans, including customer service and resolution of internal grievances. For example, the Health Plans may use PHI to conduct case management, quality improvement and utilization review, or to engage in customer service and grievance resolution activities. *However, the Health Plans are prohibited from using or disclosing genetic information for underwriting purposes, such as determinations of eligibility or benefits, or for setting premium or contribution rates.*

For Disclosure to the Company: In accordance with HIPAA requirements, the Health Plans may disclose your PHI to the Company as the plan sponsor of the Health Plans ("**Plan Sponsor**") for plan administration functions performed by Plan Sponsor on behalf of the Health Plans. Unless authorized by you in writing, your PHI may not be used by the Company for any employment-related actions or decisions or in connection with any other employee benefit plan sponsored by the Company. In addition, the Health Plans may provide summary health information to the Plan Sponsor so that it may solicit premium bids from health insurers or modify, amend or terminate a Health Plan. The Health Plans also may disclose to the Plan Sponsor information on whether you are participating in the Health Plan.

Business Associates: The Health Plans contract with individuals and entities ("**Business Associates**") to perform various functions on the Health Plans' behalf or to provide certain types of services. To perform these functions or to provide the services, the Health Plans' Business Associates will receive, create, maintain, transmit, use, and/or disclose PHI, but only after the Health Plans require the Business Associates to agree in writing to contract terms designed to appropriately safeguard the information. The Health Plans' Business Associates include their third-party administrator which administers many of the functions in connection with the operation of the Health Plans, and other companies which provide services or products which support the operation of the Health Plans.

When Legally Required: The Health Plans will use or disclose your PHI when required to do so by any federal, state or local law.

For Public Health Activities: The Health Plans may use and disclose your PHI for public health activities authorized by law, such as communicable disease reporting.

For Health Oversight Activities: The Health Plans may disclose your PHI to a government health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action, and similar activities.

To Report Abuse, Neglect, or Domestic Violence: As authorized by law, the Health Plans may disclose your PHI to a government authority if the Health Plans believe that you have been a victim of abuse, neglect, or domestic violence.

In Connection with Judicial and Administrative Proceedings: The Health Plans may disclose your PHI in response to a court or administrative order. The Health Plans may also disclose your PHI in response to a subpoena, discovery request, or other lawful process, but only if reasonable efforts have been made to either notify you about the request or to obtain an order protecting your PHI. If the Health Plans receive records from substance use disorder treatment programs subject to federal privacy restrictions, such records or testimony about their content cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent, or the Health Plans receive a court order entered after notice and an opportunity to be heard is provided to you or the holder of the record, as provided by federal privacy rules found at 42 CFR Part 2. A court order authorizing the use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

For Law Enforcement Purposes: As authorized by law, the Health Plans may disclose your PHI to a law enforcement official for certain law enforcement purposes.

To Coroners, Medical Examiners, and Funeral Directors: The Health Plans may disclose your PHI to coroners, medical examiners, and funeral directors, as authorized by law, prior to and in reasonable anticipation of death.

For Organ, Eye, or Tissue Donation: The Health Plans may use or disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of facilitating the donation and transplantation.

For Research Purposes: The Health Plans may use or disclose your PHI for research if certain requirements are met, such as approval by an institutional review board.

In the Event of a Serious Threat to Health or Safety: The Health Plans may disclose your PHI if the Health Plans, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person.

For Specified Government Functions: In certain circumstances, the Health Plans may use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

For Workers' Compensation: The Health Plans may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.

Communication with Family/Disaster Notification: Unless you object, the Health Plans may disclose to your family members or others involved in your care or payment for your care, information relevant to their involvement in your care or payment for your care, or information necessary to inform them of your location and condition. The Health Plans may also release information to disaster relief agencies so they may assist in notifying those involved in your care of your location and general condition.

AUTHORIZATION TO USE OR DISCLOSE PHI

Other than as stated above, the Health Plans will not use or disclose your PHI, other than with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes (when such notes are maintained by the Health Plans), use or disclose your PHI for marketing purposes, or sell your PHI unless you have signed an authorization.

If you (or your representative) provide a written authorization to the Health Plans to use or disclose your PHI, you may revoke that authorization in writing at any time to stop future uses or disclosures. However, the revocation will not be effective for information that the Health Plans already have used or disclosed, relying on the authorization, before you notified the Health Plans of your decision to revoke the authorization.

IMPORTANT INFORMATION ABOUT YOUR GENETIC INFORMATION

The Genetic Information Nondiscrimination Act of 2008 ("**GINA**") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Health Plans request that you not provide any genetic information when responding to a request for medical information.

"Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

You have the following rights regarding your PHI that the Health Plans maintain. *You can exercise any of these rights by sending your written request to the Health Plans contact designated under "**Contact Person**" below.*

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your PHI. However, the Health Plans are not required to agree to your request, except for requests to restrict disclosures to a health plan when you or someone on your behalf has paid in full out-of-pocket for your care and when the disclosures are not required by law. If the Health Plans agree to a restriction, the Health Plans will comply with your request unless the information is needed to provide you emergency treatment.

Right to Receive Confidential Communications: You have the right to request that the Health Plans communicate with you through alternative means or locations. The Health Plans will not request that you provide reasons for your request and will accommodate your reasonable requests. The Health Plans may require you to provide information on how payment will be handled and an address or other method to reach you. Requests must be made in writing.

Right to Inspect and Copy Your PHI: You have the right to inspect and copy your PHI that is used to make decisions about your benefits under the Health Plans, by making a request in writing. If you request a copy of your health information, the Health Plans may charge a reasonable fee for their labor and supply costs for creating the copy and postage, if applicable. If your information is stored electronically and you request an electronic copy, the Health Plans will provide it to you in a readable electronic form and format.

Right to Amend Your PHI: If you believe that your PHI records are inaccurate or incomplete, you may request that the Health Plans amend the records. A request for an amendment of records must be made in writing and must include a reason to support your request. The Health Plans may deny the request if it does not include a reason to support the amendment and for other certain reasons, including that the records are accurate and complete.

Right to an Accounting of Disclosures of PHI: You have the right to request a list of disclosures of your PHI made by the Health Plans for certain reasons. The list will not include disclosures we are not required to record, such as disclosures made pursuant to your authorization. The Health Plans will provide the first accounting you request during any 12-month period without charge. Additional accounting requests made during the same 12-month period may be subject to a reasonable cost-based fee. The Health Plans will inform you in advance of the fee, if applicable. Requests must be made in writing.

Right to a Paper Copy of this Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you have already received this Notice or previously agreed to receive the Notice electronically. A copy of the current Notice is available on the ADP website at https://workforcenow.adp.com (Home tab) under **Legal Notices**.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Health Plans. You may also file a complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services, generally within 180 days of the date the violation occurred.

Any complaints to the Health Plans must be made in writing to the Health Plans contact designated under "**Contact Person**" below. The Health Plans encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Health Plans have designated the Senior Corporate Counsel of Cracker Barrel Old Country Store, Inc. as their contact for all issues regarding privacy under the Health Plans and exercising your privacy rights. You may contact the Health Plans, in writing, at:

Cracker Barrel Old Country Store, Inc.
Attention: HIPAA Privacy Officer
307 Hartmann Drive
Lebanon, TN 37087

If you have any questions regarding this notice or any privacy-related practices please contact the Health Plans at the address above, by e-mail at Josh.Mayo@crackerbarrel.com, or by phone at (615) 443-9374.

ADDITIONAL INFORMATION

This Notice does not create any right to employment for any individual, nor does it change the Company's right to discipline or discharge any of its employees in accordance with its applicable policies and procedures or to amend or terminate the Health Plans at any time.

NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS IN THE HEALTH AND WELFARE PLAN FOR STORE HOURLY EMPLOYEES OF CBOCS, INC.

You are or may become eligible to participate in The Health and Welfare Plan for Store Hourly Employees of CBOCS, Inc. (the "Plan") (to participate, you must complete your benefit enrollment in your Workday account and pay your part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about a very important provision in the Plan. It is your right to enroll in the Plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage

under this Plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

SPECIAL ENROLLMENT PROVISION

LOSS OF OTHER COVERAGE (EXCLUDING MEDICAID OR A STATE CHILDREN'S HEALTH INSURANCE PROGRAM). If you decline enrollment for yourself or an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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.)

LOSS OF COVERAGE FOR MEDICAID OR A STATE CHILDREN'S HEALTH INSURANCE PROGRAM.
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state CHIP.

NEW DEPENDENT BY MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

ELIGIBILITY FOR MEDICAID OR A STATE CHILDREN'S HEALTH INSURANCE PROGRAM. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, you may be eligible to enroll yourself and your dependents in this Plan. However, you must request enrollment 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the Plan's special enrollment provisions, contact the Cracker Barrel Benefits Department at myhr.crackerbarrel.com.

CALIFORNIA STATE REQUIRED NOTICE

Under California law you have the right to request a confidential communication for your Medical Information. You may specify the format in which you would like the information provided. The request shall apply to all communications that disclose medical information or provider name and address related to medical services, including any Sensitive Services, you have received. The confidential communication request shall be valid until you revoke the request, or you submit a new confidential communication request.

> “Medical information” means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment.
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> “Individually identifiable” means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in

combination with other publicly available information, reveals the identity of the individual."

"Sensitive services" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections121020 and 124260 of the Health and Safety Code, obtained by a patient of any age at or above the minimum age specified for consenting to the service specified in the section."

The request may be submitted in writing by contacting our health plan carriers directly. Our health plan carriers' contact information can be found on the last page of the Benefits Enrollment Guide, located on www.mybenefitelections.com.

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.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or be required to pay the entire bill if you see a provider or visit a health care facility that isn't in Cracker Barrel's health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with Cracker Barrel's health plans. Out-of-network providers may be permitted to bill you for the difference between what your coverage under Cracker Barrel's health plan agreed to pay 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 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.**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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 may bill you is Cracker Barrel's health plan 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 care out-of-network. You can choose a provider or facility in Cracker Barrel's health plan network.

In-Network and Traditional Health Care Plan members can log on to www.bcbst.com/biscuit to find providers within Blue Cross Blue Shield of TN Network P.

Core Health Plan members can call the number on the back of your American Worker benefits ID card or visit multiplan.com/awp to find providers within the PHCS Limited Benefit network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Cracker Barrel's health plan will pay out-of-network providers and facilities directly.

- Cracker Barrel's health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

In-Network and Traditional Health Care Plan members:
Blue Cross Blue Shield of TN: 1-844-383-2275

Core Health Plan members:
The American Worker: 1-844-636-7506

Visit https://www.cms.gov/nosurprises or call 1-800-985-3059 for more information about your rights under federal law.

Applicable state balance billing laws or requirements for noted states are as follows:

INDIANA PROTECTIONS AVAILABLE

- For HMOs, with respect to emergency services provided by out-of-network professionals and facilities, state (1) requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing; and (2) prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- For HMOs and PPOs, with respect to non-emergency services provided by out-of-network professionals at in-network facilities, state prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing. This prohibition applies to all providers in the state, and therefore might also protect enrollees of self-funded plans.
- Above protections apply to services provided by all or most classes of health care professionals.
- Protections do not apply to:
    - ground ambulance services enrollees who consent to non-emergency out-of-network services

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Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP

programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - Medicaid**

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	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, 2026, or for more information on special enrollment rights, contact either:

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

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

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