TORRID



2027 Benefits Guide





At Torrid, we are dedicated to supporting all aspects of your well-being—both at work and at home—and your benefits are a big part of that. We're committed to creating a culture that prioritizes the well-being of our associates and their families by providing a comprehensive and competitive benefits package.

This guide will help you understand your medical, dental, vision, life, and disability coverage options, along with other valuable benefits available to you. You'll also find helpful information on making the most of your benefits, managing healthcare costs, and supporting your overall well-being.

Before making your benefit elections, take time to review your options so you can choose the coverage that best meets your needs and those of your family. Keep in mind that benefit elections made during Annual Open Enrollment generally remain in effect for the entire plan year unless you experience a qualifying life event.

Thank you for all that you do!

Welcome to Your 2027 Benefits Guide

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

What's Inside

GETTING STARTED 2

- Eligibility
- Enrollment Opportunities
- How To Enroll

BODY AND MIND 6

- Medical Benefits
- Terms to Know
- Medical Plan Comparison
- Pharmacy
- Dental
- Vision
- Flexible Spending Account

INCOME AND LEGAL PROTECTION 12

- Basic Life and AD&D Insurance
- Supplemental Life Insurance
- Disability
- Accident, Critical Illness, and Hospital Indemnity
- Kashable, Legal Services, Pet Health Care, Discounts

MENTAL HEALTH RESOURCES 16

- Employee Assistance Program

OTHER INFORMATION 17

- Paycheck Deductions
- Life and Disability Calculations
- Contacts

This guide highlights the main features of many of the benefit plans offered by Torrid, LLC. It does not include all plan rules, details, limitations, and exclusions. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Torrid, LLC reserves the right to modify, amend, or terminate any benefit plan or practice described in this guide at any time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Getting Started

Annual Open Enrollment

WHEN IS ANNUAL OPEN ENROLLMENT?

The Annual Open Enrollment period is October 12-23. Elections made during enrollment will be effective January 1, 2027.

Annual Open Enrollment is your once-a-year opportunity to make changes to your benefits. Before you make your decisions, review the Benefits Guide and the additional plan resources at www.TorridBenefits.com.







Need Help with Your Benefits?

When you have questions about your benefit options or need assistance with enrolling, we have you covered.

Torrid Benefits Team

For enrollment and benefits questions call
626-667-1002 (Liz x1014, Janice x1345, Robyn x0674) **or email benefits@torrid.com**.

Benefits Specialist

For personalized benefits guidance and support call **844-454-6922** or email Torrid@avantsb.com
6:30 AM-3:00 PM PST | 9:30 AM-6:00 PM EST Monday - Friday.

Eligibility

When it comes to choosing your benefits, it's important to understand what you are eligible for so you can make an informed decision about coverage.

WHO IS NOT ELIGIBLE?

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Part-time Associates who work less than 30 hours per week, temporary Associates not on Torrid's payroll, contract Associates, or Associates residing outside the United States.

ELIGIBLE ASSOCIATES

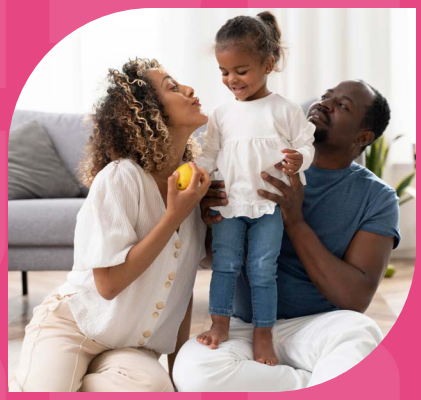
You are eligible if you are a Hawaii associate working 20 hours or more per week for 4 consecutive weeks.

ELIGIBLE DEPENDENTS

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26 (eligible to enroll in medical, dental and vision coverage). They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).
- Unmarried children under the age of 26 are eligible to enroll in supplemental life insurance.

For additional information related to benefit eligibility, please





Enrollment Opportunities

Whether you're a new hire, newly benefits-eligible due to a promotion, or experiencing a Qualifying Life Event, you'll have 30 days to enroll or make changes to your benefits. For example, if your **hire date is April 12**, your **enrollment deadline is May 12**, and your **coverage begins June 1.**

ENROLLMENT WINDOW OPENS

Your enrollment window begins on your:

- Hire date.
- Promotion effective date.
- Qualifying Life Event date.

ENROLL WITHIN 30 DAYS

Review your benefit options and complete your enrollment or benefit changes in UKG. If you're enrolling due to a Qualifying Life Event, report the event and submit any required documentation to the Benefits team.

COVERAGE BEGINS

Benefits become effective the 1st of the month following 30 days of employment. If you experience a Qualifying Life Event, coverage effective dates may vary depending on the event and plan.

If you do not enroll within 30 days, your next opportunity is Open Enrollment or if you have a Qualifying Life Event.

PROMOTIONS:

If you move into a benefits-eligible position, you have 30 days to enroll in benefits. **Coverage becomes effective** on the first of the month following 30 days of employment.

- **Sales Associate or Keyholder → Benefits-Eligible Position.**
  - Become eligible to enroll in medical, dental, vision, life, disability, and other available benefits.
  - May elect coverage for eligible dependents.
  - Gain access to voluntary benefits and associate discount programs.
- **Part-Time Assistant Store Manager → Full-Time Assistant Store Manager or Store Manager.**
  - Eligible to enroll in Short-Term Disability and Long-Term Disability Buy-Up coverage.
  - Existing health plan elections cannot be changed as part of this promotion event.
  - Employer-paid disability and basic life insurance coverage will be provided automatically.

Take action: Enrollment must be completed in UKG.

ANNUAL OPEN ENROLLMENT:

- Held once a year in October.
- **Any changes made during Open Enrollment become effective** January 1 the following year.

Take action: Enrollment must be completed in UKG.

QUALIFYING LIFE EVENTS (QLE):

Outside of Open Enrollment, you may update your benefit elections if you experience a QLE. Common QLEs include:

- Change in legal marital status (marriage, divorce or death).
- Change in number of dependents or dependent eligibility status (birth, or adoption of a baby or child).
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren).
- Change in residence that affects access to network providers.
- Change in your health coverage or your spouse's coverage due to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

Take action:

- You must report your QLE to the benefits team at benefits@torrid.com within 30 days of the event.
- You must provide dated documentation for the QLE. Please contact the Benefits team for assistance with acceptable documentation.

How To Enroll

ENROLL ONLINE WITH UKG

UKG is an online system that enables you to make all your benefit elections in one place. Medical, dental, vision, spending accounts, life insurance, disability insurance, and voluntary benefits including Accident Insurance, Critical Illness Insurance, and Hospital Indemnity Insurance can now be elected in UKG.

If you're currently enrolled in Accident Insurance, Critical Illness Insurance, or Hospital Indemnity Insurance through Corestream (torrid.corestream.com), review your elections during Annual Enrollment and make any desired changes in UKG.

BEFORE YOU ENROLL

- Review your enrollment materials to understand your benefit options and costs for the upcoming year.
- Be prepared to provide your name and associate ID, as well as:
  - Your Social Security Number.
  - Your address.
  - Your date of birth.
  - Your dependents' information, including their Social Security Number, address, date of birth, and any proof of relationship documents for compliance purposes.

LOGIN INFORMATION

OHDC and Stores: n12.ultipro.com

- Your user ID is a T followed by your six-digit associate number. Note: if your associate number is less than six digits, add "0" in front of your number to make it six digits.
- Forgot your password? Click the "Forgot your Password" link on the login page to reset.
- Locked out? Email the helpdesk at helpdesk@torrid.com with your full name and associate number requesting a password reset.

OHDC Admin, HQ, and DM: torrid.ultipro.com

- Login using your Torrid.com Single Sign-On and authenticate as prompted.
- Need assistance? Email TDHRAdmin@torrid.com.

GETTING STARTED

- **Log in** to UKG (see login information above).
- **Select your benefit plans** for the coming year by clicking on: Menu > Myself > Benefits> Classic Benefits > Life Events and select Health Plans OE 2027. Use this link to enroll/re- enroll yourself and your family members in any of the plans for which you are eligible.
- **Review** your choices and costs before finalizing.

DO I HAVE TO DO ANYTHING?

Most benefits will automatically roll over to 2027. You must enroll if you want to:

- Contribute to a Flexible Spending Account (FSA).
- Make changes to your coverage.
- Review or update your voluntary benefit elections via UKG or Corestream.

WHAT DO I NEED TO THINK ABOUT?

- Which family members do I want to cover?
- Does my family need dental or vision coverage?
- What type of coverage do we need to provide some financial protection in case of serious illness, injury, or death?
- Do I want to participate in the FSAs (depends on medical plan enrollment) to help pay for healthcare expenses by letting me contribute pre-tax money?

Adding a Dependent?

If you are adding dependents, you must provide their Social Security Number/Tax ID and verification of their eligibility during Annual Open Enrollment. Your newly added dependents will not be added to your coverage until the dependent eligibility verification process is complete. If you are not able to provide the required documentation within 30 days of enrollment, please contact the Benefits Team at 626-667-1002 or benefits@torrid.com to discuss your options.

Body and Mind

When it comes to your health, it's important to care for your body and mind. Torrid offers a variety of benefits to help you focus on your well-being.

Medical Benefits

It's important to make informed decisions about your healthcare. Torrid offers a comprehensive Health Maintenance Organization (HMO) medical plan designed to help you access quality care and support your overall well-being.

KAISER HMO HAWAII

- Health Maintenance Organization (HMO).

Your coverage includes:

- Preventive care covered at 100%.
- Prescription drug coverage.
- Access to virtual care services.
- Mental health and behavioral health support.
- Additional health and wellness resources.

Terms to Know

Benefits can be confusing! Here's a quick reference to help you navigate commonly used terms:

- **Copay:** A flat dollar amount you pay the provider when you receive a service.
- **Deductible:** The amount you pay for services before the plan begins paying some of the cost. The deductible may not apply to all services, including preventive care.
- **Coinsurance:** The portion of covered expenses you and the plan share after you meet the deductible (listed as a percentage).
- **Out-Of-Pocket Maximum (OOP Max):** The maximum amount you pay out of your pocket for covered expenses in a year. Once you reach the out-of-pocket maximum, the medical plan pays for all covered services for the rest of the year.
- **Embedded Deductible or OOP Max:** An individual family member can meet their own deductible or out-of-pocket maximum before the entire family meets the family deductible or out-of-pocket maximum. Once an individual family member meets their deductible, the plan begins paying benefits for that family member. Once an individual family member reaches their out-of-pocket maximum, the plan pays 100% of covered services for that family member for the remainder of the year.





MEDICAL PLAN AT A GLANCE

You always pay the deductible copayment ($). The coinsurance (%) shows what you pay after meeting the deductible.

	Kaiser HMO Hawaii
PLAN FEATURE	IN-NETWORK
PLAN YEAR DEDUCTIBLE	
Individual	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM (EMBEDDED)	
Individual	$2,500
Family	$7,500
YOU PAY	
Preventive Care	No charge
Office Visits	$15 copay
Specialist Visits	$15 copay
Virtual Care	None
Urgent Care	$15 copay
Emergency Room *(waived if admitted)*	$100 copay
X-Rays and Labs	$15 copay per day (basic) or 20% (specialty)
Inpatient Hospitalization and Ambulatory Surgery Center	10%
Outpatient Surgery and Procedures	$15 copay
Ambulance Service	**20%**

PHARMACY

The medical plan include prescription drug coverage through Kaiser Permanente Rx. Kaiser's network of pharmacies includes hundreds of retail locations, national chains, grocery store pharmacies, and independent community pharmacies. You will also have access to convenient home delivery.

	Kaiser HMO Hawaii
PLAN FEATURE	IN-NETWORK
PLAN YEAR DEDUCTIBLE	
Per Member	N/A
PLAN YEAR OUT-OF-POCKET MAXIMUM	
Individual	Combined with medical
Family	
RETAIL 31-DAY SUPPLY	
Generic	$3 copay for maintenance drugs ($15 copay for other generic drugs)
Brand (Preferred and Non-Preferred)	$50 copay
Specialty	$200 copay
MAIL ORDER 90-DAY SUPPLY	
Generic	$6 copay for maintenance drugs ($30 copay for other generic drugs)
Brand (Preferred and Non-Preferred)	$100 copay
Specialty	Not covered





Dental

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat. That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays.
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment.
- **Major** care goes further than basic and includes bridges, crowns and dentures.
- **Orthodontia** treatment to properly align teeth within the mouth.

For more information, visit kp.org or call 800-966-5955.

Plan Feature	Kaiser HMO Hawaii
	In-Network
Calendar Year Deductible	
Individual	None
Family	None
Calendar Year Maximum	
Per Member Adults age 19 and older	$1,200
Services	
Basic Services Exams & Cleaning X-Rays Fluoride	No charge
Major Services Restorative Prosthodontics and crowns	30% 50%
Examinations **(2x per calendar year)**	No charge
Orthodontia	
Adults Children (up to age 26)	Not covered

Vision

Vision coverage helps with the cost of eyeglasses or contacts. Even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

If you enroll in vision coverage, you must choose providers who are part of the Kaiser network. For more information, visit kp.org or call 800-966-5955.

	Kaiser HMO Hawaii
Plan Feature	In-Network
Exam	
Benefit	$150 allowance (No charge for children under age 19)
Frequency	(once every 12 months)
Frames or Contacts	
Benefit	$150 allowance



Flexible Spending Accounts (FSAs)

When you choose an FSA, it's important to understand how the account works. Torrid's FSA includes a grace period, giving you additional time to use your funds. **Eligible expenses can be incurred from January 1 through March 15 of the following year**, extending your spending period beyond the end of the plan year.

FSAs are still subject to the "use-it-or-lose-it" rule, so **any remaining funds not used for eligible expenses incurred by March 15 will be forfeited. Claims must be submitted by March 31 of the following year.**

HOW THE FSA WORKS

During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses. **Elections cannot be changed during the plan year**, unless you experience a qualifying event, and you must re-enroll in the program each year.

- To create an account once your enrollment is complete, visit member.uhc.com/myuhc
- For a list of eligible expenses, visit healthequity.com/fsa-qme

FSA TAX SAVINGS EXAMPLE (SINGLE FILERS)		
$60,000 Annual Pay, with $1,500 FSA Contribution		
$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings
$120,000 Annual Pay, with $2,850 FSA Contribution		
$684 24% Federal income tax	**$219** 7.65% FICA tax	**$903** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

FSAs AT A GLANCE

	HEALTHCARE FSA	LIMITED PURPOSE FSA	DEPENDENT CARE FSA
How much can I contribute?	Contribute up to $3,400 per year, pretax.		Contribute up to $7,500 per year, pretax, or $3,750 if married and filing separate tax returns.
Who can participate?	Associates enrolled in a Kaiser medical plan.		Available to associates who are not classified as Highly Compensated Associates (HCEs) by the IRS. Associates who earned more than $160,000 in 2026 are not eligible.
How do I use the account?	Receive a debit card to pay for eligible medical expenses, with your full annual election amount available at the beginning of the plan year. For dental and vision expenses, pay the provider directly and submit your expenses through MyUHC for reimbursement.		You must submit claims and be reimbursed if you enroll in this FSA; no debit cards are provided. Funds are available as they are contributed.
What are eligible expenses?	Eligible expenses include medical copays, coinsurance, deductibles, eyeglasses, prescription medications, over-the-counter medications, and dental expenses.	Use the funds for any qualified dental or vision expenses. No medical plan co-pays, deductibles, prescription drugs or alternative healthcare are eligible expenses through a limited purpose FSA.	Can only be used to pay for eligible dependent care expenses including day care, after-school programs and elder care programs.
What happens at the end of the year?	Expenses must be incurred between 01/01/2027 and 03/15/2028 and claims must be submitted for reimbursement no later than 03/31/2028. If you don't spend all the money in your account, you forfeit the leftover balance.		

Income and Legal Protection

No one can predict the future, but you can plan for it. That's why Torrid offers you benefits to help protect your income and give you peace of mind.

Basic Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

Torrid will provide short and long-term disability core benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) 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. Coverage is provided by Lincoln Financial Group, and premiums are paid in full by Torrid. Basic Life and AD&D provides 1x annual earnings up to a maximum of $500,000.



BENEFICIARY INFORMATION

Help protect your loved ones by keeping your beneficiary information up to date. Be sure to designate a beneficiary for each applicable benefit during enrollment.

You must select at least one beneficiary for each plan that requires one. You can review and update your beneficiary elections at any time throughout the year.

BENEFIT REDUCTION

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.



Supplemental Life Insurance

Supplemental Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln Financial Group and available for yourself, your spouse and/or child(ren).

COVERAGE TYPE	COVERAGE AMOUNT
Associate Coverage	Increments of $10,000 up to $300,000 (not to exceed 7x annual salary) Guaranteed Issue Amount: $200,000 if under age 70 or $100,000 if age 70 and over
Spouse	Increments of $5,000 up to $300,000 (amount cannot exceed associate coverage) Guaranteed Issue Amount: $150,000
Child(ren) age 6 Months – 26 Years (Unmarried)	Increments of $2,000 up to $10,000 Guaranteed Issue Amount: $10,000

Note: Benefit amount reduces to 65% at age 65 and to 45% at age 70. You must be enrolled in the associate supplemental life plan if you want to purchase spouse or child supplemental life coverage.

Evidence of Insurability (EOI)

- **First time enrollee:** If you are enrolling in life insurance for the first time and it is within 30 days of the event, you will be able to select up to $200,000 for yourself and up to $150,000 for your spouse without having to submit EOI.
- **Late enrollee:** If you are enrolling in life insurance for the first time and 30 days have elapsed since you became eligible for this benefit, you will be required to submit EOI for any coverage amount selected.
- **Exception for Open Enrollment:** If currently enrolled, associates can increase their supplemental life insurance coverage by an increment of $10,000 without having to provide an EOI form.
  - If you select coverage in an amount higher than one increment, you will be required to submit an EOI form.
  - If you have been previously denied coverage, you will be required to submit an EOI.
- If currently enrolled, spouse supplemental life insurance can be increased by an increment of $5,000 without having to provide an EOI form.
  - If you select coverage higher than one increment, you will be required to submit an EOI form.

If EOI is required, visit lincolnfinancial.com/public/individuals to complete and submit your form. The Torrid code for EOI submission is LF1319TOR.



Disability

Torrid offers Temporary Disability Insurance (TDI) and Long-Term Disability Insurance (LTD) to help replace a portion of your income if you are unable to work due to a non-work-related illness, injury, pregnancy, or childbirth recovery.

TEMPORARY DISABILITY INSURANCE (TDI)

TDI is automatically provided at no cost to eligible Full-Time and Part-Time Assistant Store Managers (PTASMs). TDI is provided through Pacific Guardian Life.

If approved, TDI may provide up to 58% of your base pay for up to 26 weeks while you are unable to work due to a covered disability.

Common reasons for TDI benefits include:

- Pregnancy and childbirth recovery.
- A serious illness or injury.
- Surgery and recovery time.

Benefits begin after a 7-calendar-day waiting period, during which no benefits are paid.

TDI benefits may be reduced if you receive income from other disability programs, such as sick pay, workers' compensation, Social Security, or state disability benefits. Torrid pays the full cost of this coverage.

SUBMITTING A CLAIM

To submit a new TDI claim, visit Pacific Guardian, select Part A and follow the instructions. If you have already submitted a claim, you can view your claim status here.

	TDI
Weekly Benefit Amount	58% of earnings, subject to max benefit
Benefits Begin After Accident Sickness	7 days
Maximum Payment Period*	2 to 26 weeks

**Maximum payment period is based on the first day you are disabled, benefits begin.*



LONG-TERM DISABILITY

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc).
- Serious injuries (accident, etc).
- Heart attack, stroke.
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. The LTD plan is administered by Lincoln Financial Group.

	LTD	LTD* BUY-UP
Monthly Benefit Amount	40% of covered monthly earnings, subject to max benefit limit	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefit	• $5,000	• $7,500
Benefits Begin After	After 90 days of disability**	
Maximum Payment Period*	Social Security normal retirement age	

** Leadership group: 60% of monthly earnings, up to $20,000*

Voluntary Plans

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

Torrid offers plans to help:

- Replace income if you're injured or ill
- Bridge the gap for special healthcare needs
- Save money on protection for your pets
- Receive access to exclusive shopping network

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.



Voluntary Health-Related Plans

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.



ACCIDENT INSURANCE

Accident Insurance from Lincoln Financial Group helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

CRITICAL ILLNESS INSURANCE

Critical Illness insurance from Lincoln Financial Group can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other covered need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance from Lincoln Financial Group can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries.

Enrollment in Voluntary Plans

Beginning in 2027, these benefits will be offered through Lincoln Financial Group. You will be able to enroll directly through UKG during the Open Enrollment process.

Voluntary Plans

LONG-TERM CARE

Long-Term Care insurance through CHUBB provides financial help if you or a covered dependent require care in a nursing facility, assisted living facility, or at home, as a result of loss of functional capacity or cognitive impairment due to injury, sickness, or advanced age. Qualifying for benefits is based upon a need for assistance with any two of the seven activities of daily living including eating, bathing, dressing, toileting, continence, ambulating, or transferring and/or cognitive impairment such as dementia or Alzheimer's disease. To enroll in Long Term Care please login to Corestream via Single Sign-On at torrid.corestream.com. You can then access the CHUBB Selerix portal. Once inside the CHUBB portal, follow the instructions to select coverage.

KASHABLE

Half of Americans today have less than $500 in savings and an average debt of about $35,000. Kashable gives you and your family access to emergency funding at the guaranteed best interest rate based on your employment tenure and salary. You can pay back the loan via payroll deduction.

- Loan amounts from $250 to $20,000.
- 6 to 24-month repayment terms.
- 5-minute application process.
- Funds are deposited on the next business day.

Plus get access to free financial coaching and tools to help you stay on the right financial path even after loan repayment including an Emergency Savings Program and Free Credit Monitoring.

LEGAL SERVICES

Legal Services through MetLaw provides you and your family with direct access to a dedicated team of lawyers who can review and prepare legal documents such as wills and assist with other personal legal matters.

PET HEALTH CARE

When your pet gets sick, bills can add up faster than expected. Pet plans are available through Nationwide and Pet Benefit Solutions to protect your pet and your wallet with exceptional savings on veterinary bills. You can enroll in this program at any time during the year.

SHOPPING DISCOUNTS

Torrid associates have year-round discounts to help save money on electronics, theme parks, travel, car rentals, and more!

Torrid offers these voluntary plans through Corestream. You have year-round access to the Pet Health Care and discount shopping. For more information, visit torrid.corestream.com.



Employee Assistance Program (EAP)

Available to all associates, our EAP partner Guidance Resources helps you and your family manage life's challenges with in-person, phone, and video counseling sessions, all at no cost to you. You can also get referrals to household services related to child/elder care, financial and legal help, and much more.

MENTAL WELL-BEING

You can receive up to five counseling sessions per issue per year. The sessions are a free and confidential service and are available face to face, online with televideo, or by phone.

Licensed counselors can help with issues such as:

- Mental health concerns.
- Emotional difficulties.
- Domestic abuse.
- Substance abuse.
- Financial worries.
- Grief and loss.
- Relationship support.
- Self-esteem and personal development.
- Stress management.
- Work-life balance.

When you need in-the-moment emotional well-being support, counselors are here to help 24/7. You can call **888-628-4824**.

WORK-LIFE ASSISTANCE

Guidance Resources also provides a wide variety of work-life support, with some services at no cost. A few of the services include:

Daily life assistance: Resources for child, elder, or pet care, and household services.

Legal support: Wills and estate planning, family, civil, criminal, and real estate.

Financial services: Budgeting, mortgages, college funding, and issues.

Identity theft services: Fraud resolution and credit restoration coaching.

Phone: 888-628-4824
Website: GuidanceResources.com WebID: LFGSupport

Note: Associates will be prompted to create their own account upon initial login.

Other Information

Paycheck Deductions

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

Your contribution toward the cost of each benefit will be displayed when you enroll online via self-service and will vary based on your enrollment elections.

BI-WEEKLY PREMIUMS: MEDICAL, DENTAL, VISION – KAISER HMO

	PRE-TAX DEDUCTION (PER PAYCHECK)	AFTER TAX DEDUCTION FOR SPOUSE/DP, ELIGIBLE FOR OTHER COVERAGE
PLAN	KAISER HMO	
Associate Only	1.5% of gross income	
Associate + 1	1.5% of gross income plus $53.23	$60
Associate + 2 or more	1.5% of gross income plus $107.46	$60

RATES FOR YOUR DOMESTIC PARTNER

You are required to pay income tax on the value of the benefit that is provided to your Domestic Partner (DP) as well as Child/ren of a Domestic Partner. Torrid will report the value of your DP benefits with each paycheck so that you are paying the applicable tax with each bi-weekly paycheck. If you would like to cover a domestic partner and want to know the cost, please email the Benefits Department at benefits@torrid.com.

SPOUSAL SURCHARGE

Employees that choose to enroll a spouse or domestic partner who is eligible for medical insurance through another employer plan will pay an additional $60 per paycheck.



LIFE AND DISABILITY INSURANCE CALCULATIONS

SUPPLEMENTAL LIFE INSURANCE- PER PAYCHECK	ASSOCIATE	SPOUSE
AGE	EE RATES PER $10,000	SP/DP RATE PER $5,000
<25	$0.23	$0.12
25–29	$0.28	$0.14
30–34	$0.37	$0.18
35–39	$0.55	$0.28
40–44	$0.78	$0.39
45–49	$1.34	$0.67
50–54	$2.17	$1.08
55–59	$3.55	$1.78
60–64	$4.66	$2.33
65–69	$7.25	$3.62
70+	$12.69	$6.35
CHILD(REN) Increments of $2,000 up to $10,000		
$2,000	$0.18	
$4,000	$0.37	
$6,000	$0.55	
$8,000	$0.74	
$10,000	$0.92	

Premium includes all eligible children. Eligible children include dependent children under age 26 if you apply for and are approved for coverage for yourself.

LIFE AND DISABILITY INSURANCE CALCULATIONS

1. Using the table to the left, enter the rate that corresponds with your / your spouse's age:

   You:_____ Spouse:_____

2. Enter the desired coverage amount in dollars:

   You:_____ Spouse:_____

3. Divide Step 2 by $10k for Associates / $5k for Spouses:

   You:_____ Spouse:_____

4. Multiply Step 1 by Step 3

   You:_____ Spouse:_____

5. Add You + Spouse from Step 4:

   Total cost per paycheck:_____

CALCULATING PER PAYCHECK COST OF LONG-TERM DISABILITY BUY-UP INSURANCE

YOUR COST LTD BUY-UP	EQUATION
BUY-UP COSTS $0.13 PER $100 OF COVERAGE:	HOURLY RATE_____ X 2080 = $_____ / 12 = $_____ (IF RESULT GREATER THAN $12,500, USE $12,500) RESULT X 0.00182 = $_____ X 12 = $_____ / 26 = $_____ (PER PAYCHECK) ANNUAL SALARY_____/ 12 = $ (IF RESULT GREATER THAN $12,500, USE $12,500) RESULT X 0.00182 = $_____ X 12 = $_____ / 26 = $_____ (PER PAYCHECK)

BI-WEEKLY PREMIUMS



ACCIDENT

HOURLY & SALARY	PER PAYCHECK
PLAN	
Associate only	$2.59
Associate + Spouse	$4.50
Associate + Child(ren)	$5.82
Family	$7.72

HOSPITAL INDEMNITY

HOURLY & SALARY	PER PAYCHECK
PLAN	
Associate only	$7.02
Associate + Spouse	$11.18
Associate + Child(ren)	$10.17
Family	$14.33

CRITICAL ILLNESS: OPTIONS OF $10,000, $20,000, OR $30,000

	ASSOCIATE	SPOUSE
AGE	EE RATES PER $1,000	SP/DP RATE PER $1,000
<25	$0.09	$0.09
25-29	$0.12	$0.12
30-34	$0.16	$0.16
35-39	$0.20	$0.20
40-44	$0.25	$0.25
45-49	$0.32	$0.32
50-54	$0.40	$0.40
55-59	$0.53	$0.53
60-64	$0.76	$0.76
65-69	$1.02	$1.02
70+	$1.58	$1.58

- **Associate age 42:** $10,000 of coverage = $2.49 per paycheck
- **Spouse age 35:** $20,000 of coverage = $3.97 per paycheck

Calculation: Coverage Amount ÷ 1,000 × Age-Based Rate

Contacts

PLAN	CARRIER	WEBSITE	PHONE
Medical	Kaiser Permanente **Group Number:** 09079-10	kp.org	800-966-5955 (TTY711)
Prescription			
Dental			
Vision			
Employee Assistance Program (EAP)	Guidance Resources	guidanceresources.com **Web ID:** LFGSupport	888-628-4824
Flexible Spending Accounts (FSAs)	UnitedHealthcare **Group Number:** 0950284	myuhc.com	800-331-0480
FSA MasterCard Spending Card	UnitedHealthcare **Group Number:**0950284	myuhc.com	866-755-2648
Life and AD&D Insurance	Lincoln Financial Group	lincolnfinancial.com **First Time Portal Users One Time Code:** LF1319TOR	Claims: 888-787-2129
Supplemental Life and Long-Term Disability			Claims: 888-408-7300
Temporary Disability Insurance	Pacific Guardian Life **Group Number:** R0000052449	pacificguardian.com	808-942-1282
Emergency Funding	Kashable	torrid.corestream.com	626-495-3850
Legal Services	MetLaw		
Pet Health Care	Nationwide and Pet Benefit Solutions		
Shopping Discounts	Corestream		
Benefits Team	Torrid	**Email:** benefits@torrid.com	Office # 626-667-1002 **Liz** x1014 **Janice** x1345 **Robyn** x0674
Benefit Specialists	Avant	**Email:** Torrid@avantsb.com	844-454-6922

Glossary

-A-

AD&D Insurance: An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

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

Ambulatory Surgery Center (ASC): A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit: A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.

After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

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 (the balance).

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 plans. You must name your beneficiary in advance.

Brand Name Drug: A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA: A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

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

Coinsurance: Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment: 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.

-D-

Deductible: The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an aggregate or embedded deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services: Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive: Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services: Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA): An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense: A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service: A service that your health plan doesn't pay for or cover.

-F-

Formulary: A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug: A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered: A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA): An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA): A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP): A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for ahealth savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network: In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance: An insurance plan that pays your beneficiary a lump sum if you die.

Long-term disability Insurance: Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long-term disability generally starts after a 90-day waiting period.100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

-M-

Mail Order: A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment: The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network: Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

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.

Family coverage may have an aggregate or embedded maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care: Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy: A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year: A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug: Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services: Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is 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.

-S-

Short-term disability Insurance: Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teladoc: A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations: Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit: An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this guide.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals.
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy.
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed.
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Illinois Consumer Coverage Disclosure Act:** Provides a list that compares the essential health insurance benefits offered by the employer's group health plan with the essential health benefits regulated by the State of Illinois.
- **Patient Protection Disclosure:** Explains who you and your family can designate as a primary care provider under the health care plans and rules around access to obstetrical/gynecological care.
- **COBRA Rights Notice:** Explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.
- **Surprise Billing Notice:** Describes surprise billing protections under the No Surprises Act.
- **Summary Annual Report:** This is a summary of the annual report of the Torrid LLC Welfare Benefit Plan.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available in the back of this guide. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Torrid LLC Welfare Benefit Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on UKG.

- Surest PPO SBC
- UnitedHealthcare HDHP SBC
- UnitedHealthcare PPO SBC
- UnitedHealthcare Indemnity SBC
- Delta Dental PPO SDBC
- DeltaCare DMO SDBC

MEDICARE PART D NOTICE

IMPORTANT NOTICE FROM TORRID ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Torrid LLC 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. Torrid LLC has determined that the prescription drug coverage offered by Torrid's medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your Torrid LLC coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Torrid's medical plans are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.If you do decide to join a Medicare drug plan and drop your Torrid's prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Torrid LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for 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 Torrid LLC changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

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

October 10, 2026 Torrid LLC
Human Resources, ATTN: Benefits
Department 18501 San Jose
Avenue, City of Industry, CA 91748
(626) 667-1002

HIPAA NOTICE OF PRIVACY PRACTICES

TORRID LLC WELFARE BENEFIT PLAN PRIVACY PRACTICES NOTICE (VERSION 02/16/2026)

This Notice describes how your Protected Health Information ("PHI") may be used and disclosed by the Torrid LLC Welfare Benefit Plan ("The Plan") and how you can get access to this information. For the purposes of this Notice, "We" refers to the Torrid LLC Welfare Benefit Plan. Please review this Notice carefully. The privacy of your PHI is important to us.

SUMMARY OF OUR PRIVACY PRACTICES

We may use and disclose your protected health information (PHI), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your PHI, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your PHI to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your PHI to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose PHI to your employer for certain limited purposes. We may disclose PHI to the Plan (your employer) for plan administration functions only after the Plan has certified that the Plan documents include privacy protections required by federal law. The Plan may use such PHI only for plan administration purposes and not for employment-related actions or decisions.

Except for certain legally approved uses and disclosures, we will not otherwise use or disclose your PHI without your written authorization.

You have the right to examine and receive a copy of your PHI. You have the right to receive an accounting of certain

disclosures we may make of your PHI. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your PHI.

You have the right to receive notice of breaches of your unsecured PHI.

Please review this entire notice for details about the uses and disclosures we may make of your PHI, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Benefits Team.

Contact Office: Torrid LLC Telephone: (626) 667-1002

E-mail: benefits@torrid.com

Address: 18501 San Jose Ave. City of Industry, CA 91748

HEALTH PLANS COVERED BY THIS NOTICE

This notice applies to the privacy practices of the health plans listed below. They may share with each other your PHI, and the PHI of others they service, for the health care operations of their joint activities.

TORRID LLC WELFARE BENEFIT PLAN

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect February 16, 2026, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all PHI we maintain, including PHI we created or received before we made the change.

USES AND DISCLOSURES OF YOUR PHI

Treatment: We may disclose your PHI, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your PHI, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your PHI to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your PHI, without your permission, for health care operations.

Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying PHI, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your PHI to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the PHI is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your PHI for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes and substance use disorder counseling notes we hold only with your authorization.

If we receive substance use disorder treatment records created by a federally assisted program or health care provider under 42 CFR Part 2, we may only use or disclose such records in accordance with the written consent you provided to the program or provider. If such records were disclosed to us with your written consent for treatment, payment, and health care operations, we may further disclose the records for these purposes without obtaining an additional written consent.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your PHI to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the PHI that is relevant to the person's involvement.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your PHI to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the PHI that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private

agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will determine, consistent with applicable law, whether the disclosure is in your best interest under the circumstances.

PHI remains protected under federal law for 50 years after an individual's death. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the PHI that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify PHI contained in the summary health information as yours. Summary health information does not include names or other direct identifiers and may be used by the Plan only for the limited purposes described above. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

Marketing and Sale of PHI: We will not use or disclose your PHI for marketing purposes, nor will we sell your PHI without your written authorization. If a use or disclosure of PHI is considered "marketing" under HIPAA or involves the sale of PHI, we will obtain your prior written authorization, and you may revoke that authorization at any time as described above.

Health-Related Products and Services: We may use your PHI to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your PHI to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your PHI, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Prohibited Uses and Disclosures: If we receive substance use disorder records created by a federally assisted program or health care provider under 42 CFR Part 2, we may not use or disclose such records, or testimony relaying the content of such records, in any civil, criminal, administrative, or legislative proceedings against you unless based on your specific written consent or a court order. We may only use or disclose records based on a court order after:

1. a notice and an opportunity to be heard is provided to you or the holder of the record, where required by 42 CFR part 2; and
2. the court order is accompanied by a subpoena or other similar legal requirement compelling the disclosure.

Other Uses and Disclosures: Any uses and disclosures of your PHI not described in this notice will be made only with your written authorization, unless otherwise permitted or required by applicable law.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your PHI, with limited exceptions. You should submit your request in writing to our Benefits Team.

Your PHI may be maintained electronically. If so, you can request an electronic copy of your PHI. If you do, we will provide you with your PHI in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your PHI directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your PHI that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the Plan's effective date (if the Plan was created less than six years ago).

Amendment. You have the right to request that we amend your PHI. You should submit your request in writing to the Benefits Team.

We may deny your request only for certain reasons. If we

deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your PHI and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your PHI for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

2. the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your PHI in confidence by means or to locations that you specify. You should submit your request in writing to the Benefits Team.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured PHI. We will provide such notice without unreasonable delay and in no case later than 60 days after the discovery of the breach, as required by law. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your PHI, the notice will be provided to your next of kin or personal representatives if the Plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you have the right to obtain a paper copy of this notice at any time upon request. To receive a paper copy, please contact the Benefits Team.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, about amending your PHI, about restricting our use or disclosure of your PHI, or about how we communicate with you about your PHI (including a breach notice communication), you may notify our Benefits Team in writing.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019. Complaints may also be filed electronically through the Office for Civil Rights website.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**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/flmedicaidtplrec overy.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

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:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

PAPERWORK REDUCTION ACT STATEMENT

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

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

ILLINOIS CONSUMER COVERAGE DISCLOSURE ACT

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the Access to Care and Treatment Benchmark Plan and the Pediatric Dental Plan to reference the pages listed below.

Employer Name:	Torrid LLC
Employer State of Situs:	California

Name of Issuer:	UnitedHealthcare and Surest
Plan Marketing Name:	UnitedHealthcare: HDHP, Choice Plus PPO, Select Plus PPO, Indemnity Surest: Surest PPO under UHC Choice Plus PPO and Select Plus PPO networks
Plan Year:	2027

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				**Employer Plan Covered Benefit?**
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes[1]
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes

22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	No
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	No
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	Yes
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes

[1]*Foot orthotics are not covered.*

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

PATIENT PROTECTION DISCLOSURE

Torrid's medical plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Benefits Department (626) 667-1002.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Torrid or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Benefits Department (626) 667-1002.

COBRA RIGHTS NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event.

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

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

- following qualifying events:
- Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

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

- because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

You become divorced or legally separated from your spouse.

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

- following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

The child stops being eligible for coverage under the Plan as a "dependent child."

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

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

- In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of
- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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

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

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights

under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and

District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Date: 10/10/2026

Name of Entity/Sender: Torrid LLC

Office: Benefits Department

Address: 18501 San Jose Avenue, City of Industry, CA 91748

Phone Number: (626) 667-1002

https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your 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 your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

- When balance billing isn't allowed, you also have the following **PROTECTIONS:**
- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
    - Your 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, please call the federal No Surprises Help Desk at 1-800-985-3059. Visit

www.cms.gov/nosurprises for more information about your rights under federal law.

Visit *www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billingprotections*

SUMMARY ANNUAL REPORT FOR TORRID LLC WELFARE BENEFIT PLAN

This is a summary of the annual report of the Torrid LLC Welfare Benefit Plan (Employer Identification Number 47-3648005, Plan Number 502) for the plan year 01/01/2025 through 12/31/2025. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Torrid LLC has committed itself to pay certain medical and healthcare FSA (medical, dental and vision) claims incurred under the terms of the plan.

INSURANCE **INFORMATION**

The plan has insurance contracts with Delta Dental of California, Lincoln National Life Insurance Company, Triple S Salud, Inc., Vision Service Plan and Kaiser Foundation Health Plan of Hawaii to pay certain life, accidental death & dismemberment, medical, dental, vision, temporary disability, long-term disability, and employee assistance claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2025 were $1,531,803.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Torrid LLC, who is a representative of the plan administrator, at 18501 E. San Jose Avenue, City of Industry, CA 91748 and phone number, 626-667-1002.

You also have the legally protected right to examine the annual report at the main office of the plan: 18501 E. San Jose Avenue, City of Industry, CA 91748, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The annual report is also available online at the Department of Labor website www.efast.dol.gov.

OMB Control number 1210-0040; Expiration Date 03/31/2026

TORRID

2027 BENEFITS GUIDE