2022 Benefits Guide

HOT TOPIC INC.

HOT TOPIC BOXLUNCH Her Universe

Table of Contents

Should You Participate in Open Enrollment?

Do you need to take any action during the Open Enrollment period? Answer the following question:
As a Hot Topic benefits-eligible employee, which of the following statements is true regarding your benefits?
Check all boxes that apply to you.

- ☐ I want to add or remove a dependent to/from my medical, dental or vision coverage.
- ☐ I want to enroll in, change or cancel medical, dental or vision coverage for myself and/or my eligible dependent(s).
- ☐ I want to enroll in, change or cancel Supplemental Life or Long-Term Disability (LTD) Buy-Up insurance for myself and/or my eligible dependent(s).
- ☐ I want to enroll or re-enroll in a Health Care and/or Dependent Care Flexible Spending Account (FSA). You must re-enroll in an FSA every plan year.
- ☐ I am currently enrolled but would like to waive my health care coverage through Hot Topic for the 2022 plan year.
- ☐ I do not want to add or remove a dependent to/from my medical, dental or vision coverage.
- ☐ I do not want to make any changes to my benefits and want to keep the exact same coverage in 2022
- ☐ I do not want to enroll in, change or cancel Supplemental Life or Long-Term Disability (LTD) Buy-Up insurance for myself and/or my eligible dependent(s).
- ☐ I do not want to enroll in a Health Care and/or Dependent Care Flexible Spending Account (FSA) for 2022. I understand that if I currently have an FSA, my elections will not roll over.
- ☐ I currently elect to waive my benefits coverage through Hot Topic, and I want to continue to waive my benefits coverage through Hot Topic.

Participate!

Based on your responses to the statements above, participating in Open Enrollment would benefit you. Don't miss this once-a-year opportunity to make changes to your benefits!

Review!

Open Enrollment participation may not be necessary however, it is encouraged that you to review your UKG profile (desktop version) your current benefits and dependents.

Open Enrollment Highlights

At Hot Topic, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason Hot Topic continues to enhance our benefits offerings to give you options to best meet your needs.

Open Enrollment is September 27 - October 8, 2021 for benefits effective January 1 - December 31, 2022.

No Changes to Your Costs of Coverage for the Third Year in a Row!

Hot Topic is very excited to announce that for the third year in a row, there will be no increase to your benefit premiums. Additionally, there will be no plan design changes such as your co-pays, out-of-pocket maximum and deductibles for 2022. That means your cost of coverage will not increase for the 2022 plan year.

To ensure we remain competitive within our industry we looked at what the top retailers offer to their employees. We compared those benefits to Hot Topic's benefits package, and we are pleased to announce that in most areas we remain above industry standard trend.

Because health care costs are constantly increasing from year to year, most of our competitors are calling for rate increases across all benefits. However, Hot Topic makes it our priority to minimize the impact of increasing health care costs to you, our valued employees. That's why Hot Topic has decided to absorb the increase in cost of coverage to keep your costs of coverage the same as it was in 2021.

What Should I Do During Open Enrollment?

Although there are no changes for this Open Enrollment, we encourage you to take advantage of this once-a-year opportunity to review current benefit elections and make changes such as:

- **Change your medical, dental and/or vision plans**
- **Add or drop dependents**
- **Increase your Supplemental Life Insurance coverage**
- **Enroll for voluntary benefits**
- **Enroll/re-enroll in Flexible Spending Accounts (FSAs) -** You must re-enroll in FSAs each plan year. Your 2021 elections will NOT roll over into the 2022 plan year. Below are the IRS annual FSA contribution limits:
    - **Health Care FSA Annual Limit** remains $2,750
    - **Dependent Care FSA Annual Limit** remains $5,000

While we've made every effort to make sure this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents or summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on page 27 for more details.

Eligibility & Enrollment

WHO IS ELIGIBLE?

Full-time employees, Part-time ASMs and Part-time DC Associates are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Your children:
  - Under the age of 26 are 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.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined. SPDs can be found on the company intranet.

WHO IS NOT ELIGIBLE?

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

- Parents
- Grandparents
- Siblings

SPOUSAL SURCHARGE

Employees who 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.

QUALIFYING LIFE EVENTS

Open enrollment is the one time each year that you can make changes to your benefit elections without a qualifying life event. Notify the Benefits Department right away if you have a qualifying life event and need to make a change (add or drop) to your coverage election.

Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or Divorce

You have 30 days to make your change.

HOW TO ENROLL

Open Enrollment is the only time during the year when you can make changes, additions or cancellations to your benefits unless you experience a qualifying life event such as marriage, divorce, adding/removing a domestic partner, birth or adoption of a child, or loss of other insurance coverage.

Should one of these life events occur, notify the Benefits Department within **30 days** of the event. New hires have 30 days from your hire date to make enrollment elections.

Enroll in Benefits

- Go to the UltiPro website: https://n32.ultipro.com/
- Your user ID is an "H" followed by your six digit employee number. Please note that if your employee number is less than six digits add "0" in front of your number to make it six digits.
- If you need to reset your Ultipro password, please email Helpdesk@hottopic.com

Enrolling a Domestic Partner

When enrolling a Domestic Partner carefully follow the instruction guide as there are two steps to complete the enrollment process.

Proof of relationship

- If you are enrolling a dependent, you are required to have proof of relationship documents (e.g., marriage license, birth certificate) on file.
- If you are enrolling a domestic partner, you are required to have a notarized domestic partner affidavit on file.
- Failure to provide proof of relationship documents will result in cancelation of benefit plans for covered dependents.
- If you need to change your marital status, please contact HTHRAdmin@hottopic.com
- You can upload documents yourself in UltiPro (see UltiPro "How to Upload Documents" guide) or contact the Benefits Department at benefits@hottopic.com.

For assistance, contact your Benefit Advocate at alliantba@alliant.com or 888-585-5399.

Helpful Terms

MEDICAL/GENERAL TERMS

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

PRESCRIPTION DRUG TERMS

Tier 1 – Lower-cost medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included. Use Tier 1 drugs for the lowest out-of-pocket costs.

Tier 2 - Mid-range cost medications that provide good overall value. A mix of brand-name and generic drugs. Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs.

Tier 3 - Highest-cost medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics. Ask your doctor if a Tier 1 or Tier 2 option could work for you

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Employee Cost of Coverage

YOUR BI-WEEKLY MEDICAL RATES (26 PAY PERIODS)

HOURLY (Non-Exempt)	UHC & Kaiser Medical Pre-Tax Deduction (per paycheck)			
Plan	**UHC Basic EPO***	**UHC EPO***	**UHC PPO****	**Kaiser HMO (CA)**
Employee Only	$5.80	$18.50	$28.50	$61.01
Employee + Spouse	$52.30	$92.80	$138.00	$192.10
Employee + Children	$46.50	$82.25	$116.70	$171.83
Employee + Family	$107.10	$172.05	$217.45	$309.84

SALARY (Exempt) Up to $149.9k	UHC & Kaiser Medical Pre-Tax Deduction (per paycheck)			
Plan	**UHC Basic EPO***	**UHC EPO***	**UHC PPO****	**Kaiser HMO (CA)**
Employee Only	$10.00	$23.90	$34.00	$66.41
Employee + Spouse	$58.10	$100.30	$146.00	$199.60
Employee + Children	$52.75	$89.40	$125.00	$178.98
Employee + Family	$112.45	$180.60	$226.00	$318.39

*CA – Select Network; Non-CA Choice Network

**CA – Select Plus Network; Non-CA – Choice Plus Network

Note: Employees with an annual salary exceeding $149k will have an additional amount added to their medical deduction. Contact HT Benefits (benefits@hottopic.com) for those amounts.

YOUR BI-WEEKLY DENTAL & VISION RATES (26 PAY PERIODS)

HOURLY & SALARY	Aetna Dental Pre-tax Deduction (per paycheck)			VSP Vision Pre-tax Deduction (per paycheck)		
Plan	**DHMO**	**DPPO**	**Premium DPPO**	**Core***	**Buy-Up**	**Premium**
Employee Only	$3.85	$5.54	$6.48	$0.00	$3.14	$4.20
Employee + 1	$11.33	$16.13	$18.02	$0.30	$4.29	$5.73
Employee + 2 or more	$18.57	$28.89	$31.91	$0.90	$7.70	$10.28

*You may only enroll in the vision core plan if you and/or your dependents are enrolled in a Hot Topic medical plan.

Domestic Partner Cost of Coverage

In accordance with the IRS, Hot Topic's cost of providing benefits for domestic partners who do not meet the IRC Section 152 definition of qualified dependents is considered imputed income and is, therefore, subject to taxes. You will be required to pay for the cost of your domestic partner's coverage on an after-tax basis; in addition, "imputed income" will be added to your W-2 wages when your domestic partner is not your tax dependent. Contact the Hot Topic Benefits Department for more information.

MEDICAL RATES FOR YOUR DOMESTIC PARTNER (DP)

HOURLY (Non-Exempt)	After-Tax Deduction (per paycheck)				Amount Taxable as Income (per paycheck)			
Plan	UHC Basic EPO*	UHC EPO*	UHC PPO**	Kaiser HMO	UHC Basic EPO*	UHC EPO*	UHC PPO**	Kaiser HMO
DP	$46.50	$74.30	$109.50	$131.09	$109.46	$119.20	$130.18	$119.19
DP + Child(ren) of a DP	$101.30	$153.55	$188.95	$248.83	$159.12	$169.55	$213.48	$169.56
EE + EE's Children + DP	$60.60	$89.80	$100.75	$138.01	$72.16	$74.92	$104.94	$74.92

SALARY (Exempt)	After-Tax Deduction (per paycheck)				Amount Taxable as Income (per paycheck)			
Plan	UHC Basic EPO*	UHC EPO*	UHC PPO**	Kaiser HMO	UHC Basic EPO*	UHC EPO*	UHC PPO**	Kaiser HMO
DP	$48.10	$76.40	$112.00	$133.19	$107.87	$117.10	$127.68	$117.09
DP + Child(ren) of a DP	$102.45	$156.70	$192.00	$251.98	$157.98	$166.40	$210.42	$166.40
EE + EE's Children + DP	$59.70	$91.20	$101.00	$139.41	$73.06	$73.52	$104.68	$73.52

*CA – Select Network; Non-CA Choice Network

**CA – Select Plus Network; Non-CA – Choice Plus Network

Note: Employees with an annual salary exceeding $149k will have an additional amount added to their medical deduction. Contact HT Benefits (benefits@hottopic.com) for those amounts.

DENTAL RATES FOR YOUR DOMESTIC PARTNER (DP)

HOURLY & SALARY	After-Tax Deduction (per paycheck)			Amount Taxable as Income (per paycheck)		
Plan	DHMO	DPPO	PREMIUM DPPO	DHMO	PPO	PREMIUM DPPO
DP Only	$7.48	$10.59	$11.54	$0.69	$1.51	$1.51
DP + Child(ren) of a DP	$14.72	$23.35	$25.43	$0.78	$3.26	$3.26

VISION RATES FOR YOUR DOMESTIC PARTNER (DP)

HOURLY & SALARY	After-Tax Deduction (per paycheck)			Amount Taxable as Income (per paycheck)		
Plan	CORE	BUY-UP	PREMIUM	CORE	BUY-UP	PREMIUM
DP Only*	$0.30	$1.15	$1.53	N/A	$0.00	$0.00
DP + Child(ren) of a DP*	$0.90	$4.56	$6.08	N/A	$0.00	$0.00

*You may only enroll your DP and/or DP's child(ren) in the vision core plan if they are enrolled in a Hot Topic medical plan.

Medical (Kaiser Permanente)

Listed below is a summary of the Kaiser HMO plan. More detailed descriptions are available in the plan documents located on the Company Intranet/Human Resources website.

	Kaiser Permanente HMO Plan
	In-Network
Plan Deductible	$500 / $1,000
Plan Out-of-Pocket Max	$3,000 / $6,000
Office Visit	
Primary Provider	$20 copay
Specialist	$20 copay
Preventive Care	No charge
Lab and X-ray	$10 copay per encounter after deductible
MRI, most CT, and PET scans	20% coinsurance up to a maximum of $150 per procedure after deductible
Physical Therapy	$20 copay per visit after deductible
Inpatient Hospitalization	
Hospitalization Services	20% coinsurance after deductible
Outpatient Surgery	20% coinsurance after deductible
Mental Health Services	
Inpatient Hospitalization	20% coinsurance after deductible
Individual Outpatient Treatment	$20 copay per visit
Group Outpatient Treatment	$10 copay per visit
Urgent Care	$20 copay
Emergency Room	20% coinsurance after deductible (waived if admitted)
Ambulance Services	$150 copay per trip after deductible
Prescription Drug Coverage	
Drug Deductible	$100 per individual
Generic (Retail & Mail Order)	$10 copay for up to a 100-day supply
Brand (Retail & Mail Order)	$30 copay for up to a 100-day supply after Drug Deductible
Specialty (Retail Only)	20% up to $200 for up to a 30-day supply after Drug Deductible

Medical (UHC)

Below is a summary of the different medical plans. More detailed descriptions are available in the Summary Plan Descriptions located on the Company Intranet/Human Resources website. Your eligibility for each plan is based on your home zip code.

	Basic EPO	EPO	PPO	
	In-Network	In-Network	In-Network	Out-of-Network
Annual Deductible	$4,000 / $8,000	$750 / $2,250	$1,250 / $3,750	$3,750 / $11,250
Annual Out-of-Pocket Max	$6,800 / $13,600	$3,250 / $7,150	$3,750 / $11,250	$7,500 / $22,500
Office Visit				
Primary Provider	$30 copay	$20 copay	$30 copay	Plan pays 50%[1]
Specialist	$50 copay	$40 copay	$50 copay	Plan pays 50%[1]
Virtual Visits[2]				
Medical	$5 copay	$5 copay	$5 copay	Not Available
Psychologist	$10 copay	$10 copay	$10 copay	Not Available
Psychiatrist (45 min initial visit)	$10 copay	$10 copay	$10 copay	Not Available
Acupuncture & Chiropractor	$30 copay	$20 copay	$30 copay	Plan pays 50%[1]
Limitations	60 Acu visits 24 Chiro visits	60 Acu visits Unlimited Chiro[3]	60 Acu visits Unlimited Chiro[3]	In-Network limitations apply
Out-Patient Mental Health Counseling	$10 copay	$10 copay	$10 copay	Plan pays 50%[1]
Physical Therapy	$30 copay	$20 copay	$30 copay	Plan pays 50%[1]
Lab and X-ray	Plan pays 70%[1]	Plan pays 80%[1]	Plan pays 80%[1]	Plan pays 50%[1]
Inpatient Hospitalization	N/A	$500 admission copay	$1,000 admission copay	$1,000 admission copay
Hospitalization coinsurance	Plan pays 70%[1]	Plan pays 80%[1]	Plan pays 80%[1]	Plan pays 50%[1]
Outpatient Surgery	Plan pays 70%[1]	Plan pays 80%[1]	Plan pays 80%[1]	Plan pays 50%[1]
Urgent Care	$125 copay	$50 copay	$50 copay	Plan pays 50%[1]
Emergency Room	$500 per visit[4]	$500 per visit[4]	$500 per visit[4]	$500 per visit[4]

[1]After deductible
[2]Medical visits accessed through Amwell and DoctorOnDemand. Mental Health visits accessed through United Behavioral Health.
[3]Subject to medical necessity
[4]Copay waived if admitted

To find additional plan info, visit our **Benefits Website** at hottopicboxlunchperks.com and enter this code: HT2020

UHC Choice vs Select:

- **Choice Network:** Non-California plan participants
- **Select Network:** California plan participant

Prescription Drugs (UHC)

Below is a summary of the different prescription drug plans. Detailed descriptions are available in the Summary Plan Descriptions located on the Company Intranet/Human Resources website. Your eligibility for each plan is based on your home zip code.

	Basic EPO	EPO	PPO
	In-Network	In-Network	In-Network
Prescription Drug Deductible	$150 per member*	$150 per member*	$150 per member*
Annual Out-of-Pocket Limit	See Medical OOP Max	$4,100 / $7,550	$3,600 / $3,450
Retail			
Tier 1	$15 copay	$15 copay	$15 copay
Tier 2	$50 copay	$50 copay	$50 copay
Tier 3	$75 copay	$75 copay	$75 copay
Specialty Medications	50% up to $200 max	50% up to $200 max	50% up to $200 max
Supply Limit	31 days	31 days	31 days
Mail & Retail			
Tier 1	$37.50 copay	$37.50 copay	$37.50 copay
Tier 2	$125 copay	$125 copay	$125 copay
Tier 3	$187.50 copay	$187.50 copay	$187.50 copay
Specialty Medications	50% up to $500 max	50% up to $500 max	50% up to $500 max
Supply Limit	90 days	90 days	90 days

*Applies to Brand Drugs in Tiers 2 & 3 combined only
NOTE: Birth Control Covered at 100% in Generic (Tier 1)

Save Money on Prescription Drugs!

- Ask if there is a generic option
- Mail order delivery of maintenance prescriptions saves you time and money
- Compare drug costs by using apps such as GoodRx or SingleCare
- Watch this ***Prescription Drugs Dos and Don'ts Video*** for more

REMINDER: Walgreens is considered out-of-network with our prescription drug plans through UHC.

Use an In-Network provider to save on your out-of-pocket expenses!

Out-of-Network (Basic EPO, EPO & PPO)

Prescription Drug Deductible	$150 per member*
Retail	
Tier 1	Plan pays 70%
Tier 2	Plan pays 70%
Tier 3	Plan pays 70%
Specialty Medications	Plan pays 70%
Supply Limit	31 days

Mail & Retail 90-day supply is not covered out-of-network

Where to Get Care

With many options for getting care, how do you choose? This chart can help you understand how you can save money when your illness or injury is not as emergent. For example, if you think you have pink eye, rather than going to Urgent Care or your Primary Care Physician, consider a Virtual Visit for a much lower cost!

Where to get care	What it is	Type of Care	Cost
Advocate4Me	Advocates have a wide range of qualifications, from nursing degrees to complex claims resolution. They also have access to a full team of clinicians, pharmacists and more.	• Benefits and claims assistance • Choosing appropriate medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthier lifestyle • Answering medication questions	**No additional cost**
Virtual Visit	A virtual visit lets you see a doctor via your smartphone, tablet or computer. Best of all, the convenience of medical virtual visits are available to you for a $5 copay when you're enrolled in one of our UHC medical plans!	• Allergies • Pink eye • Bronchitis • Cough/colds • Diarrhea • Fever • Rashes • Seasonal flu • Sinus problems • Sore throats • Stomach aches • Bladder infections	**$**
Primary Care Physician (PCP)	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Annual Physical • Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management	**$$**
Urgent Care (UC)	Urgent care is ideal for when you need care quickly, but it is not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Minor burns • Minor infections • Minor broken bones • Cuts that may need a few stitches	**$$$**
Emergency Room (ER)	The ER is for serious life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Heavy bleeding • Large open wounds • Sudden change in vision • Sudden weakness or trouble talking • Chest pain • Major burns • Spinal injuries • Severe head injury • Breathing difficulty • Major broken bones	**$$$$**

Dental (Aetna)

Listed below is a summary of the different dental plans. More detailed descriptions are available in the Summary Plan Descriptions located on the Company Intranet/Human Resources website.

	Aetna Dental DHMO	Aetna Dental DPPO		Aetna Dental Premium DPPO	
	In-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Calendar Year Deductible	$0 / $0	$50 / $150 (waived for diagnostic & preventive)	$75 / $225	$50 / $150 (waived for diagnostic & preventive)	$75 / $225
Calendar Year Maximum	Unlimited	$1,500 per member	$1,500 per member	$2,000 per member	$2,000 per member
Diagnostic & Preventive	$0 - $88 copay[1]	Plan pays 80%	Plan pays 80%	Plan pays 90%[3]	Plan pays 80%[3]
Basic Services					
Endodontics	$0 - $400 copay[1]	Plan pays 80%[2]	Plan pays 50%[2]	Plan pays 90%[2]	Plan pays 50%[2]
Periodontics	$10-$375 copay[1]	Plan pays 80%[2]	Plan pays 50%[2]	Plan pays 90%[2]	Plan pays 50%[2]
Major Services	$0-$460 copay[1]	Plan pays 50%[2]	Plan pays 50%[2]	Plan pays 50%[2]	Plan pays 50%[2]
Orthodontic Services					
Orthodontia	$2,000[1]	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Lifetime Maximum	Unlimited	$1,500 per member	$1,500 per member	$2,000 per member	$2,000 per member
Children up to age 26	Covered	Covered	Covered	Covered	Covered
Adults	Covered	Covered	Covered	Covered	Covered

[1]Refer to the copay schedule for a full list of covered services and costs

[2]After deductible

[3]Diagnostic & Preventive waived from applying to Calendar Year Maximum

Aetna Discounts on Oral Health Care Products & Personal Protective Equipment

Aetna understands how import it is to continue good oral health habits during this time. Aetna provides discounts on oral health care products so members can keep their mouth as healthy as possible. Members can also receive discounts on personal protective equipment (PPE) during these times when they need it the most.

To access these discounts, visit the Aetna member website at aetna.com.

- Sonic electric toothbrush, mini toothbrush and replacement brush heads
- Oral health care kits, which include a toothbrush, toothpaste, tongue cleaner, floss, and a pouch to carry everything:
  - Adult travel kit
  - Teen kit
  - Kids oral health kit
  - Baby oral health kit
  - Travel hygiene kit
- Personal Protective Equipment (PPE) includes:
  - 3-ply masks
  - No-touch thermometers

Check the Aetna site frequently as we will be adding additional PPE products the coming weeks.

NOTE: THESE ARE DISCOUNTS ONLY. The member is responsible for the full cost of the discounted services. Benefit plans are insured and/or administered by Aetna Life Insurance Company and its affiliates.

Vision (VSP)

Listed below is a summary of the different vision plans. VSP Provider Network for all plans: **VSP Choice.** NOTE: No ID card is necessary. Just tell your VSP network provider that you have VSP.

	VSP Vision Core		VSP Vision Buy-Up		VSP Vision Premium	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Eye Exam						
Benefit	$10 copay	Allowance up to $45	$10 copay	Allowance up to $45	$10 copay	Allowance up to $45
Frequency	12 months	12 months	12 months	12 months	12 months	12 months
Lenses						
Single	20% discount	Not covered	$25 copay	Allowance up to $30	$25 copay	Allowance up to $30
Bifocal	20% discount	Not covered	$25 copay	Allowance up to $50	$25 copay	Allowance up to $50
Trifocal	20% discount	Not covered	$25 copay	Allowance up to $65	$25 copay	Allowance up to $65
Frequency	Unlimited	N/A	12 months	12 months	12 months	12 months
Frames						
Benefit	20% discount	Not covered	Allowance up to $150	Allowance up to $70	Allowance up to $180	Allowance up to $70
Frequency	Unlimited	N/A	24 months	24 months	12 months	12 months
Contacts						
Medically Necessary	15% discount	Not covered	Covered in Full	Allowance up to $210	Covered in Full	Allowance up to $210
Elective	15% discount	Not covered	Allowance up to $120	Allowance up to $105	Allowance up to $180	Allowance up to $105
Frequency	Unlimited	N/A	12 months	12 months	12 months	12 months

Extra Savings through VSP

- **Glasses & Sunglasses:** 20% savings on complete pair of prescription glasses and sunglasses, including lens enhancements, from any VSP Provider within 12 months from your last Well Vision Exam.
- **Retinal Screening:** No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam. Not applicable to VSP Base Plan.
- **Laser Vision Correction:** Average 15% off the regular price, or 5% off the promotional price; discounts only available from contracted facilities.

EYECONIC.COM

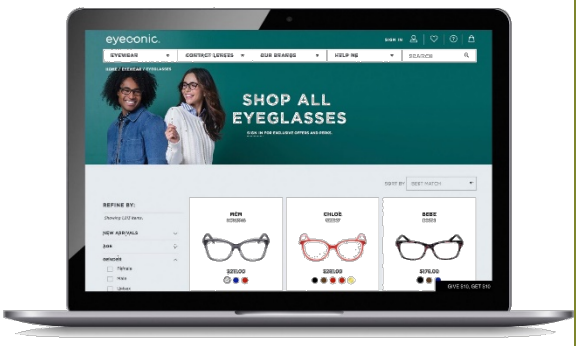
Eyeconic is the only place where VSP members can shop online for contacts and eyewear with their VSP insurance in-network.

Personalized: As a VSP-owned company, Eyeconic seamlessly connects VSP vision benefits to your account.

Simple: Save time and money on quality eyewear with a few easy clicks.

1. Connect your vision insurance.
2. Select your product.
3. Upload your prescription or provide your doctors contact info and we'll take care of the rest.

Choice: Eyeconic offers a variety of well-known brands and contact lenses. Choose from over 35 eyewear brands and over 1,600 styles.



Life & Disability Insurance (Reliance Standard)

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Basic Life and AD&D Insurance pays you or your beneficiary if you die or suffer from loss of a limb, speech, sight, or hearing. Cost of coverage is paid for by Hot Topic. *

Basic Life and AD&D Amount	$25,000

*You may opt-out by contacting Benefits

SUPPLEMENTAL LIFE

Supplemental Life Insurance allows you to buy additional life insurance to protect your family's financial security.

Employee Supplemental Life Amount	Increments of $10,000 up to $200,000
Spouse/DP Supplemental Life Amount	Increments of $5,000 up to $200,000[1]
Child(ren) Supplemental Life Amount	Increments of $2,000 up to $10,000[1,2]

[1] Not to exceed 100% of employee amount

[2] Birth to age 26, regardless of student or marital status

Supplemental Life Costs (Per Paycheck)

Employee Rates per $10,000 Coverage: Costs range between $0.23 and $12.71 depending on your age.
Spouse/DP Rate per $5,000 Coverage: Costs range between $0.11 and $6.35 depending on your Spouse/DP's age.
Dependent Child Rate: Costs range between $0.19 and $0.92 depending on the coverage amount you elect.

SHORT-TERM DISABILITY (STD)

STD Insurance helps pay the bills if you are unable to work due to a non-work-related injury, illness or pregnancy.

Weekly Benefit Amount	Plan pays 60% of covered weekly earnings
Max Weekly Benefit	$2,308
Benefits Begin After:	
Accident	7 days of disability
Sickness	7 days of disability
Max Payment Period*	12 weeks

*Maximum payment period is based on the first day you are disabled, not when benefits begin. Payments received through employer-funded disability are taxable.

LONG-TERM DISABILITY (LTD)

LTD Insurance protects a portion of your income if you are unable to work for an extended period of time.

LTD Core – Provided at no cost to you!

Monthly Benefit Amount	Plan pays 40% of covered monthly earnings
Maximum Monthly Benefit	$5,000
Benefits Begin After:	90 days of disability
Maximum Payment Period*	Social Security normal retirement age

LTD Buy-Up

Monthly Benefit Amount	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefit	$7,500
Benefits Begin After:	90 days of disability
Maximum Payment Period*	Social Security normal retirement age

*Age at which the disability begins may affect the duration of the benefits.

NOTE: There is a 12 month waiting period before benefits would be paid if you need to be off of work due to a preexisting condition.

LTD Buy-Up Insurance Cost (Per Paycheck) Calculation*

Your Cost LTD Buy-Up	Equation
Buy-Up costs $0.13 per $100 of coverage:	Hourly Rate ____ x 2080 = ____ x .0013 ÷ 26 = ____ (Per paycheck)

*This calculation method does not apply to those who earn over the cap of $150,000 annually

Short-Term and Core Long-Term Disability Costs

STD and Core LTD Insurance benefits are provided at no cost for Full-Time employees working 32 or more hours per week. STD may be coordinated with State Disability Insurance*, Social Security, and other non-company programs. Like STD, the amount of LTD pay you may receive is reduced by income received from other income sources like State Disability Insurance, if applicable.

*Employees in California may not be eligible for this benefit due to State Disability Insurance (SDI).

Flexible Spending Accounts (FSAs)

IMPORTANT CONSIDERATIONS

- Our new FSA plan year is 01/01/22 – 12/31/22
- Hot Topic allows a 2½ month grace period which means you have until 03/15/23 to incur claims
- You have until 3/31/23 (90-day claims run-out) to submit claims for reimbursement.
- USE-IT-OR-LOSE-IT. Any unused funds by the end of the plan year or grace period will be forfeited. Unused funds do NOT roll over.
- You must re-elect your FSA contribution during Open Enrollment for the next plan year. Elections from the previous plan year will NOT roll over.
- Domestic Partners are not eligible to participate in the FSA program.
- You do not have to be enrolled in a Hot Topic medical plan in order to use the Health Care or Dependent Care FSA.

WHAT IS FSA?

Flexible Spending Accounts (FSAs) allow you to direct a part of your pay, tax-free, into a special account that you can use throughout the year to pay for certain eligible out-of-pocket health and/or dependent care expenses and lowers your taxable income, which means you save more money! The catch is that FSAs are USE-IT-OR-LOSE-IT benefits meaning you will forfeit any remaining balance in your FSA account if you have not used all of your funds by the end of the plan year or the grace period (03/15/23), so plan carefully!

HEALTH CARE FSA (HC FSA)

You can pay for your qualifying expenses using your debit card OR with your own money and then submitting receipts for reimbursement.

Examples of Eligible Expenses:

- Deductibles, office visit copays
- Prescription drug copays
- Over-the-counter drugs
- Eyeglasses, contact lenses
- Hospital services, physical therapy
- Acupuncture and chiropractor visits
- Braces, dental treatments

The maximum annual amount you may elect is $2,750 in 2022. You may start to use the amount you've elected on the first day of your effective date.

DEPENDENT CARE FSA (DC FSA)

The money you put in a DC FSA can be used to reimburse your expenses incurred while you work. If married, your spouse needs to be employed, actively seeking work, or a full-time student in order for the expenses to be eligible for reimbursement.

Examples of eligible expenses include day care, senior day care, before and after school programs, and sick child care. Dependents have to be under age 13 and/or declared as a dependent on your taxes.

The annual amount you may elect up to the household max of $5,000 in 2022.

Commuter Benefits (GoNavia)

COMMUTER BENEFIT PROGRAM

The GoNavia Commuter program allows you to pay for your work-related parking and transit expenses using pre-tax dollars. In 2021, you can set aside up to $270 per month in pre-tax dollars to spend on eligible parking and transit expenses. As a month-to-month benefit, you can opt in and out of the benefit at any time based on your transit or parking needs for the upcoming month!

ELIGIBLE EXPENSES

The GoNavia Commuter Benefit covers your work-related public transit and parking expenses including, but not limited to:

- Subways, streetcars, and commuter trains
- Buses
- Ferries
- Parking lots and garages
- Vanpool
- Rideshare, including UberPOOL and Lyft Shared Rides

Ineligible expenses include any non-work related expenses and individual transportation services like a taxi or a driving service.

HOW IT WORKS

Once registered on the Navia website, you can place an order for your monthly transit and parking needs. The order amount will be deducted from your paycheck pretax and loaded onto a Navia Benefits Debit MasterCard. You'll then use that card to purchase your work-related parking and transit expenses directly from your provider.

NAVIA BENEFITS DEBIT CARD

You'll be able to use this debit card at any transit or parking authority that uses the MasterCard® system. This includes:

- Transit Offices and Kiosks
- Transit Authority Websites
- Parking Lots/Garages

Your debit card has the technology to recognize that you're paying for a transit or parking expense based on your card swipe, so you don't need to submit those receipts.

UNUSED FUNDS

If you don't have the expenses to use all of your funds within the month, the balance will automatically roll over from month-to-month as long as you are an active employee and remain eligible for the benefit.

ADDITIONAL INFORMATION

To learn more or to register for this new benefit offering, click on the following hyperlink to visit the GoNavia Commuter Benefits website.

Retirement Planning

MEDICARE ASSISTANCE PROGRAM

SGIA Medicare Consulting is a new resource available to help answer any Medicare questions you might have. Best of all, it's free!

Many times, a Medicare plan is a better, less expensive option for those who are 65 and over. SGIA's expert Medicare consultants are licensed and trained to help you make informed decisions.

With SGIA, you can get:

- Unbiased individualized needs analysis for a Medicare plan selection.
- Better understanding of how Medicare can coordinate with or replace a group health plan.
- Expert information and advice simplifying Medicare programs.
- Offerings of all major Medicare plans in your area.
- Enrollment assistance and tracking process.
- Lower coinsurance and copay costs available.
- Annual Medicare plan reviews.

For personal consultations and Medicare information, contact SGIA by phone at (888) 284-3314 or email info@sgiamedicare.com.

ROTH 401(K)

Hot Topic offers you another new way to save for retirement. Your Roth 401(K) will be deducted on a post-tax basis which means that at retirement, you will not be taxed on your employee contribution. Learn more about this new retirement plan on the benefits website.

401(K) PLAN

It's never too early or too late to plan for retirement. Hot Topic's 401(K) plan is administered by John Hancock Retirement Plan Services.

Eligibility: You must be at least 21 years old and you must have completed at least 200 hours of service. Eligibility begins the 1st of the month following 200 hours of service. Note: Employees in Puerto Rico & Canada are not eligible at this time.

Enrollment: Visit **myplan.johnhancock.com** and select the "register now, get started with your plan" link.

- Complete the registration process then make your saving and investment elections.
- Your savings deduction will start 1st of the month after you complete enrollment.

Make Changes Online: Log in to **myplan.johnhancock.com**

- **Increase or decrease your savings election:** Your new savings percentage will be effective the 1st of the month after you complete the change.
- **Stop your savings deduction:** Your new savings election will be effective 1st payroll after you complete the change.

Employee Contributions: You choose how much money you want to have deducted from each paycheck and that savings is deposited into an account for you.

Company Contributions: The Company will match 50% of the first 4% of what you contribute.

Vesting: The money the company contributes has a 3-year vesting period based on your original hire date. At the end of 1 year of employment, you are 0% vested; at the end of 2 years, 50% vested; and at the end of 3 years, 100% vested.

Investment Options: You can change your investment elections as often as you like. Some funds have trading restrictions which may limit the frequency and the amount of dollars that you can move between funds.

Refer to the fund fact sheet that was sent to you when you first became eligible for the plan. Updated investment results can be found by logging into your account at www.mylife.jhrps.com

Time Off From Work

HOLIDAYS

Hot Topic observes six paid holidays in the U.S. each year:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

BEREAVEMENT

All employees are eligible for 3 days of bereavement pay if an immediate family member passes away.

VOLUNTEER TIME OFF

Hot Topic employees or DC Manager/Supervisors can take up to 8 hours per quarter - working on a pre-approved list of companies to help out a charity of their choice. You are eligible after 90 days of service and time off is prorated.

JURY DUTY

Regular full-time employees can be paid up to 10 days missed due to jury duty service within a calendar year.

LEAVES OF ABSENCE

There are situations that may require an employee to be absent from work for an extended period of time. You may request a leave of absence for medical (including pregnancy), family care, or military service. Your leave of absence request has to be in writing on a "Request for Leave of Absence Form," indicating the dates you request to be away from work, and requires approval from both your immediate supervisor and Human Resources.

If you require a leave of absence, please e-mail LOARequests@hottopic.com for information.

SICK PAY

Sick Pay is offered to all SM, FTASM, and PTASM. Store Associates in locations listed in SOP #5025 are eligible for sick pay.

FLEX TIME OFF (FTO) & VACATION

You will accrue FTO, which will allow you to take time off from work without having to specify a reason. FTO will accrue each pay period and you can use FTO after completing thirty (30) days of employment. It accrues as noted in the tables below.

FTO ACCRUAL (HQ, DC, RD & DM)

Years of Service	Annual FTO Accrual	Accrual Max
0-4 years	120 hrs (4.615 hrs bi-weekly)	180 hrs
5-9 years	160 hrs (6.153 hrs bi-weekly)	240 hrs
10-19 years	200 hrs (7.692 hrs bi-weekly)	300hrs
20 + years	240 hrs (9.230 hrs bi-weekly)	360 hrs

VACATION ACCRUAL (STORE ASSOCIATES*)

Regular Part-Time Assistance Managers who have been with Hot Topic Inc. for at least one year are eligible for an annual vacation accrual of up to 24 hrs with accrual max of 36 hrs.

Full-Time Store Associates will be eligible to take vacation after completing their first 90-days of regular full-time employment provided accrued vacation time is available.

Years of Service	Annual Vacation Accrual	Accrual Max
0-4 years	Up to 80 hrs (3.077 hrs bi-weekly)	120 hrs
5-9 years	Up to 120 (4.615 hrs bi-weekly)	180 hrs
10-19 years	Up to 80 hrs (3.077 hrs bi-weekly)	240 hrs
20 + years	Up to 200 hrs (7.692 hrs bi-weekly)	300 hrs

*Full-Time Store Associates scheduled to work 40 hrs/week

Work / Life Perks

EMPLOYEE ASSISTANCE PROGRAM (EAP)

All covered Hot Topic employees and family members are eligible for the Employee Assistance Program (EAP) through Reliance Standard.

- Confidential counseling by phone 24 hours a day, seven days a week
- Referrals to local counselors and healthcare professionals
- 3 face-to-face counseling sessions per year[1]
- Legal information, counseling, and references
- Financial information and counseling

Phone (855) 775-4357 / Text: 858-224-2094 / Email rsli@acieap.com

Web rsli.acieap.com / Company Code: RSLI859 / Mobile App myACI

HT FOUNDATION

The Hot Topic Foundation's goal is to change lives by increasing access to mental health programs and music education. Hot Topic Foundation proudly teams up with non-profits that provide these resources to those in need. Through our appreciation of music and our Company culture, we hope to promote the arts through experiences and education that enrich the lives of young people.

TUITION ASSISTANCE PROGRAM

Working and going to school can be challenging! Affording school can be challenging. Hot Topic Inc. is a strong supporter of education and wants to help make it a little easier. The Hot Topic Inc. Tuition Assistance Program (TAP) provides eligible employees with money for school. If you meet certain eligibility requirements, you could receive $400 per course and 1 textbook per course up to $100 – three times per year.

DISCOUNTS

Hot Topic Associate Discount Amounts:

- 40% associate discount on Hot Topic apparel, accessories, shoes and select novelty items.
- 40% on Hot Topic gift cards, in-store only.
- 20% associate discount on high end collectibles over $50, CDs, vinyls, DVDs, and most electronic items, in-store and online.

BoxLunch Associate Discount Amounts:

- 30% associate discount on BoxLunch accessories, shoes, novelty items, CDs, vinyl, DVDs and select electronic items, in store only.
- 30% on BoxLunch gift cards, in-store only.

Pet Insurance:

Hot Topic Inc. offers pet insurance, which helps ensure pets receive the care they need when they need it. VPI Pet Insurance offers a 5% group discount. Call 1-877-738-7874 to enroll.

[1]Limited to 3 sessions per 6 months for CA employees

Mid-year Benefit Changes

Three rules apply to making changes to your benefits during the year:

1. Any change you make needs to be consistent with the change in status, AND
2. You need to make the change within **30 days** of the date the event occurs (unless otherwise noted above).
3. Benefit changes will be effective the first of the month following the life event (changes related to a promotion are subject to a 30-day waiting period).

Note: To enroll qualified dependents, you will be required to provide documentation, e.g. marriage/birth certificates, state/court documents, declaration of domestic partnership, etc. within 30 days of their eligibility.

CHANGING YOUR BENEFIT ELECTIONS

Other than during the annual "Open Enrollment" period, you may only make changes to your benefit elections if you experience a "qualified status change" or qualify for a "special enrollment." Qualified status changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, or death of a spouse.
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child.
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child.
- **Change in work schedule,** including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- **Change in a child's dependent status,** either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- **Change in place of residence or worksite,** when the change affects the accessibility of network providers.
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment.
- **Change in an individual's eligibility for Medicare or Medicaid.**
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have 60 days after the following events to request enrollment if:
    - Employee or dependent loses eligibility for Medicaid or CHIP.
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Mental Health Resources

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employee Assistance Program (EAP) is a service available at no cost to you or your dependents. This resource offers a variety of confidential resources to help you resolve issues, plan for life events or manage daily life stress and situations:

- Confidential counseling by phone 24/7/365
- Referrals to local counselors and healthcare professionals
- 3 face-to-face counseling sessions per year*
- Unlimited financial consultation
- Legal consultation, 25% discount for services beyond initial consultation
- Child, elder, & pet care referrals and resources
- Education, personal services, and health and wellness referrals and resources
- Veteran resources and support

*Limited to 3 sessions per 6 months for CA

LIVE AND WORK WELL

The Live and Work Well website gives you quick and secure access to all the mental health resources that are available to you through your UHC plan 24/7.

- Get help with mental health or substance use issues
- Search for mental health providers, facilities or telemental health services
- Access articles, tools and videos about substance use or a specific physical or mental health condition
- Crisis support when you or a loved one needs help now
- Securely access all your benefits programs
- Self-service options reduce the hassle of managing claims, notifications and updating personal info.

Visit liveandworkwell.com. Register and log in. Or click "I don't know my access code" and then select "I am a member of UnitedHealthcare"

HOT TOPIC MENTAL HEALTH FOUNDATION

- **Mental Health America:** Get screened anytime, anywhere with the Mental Health America's Screening Tool. Screens are anonymous, free, and confidential.
- **National Suicide Prevention Lifeline & Crisis Text Line:** If you or someone you know is in crisis, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or text MHA to 741-741 to be connected to a trained Crisis Counselor 24/7.
- **LGBTQ Community Resources:** If you're a member of the LGBTQ community and need to talk to a trained counselor, call the Trevor Project's TrevorLifeline 24/7 at 1-866-488-7386.
- **Hot Topic Benefits Website:** For more information, visit hottopicboxlunchperks.com and/or refer to our Hot Topic Mental Health Toolkit.

BEHAVIORAL HEALTH VIRTUAL VISITS

Behavioral health virtual visits provide quick and easy access to behavioral health professionals from your mobile device, tablet or computer. Use for needs such as depression, anxiety, **a**ddiction**, m**ental health disorders and counseling. And they're a part of your behavioral health benefit through UHC's EPO, PPO and Basic EPO plans for $10 copay!

To schedule a behavioral health visit:

1. **Visit myuhc.com.** Sign in or register for account.
2. **Find a doctor.** Click Find a Doctor >Mental Health Directory >People >Provider Type >Telemental Health Providers.
3. **Refine search.** Refine as needed, and choose a provider with the "telemental health provider" designation.

Call provider. Call the provider to set up a time.

Sanvello™ is a self-help app that gives you access to clinically tested techniques, coping tools and community support to help manage stress, anxiety and depression.

Relieve symptoms and build life skills through:

- Daily mood tracking
- Personalized progress
- Guided journeys.
- Community support.

The Sanvello app gives you premium access at no cost, plus ways to relax, be present and stay focused.

Talkspace is an online therapy app that allows you to securely message a licensed therapist, any time, from your phone or desktop. No office visit required.

- Find a therapist with an online matching tool.
- Start therapy within hours of choosing your therapist.
- Therapists respond daily, five days a week.
- Schedule live video sessions, when needed.
- Download the Talkspace app.

Talkspace is confidential, convenient and it's covered under our UHC EPO, PPO, and Basic EPO plans for a $10 copay.

Wellness Resources

REAL APPEAL (UHC)

UHC members now have access to a new wellness program! Real Appeal is a 52-week, no cost personalized online weight loss program that is a part of your UHC benefits. Qualified members with a BMI of 23 or higher get a Real Appeal Transformation Coach who will customize the program to specific needs, goals and lifestyles.

Real Appeal will send participants a success kit to get them started on their journey toward those lifestyle changes. The kit includes a scale, workout videos, recipe books, and more.

The Real Appeal online dashboard and mobile app offers a variety of online tools to help track food, activity and weight loss progress. Enroll now at enroll.realappeal.com.

From there, members will benefit from:

- Weekly online group sessions from the comfort of their home or office
- Entertaining, educational, and engaging video content with known celebrities
- 1:1 messaging with Transformation Coaches
- 1:1 coaching for those at-risk members

RALLY® (UHC)

Real Appeal is powered by Rally Coach. Rally is designed to help you improve and maintain your health. UHC members can start with the quick Health Survey and get your Rally Age to help you assess your overall health. Rally will offer personalized recommendations to help you move more, eat better, and stress less.

Sync your tracking device, join a Challenge, and earn virtual coins that you can exchange for rewards for taking healthy steps every day. Get started today at myuhc.com

WELLNESS COACH (KAISER)

Are you looking to make a lifestyle change? Partner with a wellness coach to create a customized plan that outlines small, easy steps that you can take to:

- Manage your weight
- Quit tobacco
- Reduce stress
- Increase activity
- Eat healthier

Schedule convenient phone sessions at times that work for you. Coaching is available at no cost to Kaiser Permanente members, in English and Spanish. No referral is needed.

For more information, visit kp.org/wellnesscoach or call (866) 862-4295 from Monday through Friday 7 a.m. to 7 p.m. (PST) to set up an appointment today.

HEALTHY LIFESTYLE (KAISER)

Kaiser members can get advice, encouragement, and tools to help you create positive change in your life with the Healthy Lifestyle Program.

These complimentary programs can help you:

- Lose weight
- Eat healthier
- Quit smoking
- Reduce stress
- Manage ongoing conditions like diabetes or depression

Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. You can also share and dicss the results with your doctor. For more, visit kp.org/healthylifestyles.

Maternity Support

Here's what to do if you or your dependent are pregnant

☐	**Congrats there is a baby on the way!** Enroll in the maternity support program with your medical benefit provider. Both employees and spouses are eligible. **UHC:** www.uhc.com/health-and-wellness/health-topics/pregnancy **Kaiser:** https://healthy.kaiserpermanente.org/health-wellness/maternity
☐	**Let's celebrate!** Once enrolled in the maternity support program reach out to benefits@hottopic.com for your exclusive Hot Topic new parent gift
☐	**Time to plan!** Reach out to HTLOARequests@hottopic.com to start planning your leave and return once baby arrives

Need more information?

Check out our Parents-to-be Guide

alliantbenefits.cld.bz/ht-2021-benguide

Visit the Benefits Website

hottopicboxlunchperks.com
(Passcode HT2020) and click the "Life/Work" tab

Mobile Resources

MEDICAL
UNITEDHEALTHCARE APP

With the UnitedHealthcare app, you can stay on top of your benefits anywhere you go.

The UnitedHealthcare app allows you to:

- Access your health plan ID card
- View your copay, annual deductible and out-of-pocket expenses.
- Find network care options for doctors, clinics and hospitals in your area.
- Talk to a doctor by video 24/7

Download the UnitedHealthcare app from the App Store or Google Play today!

MEDICAL
KAISER PERMANENTE APP

Managing your health care just got easier with the Kaiser Permanente mobile app. Once you register for an online account, you can use the app to easily:

- Check most lab results
- Email your doctor's office with non-urgent questions
- Refill most prescriptions
- Schedule routine appointments
- Pay medical bills
- Find doctors and locations

DENTAL
AETNA MOBILE APP

With Aetna Mobile, you can use your cell phone with web access to view your dental plan information — whenever you want, wherever you are. The Aetna Mobile app is available for Android™ and iPhone® mobile devices.

Features of Aetna Mobile:

- **Find a doctor -** it's easy to search for dentists in your area.
- **Pull up your dental ID card information -** if you left your ID card at home, it's no problem.
- **Check benefits and coverage information -** just clear, accurate details when you click.
- **Search claims** - no more guesswork when you don't have the paperwork with you.

VISION
VSP VISION CARE APP

Manage your eye care needs at any time, and from anywhere. Find a doctor, view your benefits, access your vision card, and see special offers. Caring for your eyes has never been so easy.

VSP Vision Care app capabilities:

- Find a VSP doctor near you.
- View your vision benefits.
- View your Member Vision Card.
- Look up your past services and previous doctor's visits.
- Get exclusive member savings from leading brands.
- See frame and contact lens brands prior to your office visit.

COMMUTER
MYNAVIA APP

The MyNavia App allows you to manage and access your benefits right from your smartphone! Available for iPhone and Android devices, the MyNavia App is a free-to-download and free-to-use tool for any Navia participant with Commuter benefits.

With the MyNavia app:

- Easy claim submission
- Receive claim alerts
- View account balances
- Fingerprint and facial ID login
- Access our list of eligible expenses
- Manage GoNavia commuter orders

Directory of Providers

YOUR BENEFIT ADVOCATE

Hot Topic offers you confidential access to Benefit Advocates who can help you with:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Coverage changes due to life events (marriage, new child, divorce, etc.)

Contact your Benefit Advocate today by emailing alliantba@alliant.com or by calling 888-585-5399 between 8:30a.m. - 5:00p.m., Monday through Friday.

Need Claims Assistance? You'll need to complete a HIPAA Authorization Form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed. NOTE: Benefit Advocate is a free service provided by Alliant Employee Benefits. You can still contact your Hot Topic Benefits Department via email at Benefits@hottopic.com.

Category	Carrier	Phone	Website	Policy/Group #
Medical	UnitedHealthcare (UHC)	800-842-2982	myuhc.com	**714347**
Medical	Kaiser Permanente (CA)	800-464-4000	kp.org	**234910**
Advocate4Me	UHC Advocate4Me	800-842-2982	myuhc.com	**714347**
Dental	Aetna	877-238-6200	aetna.com	**658727**
Vision	Vision Service Plan	800-877-7195	vsp.com	**12286153**
Life and AD&D	Reliance Standard Life and AD&D	800-351-7500 x4149	reliancestandard.com	**GL 96,000**
STD / LTD	Short- and Long-Term Disability (STD/LTD)	866-533-3438	reliancestandard.com	**STD:** G 100,001 **LTD:** LSC 97,200
EAP	ACI Specialty Benefits	855-775-4357	rsli.acieap.com	**Company Code:** RSLI859
Commuter	GoNavia Commuter Benefits	800-669-3539	naviabenefits.com	**N/A**
Benefits Questions?	Your Designated Benefits Advocate	888-585-5399	**Email:** alliantba@alliant.com	**Company Name:** Hot Topic
Human Resources	Benefits Department	626-839-4681	**Email:** benefits@hottopic.com **Fax: 626-609-2306**	**N/A**
401(k)	John Hancock Retirement Plan Services	800-294-3575	myplan.johnhancock.com	
Visit the Hot Topic Benefits Website at https://hottopicboxlunchperks.com/ Code: **HT2020**				

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices:

The HIPAA Notice of Privacy Practices is sent to participants when they become active on the plan. The information in this benefits book outlines the benefits that are effective January 1, 2022. It is not meant to be a complete explanation of each plan. Please refer to the Summary Plan Descriptions (SPDs) and insurance policies/certificates for more information. SPD's/certificates are available on the intranet. The information presented in this book is not intended to be construed to create a contract between Hot Topic Inc. and any one of Hot Topic Inc.'s employees. In the event that the content of this book or any oral representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document or insurance policies, the provisions of the plan document, insurance policy, or certificate are controlling. Hot Topic Inc. reserves the right to amend, modify, suspend, replace, or terminate, any of its plans, policies, or programs, in whole or in part.

Required Federal Notices

AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting the Benefit Advocates.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in a Hot Topic health plan for your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a Hot Topic health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective from the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Hot Topic's medical plan if your dependent becomes eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician for:

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

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this plan. You can contact your health plan's Member Services for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by Hot Topic represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Hot Topic offers a variety of benefit plans to eligible employees. The federal healthcare reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by Hot Topic are available by visiting our Hot Topic company intranet or calling the Benefit Advocates at (844) 481-9971.

CONTINUATION OF BENEFITS UNDER COBRA

If a qualifying life event occurs that causes you, your spouse, or your children to lose coverage under our group healthcare plan, you have a legal right under COBRA to purchase a temporary extension of group health coverage. Qualifying life events include reduction in work hours, termination of employment (except for gross misconduct), death of the employee, legal separation or divorce, or loss of eligibility for child coverage.

The purchase price of continuing coverage is the full cost of the premium for similarly situated active employees, plus 2 percent (50 percent in certain cases) to help pay for administrative costs. The period for which the coverage can be continued depends on the nature of the qualifying event. Employees or family members who otherwise would lose coverage must inform the COBRA Administrator of their election of COBRA coverage within 60 days of the qualifying event.

There is no waiting period, no exclusion for pre-existing conditions and no physical examination when electing continuation coverage. Any amounts already paid toward deductibles and coinsurance during the current year count under the continuation policy.

This policy statement is a brief description of the healthcare continuation plan and does not fully explain employees' rights under COBRA. You should read the COBRA notice you received when you first enrolled in the group health plan or the summary plan description for a fuller explanation.

MEDICARE PART D

Important Notice from Hot Topic 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 Hot Topic, Inc. 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. Hot Topic, Inc. has determined that the prescription drug coverage offered by Hot Topic'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 Hot Topic, Inc. coverage may 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 Hot Topic'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 Hot Topic prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Hot Topic, Inc. 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 Hot Topic, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	January 1, 2022
Name of Entity:	Hot Topic
Contact:	Human Resources
Address:	18305 E San Jose Avenue, City of Industry, CA 91748
Phone:	(626) 839-4681

PREMIUM ASSISTANCE UNDER MEDICAID & 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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: Medicaid https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/hawki Phone: 1-800-257-8563
KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6027 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid

Website: http://gethipptexas.com/	Phone: 1-800-440-0493	
UTAH – Medicaid and CHIP		
Medicaid Website: https://medicaid.utah.gov/	CHIP Website: http://health.utah.gov/chip	Phone: 1-877-543-7669
VERMONT– Medicaid		
Website: http://www.greenmountaincare.org/	Phone: 1-800-250-8427	
VIRGINIA – Medicaid and CHIP		
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm		Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm		Phone: 1-855-242-8282
WEST VIRGINIA – Medicaid		
Website: http://mywvhipp.com/	Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	
WASHINGTON – Medicaid		
Website: https://www.hca.wa.gov/	Phone: 1-800-562-3022	
WISCONSIN – Medicaid and CHIP		
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	Phone: 1-800-362-3002	
WYOMING – Medicaid		
Website: https://wyequalitycare.acs-inc.com/	Phone: 307-777-7531	

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 1/31/2023)

HOT TOPIC INC.

HOT TOPIC BOXLUNCH Her Universe

Rev. 9/10/2021