Full-Time Employee

Guide

2025

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"…and if you spend yourselves on behalf of the hungry and satisfy the needs of the oppressed, then your light will rise in the darkness, and your night will become like the noonday."

–Isaiah 58:10

Mission, Vision & Commitment

Mission

Feeding God's starving children, hungry in body and spirit.

Vision

Through God, Feed My Starving Children (FMSC) will strive to eliminate malnutrition and starvation in children throughout the world by helping to instill compassion in a generation that hears and responds to the cries of those in need, until all are fed.

Our Commitment to Excellence

We will provide for our employees a satisfying work environment that is based on trust, mutual respect and doing the right thing.

Human Resources Mission Statement

Strategically partnering in building FMSC's global operations by recruiting, developing, rewarding and retaining our national workforce and aligning it with our Christian mission and values.

Diversity, Equity and Inclusion Statement

At Feed My Starving Children, we feed kids, feed spirits, and empower communities. To do this well, we must continually invest in diversity and inclusion. All of God's children – whether they eat FMSC meals, distribute them, fund them, or work to make them possible – bear His image. Jesus calls us to love our neighbors and for us, that means welcoming, honoring, and empowering each and every one. These values are non-negotiable.

Our employees are our most valuable asset.

THAT'S WHY FMSC IS COMMITTED TO PROVIDING EMPLOYEES WITH A COMPREHENSIVE BENEFIT PROGRAM THAT SUPPORTS HEALTH AND WELLNESS.

Stay healthy

- Medical Insurance
- Dental Insurance
- Health Savings Account
- Flexible Spending Account
- Vision Plan

Feel Secure

- 401(k) Retirement Plan
- Short-term and Long-term Disability
- Basic Life with AD&D Insurance
- Voluntary Life with AD&D Insurance
- Voluntary Critical Illness Insurance
- Voluntary Accident Insurance
- Paid Parental Leave
- Public Service Loan Forgiveness
- Adoption and Infertility Treatment Assistance

Maintain work / life balance

- Health and wellness discounts and resources through HealthPartners and Guardian
- Paid Time Off
- Floating & Paid Holidays
- Paid Bereavement Leave
- Flexible work arrangements
- FMSC clothing discounts

Contact Information

Email

hr@fmsc.org

Phone

763-267-6325

Address

401 93rd Ave N.
Coon Rapids, MN 55433

Retirement Plan – 401(k)
The Standard
800-858-5420
standard.com

Medical Insurance
HealthPartners
952-883-500 or 800-883-2177
healthpartners.com

Health Savings Account
Chard Snyder
888-982-7715
chard-snyder.com

Flexible Spending Account
Chard Snyder
888-982-7715
chard-snyder.com

Dental Insurance
Guardian Life
888-Guardian (888-600-1600)
guardianlife.com

Vision Plan
EyeMed
866-939-3633
eyemedvisioncare.com

Short-Term & Long-Term Disability
Guardian Life
FMSC Benefits Department
763-267-6325

Life with AD&D Insurance
Guardian Life
FMSC Benefits Department
763-267-6325

Guardian Life Value-Added Benefits
Guardian Life
FMSC Benefits Department
763-267-6325

Paid Time Off & Holidays
FMSC Human Resources
763-404-7871

Paid Parental Leave
FMSC Benefits Department
763-267-6325

Adoption & Infertility Treatment Assistance
FMSC Benefits Department
763-267-6325

FMSC Clothing Discounts
FMSC MarketPlace
763-267-6314

Eligibility

Who is eligible and when:

Full-time employees regularly scheduled at least 30 hours per week or expected to average at least 30 hours per week over a 12-month period are eligible to enroll in the following plans on the effective date shown.

Benefit Description	Eligibility Date
Paid Time Off (PTO)	Eligible upon hire date
Holidays	
Bereavement Leave	
FMSC MarketPlace Clothing Discounts	
Medical Insurance	Eligible on the 1st of the month following full-time hire date
Employee Assistance Program (EAP)	
Health Savings Account	
Flexible Spending Account	
Dental Insurance	
Vision Benefit	
Short & Long Term Disability	
Basic Life with AD&D Insurance	
Voluntary Life with AD&D Insurance	
Voluntary Accident Insurance	
Voluntary Critical Illness Insurance	
401(k)	Eligible on the 1st of the month following a 2-month waiting period after hire date.
Paid Parental Leave	Eligible after 12 months of continuous regular employment and working at least 1,250 hours during the 12 months preceding the start of the leave
Adoption & Infertility Treatment Assistance Program	Eligible after 1-year anniversary of continuous regular full-time employment

Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse), because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment and submit the required documentation within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

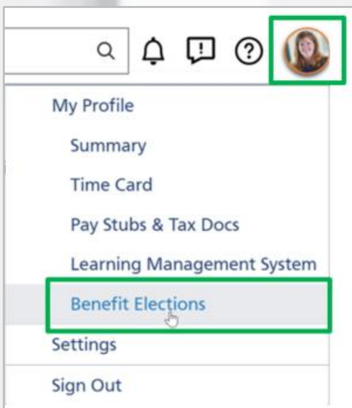
In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment and submit required documentation within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 763-267-6325 or **hr@fmsc.org**.

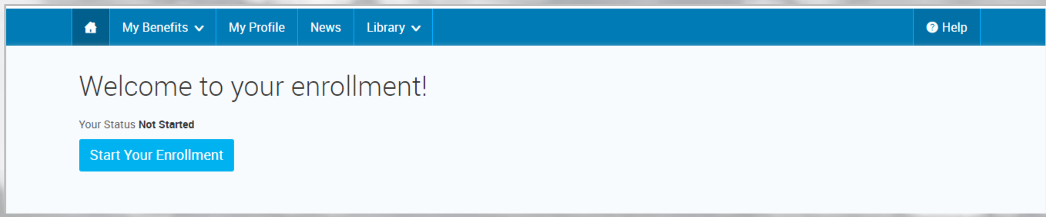
Making your Benefit Selections

This page outlines the steps to complete your benefit enrollment online in Paycor.

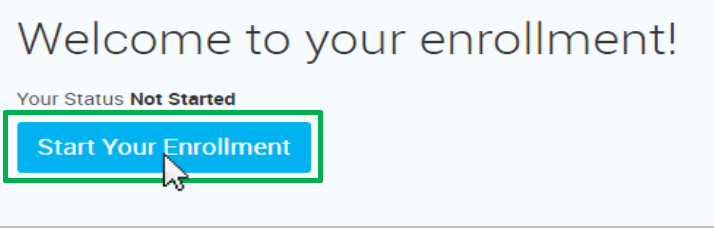
- Login to Paycor. Click your **Profile Image** on the right hand side, click **My Profile**, then click **Benefit Elections**



- You will then be directed to your Benefits home screen



- On your Benefits home screen, select **Start Your Enrollment**



For complete instructions, please view the Paycor Enrollment Guide for Full-Time Employees

Medical Insurance

There are three medical plan options to choose from. All three utilize the *Perform* network with access to HealthPartners' Cigna National network. A high-level overview is below. Please refer to the Certificate of Coverage for specific coverage levels, out-of-network coverage and/or benefit exclusions.

Coverage is also available to spouses and eligible dependents under age 26 - regardless of student or marital status.

Medical Plan Options

		PLAN OPTION #1 $1,500 - $45	PLAN OPTION #2 $3,300 – 100% HDHP	PLAN OPTION #3 $5,000 – 100% HDHP
Deductible	Individual	$1,500	$3,300	$5,000
	Family	$4,500	$6,600	$10,000
Co-Insurance		25%	0%	0%
Out-of-Pocket	Individual	$5,000	$3,300	$5,000
	Family	$10,000	$6,600	$10,000
Preventive Care		No charge	No charge	No charge
Diagnostic Test (X-ray, blood work)		Deductible, then 25% for x-ray, no charge for labs	Deductible, then 0%	Deductible, then 0%
Imaging (CT/PET scans, MRIs)		Deductible, then 25%	Deductible, then 0%	Deductible, then 0%
Office Visits (For Illness or Injury)		$45 Copay	Deductible, then 0%	Deductible, then 0%
Urgent Care or Specialist visit		$45 Copay	Deductible, then 0%	Deductible, then 0%
Convenience Care Clinic		$20 Copay	Deductible, then 0%	Deductible, then 0%
Virtuwell		No Charge	No Charge	No Charge
Emergency Room		Deductible, then 25%	Deductible, then 0%	Deductible, then 0%
Ambulance Services		Deductible, then 25%	Deductible, then 0%	Deductible, then 0%
Outpatient Hospitalization		Deductible, then 25%	Deductible, then 0%	Deductible, then 0%
Inpatient Hospitalization		Deductible, then 25%	Deductible, then 0%	Deductible, then 0%
Prescription Drugs Generic/Formulary/Non-formulary Specialty		$5-$150/$60/$150 25%; up to $500 per Rx	Deductible, then 0% Non-Formulary - Not Covered	Deductible, then 0% Non-Formulary - Not Covered

Please see the SBCs for more details. All benefit information in chart above highlights in-network coverage.

Medical Insurance

Resources and services available to those enrolled in a HealthPartners medical plan

Virtual Care/Telemedicine Options

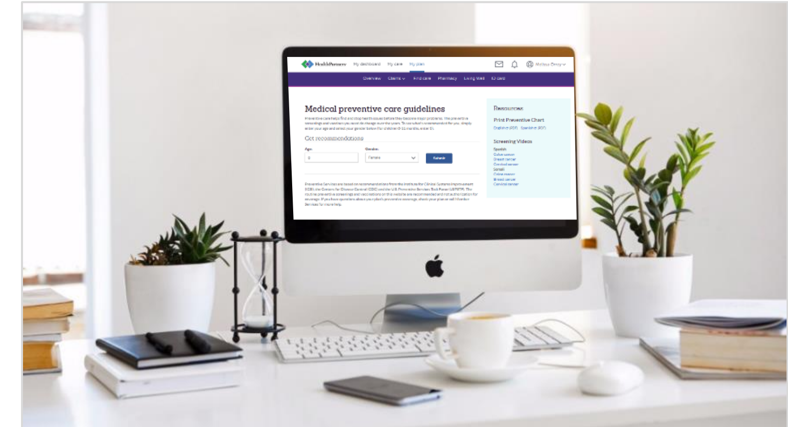
Telemedicine can be used to treat various conditions such as acne, allergies, anxiety, asthma and inhalers, athlete's foot, birth control, bladder infections, bronchitis, colds, cold sores, cough, depression, ear infections, eczema, flu, hair loss, IBS, insect bites, pink eye, prescription refills, rashes, rosacea, sinusitis, sunburn, yeast infection, and more.

Virtual care or telemedicine is an effective way to see a doctor for non-emergency situations. This option is not only more convenient but also cheaper than physically going to your doctor. Here's the best part: you don't have to leave your cozy home and sit in a stuffy waiting room when you're feeling unwell. Instead, you can connect with a certified nurse practitioner or licensed physician from the comfort of your own home! Say goodbye to traffic jams, long wait times, and uncomfortable plastic chairs – telemedicine is the way to go!

	Virtuwell	Doctor on Demand	Teladoc Health
Availability	24/7 online clinic *Only available to residents of AZ, CA, CO, CT, IA, MI, MN, NY, ND, PA, SD, VA and WI.*	24/7 online clinic *available in every state*	24/7 online clinic *available in every state*
Services	Medical, preventive care and chronic condition management	Medical, preventive care, chronic condition management, behavioral health, urgent care	Medical, behavioral health, primary care, condition management
Appointments	Online visits with a board-certified nurse practitioner	Mobile, web and phone visits with a board-certified doctor	Mobile, web, and phone visits with a board-certified doctor
Website	virtuwell.com	doctorondemand.com	teladochealth.com

Preventive Care

- Preventive care is important for your overall health and well-being and helps identify potential health problems earlier.
- Many preventive care services are folded into what you already pay for your health insurance – so you won't pay an extra cent for it. Most health plans are required, by law, to cover eligible preventive services at 100%.
- Preventive screenings may include things like routine blood work, colonoscopy, mammogram, cholesterol and blood pressure check, pap smear, and immunizations.
- Remember, preventive care happens before a problem is identified. So, the same service may or may not be considered and billed as preventive care, depending on your health situation.
- If you're not sure what preventive care you're due for, get in touch with your primary care clinic or doctor. Your online account through your health insurance company should also have information and reminders.



See your specific recommendations by visiting HP Preventive Care Recommendations

Prescription Drugs

Managing your prescriptions is a cornerstone of staying healthy. HealthPartners offers resources and tools to help fill your prescriptions, estimate cost, and get expert help. Please visit [HP Pharmacy].

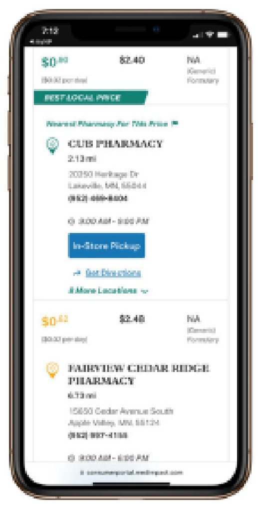
Consider Generic	Many generic medicines have the same benefits as brand-name medicines. They are just as safe and effective, but cost considerably less.
No Cost Preventive Medications	HealthPartners offers certain preventive medications at no cost to you. If you are on preventive medication and it's not on this list, talk to your doctor to see if you can switch so it is no cost to you. The ACA Preventive Drug List is located in HR Connect: ACA Preventive Drug List
Use Mail Order	Sometimes it's a better value to get a 90-day supply of medicine instead of a 30-day supply. For example, many HealthPartners members can get a three-month supply for two copays by filling their prescriptions through the Mail Order Pharmacy.
Compare prescription costs	Shop around and find the lowest price for your prescriptions at pharmacies near you. You can also choose whether to search for pharmacies that have 30-day supplies or 90-day supplies. Pharmacies marked with an *R* offer 30-day supplies; pharmacies marked with a *90* offer 90-day supplies.
Meet with a pharmacist	On a one-on-one visit, a pharmacist will review your medicines with you to make sure they're working and are right for you. Plus, *it's free*. Visit HP Medication Therapy Management to learn more.

Check your formulary

A formulary, also called a drug list, tells you what medicines are covered by your health plan and generally how much you'll pay. You'll also learn if there are any requirements before you can start a medicine.

Your formulary is called PreferredRX.

1. Go to healthpartners.com/preferredrx
2. Search by the name of type of medicine
3. Use your Summary of Benefits and Coverage (SBC) in your enrollment materials to understand how each type of medicine is covered.



- You can use the prescription shopping tool to:
- Find the lowest cost for your medicine
- Compare current prices at pharmacies near you
- Understand what medicines are covered by your health plan
- Transfer prescriptions to the lowest cost pharmacy

HealthPartners Perform Network

Your health is one of our top priorities. That includes making sure you have access to doctors and clinics throughout the United States. We're able to offer this because your HealthPartners health insurance plan works with Cigna to give you a vast network of doctors and clinics. This means it's easy for you to find a doctor wherever you are.

Here are three tips to help you find a doctor or search for care in your network:

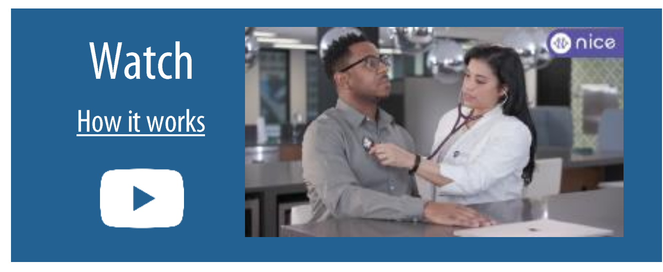
- Visit healthpartners.com/perform to search by name, specialty, condition or procedure, and more.
- Call your Member Services team at the number on the back of your member ID card. They are here for you, and happy to help.
- When you're at the doctor's office, **show your member ID card**. It has important information your doctor's office needs to file a claim. Point out the Cigna logo in the lower left-hand corner or tell them you have HealthPartners insurance with the Cigna network.

Need anything else?

Your Member Services team is always here for you and happy to answer your questions. Just give them a call at 952-883-5000 or 800-883-2177 – Monday through Friday, 7 a.m. – 7 p.m. CST.

Nice Healthcare

Integrated Primary Care Services available to those enrolled in one of FMSC's medical plans and who live within a Nice service area.



You deserve hassle-free healthcare, right? Well, the good news is that Nice Healthcare (Nice) has created an amazing system that makes getting everyday care easy-peasy, without any of the usual headaches you'd expect from our ever-so-complex healthcare system. Nice treats nearly all of your everyday healthcare needs from your home, office or wherever is most convenient for you.

Thanks to their top-notch clinicians and a super supportive care team, Nice has got you covered every step of the way. Plus, with their comprehensive care offering and same-day appointment availability, you can rest easy knowing that nearly all of your healthcare needs can be quickly and expertly taken care of. No more waiting for weeks or navigating tricky systems - with Nice, healthcare is easy and stress-free! Visit summaries can be sent to your primary doctor for integrated healthcare.

If you are enrolled in one of FMSC's medical plans and live in a Nice service area, you are covered under Nice at no cost to you. FMSC pays the monthly premium. For those on the copay plan, there is no cost to you for the services rendered under Nice. For those on one of the HDHPs, there will be a small fee beginning in 2025 as a result of the "no first dollar coverage rule" safe harbor expiring.

Why do we offer Nice? Our hope is that by offering convenient and free/low cost access to virtual care, in-home care and prescriptions, it removes the barrier of cost and time. We hope employees will schedule routine well checks and seek care when needed rather than waiting for symptoms to get worse. Access to free or low cost prescriptions will incentivize employees to take their medications regularly. Staying on top of your health may help prevent serious illness in the future! In addition, all of the Nice appointments and prescriptions are not run through your insurance. They are not included in claims analysis and should result in lower premiums for everyone at renewal time.

Nice provides the below services at NO COST (or very low cost) to you!

Nice Primary Care

- Chat, video, and home visits
- Wellness, acute, and chronic care
- Labs, testing, and imaging
- Specialist referrals

Nice Rx

- 550+ *free (or very low cost)* medications that can be prescribed by Nice clinicians
- Medication review and management
- Medication delivery

Nice Specialty Care

- Chat and video visits
- Mental health and behavioral therapy
- Physical therapy
- Diabetes management
- Close collaboration
- with primary care

Please visit **nice.healthcare/locations** to see if your home or work location is within Nice's expanding service area

Nice Healthcare

In-home and virtual appointments at NO COST to you!

Preventive
- Annual physical
- Surgery pre-op
- Child Checkups
- Camp Physicals

Acute Care
- Cold/flu
- Sinus & ear infection
- Strep throat
- UTIs
- Pink eye
- Rashes

Chronic Disease Management
- High blood pressure
- High cholesterol
- Thyroid conditions
- Diabetes
- Anxiety
- Depression

Imaging
- X-rays
- EKGs

Ready to get started?

1. Start a chat or video visit
(often with options available within an hour or two)
- Patient history
- Medication review
- Diagnosis
- Care Guidance
- Education

2. If needed, a home visit follows
(if home address is in an eligible county)
- Physical exam
- Rapid tests
- Blood draws
- Labs
- Imaging

ACCESS NICE ONLINE

Virtual Visits:	Monday – Friday 8:00 AM - 7:00 PM CST
	Saturday – Sunday 9:00 AM – 12:00 PM CST
In-Home Visits:	Monday – Friday 9:00 AM – 5:00 PM CST

Employee Medical Contributions:

Employee contributions for each medical plan option are illustrated below. Medical plan premiums are deducted from your paycheck on a pre-tax basis. These rates are based on 26 per-pay-period deductions each year.

Plan Option #1: $1,500 - $45 Copay

	Employee Per Paycheck	FMSC Per Paycheck
Employee Only	$98.68	$280.86
Employee + Spouse	$405.93	$476.52
Employee + Child(ren)	$308.12	$392.15
Family	$456.97	$605.75

Plan Option #2: Low HDHP ($3,300 – 100%)

	Employee Per Paycheck	FMSC Per Paycheck
Employee Only	$58.85	$296.72
Employee + Spouse	$249.31	$577.39
Employee + Child(ren)	$179.98	$476.04
Family	$273.14	$722.43

Plan Option #3: High HDHP ($5,000 - 100%)

	Employee Per Paycheck	FMSC Per Paycheck
Employee Only	$25.80	$296.72
Employee + Spouse	$172.47	$577.39
Employee + Child(ren)	$119.01	$476.04
Family	$180.61	$722.43

Employee Assistance Program

Provided by HealthPartners

Support you can count on, whenever you need it

When life gets tough, your HealthPartners Employee Assistance Program (EAP) offers free, confidential support 24/7 to help with whatever you're facing. Think of your EAP as a trusted resource for self-care, whether you're dealing with stress, mental health, financial concerns, childcare, eldercare, or relationship challenges.

Confidential and Free

The topics you share with EAP providers are entirely confidential between you and HealthPartners. Feed My Starving Children will never have access to any information you share via the EAP. This is a completely confidential service to support your well-being.

FMSC Employee Assistance Program Info

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Contact Information

Web

hpeap.com

Mobile App

iConnectYou

Phone

1-866-326-7194

Value Added Benefits

Resources and services available to those enrolled in a HealthPartners medical plan

Member Services: *Monday - Friday, 7 a.m. to 7 p.m. CT at 952-883-5000 or 800-883-2177.*
Contact HealthPartners Member Services when you have questions about your coverage, claims, account balances, finding a doctor or specialist and additional health plan services. They can also connect you with the Nurse, Pharmacy or Behavioral Health Navigator programs to help you further understand your benefits and find the care you need.

Nurse Navigator Program: *Monday – Friday, 7:30 a.m. to 5 p.m. CT at 952-883-5000 or 800-883-2177.*
For questions about:
- Understanding your health care and benefits
- How to choose a treatment

Pharmacy Navigators: *Monday – Friday, 8:00 a.m. to 5 p.m. CT at 952-883-5000 or 800-883-2177.*
For questions about:
- Your medicines or how much they cost
- Doctor approvals to take a medicine (prior authorization)
- Your pharmacy benefits
- Transferring medicine to a mail order pharmacy

Behavioral Health Navigators: *Monday – Friday, 8:00 a.m. to 5 p.m. CT at 952-883-5000 or 800-883-2177.*
For questions about:
- Finding a mental or chemical health care professional in your network
- Your behavioral health benefits

CareLine Services: *24/7, 365 days a year at 612-339-3663 or 800-551-0859*
For questions about:
- Whether you should see a doctor
- Home remedies
- A medicine you're taking

BabyLine Services: *24/7, 365 days a year at 612-333-2229 or 800-845-9297*
For questions about:
- Your pregnancy
- The contractions you're having
- Your new baby

Fitness & Wellness Options:

Sign in to your HP online account then select the Living Well tab or call 1-800-311-1052.

- **Omada Health:** Omada Health is a personalized program that can help you reach your health goals, whether that is losing weight, lowering your blood pressure or staying on top of your diabetes. Visit healthpartners.com/livingwell.

- **Wellbeats:** Wellbeats offers access to virtual fitness, nutrition and mindfulness classes from wherever you feel comfortable. Wellbeats has opportunities for people of every age, interest and ability level. Visit healthpartners.com/livingwell.

- **Husk Gym Network:** Provides discounts on fitness facilities, virtual subscriptions, wellness products and nutrition services.

- **The Active&Fit Direct™ Program:** A fitness membership program that provides access to over 11,000 fitness centers nationwide for a flat monthly fee.

Healthy Discounts

Get special savings from handpicked retailers as a HealthPartners member. There are lots of great products and services available to you at a discounted rate – all designed to help you live healthy every day. Save big by showing your member ID card to participating retailers. healthpartners.com/discounts. Save money on:

- Eyewear
- Exercise equipment
- Fitness and well-being classes
- Healthy eating delivery services
- Healthy mom and baby products
- Hearing aids
- Orthodontics
- Pet insurance
- Swim lessons
- And more!

Assist America

- Whether you're traveling abroad or just out of town for the weekend, you can feel confident you're in good hands when the unexpected happens. Get 24/7 help with filing lost prescriptions, pre-trip info – like immunizations and visa requirements, tracking down lost luggage, and more! Learn more at healthpartners.com/getcareeverywhere.

These resources are *free* to all employees and their dependents enrolled in one of the three FMSC medical plans.

Hearing Aid Coverage

- Each of the three HealthPartners Medical Plans cover expenses for one hearing aid per ear every three years for plan enrollees of all ages. No dollar limit may be applied. Coverage follows the benefit for durable medical equipment.
- Prior authorization is not required for hearing aids. Prior authorization is required for Bone Anchored Hearing Aids (BAHA).
- Hearing aids are subject to the usual copayment, coinsurance or rules applicable to Durable Medical Equipment (DME) as stated in your plan documents.
- More information can be found here: HP hearing aid coverage

Health Savings Account (HSA)

A Health Savings Account is a type of personal savings account you can set up to pay for certain health care costs. An HSA allows you to put money away and withdraw it tax-free, as long as you use it for qualified medical expenses like deductibles, coinsurance, prescriptions and more.

You are eligible to contribute to an HSA when you're enrolled in an HSA-eligible plan (sometimes called a High Deductible Health Plan or HDHP). With HSA-eligible plans, the monthly premium is usually lower, but you pay more out-of-pocket health care costs yourself before the insurance company starts to pay its share.

Benefits of an HSA:

- **No federal income tax**. You aren't taxed on the money you put into the HSA, or on the interest you earn. You also don't pay tax on withdrawals for qualified medical expenses.
- **Your HSA contributions do not expire**. The money stays in the HSA until you use it. You can even let it accumulate for use in future years or in retirement.
- **HSA doesn't go away if you change jobs**. You can keep your HSA, even if you change employers or retire.
- **Employees can change contributions to their Health Savings Account at any time.**

Who is eligible and when:

- Employees are eligibile to contribute to an HSA if you are enrolled in one of FMSC's High Deductible Health Plans (HDHP). The amount you can contribute is based on the tier of coverage you are enrolled in for medical. For example, if you have single coverage, you may contribute the single HSA max.
- Employees enrolled in Medicare or any other non-HSA-eligible plan are NOT eligible to contribute to an HSA. This includes a Flexible Spending Account (unless it is a Limited-Purpose account, which can only be used for dental and vision expenses). *If you anticipate large expenses such as orthodontia or Lasik, please reach out to the Benefits Analyst for options to enroll in a Limited-Purpose FSA account.*
- Employees claimed as a dependent on someone else's tax return are also NOT eligible to contribute to an HSA

2025 Annual Maximum Contributions

Single	Family	Age 55+
$4,300	$8,550*	$1,000 catch-up contribution**

**An employee is eligible to contribute the annual family maximum amount if enrolled in one of FMSC's HDHP family plans.*
***Employees age 55 and older are eligible to contribute an extra $1,000 per year towards their HSA.*

The money in the account can be used to pay for any "qualified medical expense" permitted under federal tax law for you, your spouse and/or dependent(s). Qualified expenses include most medical care and services, dental care and vision care. For a complete list of eligible expenses, please visit irs.gov

According to the IRS, you must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified medical expenses had not been previously paid or reimbursed from another source, and
- The medical expenses had not been taken as an itemized deduction in any year.

Do not send these records with your tax return. Keep them with your tax records.

Flexible Spending Account (FSA)

A Flexible Spending Account provides you with an important tax advantage that can help you pay for eligible health care and dependent care expenses on a pre-tax basis. By paying for certain expenses on a pre-tax basis, you lower your taxable income and increase your take-home pay.

Medical FSA

The Healthcare FSA allows you to pay with pre-tax dollars for certain IRS-approved medical care expenses not covered by your insurance. Expenses can be incurred by you, your spouse or eligible dependents.

Examples include:

- Your medical plan's co-pays, deductible and coinsurance
- Medical supplies such as hearing aids, crutches and orthopedic shoes
- Vision services, including contact lenses, contact lens solution, eye examinations, eyeglasses and laser eye surgery
- Dental services and orthodontia (contact Human Resources if you use the plan for orthodontia)
- Chiropractic services
- Acupuncture
- Please note: over-the-counter drugs are not eligible unless prescribed by a doctor.

Dependent Care FSA

The Dependent Care FSA allows you to use pre-tax dollars to pay for qualified dependent care expenses such as caring for children under age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per plan year (minimum contribution is $100).

Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools

Limited Purpose FSA

The Limited Purpose FSA allows you to use pre-tax dollars to pay for out-of-pocket dental and vision expenses. Employees enrolled in a HDHP with HSA may contribute to a Limited Purpose FSA but not a Medical FSA.

2025 Annual Maximum Contributions

Medical FSA	Dependent Care FSA	Limited Purpose FSA
$3,300	$5,000	$3,300

Dental Insurance

Benefits you receive:

With Guardian's Dental PPO plan, you will have access to one of the largest networks of dentists (DentalGuard Preferred Network). You can see any dentist you choose, but you will save the most money if you visit a dentist in-network because they have contracted rates that are lower than out-of-network dentists.

Coverage is also available to spouses and eligible dependents under age 26 - regardless of student or marital status

		Benefits
Deductible	Individual	$50, waived for preventive
	Family Limit	3 per family
Annual Max Benefit		$1,250
Maximum Rollover	Rollover Threshold	$600
	Maximum Rollover Amount	$300
	In-Network Only Rollover Amount	$450
	Rollover Account Limit	$1,250
Preventive Care - Cleaning once every 6 months - Fluoride Treatment (under age 14) - Oral Exam - Sealants (per tooth) - X-rays		100%
Basic Care - Fillings - Perio Surgery - Periodontal Maintenance (once every 6 months) - Root Canal - Scaling & Root Planing (per quadrant) - Simple Extractions - Surgical Extractions		80%
Major Care - Anesthesia - Bridges and Dentures - Dental Implants - Inlays, Onlays, Veneers - Repair & Maintenance of Crowns, Bridges & Dentures - Single Crowns		50%
Orthodontia (children)		50%
Lifetime Orthodontia Maximum		$1,000

This is only a partial list of dental services. Please refer to the certificate of benefits for details & exclusions.

Value Added Benefits

Resources and services available to those enrolled in Guardian dental insurance

Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases. That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.

If you go to the dentist and your claims do not exceed the paid claims threshold for a benefit year, then Guardian will roll over a portion of your unused annual dental maximum to be used in future years!

Plan Annual Max	Paid Claims Threshold	Maxium Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to a plan's annual maxium for future years	Additional dollars added if only in-network providers were used during the benefit year	The limit that cannot be exceeded within the maximum rollover account
$1,250	**$600**	**$300**	**$450**	**$1,250**

For example – You visit an in-network dentist twice a year for routine cleanings. Since these are preventive appointments, the deductible is waived and your appointments are covered at 100%. Let's pretend the cost of the preventive appointments add up to $400 (which remember, is covered 100% for you). As long as the cost of those claims is less than $600 (the Paid Claims Threshold), then Guardian will roll over $450 to use in the next plan year. If you went to an out-of-network dentist in the same scenario, the rollover would be $300.

Tobacco Cessation Program

Anyone enrolled in the dental plan that is age 15+ has access to the Tobacco Cessation program at no cost to you! Support for a tobacco-free life includes a dedicated care team, digital tools and nicotine replacement therapy.

Employee Premiums:

Dental plan premiums are deducted from your paycheck on a pre-tax basis.

Tier of Coverage	Employee Per Paycheck	FMSC Per Paycheck
Employee only	$2.28	$12.90
Employee + Spouse	$14.21	$14.21
Employee + Child(ren)	$18.63	$18.63
Family	$25.17	$25.17

Vision Plan

Benefits you receive:

Reduce your out of pocket expenses for eyeglasses and contact lenses by enrolling in this plan. This is a materials-only plan, meaning that this plan covers glasses and contacts, but not exams. Find a provider by searching the Insight Network. A snapshot of your in-network vision benefits is shown below.

Remember, one annual exam is completely covered under FMSC's medical insurance – so make sure to bring your medical insurance card to your vision exam appointment.

	In-Network Benefits
Frames	$0 copay; $130 allowance, 20% discount over $130
Lenses Single Vision, Bi-Focal, Tri-Focal, Lenticular	$25 copay
Lenses Progressive (standard) Progressive (premium) Tier 1 Tier 2 Tier 3 Tier 4	$90 copay $110 – 135 copay $110 copay $120 copay $135 copay $90 copay; 20% off charge less $120 allowance
Contact Lenses Conventional Disposable	$0 copay; $130 allowance, 15% discount over $130 $0 copay; $130 allowance, plus balance over $130
Benefit Frequency Lenses or Contact Lenses Frames	12 months 24 months
Exam	Not covered

Employee Premiums:

Vision plan premiums are deducted from your paycheck on a pre-tax basis.

Tier of Coverage	Employee Per Paycheck	Annual Premium
Employee only	$2.09	$54.36
Employee + Spouse	$3.97	$103.32
Employee + Child(ren)	$4.18	$108.72
Family	$6.15	$159.84

Basic Life with AD&D Insurance

Benefits you receive:

FMSC provides $50,000 of Basic Life insurance with Basic Accidental Death and Dismemberment insurance for benefit-eligible employees. FMSC pays 100% of the cost of this coverage.

Life Insurance can help with costly expenses involving funeral expenses, assisting your family in paying off debts or a mortgage, or even a memorial donation to a favorite charity.

The Basic Life with AD&D benefits reduce according to the following schedule:

Employee Age	Benefit Reduction
Age 65	Reduces to 65% of original face amount
Age 70	Reduces to 45% of original face amount
Age 75	Reduces to 30% of original face amount
Age 80	Reduces to 20% of original face amount

Value Added Benefits

Additionally, all regular full-time employees receive the following Guardian services at no cost as part of their employer paid life and disability insurance. More details are on page 29-30.

- **Global Emergency Assistance Services** – Helps with medical and travel emergency assistance when traveling 100+ miles away from home or outside the country for up to 90 days. This benefit is offered through Assist America.
- **ID Theft Protection Services**
- **Caregiving Services** – Comprehensive, personalized support to help assist you in the caregiving journey, including managing a health condition, childcare and teen support, caring for an aging loved one, mental health and well-being, end of life and loss as well as financial hardships. This benefit is offered through Wellthy.
- **Cancer Support Services** – If you have a cancer diagnosis, Guardian will provide you with details about this benefit as part of the disability claims process. This benefit is offered through Osara Health.
- **Estate Guidance and Online Will Prep** – Complete a customized will for free! Other resources available at a discount.

Voluntary Life with AD&D Insurance

Benefits you receive:

Employees who want to supplement their Basic Life with AD&D insurance have the opportunity to purchase additional coverage for themselves and/or their eligible dependents. Voluntary Life with AD&D insurance is packaged together. You cannot purchase them separately. A general rule of thumb is you should consider about 6-10 times your annual income, factoring in projected costs to help maintain your family's current lifestyle.

Voluntary Life w/ AD&D Options	Benefit Amount	Guarantee Issue Level*
Employee	Increments of $10,000; maximum is the lesser of 5x your basic annual earnings or $500,000	$100,000 for newly-eligible employees
Spouse**	Increments of $5,000 up to $100,000; not to exceed 100% of employee amount	$25,000 for newly-eligible spouses
Child(ren) Age 14 days – 26 years**	Increments of $1,000 up to $10,000	$10,000

** New hires qualify for the guaranteed issue level without having to submit Evidence of Insurability (medical questions). To take advantage of this opportunity, the application for coverage must be received by Human Resources within 30 days of being eligible for the benefit (your new hire eligibility period). You may request an amount above the guarantee issue, but it will be subject to Evidence of Insurability.*

***In order to elect Voluntary Life Insurance coverage for your spouse and/or your children, you must elect coverage for yourself.*

The Voluntary Life with AD&D benefits reduce according to the following schedule:

Employee Age	Benefit Reduction
Age 70	Reduces to 65% of original face amount
Age 75	Reduces to 50% of original face amount

Please note that spouse coverage terminates at age 70.

Voluntary Life with AD&D Insurance

Voluntary Life with AD&D insurance is paid for by the employee via payroll deduction. For Voluntary Life insurance, employee and spouse premiums are calculated based on the age of the employee. Below is a rate table that includes the most common volumes purchased. For the full rate table, please refer to the enrollment kit.

Employee Monthly Rates

Amount	< 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$10,000	$1.03	$1.23	$1.69	$2.46	$3.80	$6.01	$9.13	$16.59
$50,000	$5.15	$6.15	$8.45	$12.30	$19.00	$30.05	$45.65	$82.95
$100,000	$10.30	$12.30	$16.90	$24.60	$38.00	$60.10	$91.30	$165.90
$150,000	$15.45	$18.45	$25.35	$36.90	$57.00	$90.15	$136.95	$248.85
$200,000	$20.60	$24.60	$33.80	$49.20	$76.00	$120.20	$182.60	$331.80
$250,000	$25.75	$30.75	$42.25	$61.50	$95.00	$150.25	$228.25	$414.75
$300,000	$30.90	$36.90	$50.70	$73.80	$114.00	$180.30	$273.90	$497.70
$350,000	$36.05	$43.05	$59.15	$86.10	$133.00	$210.35	$319.55	$580.65
$400,000	$41.20	$49.20	$67.60	$98.40	$152.00	$240.40	$365.20	$663.60
$450,000	$46.35	$55.35	$76.05	$110.70	$171.00	$270.45	$410.85	$746.55
$500,000	$51.50	$61.50	$84.50	$123.00	$190.00	$300.50	$456.50	$829.50

Spouse Monthly Rates

Amount	< 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$5,000	$0.52	$0.62	$0.85	$1.23	$1.90	$3.01	$4.57	$8.30
$25,000	$2.58	$3.08	$4.23	$6.15	$9.50	$15.03	$22.83	$41.48
$50,000	$5.15	$6.15	$8.45	$12.30	$19.00	$30.05	$45.65	$82.95
$75,000	$7.73	$9.23	$12.68	$18.45	$28.50	$45.08	$68.48	$124.43
$100,000	$10.30	$12.30	$16.90	$24.60	$38.00	$60.10	$91.30	$165.90

Child(ren) Monthly Rates

Amount	Any age
$1,000	$0.29
$5,000	$1.46
$10,000	$2.91

Disability Insurance

If you get sick or injured and are unable to work, you don't want to worry about paying for groceries or covering next month's mortgage. Disability insurance can help replace a significant portion of your income. Some think of it as "paycheck protection."

FMSC pays the *entire* cost of both Short-Term *and* Long-Term Disability Insurance for all regular Full-Time Employees.

Benefits you receive:

Employees who become disabled will be provided with both Short-Term and Long-Term Disability insurance. FMSC pays the *entire* cost of coverage. Any disability benefit received will be taxable to the employee.

	Short-Term Disability	Long-Term Disability
Income replacement	60% of salary	60% of salary
Maximum benefit	$1,200 per week	$5,000 per month
Benefits begin	8th day	91st day of disability (following short term disability)
Maximum benefit duration	up to 12 weeks	To Social Security Normal Retirement Age (SSNRA)

Musculoskeletal disorders are the #1 cause of disabilities. Examples include arthritis, back pain, spine/joint disorders, fibromyitis, etc.
Council for Disability Awareness, Disability Statistics, 2024

One in five working Americans have been out of work for an extended period during the past 10 years due to a condition, injury or illness.
Guardian's 12th annual Workplace Benefits Study, 2023

Voluntary Accident Insurance

Benefits you receive:

Although accidents are unexpected and usually come without warning, you don't have to let an injury catch you off guard. You can be prepared to handle the accompanying medical expenses with the help of the Accident Insurance offered through Guardian.

The Accident Insurance pays a lump-sum cash benefit for covered injuries that employees or an insured family member sustains as a result of an accident (as defined by the policy). Because accident insurance is supplemental, it works in addition to other any other insurance you may have.

The cash benefit from accident insurance can be used to:

- Pay for out-of-pocket medical expenses
- Supplement daily living expenses
- Cover lost income from unpaid time off

Examples of reimbursable expenses:

Urgent care, broken bones, burns, hospital stay, crutches, and much more!

Example:

You broke your leg!

In exchange for your life of adventure, you receive bills for a visit to the Emergency Room, x-rays, crutches, and two follow-up appointments.

- Emergency Room: $200
- Broken leg (open fracture): $3,600
- X-ray: $75
- Crutches: $50
- Follow-up visits: $150 total

You receive a total reimbursement of **$4,075.**

Employee Premiums

Tier of Coverage	Employee Per Paycheck
Employee Only	$5.10
Employee + Spouse	$8.11
Employee + Child(ren)	$11.06
Family	$14.06

This outline of coverage is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of you, the policyholder and the insurance company. It is, therefore, important that you read your certificate carefully! **This policy is not considered health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.**

Voluntary Critical Illness Insurance

Benefits you receive:

An unexpected critical illness often comes without warning and may have lasting effects on you and your families — both physically and financially.

Examples of a critical illness:

Heart attack, stroke, cancer & Alzheimer's.

The Critical Illness Insurance policy offered through Guardian can help provide you with the extra financial security you may need to lessen the financial impact associated with the treatment and recovery of a critical illness such as a heart attack, stroke, or cancer.

This benefit provides a lump-sum cash benefit upon the diagnosis of a critical illness, as defined by the policy. You have the flexibility to use the cash benefit as you see fit, including payment for:

- Out-of-pocket medical expenses
- Home or car alternations/modifications
- Mortgage/ rent or child/adult care
- Daily living expenses

Health Screening Benefit:

There is a health screening benefit of $50 per covered person per year. That means if you get your health screening and file a wellness claim, you will be reimbursed $50!!

Employee Premiums

Employee Age	Employee + Child(ren)* Coverage		Spouse Coverage	
	$10,000 Benefit	$20,000 Benefit	$5,000 Benefit	$10,000 Benefit
	Per Paycheck	Per Paycheck	Per Paycheck	Per Paycheck
<30	$1.52	$3.05	$0.76	$1.52
30-39	$2.77	$5.54	$1.38	$2.77
40-49	$6.14	$12.28	$3.07	$6.14
50-59	$13.06	$26.12	$6.53	$13.06
60-69	$27.37	$54.74	$13.68	$27.37
70+	$51.37	$102.74	$25.68	$51.37

*Child benefit is 25% of employee's lump sum benefit. Spouse benefit may be up to 50% of the employee amount, to a maximum of $10,000. Spouse premium is based on the employee's age. A pre-existing condition limitation applies. A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment or took prescribed drugs. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered. Please refer to certificate booklet for full explanation of the plan's benefits, exclusions, limitations, and reductions. **This policy is not considered health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.**

Guardian Value-Added Benefits

Global Emergency Assistance Services

Provided by Guardian

Global Emergency Assistance Services connects you to qualified healthcare providers, hospitals, pharmacies and other services if you experience an emergency while traveling 100+ miles away from your home or outside the country for up to 90 days.

Medical Emergency Assistance

- Medical consultation, evaluation, and referrals
- Medical monitoring
- Emergency medical evacuation

Travel Emergency Assistance

- Care for minor children
- Compassionate visit
- Return of traveling companion

Additional Emergency Assistance Services

- Lost luggage
- Document assistance
- Legal and interpreter referrals

Call

1-800-872-1414 (within the US)
1-609-986-1234 (outside the US)

Reference # 01-AA-GLI-10231

Download the Assist America

ID Theft Protection Services

- Prevention & resolution tools to safeguard your data and restore its integrity if it is used fraudulently. Services include 24/7 access to identity protection specialists
- Credit card & document registration
- Lost & stolen credit and debit card assistance
- 24/7 identify fraud support

Call

1-877-409-9597 (within the US)
1-816-396-9192 (outside the US)

Access code = 18327

Global Emergency Assistance services are provided by ComPsych through its subcontractor Assist America. Guardian does not control or provide any part of the services and does not bear any liability for their provision. Services may not be available in all states

Guardian Value-Added Benefits

Provided by Guardian

Tobacco Cessation

- Available to those enrolled in the dental benefits
- There is a connection from tobacco use to poor oral health. That's why Guardian provides personalized resources that can help you or your family member quit.
- Dedicated care team
- Digital tools
- Nicotine replacement therapy

Caregiving Service (offered through Wellthy)

- Available to all full-time employees
- Comprehensive support for every stage of life.
- Help managing a health condition
- Childcare and teen support
- Caring for an aging loved one
- Mental health & well-being
- End of Life and Loss
- Financial Hardships

Cancer Support Service (offered through Osara Health)

- For employees who have cancer and are on disability.
- Personalized, empathetic support to help you navigate a cancer diagnosis
- Dedicated health coach
- Digital Resource modules
- Tailored well-being information

Estate Guidance & Online Will Preparation

Provided by Guardian – services through EstateGuidance

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation. That's why it's good you have access to FREE online will preparation services provided by EstateGuidance.

Easy, Free and Secure

EstateGuidance makes drafting a will easy with online tools that walk you through the process in minutes.   You can also draft a living will to ensure you get the end-of-life care you desire and a final arrangements document expressing your wishes for your funeral services.

How EstateGuidance can help:

- Complete a Customized Will = FREE
- Have your will printed & sent to you = $14.99
- Draft a Living Will = $14.99
- Draft a Final Arrangements Document = $9.99

Visit **Estateguidance.com**
Use promo code: Guardian

Or call 1-855-239-0743

Retirement Plan – 401(k)

Benefits you receive:

Saving for retirement is a crucial part of financial planning. That's why FMSC offers a 401(k) plan, where you can contribute a percentage of your biweekly earnings into a retirement savings account. This tax-advantaged investment account grows over time and provides a financial cushion for your post-work years. And as a gift to you, FMSC chips in too: we match your contributions to help support your retirement goals (see employer match table below).

Who is eligible and when:

New Hire *(You have **not** previously been employed by FMSC)*

- Regular employees 18 and older are automatically enrolled in contributing 1% of their earnings to this plan starting the first of the month following a 2-month waiting period. You can change or cancel your contribution percentage at any time.

Rehire *(You have previously been employed by FMSC)*

- Regular employees 18 and older who were previously employed by FMSC and met eligibility requirements during their previous employment dates are eligible to enroll on their first day of employment as soon as administratively possible.

Plan features:

To help you meet your retirement goals, FMSC will contribute up to 4% matching contributions as shown below. Your contributions and FMSC's employer match contributions are 100% vested (meaning you fully own the money you contribute, and it cannot be forfeited, even if you leave FMSC).

Employee Contribution	Employer Match	Total
1%	1%	2%
2%	2%	4%
3%	3%	6%
4%	3.5%	7.5%
5%	4%	9%
>5%	4%	>9%

2024 Contribution limit:	$23,000
Catch-up contribution (age 50+)	$7,500

You May:

- Roll over account balances from a prior employer's plan and/or IRA
- Contribute up to 90% of your eligible compensation
- Choose to contribute either pre-tax or post-tax (Roth) deferrals. You can learn more about these tax-advantaged accounts by visiting the Benefits page in HR Connect or the FMSC 401(k) Resource Center

Floating and Paid Holidays

Floating holidays:

On an employee's full-time hire date and then on each subsequent anniversary, they receive 3 floating holidays to be used on days of their choosing within the next 12 months.

Paid holidays:

FMSC recognizes the following paid holidays:

- New Year's Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

Paid Time Off (PTO)

Benefits you receive:

FMSC provides a flexible PTO program that combines vacation, sick and personal paid time away into one bank of time. During an employee's first 12 months of regular full-time employment, PTO is accrued at a rate of .0615 hours of PTO for every paid hour. For an employee working on average 40 hours per week, that translates to 16 days of PTO during their first year. The employee's PTO accrual increases by approximately one day each year for the first 10 years of employment to a maximum of 26 days per year.

PTO does not expire, but there is a cap on the amount of accrued unused PTO an employee may have in their bank.

*See the policy in the **Employee Handbook** for more information.*

Paid Parental Leave

Benefits you receive:

FMSC will provide eligible employees with up to one week of Paid Parental Leave following the birth of the employee's child or the placement of a child in the employee's home for adoption. The purpose of Paid Parental Leave is to provide the employee with paid time to care for and bond with their new child.

*See the policy in the **Employee Handbook** for more information, including eligibility requirements.*

Adoption & Infertility Treatment Assistance

Benefits you receive:

Employees with at least one year of continuous service in a regular, full-time position at FMSC are eligible for reimbursement up to $2,500 per calendar year with a lifetime maximum of $5,000 for expenses incurred towards adoption and/or infertility treatment.

*See policy in the **Employee Handbook** for more information.*

Remote Work

Feed My Starving Children is happy to provide flexible work arrangements that allow you to accommodate personal life demands and work in such a way that you feel most productive. Some of our jobs are conducive to a hybrid work structure, where employees have the choice to work remotely or from the office, based on the demands of specific tasks and personal work preferences. FMSC also encourages in-office work to strengthen team collaboration and facilitate face-to-face interactions that build strong connections. Please discuss with your manager whether or not your job is suitable for working remotely

Public Service Loan Forgiveness Program

From the Office of the U.S. Department of Education

Benefits you receive:

The Public Service Loan Forgiveness (PSLF) Program was established to encourage individuals to work in public service and non-profits by forgiving the remaining balance of the Direct Loans after they have made 120 qualifying payments while employed full time by a qualifying employer. Feed My Starving Children is a 501(c)(3) nonprofit charitable organization, therefore is a qualified employer.

To benefit from PSLF, you should complete and submit the PSLF certification form every year while you're making progress towards PSLF.

- **PSLF Fact Sheet**
- **PSLF Frequently Asked Questions**

For details about the program, including eligibility and the certification process, please visit **StudentAid.gov/publicservice**. To apply online, visit **StudentAid.gov/PSLF**

Clothing Discounts

From the FMSC MarketPlace

Benefits you receive:

Employees get an in-store $10 discount on FMSC T-shirts and sweatshirts sold in our MarketPlace. This discount does not apply to online MarketPlace purchases, the Donation T-Shirt or other MarketPlace goods (jewelry, handbags, etc.).

HR Connect

Be sure to visit Human Resource's new internal SharePoint page, **HR Connect**, your hub for all things HR. You must be logged into the network to access HR Connect.

This document is a summary and is not intended as policy or a complete description of benefits. This document is not a guarantee of benefits and is subject to change at any time. Details of each plan are contained in the plan documents which legally govern the operation of the programs. If there is any conflict between this document and any of the plan documents, the plan documents will always govern.

Tax Implications

Some benefits in this Guide are income tax-advantaged and subject to U.S. Internal Revenue Service (IRS) Code. However, no language in this Employee Benefit Guide is intended, nor should be construed as tax advice. Please consult your personal tax preparer, accountant, or financial planner with any questions regarding benefit taxability.

Crisis & Support Hotlines

Hotlines	
911 - An emergency is any situation that requires immediate assistance from the police, fire department or ambulance.	
988 Suicide & Crisis Lifeline	Call or text 988; or chat at 988lifeline.org
National Domestic Violence Hotline	Call: 800-799-7233

Arizona	
La Frontera EMPACT – Suicide Prevention Center	Call: 480-784-1500

Illinois	
Suicide Prevention Services – Depression Line	Call: 630-482-9696

Minnesota	
United Way Hotline	Call: 211 or 800-543-7709 or 651-291-0211 Text your zip code to 898-211

Pennsylvania	
Centre Helps	Call: 814-237-5855

Texas	
Integral Care	Call: 512-472-4357

Additional Resources Available on HR Connect (HR's SharePoint site)

IMPORTANT LEGAL NOTICES

As required by Federal Law

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2025

Should you have any questions regarding the contents of the notices, please contact us at HR@fmsc.org or 763-267-6325

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 pages 15-16 for more information.

<u>IMPORTANT NOTICE</u>: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

Women's Health and Cancer Rights

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductible and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description of the plan you selected.

If you would like more information on WHCRA benefits, call Human Resources at 763-267-6325.

Newborns Act Disclosure – Federal

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).

Special Enrollment Rights (HIPPA)

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).

If you decline enrollment in Feed My Starving Children Group Health Plan for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Ins. Program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Statement of Rights (ERISA)

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants. No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $149 per day (up to a $1,496 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court

may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- your past, present or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present or future payment for the provision of health care to you.

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

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Feed My Starving Children HIPAA Privacy Officer or the Human Resources Department:

Feed My Starving Children
Attention: HIPAA Privacy Officer
Jeanie Picardi, VP of Human Resources

Effective Date

This Notice as revised is effective November 1, 2024.

Our Responsibilities

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

We are required by law to:

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

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

For more information see: hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

How We May Use and Disclose Your Protected Health Information

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

For Treatment

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

For Payment

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

For Health Care Operations

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

To Business Associates

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

As Required by Law

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

To Avert a Serious Threat to Health or Safety

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

To Plan Sponsors

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

Special Situations

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

Organ and Tissue Donation

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

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

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

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

Health Oversight Activities

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

Lawsuits and Disputes

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

Law Enforcement

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

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

Coroners, Medical Examiners and Funeral Directors

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

National Security and Intelligence Activities

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

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

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

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

Required Disclosures

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

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

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

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

Other Disclosures

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

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

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

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

Your Rights

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

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

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

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

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

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

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

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists,

we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

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

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

Right to Request Confidential Communications

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

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Human Resources at 763-267-6325 or HR@fmsc.org.

For more information, please see Your Rights Under HIPAA.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting hhs.gov/ocr/privacy/hipaa/complaints/.

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

General Notice of

COBRA Continuation Coverage Rights

** 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."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- the end of employment or reduction of hours of employment;
- death of the employee; *or*
- the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Human Resources within 60 days after the qualifying event occurs. You must provide this notice to: HR@fmsc.org, or by calling Melissa Orrey, Benefits Analyst at 763-267-6325. Additional information on necessary documentation for qualifying events can be found in HR Connect, your hub for all things HR https://fmscit.sharepoint.com/:u:/s/HR/EdBAMNAOwwRKsAJRy1oor20Bxd5FVo9DKdwV4CPPtV2gcQ?e=A7TJqh

How is COBRA continuation coverage provided?

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

Name of Entity/Sender: Jess Jadwin
Contact--Position/Office: Benefits Specialist, Human Resources
Address: 401 93rd Ave N. Coon Rapids, MN 55433
Phone Number: 469-830-8703

[1] medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Medicare Part D

Creditable Coverage Notice

IMPORTANT NOTICE FROM HEALTHPARTNERS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Enrollees of any of the three (3) Medical Plans

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

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current HealthPartners coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current HealthPartners 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 HealthPartners 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 Feed My Starving Children's Human Resources department for further information by email at hr@fmsc.org or call 763-267-6325.

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 HealthPartners changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at **1-800-772-1213** (TTY **1-800-325-0778**).

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

Name of Entity/Sender: Jess Jadwin
Contact--Position/Office: Benefits Specialist, Human Resources
Address: 401 93rd Ave N. Coon Rapids, MN 55433
Phone Number: 469-830-8703

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 January 1, 2024. 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: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaida-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/

	Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-andeligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 1, 2024, 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. OMB Control Number 1210-0137 (expires 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income..1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[1] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td>3. Employer Name
Feed My Starving Children</td><td colspan="2">4. Employer Identification Number (EIN)
41-1601449</td></tr>
<tr><td>5. Employer Address
401 93rd Avenue NW</td><td colspan="2">6. Employer Phone Number
763-504-2919</td></tr>
<tr><td>7. City
Coon Rapids</td><td>8. State
Minnesota</td><td>9. ZIP Code
55433</td></tr>
<tr><td colspan="3">10. Who can we contact about employee health coverage at this job?
Melissa Orrey, Benefits Analyst</td></tr>
<tr><td>11. Phone Number (if different from above)
763-267-6325</td><td colspan="2">12. Email Address
morrey@fmsc,org</td></tr>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are:

  Full-Time, regular employees working 30+ hours per week.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  -Enrollee's current legal spouse
  -Dependent children (natural or legally adopted, child for whom enrollee or spouse is legal guardian, child covered under a qualified medical child support order) up to age 26 or disabled.

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be adorable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Qualified Medical Child Support Orders

Procedures for Feed My Starving Children's Group Health Plans

ARTICLE I. INTRODUCTION

This document sets forth the procedures to be followed by Feed My Starving Children's group health plans upon receipt of "qualified medical child support orders" (QMCSOs), including National Medical Support Notices (NMSNs). These QMCSO procedures have been developed in accordance with Section 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA), which requires group health plans to establish reasonable administrative procedures for determining whether orders are QMCSOs and administering the provision of benefits under QMCSOs. They are designed to assist the Plan Administrator in determining whether a particular order is a QMCSO and in carrying out its responsibilities relating to QMCSOs.

These procedures do not apply to benefits that are not "group health plan" benefits under ERISA, such as life insurance benefits and retirement benefits.

All actions related to QMCSOs and NMSNs must be taken in accordance with these procedures and must be performed on a timely basis.

〉 WHAT IS A QMCSO?

A QMCSO is a judgment, decree, or order, issued by a court or through a state administrative process, that requires health plan coverage for the child of a participant (called an "alternate recipient") and that meets certain legal requirements. Such orders typically are issued as part of a divorce or as part of a state child support order proceeding, and are typically drafted by divorce lawyers. Unlike NMSNs, they are not required to follow a standard format. As a result, they may vary widely in terminology, format, and sophistication. Federal law requires a group health plan to provide benefits in accordance with such an order, if it is "qualified."

A QMCSO may apply to an employer's major medical plan, as well as to other types of group health plans such as dental plans, vision plans, and health FSAs.

In general, a child who is an alternate recipient under a QMCSO must be treated the same as any other child covered by the plan. If the Medical Child Support Order is not qualified, the group health plan will not provide group health plan coverage to the child, unless the child is otherwise eligible for and enrolled in the plan. More information on QMSCOs can be found at dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf.

〉 WHAT IS AN NMSN?

State child support enforcement agencies are required to use an NMSN when enforcing the provision of health care coverage to children under an employment-related group health plan. This is a standard form that was jointly developed by the DOL and HHS. When properly completed by the issuing agency, the NMSN will constitute a QMCSO.

In some cases, orders will refer to or require a plan to comply with state laws enacted in response to Section 1908A of the Social Security Act, which requires states to enact certain medical child-support laws in order to receive federal Medicaid funds. These state laws are designed to help state governments and non-employee parents obtain private-sector health coverage for children, including coverage under employer-sponsored group health plans.

The NMSN will normally be sent to the employer. If the Feed My Starving Children determines that the NMSN cannot be implemented, the employer is required to notify the issuing agency, which is then responsible for notifying the child and/or parents. If the Feed My Starving Children determines that the specified conditions that might prevent the NMSN from being are not present, Feed My Starving Children is then required to forward Part B of the NMSN to the Plan Administrator, at which point the Plan Administrator becomes responsible for complying with the applicable notification requirements.

〉 What Are the Plan's Rights and Responsibilities Relating to QMCSOs and NMSNs?

Plans are not required to provide coverage in accordance with a child support order or other court order unless the order is "qualified" in accordance with ERISA §609(a). The Plan Administrator has the authority to determine whether an order meets the requirements of ERISA §609(a). If the order does not meet these requirements, the Plan need not (and should not) provide any benefits to the alternate recipient, unless the child is otherwise eligible for and enrolled in the Plan or the order's deficiencies are corrected by the parties.

Article II. Procedures for Determining Whether Orders Are QMCSOs

The procedures to be followed upon the receipt by the Plan Administrator of a child support order depend on whether the order is an NMSN or another type of order.

〉 Upon Receipt of Any Order Other Than an NMSN

1. Notification to the Participant and the Alternate Recipient Upon Receipt of the Order

Upon receipt of any order other than an NMSN, the Plan Administrator must promptly provide written notification to both the participant and the alternate recipient(s) named in the order. The notification must inform the participant and the alternate recipient(s) that the Plan has received the order and should include a copy of the Plan's QMCSO procedures.

For the participant, the Plan Administrator should send the notification to the participant at the address shown in the employer's records. If the participant is represented by legal counsel, the notification may be sent to the participant in care of the participant's legal counsel.

For the alternate recipient(s), the Plan Administrator should send the notification to the address in the order, or if the order does not specify such an address, to the last-known address shown in the employer's records. If there are multiple alternate recipients named in the order, a single notification may be sent addressed to those alternate recipients who are, so far as the Plan Administrator is aware, residing at the same address. If the alternate recipients are minors, the notification may be sent to them in care of the parent with whom they are residing or, if they are represented by legal counsel, in care of their legal counsel.

2. Review of the Order

The Plan Administrator must review the order using the checklist attached to these procedures to determine if it meets the legal requirements for a QMCSO. If the Plan Administrator considers it to be necessary or advisable, the Plan Administrator may seek the assistance of legal counsel in reviewing a proposed QMCSO.

3. Notification to the Participant and the Alternate Recipient Following Review of the Order

Within a reasonable time after receipt of the order, the Plan Administrator must notify the participant and alternate recipient of the determination that it has reached as to whether the order is, or is not, a QMCSO. If the Plan Administrator determines that the order is not a QMCSO, an explanation of the defective or missing provisions should be included.

4. Time Period for the Plan Administrator's Review

The Plan Administrator should review a proposed QMCSO as quickly as possible. Under normal circumstances, the Plan Administrator's review must be completed within 40 business days following receipt of the proposed QMCSO.

5. Combining Notifications to the Participant and Alternate Recipient

When the Plan Administrator is able to review a proposed QMCSO immediately upon its receipt of the proposed order, the Plan Administrator may provide a single notification to the participant and the alternate recipient(s) informing them of its receipt of the proposed order, of the Plan's QMCSO procedures, and of the determination it has made as to whether the proposed order should be recognized as a valid QMCSO. Alternatively, the Plan Administrator may include separate notifications in the same envelope sent to the participant or to the alternate recipient(s).

〉 Upon Receipt of an NMSN

Upon receipt of an NMSN, the Plan Administrator must follow the "Instructions to Plan Administrator" that are included in Part B of the NMSN. In addition, because a properly completed NMSN is deemed to be a QMCSO under ERISA, the Plan Administrator must also ensure that the notifications to the participant and to the alternate recipient(s) that are required upon the receipt of a proposed QMCSO are also provided upon the receipt of an NMSN.

The required notifications can generally be provided by sending copies of the completed "Plan Administrator Response" to the NMSN to the parties using the addresses on Part B of the NMSN. In addition, if the NMSN is determined to be a QMCSO, the parties must be provided with certain information, such as the effective date of the child's coverage (or the steps necessary to effectuate coverage), a description of the coverage, and any forms or documents necessary to enroll in the Plan. (See the instructions to the NMSN.)

〉 Designation of Representative

An alternate recipient may designate a representative to receive copies of notices that are sent to him or her with respect to an order. If an alternate recipient is a minor, the custodial parent or the issuing agency will be deemed to be the representative of the alternate recipient unless contrary instructions have been provided. If any party is represented by legal counsel, that party's legal counsel will be deemed to be that party's representative for purposes of the notification requirements in these procedures.

〉 Disputes

Within 30 days after the date of the Plan Administrator's notice as to whether an order is a QMCSO, the parties (or their legal counsel) will have the right to submit written comments regarding the determination. After considering any comments received, the Plan Administrator will make a final determination as to the qualified status of the order. If no comments are received during the 30-day period, the decision will become final.

〉 Resubmitted Orders

If an order (including an NMSN) is determined to not be a QMCSO, the parties or agency may submit a revised order to cure the deficiencies. If a revised order is submitted, the evaluation process in subsection A or B is repeated.

Article III. Additional Considerations

〉 Forms and Information

Additional forms and information may be necessary to effectively administer benefits under an order that has been determined to be a QMCSO and to enroll the alternate recipient in the applicable plans. These forms and information include the following:

The name and address of the alternate recipient's custodial parent, legal guardian, or other person(s) to whom the SPDs and other plan-related information and correspondence should be furnished following the alternate recipient's enrollment. Where an agency is involved (as in the case of a National Medical Support Notice), it may be necessary or appropriate to provide certain plan information and/or correspondence to the agency as well.

A completed enrollment form, if required under the Plan.

A change in the participant's cafeteria plan election, if applicable. If benefits required to be provided under a QMCSO are paid for on a pre-tax basis, the QMCSO may qualify as a permitted election change event under the company's cafeteria plan. If applicable, and if the cafeteria plan document permits an election change on account of the QMCSO, the participant may submit a change in his or her cafeteria plan election in accordance with the cafeteria plan's rules.

The name and address of an individual to whom it is expected that benefit reimbursements, (including Feed My Starving Children's Dental Reimbursement plan), may be made for the alternate recipient's child's claimed expenses. The QMCSO rules provide that if medical expenses are paid by either the alternate recipient or the alternate recipient's custodial parent or legal guardian, a plan must reimburse that person (not the employee) for those expenses. If expenses are submitted for reimbursement, information identifying the individual to receive payment should be provided to the Plan.

Note that a QMCSO may provide that a person or entity other than the participant is responsible to pay for the alternate recipient's coverage. In such cases, the Plan Administrator should indicate how and when payment is to be made. For example, payments might be required concurrent with each payroll period or on a monthly basis as required of qualified beneficiaries receiving COBRA continuation coverage. The Plan Administrator should also make sure that it has contact information for the person or entity who will be making the payments.

〉 Alternate Recipient as "Beneficiary"

In general, the alternate recipient must be treated like any other covered child under each plan in which he or she is enrolled.

Unless a QMCSO is more restrictive, the alternate recipient should be given the same coverage as would be provided to any other dependent child under the Plan.

The alternate recipient should be treated as a qualified beneficiary and offered COBRA continuation coverage upon the occurrence of a COBRA qualifying event (such as the participant's termination of employment or the alternate recipient's ceasing to qualify as a dependent child under the Plan due to age).

〉 ALTERNATE RECIPIENT AS "PARTICIPANT"

With respect to ERISA reporting and disclosure rules, the alternate recipient generally is to be treated like a participant under each plan in which he or she is enrolled. Therefore, the alternate recipient should be sent copies of all applicable disclosures as required by ERISA or other applicable laws, including, for example, summary plan descriptions and summaries of material modifications. These items generally should be furnished to the alternate recipient's custodial parent or guardian. (If the alternate recipient is an adult, the Plan Administrator may provide copies to both the alternate recipient and the custodial parent or guardian.) Where an agency is involved (as in the case of an NMSN), it may be necessary or appropriate to provide copies of these items to the agency as well. Note that the alternate recipient need not be counted as a participant for purposes of the annual report (Form 5500).

〉 EFFECTIVE DATE OF ENROLLMENT

If an order is determined to be a QMCSO or an NMSN is determined to be valid, that order will be given effect as soon as administratively practicable following such determination or, if later, as of the date specified in the order. Retroactive coverage will not, however, be provided. If an employee is eligible for the Plan but is not enrolled, he or she will also be enrolled if his or her enrollment is necessary for the alternate recipient to have the coverage required under the QMCSO. However, if the employee has not yet satisfied the Plan's waiting period, enrollment of the alternate recipient and employee will be delayed until the employee has completed the waiting period.

〉 TERMINATION OF COVERAGE

Coverage for the alternate recipient will cease, subject to COBRA, if the alternate recipient ceases to be eligible to participate in the Plan for any reason, including the following:

- The period for coverage under the QMCSO ends;
- The QMCSO is revoked or materially amended by a court of competent jurisdiction or through an administrative process;
- The participant ceases to be a participant under the terms of the Plan or an applicable component plan of the Plan;
- The participant ceases to be eligible for coverage under the terms of the Plan or an applicable component plan of the Plan; or
- Similarly situated beneficiaries cease to be eligible for coverage under the terms of the Plan or an applicable component plan of the Plan.

〉 SPECIAL CONSIDERATION-CHILD ALREADY ENROLLED

The parties may submit an order (including a National Medical Support Notice) that purports to require that a child be covered under a plan in which he or she is already enrolled. In this circumstance, the plan administrator should process the order under these procedures but should also inform the parties of the child's status as a current beneficiary under the Plan.

〉 PLANS WITH MULTIPLE OPTIONS

An otherwise-qualified order may identify a plan or type of coverage with multiple options without designating the option in which the alternate recipient is to be enrolled or the manner in which an option is to be chosen. In the case of an NMSN, the Plan Administrator should follow the instructions in the NMSN regarding plans with multiple options. For other orders, the Administrator should enroll the alternate recipient in the same option as the employee if the employee is enrolled in the Plan. Otherwise, the Plan

Administrator may follow procedures similar to those in the NMSN. That is, the Plan Administrator may, instead of rejecting the order, provide the parties with information about the available options and direct them to make a selection. If a selection is not made, the Plan Administrator may notify the parties that the alternate recipient and employee will be enrolled in Feed My Starving Children's default medical option (*HealthPartners $5,000 HSA Plan*) if a response is not received within a 20 business days.

Illinois Act – Benefit Disclosure

Illinois Consumer Coverage Disclosure Act (SB 1905)

The Illinois Consumer Coverage Disclosure Act (AB 1905) requires an “employer that provides group health insurance coverage to its employees” to disclose differences between its plan’s benefits compared to the “essential benefits” that an individual medical insurance policy includes.

You can find Feed My Starving Children’s Medical Summaries of Benefits and Coverages on HR Connect, your hub for all things HR: **Medical Plan Documents & SBCs** (**https://fmscit.sharepoint.com/:f:/s/HR/EnnmFnXp-UtJgN7b_EUo5iQB9hxJMAVii4gxxbGWOJ6UHg?e=pqM6GT**) or if you would like a paper copy of any of these notices for you records free of charge, please contact HR@fmsc.org or call 763-267-6325.

The benefits available to Illinois employees can view and compare Essential Health Benefits found on the cms.gov website here: **https://labor.illinois.gov/content/dam/soi/en/web/idol/laws-rules/fls/ccda/ildol-employer-ehb-list-pa-102-0630.pdf**

Uniform Glossary

The Uniform Glossary is available to you here, and also on HR Connect, your hub for all things HR: **DOL Uniform Glossary.pdf (https://fmscit.sharepoint.com/:b:/s/HR/ETEbDyyfeLJAntqEqHyJnz4BW0gSFmp6keIRjwGGy67snw?e=egZrsA**) If you would like a paper copy of any of this document for you records free of charge, please contact HR@fmsc.org or call 763-267-6325.

These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

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

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

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

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

can be found on HR Connect, your hub for all things HR

Feed My Starving Children Master Wrap Document:

- https://fmscit.sharepoint.com/:f:/s/HR/EgyH3DipguNMvAuUezC9OtYB0dHXwe_YkOsYa0oAwATcyg?e=nAvtPz

Medical Summary of Benefits and Coverage:

- Plan #1, #2, and #3 – https://fmscit.sharepoint.com/:f:/s/HR/EnnmFnXp-UtJgN7b_EUo5iQB9hxJMAVii4gxxbGWOJ6UHg?e=XBQk9a

Medical Summary Annual Report:

- https://fmscit.sharepoint.com/:f:/s/HR/EgyH3DipguNMvAuUezC9OtYB0dHXwe_YkOsYa0oAwATcyg?e=mgocDr

Dental Plan Documents:

- https://fmscit.sharepoint.com/:f:/s/HR/EiGXMK32cBtAs6ZI_D7YHv4BvdoGXTtmui9vZFvm5F35-A?e=2Si5Xx

Employee Rights under the Family and Medical Leave Act (FMLA)

- dol.gov/sites/dolgov/files/WHD/legacy/files/fmlaen.pdf
- Page 32 of the Employee Handbook: https://fmscit.sharepoint.com/:b:/s/HR/EUJA_0YTdQVJsRYXJB6IAC4BCFVilfpFh39UhxOg-oDPWQ?e=cywpcW

Employee Rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

- dol.gov/sites/dolgov/files/VETS/files/USERRA-Poster.pdf
- Page 40 of the Employee Handbook: https://fmscit.sharepoint.com/:b:/s/HR/EUJA_0YTdQVJsRYXJB6IAC4BCFVilfpFh39UhxOg-oDPWQ?e=cywpcW

Right to a Paper Copy of This Notice

You have the right to a paper copy of any of these notices. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive these notices electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Human Resources at 763-267-6325 or HR@fmsc.org.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-883-2177 or visit us at www.healthpartners.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,500 Individual, $4,500 Family Out-of-network: $7,500 Individual, $22,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Coinsurance marked with * under What You Will Pay and copays and benefits with no charge are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network medical/pharmacy: $5,000 Individual, $10,000 Family Out-of-network medical/pharmacy: $15,000 Individual, $30,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthpartners.com/Perform or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: $45 copay Convenience Care: $20 copay Virtuwell: No charge	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	$45 copay	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance for x-ray/No charge for lab	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary Low Cost: $5 copay at retail, $15 copay at mail Formulary High Cost: $25 copay at retail, $75 copay at mail Non-preferred: $150 copay at retail, $450 copay at mail	Formulary: 50% coinsurance at retail, mail not covered Non-preferred: 50% coinsurance at retail, mail not covered	Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month.
	Formulary brand drugs	$60 copay at retail, $180 copay at mail	50% coinsurance at retail, mail not covered	
	Non-preferred brand drugs	$150 copay at retail, $450 copay at mail	50% coinsurance at retail, mail not covered	
	Specialty drugs	25% coinsurance*	50% coinsurance at retail, mail not covered	$500 maximum copay per prescription. Formulary oral chemotherapy drugs follow the Specialty drug benefit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	$45 copay	$45 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$45 copay	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	$45 copay	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	$45 copay	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	$45 copay	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	25% coinsurance	50% coinsurance	120 days per calendar year
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	25% coinsurance*	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery • Cosmetic surgery • Dental care (Adult)	• Infertility treatment • Long-term care • Private-duty nursing	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, limit of 15 visits • Chiropractic care	• Hearing aids • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at 1-800-883-2177. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. If your plan is not subject to ERISA, contact the US Dept. of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. If your plan is subject to ERISA; contact the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan at 1-800-883-2177. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. For group health plans subject to ERISA, the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,500**
- **Specialist copay** **$45**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,770**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copay** **$45**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,500**
- **Specialist copay** **$45**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-883-2177 or visit us at www.healthpartners.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $3,300 Individual, $6,600 Family Out-of-network: $13,000 Individual, $26,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Coinsurance marked with * under What You Will Pay and benefits with no charge are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network medical/pharmacy: $3,300 Individual, $6,600 Family Out-of-network medical/pharmacy: $20,000 Individual, $40,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthpartners.com/Perform or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance Virtuwell: 0% coinsurance	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: 0% coinsurance Non-preferred: 0% coinsurance	Formulary: 50% coinsurance at retail, mail not covered Non-preferred: 50% coinsurance at retail, mail not covered	Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month.
	Formulary brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Non-preferred brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Specialty drugs	0% coinsurance	50% coinsurance at retail, mail not covered	Formulary oral chemotherapy drugs follow the Specialty drug benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	transportation			network deductible
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance	50% coinsurance	120 days per calendar year
	Durable medical equipment	0% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery • Cosmetic surgery • Dental care (Adult)	• Infertility treatment • Long-term care • Private-duty nursing	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, limit of 15 visits • Chiropractic care	• Hearing aids • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at 1-800-883-2177. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. If your plan is not subject to ERISA, contact the US Dept. of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. If your plan is subject to ERISA; contact the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan at 1-800-883-2177. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. For group health plans subject to ERISA, the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

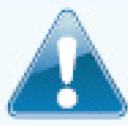
Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,300**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,300**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3,300**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
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Important Questions	Answers	Why This Matters:
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Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network medical/pharmacy: $5,000 Individual, $10,000 Family Out-of-network medical/pharmacy: $20,000 Individual, $40,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthpartners.com/Perform or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

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	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: 0% coinsurance Non-preferred: 0% coinsurance	Formulary: 50% coinsurance at retail, mail not covered Non-preferred: 50% coinsurance at retail, mail not covered	Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month.
	Formulary brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Non-preferred brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Specialty drugs	0% coinsurance	50% coinsurance at retail, mail not covered	Formulary oral chemotherapy drugs follow the Specialty drug benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
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If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	transportation			network deductible
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
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	Hospice services	0% coinsurance	50% coinsurance	None
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	Children's glasses	Not covered	Not covered	None
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- Infertility treatment
- Long-term care
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- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, limit of 15 visits • Chiropractic care	• Hearing aids • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)

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Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Your dental coverage

PPO plan, you'll have access to one of the largest networks of dentists with two reimbursement levels that give you more control over savings. You will always save money with any dentist in Guardian's network and when they belong to a tier in the Tier I reimbursement level you will maximize your savings. Reimbursement for covered services received from a non-contracted dentist will be based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**PPO**	
	Tier I	Tier 2
Your Network is DentalGuard Preferred Network	In-Network	Out-of-Network
Calendar year deductible	*Tier I*	*Tier 2*
Individual	$50	$50
Family limit	3 per family (applies to all levels)	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*Tier I*	*Tier 2*
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$1250 (applies to all levels)	
Maximum Rollover	Yes (applies to all levels)	
Rollover Threshold	$600	
Rollover Amount	$300	
Rollover Amount	$450	
Rollover Account Limit	$1250	
Lifetime Orthodontia Maximum	$1000 (applies to all levels)	
Dependent Age Limits	26 (applies to all levels)	

Your dental coverage

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		Tier 1	Tier 2
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months (applies to all levels)	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 14 (applies to all levels)	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Fillings‡	80%	80%
	Perio Surgery	80%	80%
	Periodontal Maintenance	80%	80%
	Frequency:	Once Every 6 Months (applies to all levels)	
	Root Canal	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%
	Simple Extractions	80%	80%
	Surgical Extractions	80%	80%
Major Care	Anesthesia*	50%	50%
	Bridges and Dentures	50%	50%
	Dental Implants	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%
	Single Crowns	50%	50%
Orthodontia	Orthodontia	50%	50%
	Limits:	Child(ren) (applies to all levels)	

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. These tiers represent specific benefit levels as described in Your Schedule of Benefits. Network access varies by geographic location and zip code. Please visit www.Guardianlife.com to confirm your Dentist's tiered participation.

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

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