FEED MY STARVING CHILDREN

Part-Time Employee

Benefits Guide

2025

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"…and if you spend yourselves in 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.

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

Vision Plan
EyeMed
866-939-3633
eyemedvisioncare.com

Paid Time Off
FMSC Human Resources
763-404-7871

FMSC Clothing Discounts
FMSC MarketPlace
763-267-6314

Eligibility

Who is eligible and when:

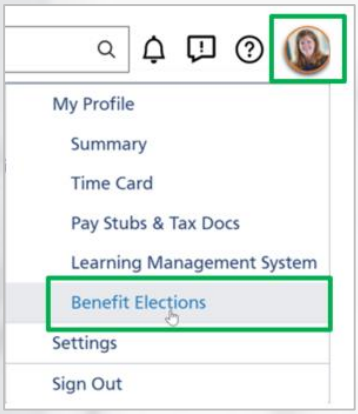
Regular, part-time employees are eligible to enroll in the following plans on the effective date shown.

Benefit Description	Eligibility Date
Paid Time Off (PTO)	Eligible upon hire date
Bereavement Leave	Eligible upon hire date
FMSC MarketPlace Clothing Discount	Eligible upon hire date
Vision Benefit	Eligible on the 1st of the month following hire date
Employee Assistance Program (EAP)	Eligible on the 1st of the month following hire date
401(k)	Eligible on the1st of the month following a 2-month waiting period after hire date

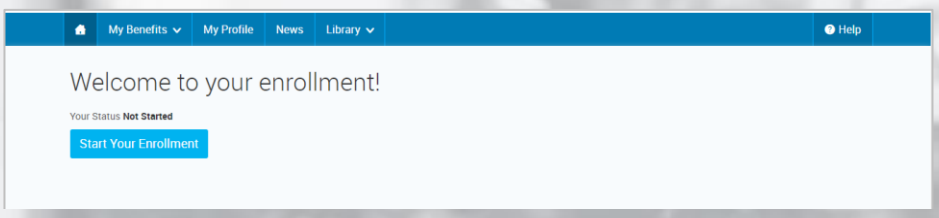
Making your Benefit Selections

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

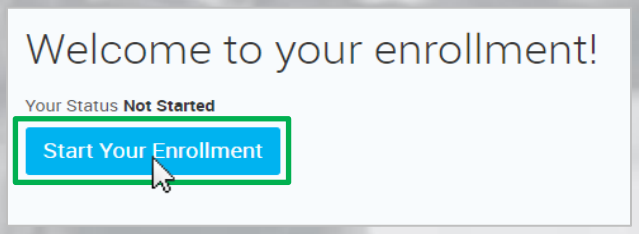
Login to Paycor. Click your **Profile Image** on the right hand side, click **My Profile**, then click **Benefit Elections**



You will then be directed to your Benefits home screen



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



For complete instructions please view **Paycor Enrollment Guide for Part-Time Employees**

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:

- Contribute up to 90% of your eligible compensation
- Roll over account balances from a prior employer's plan and/or IRA
- 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

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.

	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

Please refer to the Summary of Benefits for full details.

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

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

Contact Information

Web

hpeap.com

Mobile App

iConnectYou

GET IT ON Google Play

Download on the App Store

Phone

1-866-326-7194

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.

Paid Time Off (PTO)

Benefits you receive:

FMSC provides a 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 part-time employment, PTO is accrued at a rate of .04 hours of PTO for every paid hour of work. For an employee working on average 20 hours per week, that translates to about 42 hours of PTO during their first year. The employee's PTO accrual increases each year for the first 4 years of employment.

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

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

Bereavement Leave

Benefits you receive:

FMSC provides paid bereavement leave to employees who wish to take time off due to the death of a family member*, including biological, adopted, and stepfamily. The amount of time granted is dependent on the relationship to the employee.

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

Clothing Discount

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.

Crisis & Support Hotlines

National Hotlines	
Emergency	911
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

988 SUICIDE & CRISIS LIFELINE

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

Contents

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.

IMPORTANT NOTICE: This document is provided to help employees 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 (HIPAA)

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.

(HIPAA Notice of Privacy Practices)

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:

a. 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.

b. 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

Premium Assistance

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

Phone: 1-800-657-3739	
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%1 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..12

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.
2 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 physic ian 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

_____.

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

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.

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

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 never 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.

Other Documents 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.