2025

# Benefits Guide

An overview of the wide array of benefits provided by Hirshfield's Inc. to help you enjoy increased well- being and financial security.

These benefits are effective on January 01, 2025.

Hirshfield's
Paints • Wallcoverings • Window Fashions

Prepared by Christensen Group, Inc. for Hirshfield's Inc.

# Contents

Hirshfield's Inc. is proud to offer a comprehensive benefits package for you and your family. This program is designed to take great care of you when you need it. Make sure to explore your options to help you make the selections that best meet your needs.

## Benefits Offered

Throughout this booklet we will cover the following employee benefits being offered by Hirshfield's Inc.

Medical Insurance
Health Savings Account (HSA)
Flexible Spending Account (FSA)
Dependent Care FSA
Dental Insurance
Vision Insurance
Basic Life Insurance
Voluntary Life Insurance
Long Term Disability Insurance
Employee Assistance Program (EAP)
401(k) Plans
Medicare Advisor
Legal & ID Shield

This document does not replace the certificate booklets or Summary Plan Descriptions (SPDs). The benefits described in this document are only summaries; in case of error and for all claim adjudication, the Master Contracts will prevail Hirshfield's Inc. reservices rights to change, amend, terminate, or otherwise alter any plan at any time. Please refer to your certificates for more details and complete information.

# Benefits Eligibility

As an employee of Hirshfield's Inc. you may opt-in to annual benefits for you and your dependents when you meet certain work requirements.

## Eligible dependents

In addition to the employee, the following dependents are eligible to receive benefits:

Employee
Legal Married Spouse
Legal Children
Step-Children

## Work requirements

All regular, full-time employees scheduled to work 30 hours or more per week and their eligible dependents are benefit eligible.

## When your benefits begin

Medical, HSA, Vision, FSA, & Dependent Care FSA are effective the first of the month following 30 days of employment. All other benefits are effective first of the month following 90 days of employment.

# Benefits Elections

There is specific window of time each year where you must complete your benefits elections.

**All employees must complete the New Hire Benefits checklist on the UKG website regardless if they enroll or waive benefits. This website can be accessed from anywhere.**

**https://secure4.saashr.com/ta/6159191.login?rnd=DBN**

## New Hire Benefit checklists

All New Hires receive a due date Checklist that is emailed to the Store Manager. New Hires should check with their manager for the deadline checklist.

Employees who DO NOT complete their checklists on UKG will not be able to enroll in any benefits until the next following Open Enrollment Period.

## Hirshfield’s Connect

For more detailed benefit information, as well as info on additional employee perks, visit https://www.hirshfields-connect.com

# Benefits Summary

Hirshfield's Inc. provides an array of benefits that can help you enjoy increased well-being, deal with an unexpected illness or accident, build and protect your financial security, balance your personal and professional life and meet everyday needs. These benefits are affordable, comprehensive and competitive.

The table below summarizes the benefits available to eligible employees and their dependents. These benefits are described in greater detail in this booklet.

## QUESTIONS?

If you have any questions about your benefit options, please contact:

Eva Quist
Human Resources Director
Hirshfield's Inc.
(C) 612-810-0374
equist@hirshfields.com

| Coverage | Carrier | Group # | Phone | Website |
|---|---|---|---|---|
| Medical | Blue Cross Blue Shield of MN | 201458 | (866) 873-5943 | www.bluecrossmnonline.com |
| Health Savings Account (HSA) | Lively | - | (888) 576-4837 | www.livelyme.com |
| Flexible Spending Account (FSA) | Hirshfield's | - | See HR | |
| Dependent Care FSA | Hirshfield's | - | See HR | |
| Dental | Delta Dental of MN | 1183 | (800) 448-3815 | www.deltadentalmn.org |
| Vision | EyeMed | 1008426-1001 | (866) 939-3633 | www.eyemed.com |
| Basic Life | Sun Life | 220648 | (800) 247-6875 | www.sunlife.com |
| Voluntary Life | Sun Life | 220648 | (800) 247-6875 | www.sunlife.com |
| Long Term Disability | Sun Life | 220648 | (800) 247-6875 | www.sunlife.com |
| Employee Assistance Program (EAP) | Sun Life | - | (800) 460-4374 | www.sunlife.com |
| 401k | Fidelity | - | (800) 835-5097 | www.401k.com |
| Legal & ID Protection | LegalShield | 152386 | (800) 654-7757 | www.legalshield.com |

# Key Terms

## Annual deductible (ded)

The amount you must pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

## Out-of-pocket maximum

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible, copays and coinsurance.

## Copays & coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service and is generally billed to you after the health insurance company reconciles the bill with the providers.

## Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

## Premium

The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

## Preventative care

Preventive care helps detect or prevent serious diseases and medical problems before they can become major. Annual check-ups, immunizations, and flu shots, as well as certain tests and screenings, are a few examples of preventive care. This may also be called routine care.

## Embedded vs. non-embedded

Embedded plans effectively have two deductibles amounts within one plan; single and family. The single deductible is embedded in the family deductible, so no one family member can contribute more than the single amount toward the family deductible.

Non-embedded means the entire family deductible must be met before the plan pays.

# Medical Plan

## What is a medical plan?

A medical plan is a type of benefit that pays all or a portion of eligible medical expenses if you or a covered family member is ill or injured.

## Who is the carrier?

Your medical plans are administered through Blue Cross Blue Shield of MN. The specific networks you can choose from are:

Aware
High Value

Blue Cross Blue Shield of MN
(866) 873-5943
www.bluecrossmnonline.com

## Do you need to take action?

You may choose one plan for you and your dependents, including children to age 26. Your plan option may be changed once each year at annual enrollment time.

Hirshfield's Inc. pays a significant portion of your total enrolled premium for health insurance if you enroll in a plan. The amount you contribute, paid pre-tax through payroll deductions, is shown at the bottom of each plan option.

# Medical Plan

## Preventative Care

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporate healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations.

Through the plan offered by Hirshfield's Inc. all covered employees and dependents are eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers.

The following is a list of common services that are included in the plans offered this year.

### Covered preventative care services

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation Programs
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

# Medical Plan

## Summary of Plan Options

The following plans are your medical insurance options for the upcoming year.

| | $2,500-20% Copay Plan PPO Plan – Aware Network | |
|---|---|---|
| **In Network** | | |
| Deductibles (Single / Family) – Calendar Year | $2,500 / $7,500 | |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $5,500 / $11,000 | |
| Preventative Care | Covered 100% | |
| Primary Care Visit | $40 Copay | |
| Specialist Visit | $40 Copay | |
| Inpatient & Outpatient | Ded; then 20% coverage | |
| Emergency Room | Ded; then 20% coverage | |
| Urgent Care | $40 Copay | |
| Pharmacy / RX (30 Day Supply) | Tiers 1-4: $20/$50/$70/$120 | |
| **Out of Network** | | |
| Deductibles (Single / Family) – Calendar Year | $5,000 / $10,000 | |
| Coinsurance | 50% | |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $10,000 / $20,000 | |
| **Employee Contribution Semi-Monthly Pay Period** | **Hired Prior to 1990** | **Hired AFTER 1990** |
| Employee | 30% $125.48 | 35% $146.39 |
| Employee + 1 | 30% $262.43 | 35% $306.16 |
| Employee + Family | 30% $400.17 | 35% $466.87 |

# Medical Plan

## Summary of Plan Options *continued*

| | $2,500-20% Copay Plan PPO Plan– High Value Network | |
|---|---|---|
| **In Network** | | |
| Deductibles (Single / Family) – Calendar Year | $2,500 / $7,500 | |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $5,500 / $11,000 | |
| Preventative Care | Covered 100% | |
| Primary Care Visit | $40 Copay | |
| Specialist Visit | $40 Copay | |
| Inpatient & Outpatient | Ded; then 20% coverage | |
| Emergency Room | Ded; then 20% coverage | |
| Urgent Care | $40 Copay | |
| Pharmacy / RX (30 Day Supply) | Tiers 1-4: $20/$50/$70/$120 | |
| **Out of Network** | | |
| Deductibles (Single / Family) – Calendar Year | $5,000 / $10,000 | |
| Coinsurance | 50% | |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $10,000 / $20,000 | |
| **Employee Contribution Semi-Monthly Pay Period** | **Hired Prior to 1990** | **Hired AFTER 1990** |
| Employee | 30% $ 114.75 | 35% $ 133.88 |
| Employee + 1 | 30% $239.99 | 35% $279.99 |
| Employee + Family | 30% $365.96 | 35% $426.96 |

# Medical Plan

## Summary of Plan Options *continued*

| | $3,500-25% HSA Plan – Aware Network | |
|---|---|---|
| **In Network** | | |
| Deductibles (Single / Family) – Calendar Year | $3,500 / $7,000 | |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $5,400 / $10,800 | |
| Preventative Care | Covered 100% | |
| Primary Care Visit | Ded; then 75% coverage | |
| Specialist Visit | Ded; then 75% coverage | |
| Inpatient & Outpatient | Ded; then 75% coverage | |
| Emergency Room | Ded; then 75% coverage | |
| Urgent Care | Ded; then 75% coverage | |
| Pharmacy / RX (30 Day Supply) | Ded; then 75% coverage | |
| **Out of Network** | | |
| Deductibles (Single / Family) – Calendar Year | $5,000 / $10,000 | |
| Coinsurance | 50% | |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $10,000 / $20,000 | |
| **Employee Contribution Semi-Monthly Pay Period** | **Hired Prior to 1990** | **Hired AFTER 1990** |
| Employee | 30% $117.92 | 35% $137.57 |
| Employee + 1 | 30% $246.61 | 35% $287.72 |
| Employee + Family | 30% $376.06 | 35% $438.74 |

# Medical Plan

## Summary of Plan Options *continued*

| | $3,500-25% HSA Plan – High Value Network | |
|---|---|---|
| **In Network** | | |
| Deductibles (Single / Family) – Calendar Year | $3,500 / $7,000 | |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $5,400 / $10,800 | |
| Preventative Care | Covered 100% | |
| Primary Care Visit | Ded; then 75% coverage | |
| Specialist Visit | Ded; then 75% coverage | |
| Inpatient & Outpatient | Ded; then 75% coverage | |
| Emergency Room | Ded; then 75% coverage | |
| Urgent Care | Ded; then 75% coverage | |
| Pharmacy / RX (30 Day Supply) | Ded; then 75% coverage | |
| **Out of Network** | | |
| Deductibles (Single / Family) – Calendar Year | $5,000 / $10,000 | |
| Coinsurance | 50% | |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $10,000 / $20,000 | |
| **Employee Contribution Semi-Monthly Pay Period** | **Hired Prior to 1990** | **Hired AFTER 1990** |
| Employee | 30% $107.84 | 35% $125.81 |
| Employee + 1 | 30% $225.53 | 35% $263.11 |
| Employee + Family | 30% $343.91 | 35% $401.22 |

# Medical Plan

## Summary of Plan Options *continued*

| | $8,300-0% HSA Plan – Aware Network |
|---|---|
| **In Network** | |
| Deductibles (Single / Family) – Calendar Year | $8,300 / $16,600 |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $8,300 / $16,600 |
| Preventative Care | Covered 100% |
| Primary Care Visit | Ded; then 100% coverage |
| Specialist Visit | Ded; then 100% coverage |
| Inpatient & Outpatient | Ded; then 100% coverage |
| Emergency Room | Ded; then 100% coverage |
| Urgent Care | Ded; then 100% coverage |
| Pharmacy / RX (30 Day Supply) | Ded; then 100% coverage |
| **Out of Network** | |
| Deductibles (Single / Family) – Calendar Year | $10,000 / $20,000 |
| Coinsurance | 50% |
| Out-of-Pocket Max (Single / Family) – Calendar Year | $15,000 / $30,000 |
| **Employee Contribution Semi-Monthly Pay Period** | **ALL EMPLOYEES** |
| Employee | $93.81 |
| Employee + 1 | $227.17 |
| Employee + Family | $346.41 |

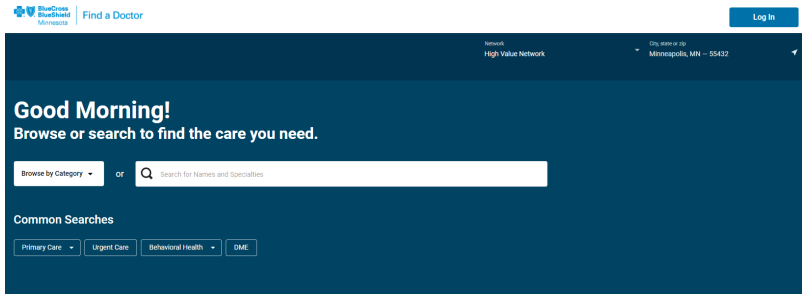
# Medical Plan

## Blue Cross Blue Shield Of MN Networks

### Aware

The Aware network includes all Blue Cross Blue Shield-contracted providers, including Mayo Clinic Health System.

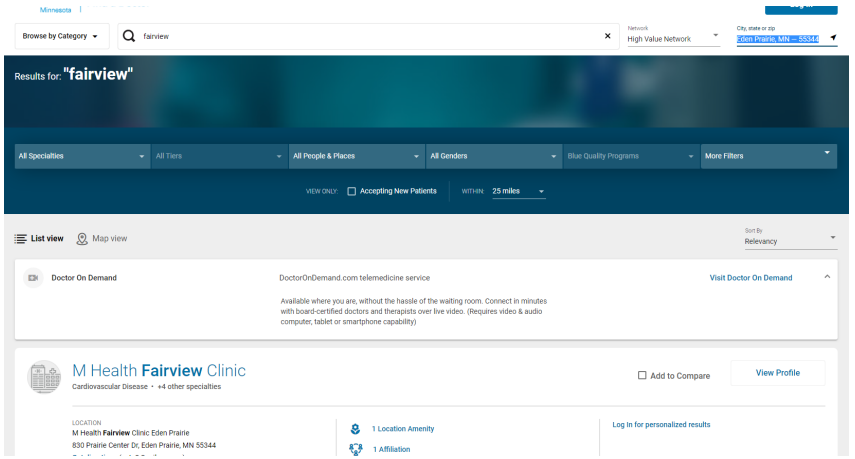
To search the Aware network, go to:
https://findadoctormn.sapphirecareselect.com/?ci=bcbsmn&network_id=310&geo_location=45.094896,-93.261556&locale=en_us




### High Value

The High Value network gives you access to a variety of quality health care systems across most of Minnesota, including: Allina, Fairview, HealthEast, North Memorial, Ridgeview, and U of M Physicians as well as many more outside the Metro area. Does not include Mayo Clinic Health System.

To search the High Value Network, go to:
https://findadoctormn.sapphirecareselect.com/?ci=bcbsmn&network_id=273&geo_location=45.094896,-93.261556&locale=en_us



# Medical Plan

## Blue Cross Blue Shield Of MN Networks

| | Aware Network | High Value Network |
|---|---|---|
| **METRO** | | |
| Allina | X | X |
| Avera | X | |
| CentraCare Health | X | X |
| Children's Hospitals & Clinics | X | X |
| Entira | X | X |
| HealthPartners Health System | X | |
| Hennepin County Medical Center | X | |
| M Health Fairview | X | X |
| Mankato Clinic Ltd | X | X |
| Mayo Health System | X | |
| North Memorial | X | X |
| Northfield Hospital and Clinic | X | X |
| Park Nicollet | X | |
| Ridgeview | X | X |
| St. Croix Regional Medical Center | X | X |
| University of Minnesota Physicians | X | X |
| Veterans Admin Medical Center | X | |

# Medical Plan

## Blue Cross Blue Shield Of MN Networks

| | Aware Network | High Value Network |
|---|---|---|
| **CENTRAL** | | |
| Carris Health | X | X |
| CentraCare Health | X | X |
| Cuyuna Regional Medical Center | X | X |
| Essentia | X | |
| HealthPartners Health System | X | |
| Hutchinson Health | X | |
| Integrity Health Network | X | X |
| M Health Fairview | X | X |
| Veterans Admin Medical Center | X | |
| **NORTHEAST** | | |
| Essentia | X | |
| Welia Health | X | X |
| Grand Itasca Clinic and Hospital | X | X |
| Integrity Health Network | X | X |
| M Health Fairview | X | X |
| St. Luke's | X | X |
| Veterans Admin Medical Center | X | |

# Medical Plan

## Blue Cross Blue Shield Of MN Networks

| | Aware Network | High Value Network |
|---|---|---|
| **SOUTHEAST** | | |
| Allina | X | X |
| Children's Hospitals & Clinics | X | X |
| Gundersen Health System | X | X |
| Mankato Clinic LTD | X | X |
| Mayo Health System | X | |
| Northfield Hospital and Clinics | X | X |
| Olmsted Medical Center | X | X |
| Veterans Admin Medical Center | X | |
| Winona Health | X | X |
| **NORTHWEST/SOUTHWEST** | | |
| Alomere Health | X | X |
| Altru Health System | X | X |
| Avera | X | |
| Carris Health | X | X |
| Essentia | X | |
| Integrity Health Network | X | X |
| Lake Region Healthcare Corp | X | X |
| Lakewood Health System | X | X |
| Mayo Health System | X | |
| Sanford Health | X | X |
| Swift County Benson Health Services | X | X |

# Medical Plan

## Blue Cross Blue Shield Of MN Value Adds

### These services are free to all employees enrolled in any of the BlueCross BlueShield plans offered by Hirshfield's

### Online Member Portal

Access important plan information in one place, 24 hours a day, seven days a week. After registering for an account at bluecrossmn.com, you can:

- Find healthcare providers with the Find a doctor online tool
- View claims and Explanations of Benefits (EOBs) for medical, dental and vision services
- Set up your medical spending accounts (if applicable)
- Send secure emails to customer service
- View, print, email or order member ID cards
- Access health and wellbeing benefits

### Learn To Live

Mental health struggles are more common than cancer, diabetes, and heart disease and yet three out of four people don't get the help they need. Now there's an easy way to get it, in the privacy of your own home. To get started, visit learntolive.com/partners and use code Blue4.

### Get Active

Get active with Blue Care Advisor℠ earn rewards for taking steps toward your health. Earn up to $240 annually. Avaliable to enrolled employees and their enrolled spouse.

With your new Blue Care Advisor Get Active program, small steps can lead to big benefits – and rewards. Simply track your daily steps or your favorite fitness activity and earn points that translate to real dollars. When your health plan is effective:

1. Register at bluecrossmn.com/bca or download the Blue Care Advisor app.
2. Complete a short Health Assessment and earn 100 points, fill out the form located on the homepage or under "Benefits" to start earning points. Based on your Health Assessment results, you'll receive personalized recommendations including helpful tips and resources.

### Omada

An online program that can help you lose weight, feel great and lower your risk for type 2 diabetes and heart disease through one-on-one guidance from a professional health coach and interactive tools. Omada combines science and support to help you develop healthy habits that last. You get personal support and interactive tools to get and keep you motivated. This program is available at no cost to you and adult family members if you qualify.

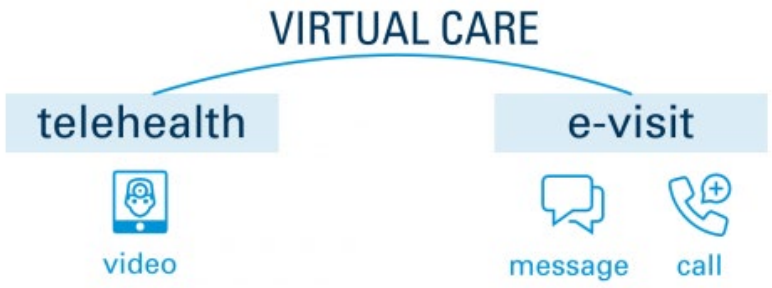
Visit omadahealth.com/bcbsmn1

# Medical Plan

## Blue Cross Blue Shield Of MN Value Adds

**When enrolled in the Blue Cross $2500-$40 copay medical plan offered by Hirshfield's, every covered member receives FIVE free general health e-visits per year! Telehealth visits are subject to a copay.**

**Both e-visits and telehealth are subject to the deductible on the HSA plans offered by Hirshfield's.**




### When should I use virtual care?

Telehealth is used for real time, non-urgent care for common illness and injury. Can also be used for mental health visits.

E-visits are used for non-urgent care for common illness and injury through the phone or electronic messaging. Care may be real time or delayed interaction.

### How do I know if my provider offers virtual care?

Virtual care options, what they are called and how you schedule an appointment varies by provider. Check with your favorite providers to see what virtual care options are available.

Ex. North Memorial Health offers e-visits in MyChart for scheduling a primary or specialty care virtual visit in addition to booking an in-office visit.

Lively

# Health Savings Account (HSA)

## What is an HSA?

A health savings account (HSA) is a health care account and savings account in one. The main purpose of this account is to offset the cost of a qualifying high deductible health plan (HDHP) and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement.

An HSA is a "portable" account. You own your HSA. It's included in your employee benefits package, but after you set up your account, it's yours to keep, even if you change jobs or retire.

## Who is the administrator?

Your HSA is administered by Lively.

Lively
(888) 576-4837

To register:
https://bmo.livelyme.com/signup?partner=BMO12

Ongoing Administration:
www.livelyme.com

## Do you need to take action?

Only certain health plans are eligible for HSAs. Depending on which health plan you select, you may or may not be eligible for an HSA.

If you are eligible for an HSA via your health plan, please follow the steps on the following page to set up your account. Once the account is set up, you need to provide you account number to HR at equist@hirshfields.com or fax to 612-930-0203

Lively

# Health Savings Account (HSA)

The following explains how you will be eligible to receive contributions from Hirshfield's if you are covered by a High Deductible Health Plan (HDHP) as well as HSA Account set up instructions.

Hirshfield's provides contributions to the Health Savings Account (HSA) of each employee who is an active employee and enrolled in a Hirshfield's provided High Deductible Health Plan ("eligible employee"). Hirshfield's contributes $50.00 for single coverage, $58.33 for Single +1, $66.67 for family coverage on the first pay date of each month to an eligible employee.

If you are an eligible employee, you must do the following to receive an employer contribution as well as contribute via Payroll Deductions to your HSA account:

(1) Establish an HSA on or before the 15th day of the prior month for which you are actively enrolled in a HDHP.

Example: Eligible to enroll in a HDHP: 03/01/202X– you need to enroll in the Lively HSA account by no later than 02/15/202x and provide HR with the information listed below.

(2) Notify Eva Quist, Director of HR of your HSA account information on or before 15 days prior to your health insurance effective date.

a) Notifications can be done via email: equist@hirshfields.com or fax: 612-930-0203 and need to contain the following information:

Last Name, First Name, Address, Date of Birth, last 4 digits of SS#, Lively Routing Number and Account Number. **Please note that Hirshfield's is not responsible for ensuring that the account number details you are providing is accurate.**

4) **Note for New Hires**: Failure to establish and/or notify HR by the required deadline means that Hirshfield's will not be making any contributions to your HSA account until the account # is received by HR.

If you do not establish an HSA account prior to the deadline and inform HR of the information needed (2) , and if you elect to contribute to the HSA, your contribution will be delayed until such information is received. Hirshfield's monthly contribution will not be made retrospectively. It is **NOT** Hirshfield's responsibility to inquire/remind the employee to submit their Lively account number to HR.

**5) Open Enrollment:** If you change to a HDHP during open enrollment you must follow the steps above (Under New Hire) to enroll in an HSA. It is your responsibility to review your paychecks for accuracy and correct information. **Waiving the HSA option during open enrollment means that you waive the Hirshfield's monthly contribution as well as your own contribution for the entire calendar year**.

If you have any questions about this notice, you can contact Eva Quist via email at equist@hirshfields.com or 612-810-0374.

# HSA

## Overview & Details

HSAs benefit everyone who is eligible to have this account – single individuals, families, and soon-to-be retirees. You save money on taxes in three ways:

**Tax-Free Deposits**
The money you contribute to your HSA isn't taxed (up to the IRS annual limit)

**Tax-Free Earnings**
Your interest and any investment earnings grow tax-free

**Tax-Free Withdrawals**
Money used toward eligible health care expenses isn't taxed – now or in the future

Setting aside pre-tax dollars into your HSA you pay fewer taxes and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket. For example, if you are in the 30 percent tax bracket, you can save $30 on every $100 spent on eligible health care expenses.

You can change your HSA contribution amount anytime throughout the year, no qualifying event needed.

HSA funds roll over from year to year and accumulate in your account. There is no "use-it-or-lose-it" rule with HSAs, and you decide how and when to use your HSA funds, which can be used for eligible expenses you have now, in the future, or during retirement. Additionally, When you have a certain balance in your HSA, investment opportunities are available.

### 2025 HSA Contribution Limits

Single Coverage: $4,300

Family Coverage: $8,550

If you are 55 or older, you can contribution an additional $1,000 "catch-up" on top of the limits listed above

## EMPLOYER CONTRIBUTION

Hirshfield's makes an HSA contribution monthly to your HSA account on the first payroll of each month you are eligible.

Contribution amounts are equivalent to:

Employee Only: $600 per year
Employee + One: $700 per year
Family: $800 per year

# Flexible Spending Account (FSA)

## What is an FSA?

A flexible spending account (FSA) is an account that reimburses the employee for qualified health care or dependent care expenses. It allows an employee to fund qualified expenses with pre-tax dollars deducted from the employee's paychecks. The employee can receive cash reimbursement up to the total value of the account for covered expenses incurred during the benefit plan year and any applicable grace period.

## Who is the administrator?

Your FSA is administered by Self-Administered.

Hirshfield's
See HR with any questions on the FSA

## Do you need to take action?

If you want to participate in either type of FSA, you will need to make an enrollment election every year.

# FSA

## Overview & Details

As a reminder, FSAs are use it or lose it accounts. Unlike HSAs, the IRS only allows a certain amount to be carried over to the next calendar year. Therefore, it's important to not over-fund your FSA.

### 2025 FSA Contribution Limits

**Election Maximum:** $3,300

Per IRS you are allowed to roll over up to $660 from 2025 to 2026.
- Any additional funds not claimed my March 1, 2026 will be lost per IRS rules)

### Health FSA Eligible Expenses

- Medical expenses: co-pays, co-insurance, and deductibles
- Dental expenses: exams, cleanings, X-rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services: physical therapy, chiropractor, and acupuncture
- Prescription drugs and insulin
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.

### Limited FSA Eligible Expenses

If you are enrolled on an HSA plan, you are not able to use FSA dollars on medical expenses. But you can use them on:

- Dental expenses: exams, cleanings, X-rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery

# Dependent Care FSA

## What is a Dependent Care FSA?

A dependent care FSA is a type of Flexible Spending Account (FSA). The Dependent Care FSA is an account in an employee's name that reimburses the employee for qualified dependent care expenses. It allows an employee to fund qualified expenses with pre-tax dollars deducted from the employee's paychecks. The employee can receive cash reimbursement up to the total value of the account for covered expenses incurred during the benefit plan year and any applicable grace period.

## Who is the administrator?

Your Dependent Care FSA is administered by Other.

Hirshfield's
See HR with any questions on the Dependent Care FSA

## Do you need to take action?

If you want to participate in the Dependent Care FSA , you will need to make an enrollment election every year.

# Dependent Care FSA

## Overview & Details

As a reminder, Dependent Care FSA are use it or lose it accounts. Unlike HSAs, money in your Dependent Care FSA at the end of the year will not carry over to the next year. Therefore, it's important to not over-fund your Dependent Care FSA.

### Dependent Care FSA Eligible Expenses

- Care for your child who is under age 13
- Before and after-school care
- Baby sitting and nanny expenses
- Day care, nursery school, and preschool
- Summer day camp
- Care for a relative who is physically or mentally incapable of self-care and lives in your home

### Dependent Care FSA

**Election Maximum:** $5,000
($2,500 if married, filling separately)

# Dental Insurance

## What is Dental Insurance?

Dental insurance is designed to pay a portion of the costs associated with dental care. Like medical insurance there can be copays, deductible and coinsurance for certain type of services; however preventive services are almost always covered at 100%.

## Who is the provider?

Your Dental Insurance is provided by Delta Dental of MN.

Delta Dental of MN
(800) 448-3815
www.deltadentalmn.org

## Do you need to take action?

You will need to make an enrollment election every year to participate in the dental plan.

# Dental Insurance

## Summary of Coverage

Delta Dental of Minnesota

The following plan is your dental insurance option for the upcoming year.

| | Delta Dental | |
|---|---|---|
| In Network | PPO & Premier Networks | |
| Calendar Year Deductible (Single / Family) | $25/$75 | |
| Calendar Year Maximum (per person, all services except Prosthetics ) | $3,000 | |
| Calendar Year Maximum (per person, Prosthetics only – This is in addition to the $1,000 maximum you have for all other services) | $3,000 | |
| Preventative Care: *Exams, Cleanings, X-rays, Space Maintainers & Sealants* | 100% | |
| Basic Services: *Palliative Treatment, Periodontal Maintainers, Fillings, Simple Extractions, Endodontics* | 90% | |
| Major Services: *Oral Surgery, General Anesthesia, Crowns, Bridges, Dentures, Implants* | 90% | |
| Orthodontics (per person, ages 8 & up) | 50%<br>Lifetime maximum: $1,500 | |
| **Employee Contribution per Semi-Monthly Pay Period** | **Hired Prior to 1990** | **Hired AFTER 1990** |
| Employee | 30% $7.97 | 35% $9.30 |
| Employee + Family | 30% $22.21 | 35% $25.91 |

### Finding an In-Network Provider

Visit https://www.deltadentalmn.org/find-a-dentist/#/start

You can see any dentist in either the PPO or Premier network

# Vision Insurance

## What is Vision Insurance?

Vision insurance is designed to provide routine preventive care such as eye exams, eyewear and other vision services at a reduced rate.

## Who is the provider?

Your Vision Insurance is provided by EyeMed.

EyeMed
(866) 939-3633
www.eyemed.com

## Do you need to take action?

You will need to make an enrollment election every year to participate in the vision plan.

# Vision Insurance

## Summary of Coverage

The following plan is your vision insurance option for the upcoming year.

| | EyeMed Materials-only Vision Plan |
|---|---|
| **In Network** | **Insight Network** |
| Lenses (Once every 12 months) | $130 Allowance |
| Single | $10 Copay |
| Bifocal | $10 Copay |
| Trifocal | $10 Copay |
| Progressive | $75-$120 Copay ; 20% off retail price less $120 allowance |
| Frames (Once every 24 months) | $0 Copay ; 20% off balance over $130 allowance |
| Elective Contact Lenses (in lieu of lenses and frames) | $0 Copay ; 15% off balance over $130 allowance |
| Conventional | $0 Copay ; 15% off balance over $130 allowance |
| Disposable | $0 Copay ; 100% off balance over $130 allowance |
| Medically Necessary Contact Lenses (Once per 12 months) | $0 Copay ; paid in full |
| **Employee Contribution per Semi-Monthly Pay Period** | |
| This is your contribution, paid pre-tax through payroll deductions. | |
| Employee | $ 2.47 |
| Employee + 1 | $ 4.70 |
| Employee + Family | $ 6.90 |

**Finding an In-Network Provider**

Visit https://www.eyemed.com and click on find an eye doctor.
For the richest benefits, use a provider in the Insight Network

# Life Insurance and AD&D

## What is Life Insurance?

Life insurance and accidental death and dismemberment (AD&D) is designed to pay a specified benefit in the event of the covered person's death.

## Who is the carrier?

Your Basic Life Insurance is administered by Sun Life.

Sun Life
(800) 247-6875
www.sunlife.com

Your Voluntary Life Insurance is administered by Sun Life.

Sun Life
(800) 247-6875
www.sunlife.com

## Do you need to take action?

Your basic life insurance coverage is paid for by your employer. There is no enrollment action needed other than to meet your employer's requirements for eligibility.

**Note:** Annual benefits renewal is a good time to update your life insurance beneficiary.

Your voluntary life insurance coverage is entirely paid for by the employee. You will need to make an enrollment election for yourself and your dependents.

If you do not enroll in the voluntary life when you are first eligible and want to add the coverage later, you will need to complete an evidence of insurability for any requested amounts of coverage.

**Note:** Annual benefits renewal is a good time to review your benefit election amount and update your beneficiary.

# Life and AD&D

## Summary of Coverage

Hirshfield's Inc. pays 100% of premiums for your Basic Life and AD&D Insurance.

| Employer paid Plan Features | Benefit |
|---|---|
| Employee Life & AD/D Benefit Amount | 1 x Annual Salary; to a maximum of $200k |

You pay 100% of premiums for your Voluntary Life and AD&D Insurance.

| Employee paid Plan Features | Benefit |
|---|---|
| Employee Life Benefit Amount | 5x Annual Salary; to a maximum of $500,000 (in increments of $10,000) |
| Employee Guarantee Issue | $100,000 |
| Spouse Life Benefit Amount | Up to $250,000; maximum of 100% of employee amount (in increments of $5,000) |
| Spouse Guarantee Issue | $ 25,000 |
| Child Life Benefit Amount (children aged 14 days to 23 years or 25 years if a full-time student) | Up to $ 10,000; maximum 100% of employee amount (in increments of $2,000) |

### Guarantee Issue

The employee guarantee amount is the amount of voluntary life insurance you can opt in to without answering any medical questions. Guarantee issue only applies when you are first eligible for coverage. After that time, you would need to complete an evidence of insurability for any coverage amounts requested.

# Long Term Disability (LTD)

## What is Long Term Disability Insurance?

Long Term Disability provides a portion of your income if you are unable to work due to a qualified disability.

## Who is the carrier?

Your Long Term Disability Insurance is administered by Sun Life.

Sun Life
(800) 247-6875
www.sunlife.com

## Do you need to take action?

Long term disability coverage is entirely paid for by the employee. You will need to make an enrollment election for yourself.

If you do not enroll in the long term disability when you are first eligible and want to add the coverage later, you will need to complete an evidence of insurability when requesting coverage.

# Long Term Disability

## Summary of Coverage

The following is your Long Term Disability benefit for the upcoming year.
You pay 100% of the cost of this plan

| Plan Features | |
|---|---|
| Employee Benefit Amount | Up to 60% of pre-disability earnings |
| Maximum Benefit Amount | $5,000 per month |
| Elimination Period | 90 days |
| Benefit Duration | Social Security Normal Retirement Age |

# Employee Assistance Program (EAP)

## This program is FREE to all Hirshfield's employees

### What is an EAP?

Provided by Sun Life, your Employee Assistance Program EAP) provides you and your household members with **free,** confidential, in-the-moment support to help with personal or professional problems that may interfere with work or family responsibilities.

Common reasons to call your EAP are relationship issues, birth, death, illness, marriage issues, burnout/anger, depression, anxiety, substance abuse, challenges of daily responsibilities, and parenting.  The EAP is available 24/7

### Who is the carrier?

Your EAP is administered by Sun Life.

Sun Life
(800) 460-4374
Online: Guidanceresources.com
App: GuidanceNow
Web ID: EAPEssential

### Do you need to take action?

The EAP is paid for 100% by Hirshfield's for all employees – both part time and full time.

You are automatically enrolled in this coverage - no action is needed from you.

# EAP – 24/7 Confidential Support

## Details

### Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

### Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

### Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25%reduction in fees.

### Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

### Online Support

GuidanceResources®Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

### What happens when I call for support?

When you call, you will speak with a GuidanceConsultantSM, a master's-or PhD-level counselor who will collect some general information about you and will talk with you about your needs. The GuidanceConsultant will provide the name of a counselor who can assist you. You will receive counseling through the EAP up to 3 telephonic sessions per issue, per person, per calendar year. You can then set up an appointment to speak with the counselor over the phone.

# 401(k) Plan Information

## What is a 401(k)?

A 401(k) is a retirement savings plan sponsored by your employer. It lets you save and invest a piece of your paycheck before taxes are taken out. Taxes aren't paid until the money is withdrawn from the account. Generally, a 401(k) participant may begin to withdraw money from his or her plan after reaching the age of 59+1/2 without penalty.

## Who is the provider?

Your 401(k) plan provider is Fidelity.

Fidelity
800-835-5097
www.401k.com

## Do you need to take action?

A 401(k) account will automatically be created for you, and 4% of your pay will be deposited per pay period. That amount will increase automatically each year up to 10% unless you opt out of this option.

Hirshfield's will match 35% of your contribution up to 12%. Any contributions over 12% are not matched by Hirshfield's. You are fully vested immediately.

Catch up contributions are not matched.

You will be able to change this at any time online at www.401k.com (including your investment options).

# 401(k) Plan
## Details

### Eligibility Requirements

Employees must be 21 years old and have three (3) months of service with Hirshfield's can participate starting the first day of the next month. You may change your deferral amount at any time after the initial eligibility requirements are completed.

Please verify your beneficiary information by visiting this link to the Fidelity website.

### Contribution Limits

Currently, the maximum 401(k) contribution is $23,000 per individual. If you are over 50 years old before 12/31, you may contribute additional "catch-up" contribution of up to $7,500 ($30,500 total). The IRS may update this contribution limit at their discretion.

Note: starting in 2025, the "catch-up" contribution limit will be increased for individuals ages 60-63 to the greater of (1) $10,000 or (2) 150% of the regular annual catch up limit.

### Vesting

Employer match is 100% vested immediately

### Rollovers

Rollovers are accepted from qualified retirement plans (401(k), profit sharing, pension) and traditional/pre-tax IRAs.

### Withdrawals

You may make a withdrawal from your 401(k) account upon a qualifying distribution event: Retirement, Death, Disability, Termination of Service, Financial Hardship (as defined by the Internal Revenue Code).

### Employer Contribution

Hirshfield's will make a matching contributions equal to $0.35 for each $1.00 deferred on the first 12% of pay savings into your 401(k) plan.

### Contact Information

Fidelity
800-835-5097
www.401k.com

You also have access to free 401k financial investment advisor at Christensen Group. You can reach Spencer Rose at 952-653-1047 or srose@cgfinancial.com

# 401(k) Plan

## Details: Fidelity NetBenefits®

### NetBenefits®Information

**If you have already registered with Fidelity.com, NetBenefits, or eWorkplace, you do not need to register again. Use your existing username and password to access your new account.**

### New user registration

*During the new user registration process, you may be asked to take an additional security step to help us authenticate your account.*

**1 Verify your identity**

Enter information in the following required fields:

- Your first and last name
- Your date of birth
- Last four digits of your Social Security number

Select the **Submit** button.

**2 Set up your username**

We require that you create a **unique username.**

- Use 6–15 characters, including at least two letters.

Select **Check Availability** to ensure the username is not already in use.

You may **not** use:

- Special characters or symbols
- Sequences (e.g., 12345 or 11111)
- Personal info (SSN, phone #, DOB)

**3 Create a password**

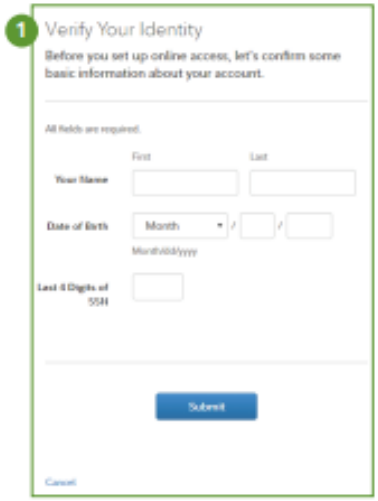
Your password protects your account from unauthorized users.

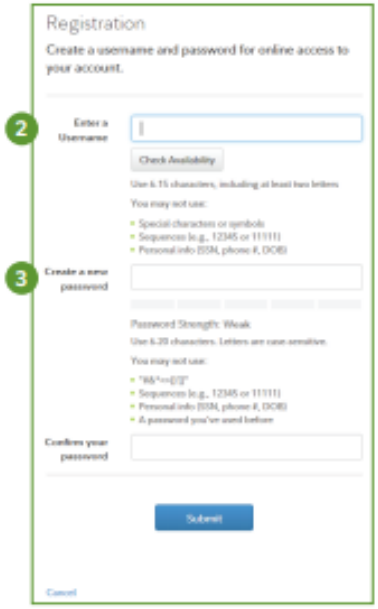
- Use 6–20 characters.
- Letters are case sensitive.

You may **not** use:

- *#&*<>{}'[]"
- Sequences (e.g., 12345 or 11111)
- Personal info (SSN, phone #, DOB)
- A password you've used before

After confirming your password, select **Submit.**




For illustrative purposes only.

# 401(k) Plan

## Details: Fidelity NetBenefits®

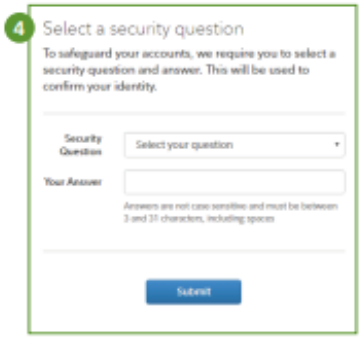
**4 Select a security question**

If you ever forget your password, you can reset it after Fidelity verifies your identity using your new or updated security question and answer.

Pick a security question you can easily answer and enter your answer.

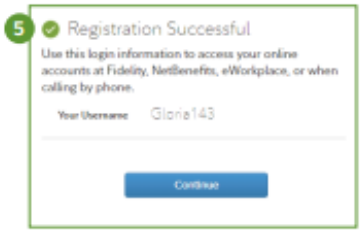
- Answers must be between 3 and 31 characters
- Answers are not case sensitive

Select **Submit.**



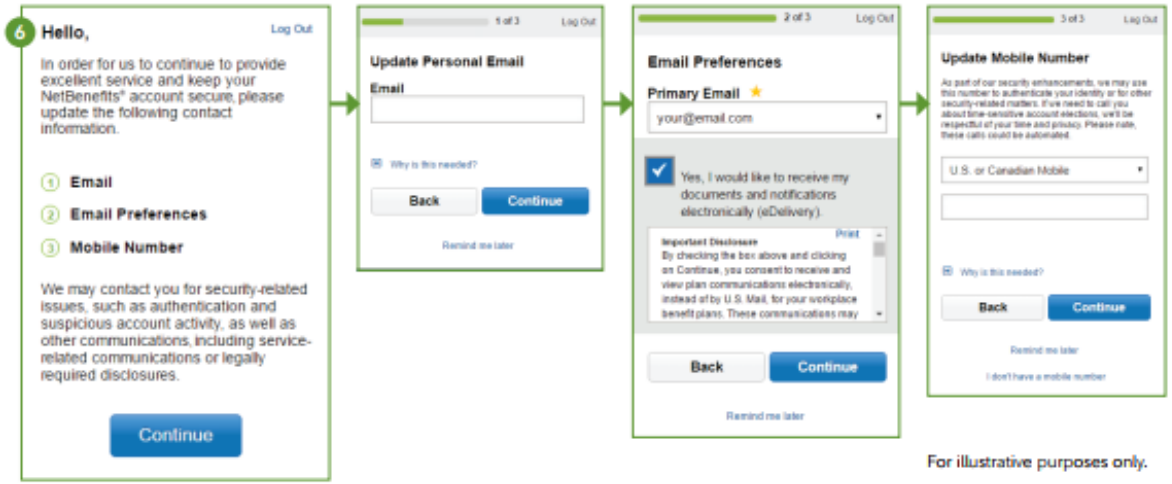

**5 New user registration confirmed**

You have successfully registered. If you have other accounts through Fidelity.com, NetBenefits, or eWorkplace, your new login information applies to these accounts, as well as to accessing your account by phone.




**6 When you log in to NetBenefits, you'll be asked to provide your email address, email preferences, and mobile phone number.**

Fidelity uses the contact information you provide to send you important communications about your benefits, as well as timely service-related and legal notifications, including messages about educational and new service offerings.




For illustrative purposes only.

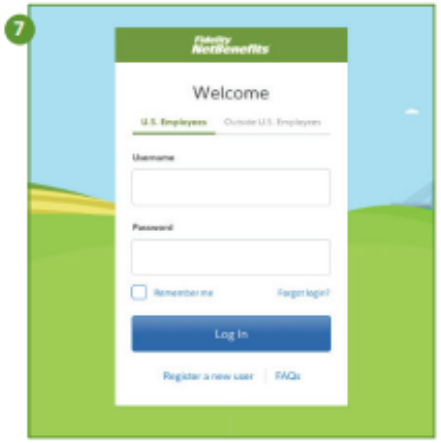
# 401(k) Plan

## Details: Fidelity NetBenefits®

### 7 Begin using NetBenefits

After you log in with your new account username and password, and update your email address, email preferences, and mobile phone number, you can:

- Enroll in your plan, if you haven't already
- Check your account balances
- Update how much you set aside to save from your paycheck
- Make changes to your investments
- Visit the Planning & Guidance Center and set up important financial goals, such as saving for retirement, college, and other personal goals (e.g., buying a home)
- Access educational resources in the NetBenefits Library to improve your financial know-how on a wide range of topics (Social Security, loans, budgeting, etc.)




For illustrative purposes only.

**Need help setting up your account?**
**Call your Plan's toll-free number.**

# 401(k) Plan

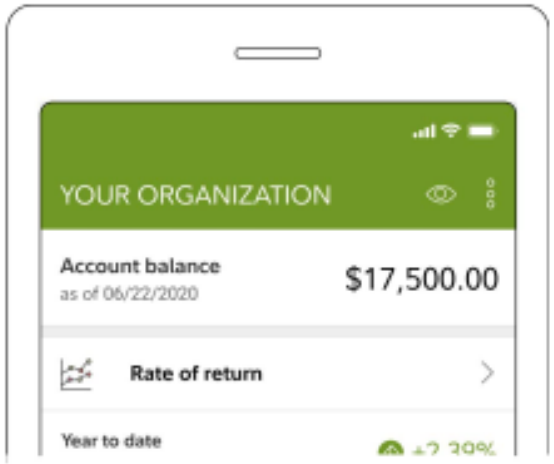
## Details: Fidelity NetBenefits® Mobile App

### Take NetBenefits with you

Get instant access to balances, investments, educational resources, and more.

**Download our mobile app today.**

NetBenefits®smartphone and iPad® app






Download on the App Store | GET IT ON Google Play

Go to NetBenefits.com

# Medicare Advisor

## This program is FREE to all Hirshfield's employees

### What is a Medicare Advisor?

If you are Medicare eligible, or will be soon, Lauren Miller with Christensen Group can help you decide what your best benefit options are.

Lauren has access to the Hirshfield's benefit overview (including cost) so she can give you a comprehensive comparison between the Medicare & Hirshfield's options available to you.

### Who is the contact?

Lauren Miller
lmiller@christensengroup.com
952-653-1134

Hanna Barr
hbarr@christensengroup.com
952-653-1307

### Do you need to take action?

This optional service is free to all Hirshfield's employees and their families.

If you (or your family) member is Medicare eligible or will be soon, you can schedule an appointment with Lauren by visiting:
https://calendly.com/lamillercg

# Legal & Identity Theft Protection

## What is a Legal & Identity Theft Insurance?

Legal protection gives you the ability to talk to an attorney without worrying about high hourly costs.  You pay one monthly fee for access to legal advice, will preparation and other legal services.

Identity Theft protection provides coverage if your identity has been stolen and credit monitoring with alerts.

## Who is the administrator?

Your Legal & Identity Theft Insurance is administered by Legal Shield.

Legal Shield
(800) 654-7757
www.legalshield.com

## Do you need to take action?

You will need to make an enrollment election every year to participate in either the legal or the identity theft protection plan.

# Legal & Identity Theft

## Summary of Coverage

This plan, administered by Legal Shield, provides coverage for legal advice, will preparation and access to online legal forms. Once enrolled, you will receive a directory of attorneys, and a listing of their corresponding areas of law in which they specialize.

| Plan Features | Employee Contribution per Semi-Monthly Pay Period |
|---|---|
| Individual Legal | $8.48 |
| Family Legal | $9.48 |
| Individual ID Shield | $4.49 |
| Family ID Shield | $8.48 |
| Individual ID Shield and Individual Legal | $12.96 |
| Family Legal and ID Shield | $16.95 |

### About Identity Theft

Identity theft occurs when others obtain and use your personal information without your permission. Once your personal information is obtained, thieves can use existing or open new credit cards in your name, write bad checks or take out loans.

Before you catch wind that your identity has been stolen, your credit may be tarnished and thieves may have racked up significant debt, all in your name!

# Legal Notices

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

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

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

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

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

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –**

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

| GEORGIA – Medicaid | INDIANA – Medicaid |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1 GA CHIPRA<br>Website:<br>https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment Program All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>Iowa Medicaid \| Health & Human Services Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)<br>Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov KCHIP Website:<br>https://kynect.ky.gov Phone: 1-877-524-4718<br>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<br>1-855-618-5488 (LaHIPP) |

| MAINE – Medicaid | MASSACHUSETTS – Medicaid and CHIP |
|---|---|
| Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672 | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |

| NEVADA – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711) | 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 and CHIP** |
| 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.pa.gov/en/services/dhs/apply-for-medicaid- health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or<br>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<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium- assistance/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/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |

| WISCONSIN – Medicaid and CHIP | WYOMING – Medicaid |
|---|---|
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 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 (expires 1/31/2026)

## 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 the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.**

**How is COBRA continuation coverage provided?**

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

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

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

***Disability extension of 18-month period of COBRA continuation coverage***

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

***Second qualifying event extension of 18-month period of continuation coverage***

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

**Are there other coverage options besides COBRA Continuation Coverage?**

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

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

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

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

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

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

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

**If you have questions**

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

**Keep your Plan informed of address changes**

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

## Family Medical Leave Act (FMLA)

**Who is eligible for FMLA leave?**

An employee is eligible for FMLA leave if the employee has been employed by a covered employer for at least 12 months and has worked at least 1,250 hours for that employer during the previous 12-month period. An eligible employee must also be employed at a worksite where the employer employs at least 50 employees within a 75-mile radius of the worksite.

For purposes of determining whether an employee who is a flight crew member meets the hours-of-service requirement above, the employee will be considered to meet the requirement if he or she:

- Has worked or been paid for not less than 60 percent of the applicable total monthly guarantee for the previous 12-month period; and
- Has worked or been paid for not less than 504 hours during the previous 12-month period.

### *What are the qualifying reasons for FMLA leave?*

The following circumstances qualify for **12 workweeks** of FMLA leave:

- ✓ Birth and care of an employee's son or daughter;
- ✓ Placement of a son or daughter with the employee for adoption or foster care;
- ✓ Care for an employee's spouse, son, daughter or parent who has a serious health condition;
- ✓ An employee's own serious health condition that makes the employee unable to perform any one of the essential functions of the employee's position; or

- ✓ Any qualifying exigency arising out of the fact that a family member (spouse, son, daughter or parent of the employee) is a covered military member on covered active duty or has been notified of an impending call or order to covered active duty in the Armed Forces.

In addition, eligible employees may take **26 workweeks** of leave in a single 12-month period to care for a spouse, son, daughter, parent or next of kin who is a covered service member with a serious injury or illness.

### *What is a "serious health condition" under the FMLA?*

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment** by a health care provider. The FMLA does not apply to routine medical examinations, such as a physical, or to common medical conditions, such as an upset stomach, unless complications develop.

For all conditions, "incapacity" means inability to work, including being unable to perform any one of the essential functions of the employee's position, or inability to attend school, or perform other regular daily activities due to the serious health condition, treatment of the serious health condition, or recovery from the serious health condition. The term "treatment" includes, but is not limited to, examinations to determine if a serious health condition exists and evaluations of the condition.

Serious health conditions may include conditions that involve an inpatient hospital stay or ones that include one or more visits to a health care provider and ongoing treatment. Chronic conditions and long-term or permanent periods of incapacity may also meet the requirements. Certain conditions requiring multiple treatments may also be FMLA-qualifying.

### When should an employee provide notice of his or her need for FMLA leave?

Employees should give employers as much notice as possible when requesting leave under the FMLA. While not required to use the term "FMLA" when seeking leave, the employee must provide sufficient information for the employer to determine if the leave qualifies for FMLA protection. When an employee seeks leave due to an FMLA-qualifying reason for which the employer has previously provided FMLA-protected leave, the employee must specifically reference the qualifying reason for leave in notifying the employer.

If leave is foreseeable for the birth of a child, to adopt or place a foster child, for planned medical treatment of a serious health condition of the employee or family member, or for the planned medical treatment for a serious injury or illness of a covered service member, employees must provide the employer with **at least 30 days' advance notice** before the leave begins. If 30 days' advance notice is not provided, the employer has the right to delay the taking of FMLA until 30 days' notice is provided.

When leave will begin in less than 30 days, employees must give notice to an employer as soon as practicable.

For foreseeable qualifying exigency leave, notice must be provided as soon as practicable, regardless of how far in advance the leave is foreseeable.

## Plan Benefits While on FMLA Leave

If you take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), the way in which you participate in the Plan will depend on whether or not you continue to get a paycheck from your employer while you are on leave. If your employer does not pay you while you are on leave, your participation in the Plan will be treated in the same way as if you had terminated your employment, unless you pay for benefits, on an after-tax basis while you are on leave. When you return to work your prior benefits will start again.

If you take a leave of absence that is a family or medical leave under the FMLA, you should contact the employer in order to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid family or medical leave under the FMLA, you may continue to participate in the Plan, but you may be required to continue your contribution.

Please contact the company as soon as you know you will be taking a Family or Medical Leave.

## Women's Health and Cancer Rights Act of 1998 Notice

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As specified in the Act, if you or a covered family member had or are going to have a mastectomy, you maybe 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 at all stages of the mastectomy, including lymphedema.

The coverage will be provided in a manner determined in consultation with the attending physician and the patient. Deductibles and co- insurance established for other benefits under your plan also apply to these reconstructive surgery benefits.

**USERRA Rights**

If you, or your spouse or dependent, are absent from work for uniformed service, you may have the right to continue participating in the Plan under the Uniform Services Reemployment and Rights Act (USERRA). USERRA is intended to lessen the difficulty that may occur if you need to be absent from your civilian employment to serve in the United States uniformed services. USERRA seeks to make sure that those who serve their country can keep their civilian employment and benefits and can seek reemployment without discrimination because of their service.

Under USERRA, employees absent for uniformed service (and their covered spouse and covered dependents) are eligible for continuation coverage for the period of service (plus time allowed under USERRA to apply for reemployment) or for up to twenty-four (24) months, whichever is less. If your service is for less than thirty-one (31) days, the plan may charge only your share of the monthly health care premium. If your service is more than thirty-one (31) days, your employer may charge the full premium plus 2% (for a total of 102% of the premium). You may have rights under both COBRA and USERRA and are entitled to the continued coverage that provides the more favorable benefit.

An individual who serves in the military will be considered on leave of absence and will be entitled to all rights and benefits not determined by seniority that are generally provided to similarly situated employees on leave of absence or other types of leave.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA.

## Mental Health Parity and Addiction Equity Act of 2008

Under the Mental Health Parity and Addiction Equity Act of 2008, the conditions (for example, copayments and deductibles) and treatment limitations for mental health and substance use disorders generally must not be more restrictive than those applicable to medical and surgical procedures. Review your plan documents for additional information about mental health coverage.

## Michelle's Law

Certain covered dependents may be eligible to extend their plan coverage for a limited period of time when that coverage would otherwise end due to loss of student status.

Under Michelle's Law, the Plan cannot terminate coverage for a dependent child whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a medically necessary leave of absence. In this situation, the Plan will continue the dependent's coverage until the earlier of:

The date that is one year after the first day of the medically necessary leave of absence. The date on which the dependent's coverage

would otherwise end under the Plan's terms.

A dependent in this situation will be eligible for continued Plan coverage under Michelle's Law if you provide the Plan a written certification from the dependent's treating physician stating that:

The dependent is suffering from a serious illness or injury.

The leave of absence (or other change of enrollment) is medically necessary.

A medically necessary leave of absence means a leave of absence from a postsecondary educational institution, or any other change in enrollment of the dependent at the institution, that:

Begins while the dependent is suffering from a serious illness or injury.

Causes the dependent to lose student status for purposes of coverage under the Plan's terms.

## Newborns' and Mothers' Health Protection Act

Generally, group health plans, cannot restrict any hospital length of stay in connection with childbirth for the mother or the baby to less than forty-eight (48) hours after a vaginal delivery, or less than ninety-six (96) hours after a cesarean delivery. Group health plans cannot require that an attending doctor get permission from the plan to keep the mother and baby longer than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean delivery. The attending doctor may consult with the mother and decide to release the mother and baby earlier than forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a cesarean delivery.

## 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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes numerous requirements on employer health plans regarding how certain individually identifiable health information – known as protected health information or PHI – may be used and disclosed. This Notice describes how the plan, and any third party that assists in the administration of the plan, may use and disclose your protected health information for treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information that is maintained or transmitted by the Plans, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We will use PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request of it. Our insurers' Notices of Privacy Practices will apply, except for the limited medical information the we may receive and maintain from you when you ask us to assist you in a claims processing or benefit determination dispute, information related to your enrollment or disenrollment in the plan, and certain summary health information.

Your personal doctor or health care provider may have different policies or notices regarding their use and disclosure of your medical information.

We are required by law to abide by the terms of this notice to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect.

**It is important to note that these rules apply to the Plans, not the company as an employer.**

1. How We May Use and Disclose Medical Information About You. HIPAA generally permits use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. These uses and disclosures are more fully described below. Please note that this Notice does not list every use or disclosure; instead it gives examples of the most common uses and disclosures.

- Treatment: When and as appropriate, medical information may be used or disclosed to facilitate medical treatment or services by providers.

- Payment: When and as appropriate, medical information may be used and disclosed to determine your eligibility for the Plans' benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility and coverage under the plan, or to coordinate your coverage.
- Health Care Operations: When and as appropriate, medical information may be used and disclosed for the plan's operations, as needed. Your genetic information will not be used or disclosed for underwriting purposes.
- The plan will always try to ensure that the medical information used or disclosed is limited to a "Designated Record Set" and to the "Minimum Necessary" standard, including a "limited data set," as defined in the law for these purposes.

OTHER PERMITTED USES AND DISCLOSURES

- Disclosure to Others Involved in Your Care: Medical information may be disclosed to a relative, a friend, or to any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care.
- Disclosure to Health Plan Sponsor: Information may be disclosed to another health plan for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to personnel solely for purposes of administering benefits under the plan.
- Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- To Comply with Federal and State Requirements: Medical information will be disclosed when required to do so by federal, state, or local law.
- To Avert a Serious Threat to Health or Safety: Medical information may be disclosed 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 who is able to help prevent the threat.
- Military and Veterans: If you are a member of the armed forces, medical information may be released as required by military command authorities.
- Business Associates: Medical information may be disclosed to business associates. We have contracted with entities (defined as "business associates" under HIPAA) to help us administer your benefits. We will enter into contracts with these entities requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.
- Other Uses: If you are an organ donor, we may release your medical 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. We may release your medical information to a coroner or medical examiner. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Uses and disclosures other than those described in this notice will generally require your written authorization. Your written authorization is required for: most uses and disclosures of psychotherapy notes; uses and disclosures of PHI for marketing purposes; and disclosures that are a sale of PHI. You may revoke your authorization at any time, but you cannot revoke your authorization if the Plans have already acted on it.

The privacy laws of a particular state or other federal laws might impose a more stringent privacy standard. If these more stringent laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974 (ERISA), the plan will comply with the more stringent law.

2. Your Rights Regarding Medical Information About You. You have the following rights regarding medical information that we maintain about you:

Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your benefits under the Plans. If you request a copy of the information, we may charge a 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 medical information, you may request that the denial be reviewed. If the Plans do not maintain the health information, but know where it is maintained, you will be informed of where to direct your request.

- Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You also 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 any of the following information:
    - Information that is not part of the medical information kept by or for the plan.
    - Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
    - Information that is not part of the information which you would be permitted to inspect and copy.
    - Information that is accurate and complete.
- Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" (that is, a list of certain disclosures the plan has made of your health information). Generally, you may receive an accounting of disclosures if the

disclosure is required by law, made in connection with public health activities, or in situations similar to those listed above as "Other Permitted Uses and Disclosures". You do not have a right to an accounting of disclosures where such disclosure was made:

- For treatment, payment, or health care operations.
- To you about your own health information.
- Incidental to other permitted disclosures.
- Where authorization was provided.
- To family or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a limited data set where the information disclosed excludes identifying information.

To request this list or accounting of disclosures, you must submit your request, which shall state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. Notwithstanding the foregoing, you may request an accounting of disclosures of any "electronic health record" (that is, an electronic record of health-related information about you that is created, gathered, managed, and consulted by authorized health care clinicians and staff). To do so, however, you must submit your request and state a time period, which may be no longer than three years prior to the date on which the accounting is requested.

- Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. If the Plans do agree to a request, a restriction may later be terminated by your written request, by agreement between you and the Plans (including orally), or unilaterally by the Plans for health information created or received after the Plans have notified you that they have removed the restrictions and for emergency treatment. To request restrictions, you must make your request in writing and must tell us the following information:
    - What information you want to limit.
    - Whether you want to limit our use, disclosure, or both.
    - 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.

3. Breach Notification. Pursuant to changes to HIPAA required by the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH Act") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), this Notice also reflects federal breach notification requirements imposed on the Plans in the event that your "unsecured" protected health information (as defined under the HITECH Act) is acquired by an unauthorized party.

- The plan will notify you following the discovery of any "breach" of your unsecured protected health information as defined in the HITECH Act (the "Notice of Breach"). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by email if you have previously agreed to receive such notices electronically. If the breach involves:
    - 10 or more individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute individual Notice of Breach by either posting the notice on the benefits website on the company intranet or by providing the notice in major print or broadcast media where the affected individuals likely reside.
    - Less than 10 individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute Notice of Breach by an alternative form.

Your Notice of Breach shall be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and shall include, to the extent possible:

- A description of the breach.
- A description of the types of information that were involved in the breach.
- The steps you should take to protect yourself from potential harm.
- A brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches.
- Relevant contact information.

Additionally, for any substitute Notice of Breach provided via web posting or major print or broadcast media, the Notice of Breach shall include a toll-free number for you to contact us to determine if your protected health information was involved in the breach.

4. Changes to This Notice. We can change the terms of this notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will send you a copy of the revised notice.

5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the plan or with the Secretary of the Department of Health and Human Services.

All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

6. Other Uses of Medical Information. Other uses and disclosures of medical information that are not covered by this notice or the laws that apply to us will be made only with your written permission. If you grant us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we may be required to retain our records related to your benefit determinations and enrollment.

## HIPAA Initial Notice of Special Enrollment Rights

This notice is to inform you of your right, under a federal law called the Health Insurance Portability and Accountability Act (HIPAA), to enroll in Plan at times other than the Plan's annual open enrollment periods, upon the occurrence of specified events (for example, if have a baby). These enrollment periods are known as "special enrollment" opportunities. Generally, you must request enrollment within 30 days or as outlined in the plan documents.

- If you or your dependents lose eligibility for other coverage that you were enrolled in, you may be able to enroll in this plan.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan.
- If you, you spouse, or your dependents become eligible for assistance under Medicaid or a state children's health insurance program, or lose coverage under such a program, you may be allowed to enroll yourself and your dependents in the Plan.

## Qualified Medical Child Support Orders (QMCSOs)

A description of the procedures governing qualified medical child support orders (QMCSOs) can be obtained, without cost, from the plan administrator.

## Wellness Plans

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us your employer and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

## Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers covered under the law from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by the law. GINA's employment nondiscrimination requirements prohibit the company from discriminating against any employee or applicant with respect to hiring, discharge, compensation, terms, conditions or privileges of employment on the basis of genetic information with respect to the employee or applicant. As a result, the company will not fail or refuse to hire, or discharge any employee or applicant because of genetic information. The company will not limit, segregate or classify employees or applicants in any way that would deprive or tend to deprive them of employment opportunities or adversely affect their status as employees because of genetic information relating to the employees or applicants. The company will not discriminate or retaliate against individuals who oppose unlawful practices under GINA, or who make a charge, testify, assist or participate in any investigation, proceeding or hearing related to the employment nondiscrimination requirements. However, the company will not violate GINA if they limit or restrict an employee's job duties based on genetic information because they were required to do so by a law or regulation mandating genetic monitoring.

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

Additionally, the plan will generally not:

- Request or require individuals or their family members to undergo genetic testing.
- Use genetic information to determine eligibility for coverage or to impose preexisting condition exclusions.
- Collect genetic information for underwriting purposes or with respect to any individual before enrollment or coverage.
- Adjust group premium or contribution amounts on the basis of genetic information.

## Notice Regarding Designation of Primary Care Providers

The plan may allow or even require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your employer. For children, you may designate a pediatrician as the primary care provider.

## Notice Regarding Coverage for Obstetric or Gynecological Care

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

## Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

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

"Out –of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network cots for the same service and might not count toward your annual out-of- pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out –of-network facility but are unexpectedly treated by an out-of-network provider.

**You are protected from balance billing for:**

**Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be

balance billed for these emergency services. This includes services that you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

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

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

**Minnesota law prohibits balance billing**

A network provider is prohibited from billing you for any amount in excess of the allowable amount the health carrier has a contractor for with the provider as a total payment for the health care service. A network provider is permitted to bill you the approved co-payment, deductible, or coinsurance. A network provider is permitted to bill you for services not covered by your health plan as long as you agree in writing in advance before the service is performed to pay for the noncovered service.

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

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

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

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed,** you may contact the No Surprise Help Desk (NSHD) at 1-800-985-3059 or the Minnesota Attorney General's Office at: 445 Minnesota St., Ste.1400, St. Paul, MN 55101; (800) 657-3787.

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

Visit https://www.ag.state.mn.us/consumer/publications/MedicalBillingPointers.asp for more information about your rights under Minnesota state law, or for information about complaints related to health care, visit https://www.health.state.mn.us/facilities/insurance/clearinghouse/complaints.html

Form Approved
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# Health Insurance Marketplace Coverage Options and Your Health Coverage

## 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..1[2]

**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.

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

2An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

## What about Alternatives to Marketplace Health Insurance Coverage?

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

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

## How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description

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

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|---|---|---|
| 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 | | 4. Employer Identification Number (EIN) |
| 5. Employer Address | | 6. Employer phone number |
| 7. City | 8. State | 9. Zip code |
| 10. Who can we contact about employee health coverage at this job? | | |
| 11. Phone number (if different from above) | 12. Email address | |

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:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ 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 affordable, 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.

## Other notices that require plan-specific customization:

Creditable Coverage Notice: Plan sponsors must provide annual notice to Medicare eligible participants about whether their prescription drug coverage is at least as good as Medicare prescription coverage.

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index?redirect=/CreditableCoverage/

# Disclaimers

This Guide is only a summary provided for your information. If there is a discrepancy between this Guide and the contract/certificates used for clarification of coverage/rates; the contract/certificates are deemed correct.  reserves the right to change, amend, terminate, or otherwise alter any benefit described in this Guide at any time.

**Value Added Services Disclaimer**

This Guide provides a general outline of value-added services; they are subject to be amended or changed based carrier agreements. Please see your member materials from the carrier providing the value-added services for a full description  of the services included with your specific coverage.