2025 Employee Benefits

Open Enrollment

Family service rochester

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 56 for more details.

Eligibility

You're eligible for benefits if you are an employee working on average 30 hours per week. Your eligible dependents may also participate in the Family Service Rochester Inc benefits program.

Generally, for the Family Service Rochester Inc benefits program, dependents are defined as:

- Your legal spouse
- Dependent "child" up to age 26. (Child means the employee's natural child or adopted child and any other child as defined in the certificate of coverage)

The open enrollment elections you make will be effective January 1, 2025.
You may only change coverage if you experience a qualifying life event.

You may change your benefit elections during the year if you experience an event such as:

- Marriage
- Divorce or legal separation
- Birth of your child or your domestic partner's child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse/domestic partner or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

What's New in 2025

To keep up with evolving trends, below are changes you will see in this year's benefit package:

The Medical Plan will remain with Meritain. Family Service Rochester will offer two medical plan options for employees to consider:

- **Plan 1 (OMC Preferred Plan) -** This plan is offered with a 2-Tier provider network design and paired with a Health Savings Account (HSA). Listed below are descriptions of Tier 1 & 2 providers.
    - **Tier 1** - You will receive the highest benefit and pay the least out-of-pocket if you utilize an Olmsted Medical Center (OMC) provider. All OMC providers are in Tier 1.
        - The Tier 1 family deductible/out-of-pocket will be changing to $3,300 per person and $6,000 per family.
    - **Tier 2** – Utilizes the Aetna CPII open access network through Meritain.
        - The Tier 2 family deductible/out-of-pocket will remain at $3,500 per person and $7,000 per family.
- **Plan 2 (Open Access Plan) -** Utilizes the Aetna CPII open access network through Meritain.

The Pharmacy Benefit Manager (PBM) will remain with SmithRX:

- The OMC Preferred Plan is offered with a 2-Tier pharmacy network. Tier 1 utilizes Olmsted Medical Center pharmacies. Tier 2 utilizes SmithRX participating pharmacies outside of Olmsted Medical Center.
- The Open Access Plan utilizes SmithRX participating pharmacies.

In 2025, due to a change in government issues compliance regulations Nice Healthcare will now have a copay of $1 for each visit.

Health Savings Account (HSA)

- HSA Employer contributions will discontinue in 2025.
- The maximum contribution to an HSA increased in 2025:
    - Single contribution maximum increased to $4,300.
    - Family contribution maximum increased to $8,550.
- If you are over the age of 55, the catch-up contribution will remain at $1,000

Health Plan Options

OMC Preferred Plan

The OMC Preferred Plan is offered with a 2-Tier provider network design and paired with a Health Savings Account (HSA). Listed below are descriptions of Tier 1 & 2 providers.

- **Tier 1** - You will receive the highest benefit and pay the least out-of-pocket if you utilize an Olmsted Medical Center (OMC) provider. All OMC providers are in Tier 1.
- **Tier 2** – Utilizes the Aetna CPII open access network through Meritain.

Deductible and out-of-pocket costs cross apply between Tier 1 and Tier 2.

OMC Preferred Prescription Drug Plan

The OMC Preferred Plan is offered with 2-Tier pharmacy network options for prescription drugs. While you can go to any pharmacy you choose, you receive the highest benefits when utilizing a Tier 1 Olmsted Medical Center pharmacy. Listed below are descriptions of Tier 1 and Tier 2 pharmacies:

Tier 1 – OMC Northwest Pharmacy, OMC Southeast Pharmacy, OMC Chatfield Pharmacy, and OMC Pine Island Pharmacy.

Tier 2 – Includes pharmacies outside of OMC that participate with SmithRX.

You can utilize Tier 1 or Tier 2 pharmacies for a 30-day or 90- day supply of your prescription. All Prescriptions are combined with the Tier 1 medical deductible. (Single per person $3,000 and family $3,300 per person/$6,000 per family)

The cost for prescription drugs will be the full cost until the deductible is satisfied. Certain preventive medications are covered under the SmithRX Preventive Drug List. If you utilize a Tier 1 pharmacy for eligible preventive medication, there is no cost share. If you utilize a Tier 2 pharmacy for eligible preventive medication, you will pay a $15 copay. Please refer to the benefit summary for further details.

Health Plan Options

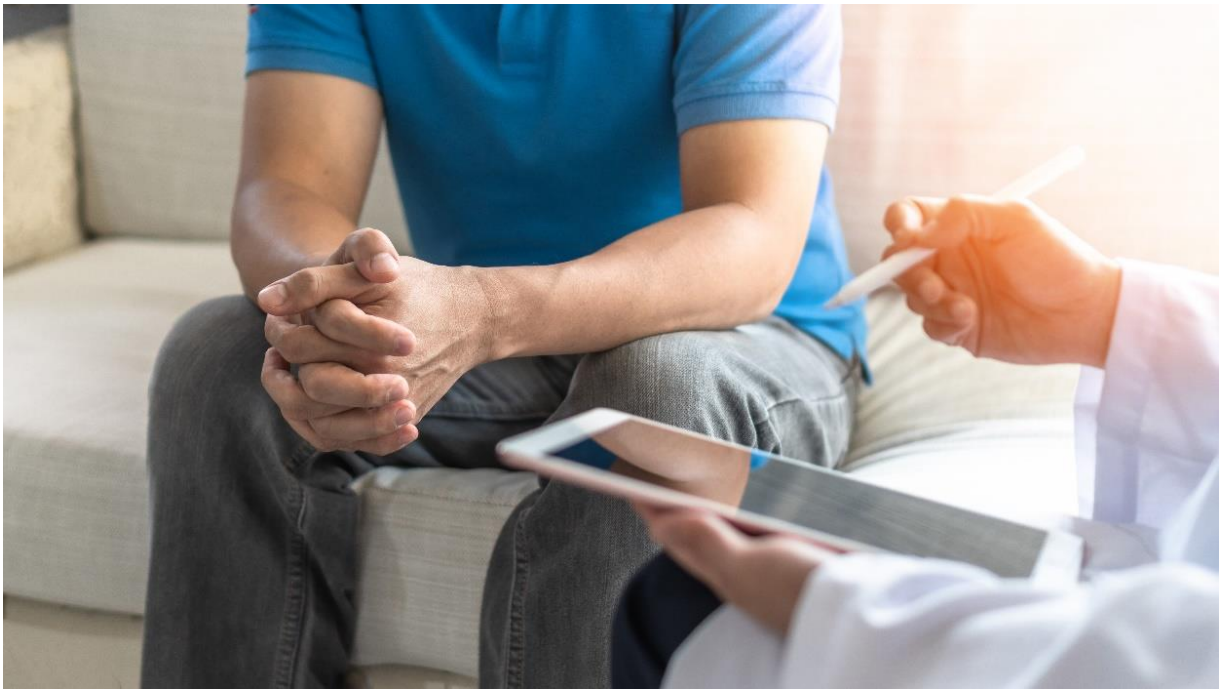
Open Access Plan

The Open Access plan is offered with the Aetna CPII network and paired with a Health Savings Account (HSA).

Open Access Prescription Drug Plan

The Open Access Plan is offered with the SmithRX pharmacy. You can purchase prescription drugs with a 30-day supply or a 90-day supply. All prescriptions are combined with the medical deductible.

The cost for prescription drugs will be the full cost until the deductible is satisfied. Certain preventive medications are covered under the SmithRX Preventive Drug List with a $15 copay. Please refer to the benefit summary for further details.



Medical Plans

All eligible medical expenses and prescription drugs are subject to the deductible then applicable coinsurance. Once the out-of-pocket maximum is satisfied, all eligible medical expenses and prescription drugs will pay at 100%. Preventive care is covered at 100% and no deductible applies.

	Plan Option #1 OMC Preferred HSA		Plan Option #2 Open Access HSA
SERVICE	In Network		In Network
	(Tier 1) OMC Provider	(Tier 2) All Other In-Network PPO Providers	
Deductible Limit			
Single/Person	$3,000	$4,000	$3,500
Family	$3,300/Person $6,000/Family	$4,000/Person $8,000	$7,000
Co-Insurance Percentage			
After Deductible Plan Pays:	100%	80%	100%
Out-of-Pocket Maximum			
Single/Person	$3,000/Single	$6,000/Single	$3,500
Family	$3,300/Person $6,000/Family	$6,000/Person $12,000/Family	$7,000
Office Visits Inpatient Hospital Outpatient Hospital	100% after Deductible	80% after Deductible	100% after Deductible
Emergency Care **Urgent Care**	100% after Deductible		100% after Deductible
Preventive Care	100% No Deductible		100% No Deductible
Additional Coverage Details on Deductibles & Out-of-Pocket	**Deductible and Out-of-Pocket Costs Cross-Apply Between Tiers 1 &** 2 **Tier 1 Deductible Applies to all Pharmacy**		N/A

Prescription Drugs

	Plan Option #1 OMC Preferred		Plan Option #2 Open Access
Pharmacy Coverage	Tier 1 Olmsted Medical Center Pharmacy	Tier 2 Network Pharmacy SmithRx	In network
Platform	OMC pharmacy locations or the SmithRx network can dispense all medications. Preferred benefits received at OMC Pharmacies		SmithRx
Deductible (Calendar Year)	All Prescriptions Combined with Tier 1 Medical Deductible Single per person $3,000; Family $3,300 per person/$6,000 Family		Combined with Medical Deductible
SmithRx Preventive Drugs	100% Covered	$15 Copay then 100%	$15 copay than 100%
30-day Retail Generic Preferred Brand Non-Preferred Brand	Can be filled at OMC pharmacies and SmithRx Network Pharmacies. 100% after Deductible 100% after Deductible 100% after Deductible		 100% after Deductible 100% after Deductible 100% after Deductible
90 -day Retail & Mail Generic Preferred Brand Non-Preferred Brand	 100% after Deductible 100% after Deductible 100% after Deductible		 100% after Deductible 100% after Deductible 100% after Deductible

Health Plan Premiums

Family Service Rochester will continue to pay a portion of your premiums. Premiums are shown per pay period (24), effective January 1, 2025.

Bi-Monthly Per Pay Period Rates	OMC Preferred	Open Access
Employee	$37.50	$117.78
Employee + Spouse	$251.56	$319.33
Employee + Children	$256.10	$320.77
Family	$372.32	$466.03

ID Cards will be issued only if you are new to the plan or if you made changes.

Prescription Drugs-SmithRx

SmithRx is your new prescription benefit provider. SmithRx is dedicated to giving you the best services and resources to help you and your family make better healthcare decisions.

Formulary Changes

As of January 1, 2025, the Formulary, a list of covered prescriptions, will be available through SmithRx. If you are a current member under the health insurance currently taking a prescription that is not on the SmithRx formulary list, your medication will be grandfathered for the first three months, and you will receive a letter in the mail from SmithRx explaining the changes to the Formulary. SmithRx will also provide the comparable drug alternative(s) that are covered under the new formulary list. To access the new formulary, CLICK HERE.

SmithRX Preventive Medications

Preventative medications can be an important part of maintaining good health and preventing more serious health issues in the future when taken as prescribed.
This preventive drug list is periodically reviewed and updated and contains a list of medications that are not subject to the deductible and covered at standard copay or $0 copay. Please visit SmithRx Preventative list for the most current list of Preventive Medications available.

Current Prescription and Prior Authorizations

If you are currently prescribed a prescription that required prior authorization, the prior authorization will not be transferred to SmithRx. You will need to contact SmithRX member support at 844.454.5201. The member Support Team will work with you to prior authorize the medication if needed.

Find SmithRX Pharmacy

To locate SmithRx Network Pharmacies:

Access your member portal account by visiting www.smithrx.com

Click "Pharmacy Lookup" under Resources on the bottom right corner

Enter in pharmacy name/city/state/ZIP and click “Search”

The search will present all pharmacies in the network that match your search criteria.

Prescription Drugs-SmithRx

Step Therapy

In some cases, you may be required to first try one medication to treat your medical condition before it will cover another medication for that condition. For example, if Drug A and Drug B both treat your medical condition, your physician may be required to prescribe Drug A first. If Drug A does not work for you, then the plan will cover Drug B.

Prior Authorization

If your physician prescribes a medication requiring a prior authorization, you will need to go through an additional authorization process. SmithRx reviews these medication requests to help ensure appropriate and safe use of medication for medical condition(s). To see if your medication(s) require prior authorization, please contact Customer Service at 844.454.5201.

Quantity Limits

For certain medications, you may be limited to the amount of the medication that will be covered per prescription or for a defined period of time. Amounts exceeding these limits will require additional review for coverage.

Online Tools

Secure online connection at www.mysmithrx.com, protecting your confidentiality and providing:

- Drug Formulary
- Real-time Benefit information
- View and download pharmacy claims
- Download claim reimbursement, prior authorization request

SmithRx –Patient Assistance

The Patient Assistance Program connects you to the lowest cost prescription solutions. Here is a list of frequently asked questions members have regarding the Patient Assistance Program. If you still have questions after reviewing this document or would like to speak to someone regarding your individual situation, please reach out to SmithRx by calling 844.454.5201 or emailing help@smithrx.com.

What is the Patient Assistance Program and how was it designed?
Many high-cost specialty medications can be accessed through advocacy foundations and grant programs when a medication is not covered under the pharmacy benefit. SmithRx assists in navigating the patient assistance landscape to obtain medication coverage. Our dedicated member support specialists will assist you in navigating and applying to these different programs.

What are the benefits of the program?
If you meet the qualifications of the patient assistance programs, you will be able to receive your medication at no cost to you or your employer.

How will I know that my medication is a part of the Patient Assistance Program?
If you are taking medications that qualify for the Patient Assistance Program, you will receive communication from our support specialists via phone or email. It is important that you engage with them and provide them the information they request.

Is there any way to "opt out" of the program?
No. It is considered part of the plan benefit design and thus subject to program requirements for continued coverage under the plan.

Do I still need to go through the program if I already pay $0 for my medication?
Yes. Many members currently utilize copay coupon cards that help bring down their out-of-pocket costs, but the employer still pays the remainder of the cost. If you meet the qualifications of the patient assistance programs, you will be able to receive your medication at no cost to you or your employer.

SmithRx –Patient Assistance

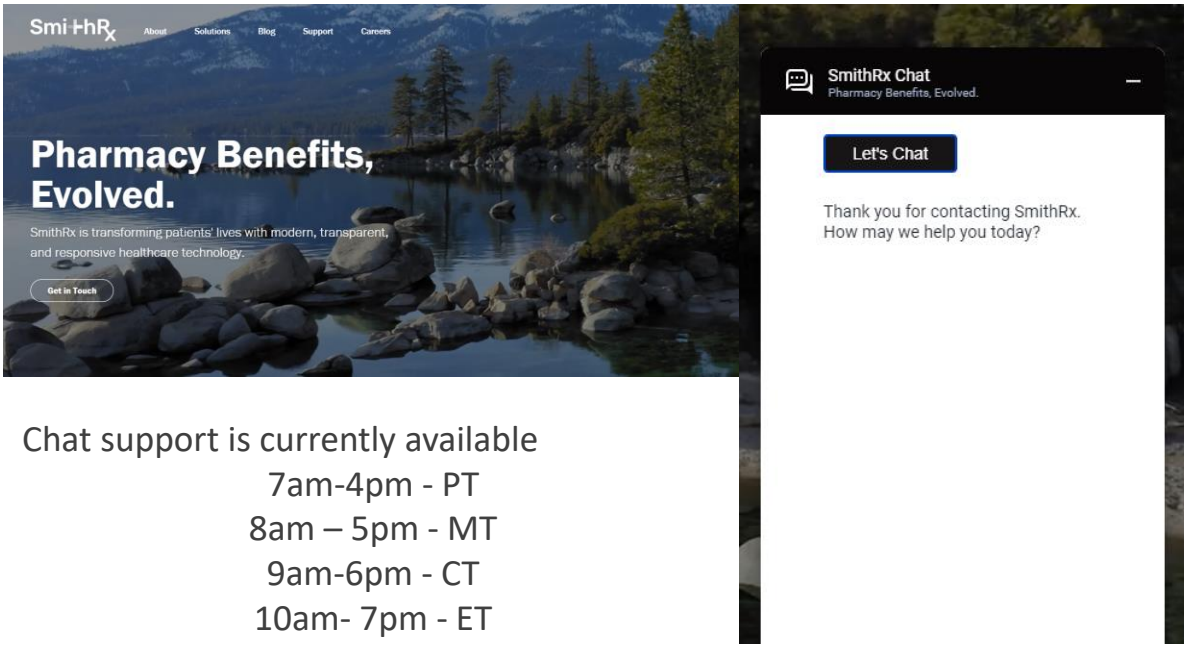
What steps do I need to take if my medication qualifies for the Patient Assistance Program?

1. You will be contacted by our support specialist to begin the enrollment process.
2. You will need to electronically sign an authorization form that allows our specialist to act on your behalf for the sole purpose of applying for these grant programs.
3. Some applications may require additional documentation (i.e., tax return, medical expense summary). You will be asked to submit this documentation to us via secure encrypted email.
4. Some applications may require us to work with your doctor. If that is the case, we may ask you to contact your doctor to request that they submit the required forms.
5. It is important that you work with us throughout this process to ensure timely approval of your application and prevent any delays in your medical treatment. If approved, how much will I need to pay for my medications?

If approved, the medication will be shipped to you free of charge.

What if my application is denied?
If denied, you may be able to continue to get your medication through the benefit. Please contact the SmithRx member support team at 844.454.5201 for further information.

SmithRx Chat Feature



Chat support is currently available

7am-4pm - PT

8am – 5pm - MT

9am-6pm - CT

10am- 7pm - ET

*these hours will be extending soon

You can chat with a live member support specialist right from the website www.smithrx.com.

Member support specialists can help you with any of your inquiries and are eager to assist.

Providers

To find Olmsted Medical Center providers to receive the highest benefit:

1. Visit www.olmmed.org.
2. Click Find a Provider link at the top of the page.
3. Use the search boxes to enter applicable information. The search will present provider, facility, and specialist options based on what is entered.

FIND OLMSTED MEDICAL CENTER PHARMACY

Currently, there are four participating pharmacies with Olmsted Medical Center. Utilize one of the OMC pharmacies to receive the highest pharmacy benefit:

OMC Northwest Pharmacy	OMC Southeast Pharmacy	OMC Chatfield Pharmacy	OMC Pine Island Pharmacy
5067 55th Street NW Rochester, MN 55901 Phone: (507) 535-1974 Fax: (507)281-7685 Hours: 7:30am – 5:30pm M-F	210 Ninth Street SE Rochester, MN 55904 Phone: (507)292-7255 Fax: (507)292-7256 Hours: 7:30am - 5:30pm M-F	237 Main St North Chatfield, MN 55923 Phone: (507)867-3989 Fax: (507)867-1477 Hours: 8:30am – 5:30pm M-F	111 County Road 11 Pine Island, MN 55963 Phone: 507.356.2476 Fax: 507.280.1700 Hours: 8am-5pm M-F

FIND AETNA PROVIDERS

You can use the DocFind directory anywhere you have Internet access. Just:

1. Visit **http://www.aetna.com/docfind/custom/mymeritain/**.
2. Key in the type of provider or provider name, specialty, procedure or condition under Who or what are you looking for? and the desired geographical area under Where?. Click Search.
3. Choose Aetna Choice® POS II (Open Access) under Select a Plan. OR
4. Click on one of the options listed under Provider Types, Conditions or Procedures. You will be prompted to key in the desired geographical area and select your plan (as shown in step three).
5. Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.
6. Narrow your search results by using the filters under Narrow Your Results.
7. For more search tips, you can click on Search Tips and FAQs on the home screen.

If you have questions while searching for a doctor or hospital, simply click on the Contact DocFind link. It's at the top of any DocFind page. You'll be able to send a quick comment or question or call 800.343.3140 from 8:00 a.m. – 9:00 p.m. ET, Monday through Friday.

Meritain Tools & Resources

Your personalized member website

Once enrolled as a Meritain Health member, you will have access to the **Meritain Health member website**. When you log in, you'll find everything you need to know about your benefits—from eligibility, to enrollment, to what's covered. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed.

Registration for the member website is easy

If you're already registered to access your online account, simply enter **www.meritain.com** into your browser and login from the homepage.

If you're not yet registered, it's OK. Registration is an easy three-step process.

1 Scan the QR code and click on the link to register or visit **www.meritain.com**. Then, in the top right corner, click *Register*.

2 Next, select *Member* under *I am a* and enter your group ID. You can find your group ID on the front of your member ID card. (If you are new to the plan, you will soon receive your member ID card in the mail.) Then, click *Continue*.

Please note: *You may set up a login for yourself, as well as any children under age 18 who are covered by your plan. For privacy purposes, your spouse and dependents over the age of 18, covered by the plan, must each establish logins to access their individual information.*

3 You will need to fill in your:

- Group ID (located on your member ID card).
- Member ID (located on your member ID card).
- Date of birth.
- Name.
- ZIP code.
- Email address.

You can then create a username and password. After that, you will be asked to confirm your email address—then you're done! The next time you log in, just use the same username and password.

Members have the right to ask their health plan to place restrictions on (i) the way the health plan uses or discloses their PHI for treatment, payment or health care operations; and (ii) the health plan's disclosure of their PHI to persons who may be involved in their health care or payment thereof (e.g., family members, or close friends).

Meritain Tools & Resources

Convenient Tools and Resources

Important plan contacts

What do you need help with?

My medical benefits
In-network doctors or hospitals Meritain Health Customer Service **1.800.925.2272** Access your Meritain Health member portal at **www.meritain.com**
The Aetna Choice® POS II provider network Aetna provider line **1.800.343.3140** **www.aetna.com/docfind/custom/mymeritain**
My prescription drug benefits SmithRX Customer Service **1.844.454.5201**
Precertification Meritain Health Medical Management **1.800.242.1199**
My enrollment or benefit elections Family Service Rochester Human Resources representative **1.507.287.2010**

Meritain Tools & Resources

MERITAIN® HEALTH
An Aetna Company

Discounts Available to Meritain Health® Members

Enjoy healthy discounts with your Meritain Health plan

Meritain Health, through its affiliation with Aetna®, has partnered with OMRON to provide our members discounts on blood pressure monitors, pedometers and activity trackers, TENS units, and many other OMRON products. Receive 10 percent off OMRON's current prices when you use code **AETNA10** at checkout. The code is case sensitive. This is a savings of up to 60 percent off retail price. Offer excludes HeartGuide™, Complete™, AliveCor, pad subscriptions, and nebulizer products. If you have any questions, please contact OMRON's Customer Support team at **1.866.216.1333**.

To begin shopping, please visit **www.omronhealthcare.com** and click on the *Product* drop-down in the top navigation to select a product category.

ADVOCATES FOR HEALTHIER LIVING

We are Meritain Health

As Advocates for Healthier Living, we provide easy-to-use health care benefits you can use to live well. We also take steps to help you save on the cost of your care. Contact us at the number on your ID card if you have any questions about your plan.

Meritain Tools & Resources

MERITAIN® HEALTH
An Aetna Company

Claim Your Wellness Savings

Your nationwide deals await

LifeMart Employee Discount Program

Browse major savings on major brands for all your health and wellness needs. LifeMart is your employer's way of saying thanks for your hard work and helping you keep more of your paycheck.

Access LifeMart anywhere, anytime, on any device. It's the fast and easy way to:

- Save money on all your health and wellness needs—from gyms, to diet plans and groceries and everything in between.
- Access offers on personal wellness products and services—LifeMart also offers deals on everyday needs such as travel, tickets, car rentals, electronics and more.
- Get deals for the family—pet products, child care discounts, products for aging loved ones and more!
- Save time with instant, one-stop shopping—no need to run out to the store or search the web.
- Have fun discovering exclusive new deals on the brands you love—offers are updated regularly.

Getting Started with LifeMart

Accessing LifeMart is easy. Just complete the online registration by filling out your first name, last name, email address and a password. Once you're registered, you will be able to view and access discounts. Members also have the option to sign up for or opt out of email notifications.

There are a few different ways to access LifeMart

- Through your Meritain Health® Member Portal. Click the *LifeMart* link under *Tools and Resources*, or on the LifeMart tile at the bottom of your home page.
- By following this link: **http://meritain.lifemart.com**.
- With the LifeMart mobile app, you can access LifeMart discounts anywhere, anytime. Simply download the app and you can browse major savings on the go. Available for download in the Google Play Store™ and iTunes Store®. Please note: you need to register online to get access to the LifeMart mobile app.

Need Help?

You can reach out to our help desk via email for assistance. Just click on the *Need Help* link in LifeMart! The Need Help feature also has commonly asked questions and answers to assist you. You can also use the direct customer support email **helpdesk@lifecare.com**.

HealthJoy

HealthJoy Makes it Easier to be Healthy and Well.

HealthJoy is the virtual access point for all your healthcare navigation and employee benefits needs. We're provided free by your employer to help understand and make the most of your benefits. We connect you and your family with the right benefits at the right moment in your care journey, saving you time, money, and frustration.

Help For Your Healthcare Journey.

With 24/7 access to our dedicated healthcare concierge team, visits, and care navigation tools, you never have to walk alone. HealthJoy helps you locate in-network doctors, find extra savings on your prescriptions, and navigate your benefits. Our mobile app and dedicated member support team are always on hand to help make it easier to stay healthy and well.

BENEFITS WALLET | HEALTHCARE CONCIERGE | RX SAVINGS REVIEW | APPOINTMENT BOOKING | PROVIDER RECOMMENDATIONS

How do I get started with HealthJoy?

To get started, all you need to do is activate your account Download the HealthJoy app, verify your personal information, create your password, and log in. The setup process takes less than 5 minutes.

If you would like for us to resend your activation link, visit:

GO.HEALTHJOY.COM/ACTIVATENOW

SCAN ME

You can also activate your account by visiting:

WWW.HEALTHJOY.COM/DOWNLOAD

Health Savings Account

- Contributions are tax deductible and interest earnings are tax-free.
- Your HSA contributions accumulate and roll over each year.
- Account funds remain until spent. There is no use it or lose it rule.
- Account funds should only be used for qualified expenses.
- Non-qualified expenses are subject to a 20% penalty and charged as taxable income.
- Withdrawals are tax-free when used for eligible expenses.
- Maximum contributions are **$4,300 single or $8,550 family for 2025**.
- If you fund a new HSA with the max contributions, you will need to be enrolled in the HSA for the entire plan year, or penalties apply.
- Catch-up contributions may be made annually for those 55 and older, up to $1,000.
- HSA accounts are not available to employees who are eligible for a spouse's medical flexible spending arrangement (FSA), unless the spouse's medical FSA is a limited medical FSA.
- Contributions cannot be made to the HSA of members who are entitled to (eligible and enrolled in) benefits under Medicare, or other disqualifying coverage. Please notify HR if you enroll in Medicare or other disqualifying coverage to terminate HSA contributions and avoid adverse tax consequences. If you are eligible for (but not enrolled in) Medicare please contact HR before continuing any HSA contributions.

Important Changes: Family Service Rochester will not be contributing to the employee's Health Savings Account in 2025.

HSA Advantages

Is a Health Savings Account right for me?

- Like any health care option, an HSA has advantages and disadvantages. As you weigh your options, think about your budget and what healthcare you are likely to need in the next year.

- If you are generally healthy and want to save for future health care expenses, an HSA may be an attractive choice.

- Or if you are near retirement, an HSA may make sense because the money in the HSA can be used to offset costs of medical care after retirement.

- Contributions cannot be made to the HSA of members who are entitled to (eligible and enrolled in) benefits under Medicare, or other disqualifying coverage.

- If you are covered on the High Deductible Health Plan (HDHP), but you are also covered on another group health plan (such as your spouse's group plan) that is not an HDHP, you would also be ineligible to make contributions to an HSA.

- Also, an HSA is not available to employees who are eligible for a spouse's medical flexible spending arrangement (FSA), unless the spouse's medical FSA is a limited medical FSA.

- Please notify HR if you become enrolled in Medicare or other disqualifying coverage so that HSA contributions can be terminated and avoid adverse tax consequences for you. If you are eligible for, but not enrolled in Medicare, please contact HR before deciding to continue any HSA contributions.

Top 10 Reasons for HSA

Tax Saving & Earned Interest — Contributions are tax-deductible and earn tax-free interest.

Portability — You own your account, so even if you change jobs, your HSA funds are yours to keep.

Affordable Health Coverage — Use the HSA to cover 100% of out-of-pocket costs for routine medical expenses, such as office visits, lab tests, and prescription medications.

Reduced Insurance Premiums — The cost of coverage under a qualified HDHP is typically lower than the other plan.

Long-Term Savings — Contributions to your HSA accumulate and roll over year-to-year with no limit, which allows the account to grow tax deferred.

Retirement Bonus — After age 65, funds may be withdrawn for any reason with no penalties. (If used for non-medical purposes, however, taxes will be imposed.)

Safety Net — AN HSA has no “use it or lose it" restrictions, so balances can be built up to use for major medical events.

Coverage for the “Extras” — HSA funds may be used to pay for services often not covered by a medical plan, including dental and vision expenses.

Money That Works for You — Balances over a certain amount may be invested.

Empowerment — Take control of your health care decisions, including which providers you want to use, to ensure your health care dollars are spent wisely.

Paying with HSA

HOW DO I USE THE HSA TO PAY FOR MEDICAL CARE?

It is rather simple. Here are the steps:

1. You and/or the agency puts money into the HSA.
2. You or a dependent receives medical services.
3. The bill is submitted as a claim to the health insurance carrier, then you will receive the EOB.
4. You receive an Explanation of Benefits for the service, which will reflect the amount due to the provider.
5. At this time you can choose to:
    - Use your HSA funds to pay the provider directly for the amount due
    - Pay the provider with personal funds and request reimbursement
    - Use your funds and save your HSA dollars for future medical expenses
6. Process repeats until deductible and out-of-pocket maximums are met, after which benefits are paid for the remaining plan year.

How do I find information about medical costs and quality so I can make informed choices?

Call Member Services or log on to www.meritain.com to search for providers and clinics that offer the medical services you need at the best cost.

Can I withdraw money from an HSA for nonmedical expenses?

Yes, but if you withdraw funds for nonmedical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you pay normal income taxes but no penalties.

Nice HealthCare

What is Nice Healthcare?

Nice healthcare is a primary care clinic that offers you and your benefit eligible dependents unlimited virtual and in-home visits with clinicians. Your employer has covered 100% of these costs, so this service is free for you to use except for a $1 copay.

Who can use Nice?

All of Nice's services, including primary care, mental health, physical therapy, and prescriptions are available to employees and their benefit-eligible dependents, including those over 65. Yes, you heard that right, over 65! Over age 65 is limited to Free Services only and offered to you and your spouse only, no parents, etc.

The Clinic that Comes to You

Chat and Video Visits

Diagnosis, prescriptions, treatment plans, care guidance, referrals, and more – care when you need it from anywhere you happen to be.

In-Home Visits

Need a blood draw, a rapid test, and/or a physical exam? Nice will come to you with 35 free labs and physical tests!

Full-Service Prescriptions

Nice integrates with nearly every pharmacy in the country and provides white glove support to make your prescriptions experience simple. Nice provides an additional 550 medications for free.

Virtual Physical Therapy

You'll get access to licensed physical therapists who are trained to diagnose and treat virtually, allowing you to get better without the hassle of endless in-person visits.

Virtual Mental Health Therapy

Nice mental health therapists focus on prevention, helping you to self-manage your mild to moderate mental health needs. Don't wait to start feeling better! This service is available for those 18+.

In-Home X-rays and EKGs

Nice can send a mobile imagining technician right to your home to conduct x-rays, EKGs, and other imagining services.

Nice HealthCare

When to Use Nice

Routine Checkups:
- Annual Wellness Exam
- Sports Physicals
- Child Checkups

Chronic Care:
- High Blood Pressure
- High Cholesterol
- Thyroid Conditions
- Diabetes

Sick Care:
- Cold/Flu
- Strep Throat
- Sinus & Ear Infections
- UTIs
- Pink Eye
- Rashes

Short-Term Mental Health:
- Anxiety
- Depression
- Grief & Loss

Virtual Physical Therapy:
- Back Pain
- Neck Pain
- Injury Recovery

Imaging:
- X-Rays
- EKGs

35+ Labs:
- Blood Work
- A1c

Home Visit Hours (local time)

mon – fri	9am – 5pm

Online Visit Hours

mon – fri	8am – 7pm CT
sat – sun	9am – 12pm CT
mon – fri	7am – 6pm MT
sat – sun	8am – 11am MT
mon – fri	6am – 5pm PT
sat – sun	7am – 10am

NICE HEALTHCARE'S MINNESOTA SERVICE AREA

- The shaded areas on the map represents where Nice offers home visits to their patients.
- Employees who live outside of the shaded region can still use any of their virtual services and pharmacy program. They can also have a Nice clinician meet them at their workplace, or a friend/family member's home for an in-person visit if their home is not within their service area.
- To see an interactive map, visit www.nice.healthcare/locations, or find the "Locations" page on their website.

It All Starts with the App

Use the Nice app to schedule visits, chat with clinicians, attend video visits, review treatment plans, upload documents, and more.

Scheduling a Visit

Whenever you and your dependents need Nice, you'll begin the process by scheduling a virtual visit with a clinician. All virtual services are conducted using the Nice app, including chat and video visits, physical therapy and mental health therapy. In addition to scheduling and conducting visits, you will also use the Nice app to review treatment plans, upload documents and manage your accounts.

Voluntary Dental

Dental Plan: This is a comprehensive plan for all dental services and covers preventive care at 100% in-network after the lifetime deductible. You may use any dentist for your dental services; however, using an in-network provider will reduce your out-of-pocket expense. You pay 100% of the Dental Premiums. You have the option to choose from the Base or Buy-up plan.

Features	SunLife Base	SunLife Buy Up
Annual Maximum	$1,000	$1,500
Deductible	$50/individual $150/family	$25/individual $75/family
Diagnostic & Preventative	You pay 0%	You pay 0%
Basic Restorative Care Amalgam & Resin Filling	You pay 20%	You pay 20%
Oral Surgery Simple extractions	You pay 45%	You pay 50%
Endodontic Therapy** Root Canal	You pay 45%	You pay 50%
Periodontics ** Gum Disease	You pay 45%	You pay 50%
Major Restoratives ** Resins, Crowns	You pay 45%	You pay 50%
Prosthetics and Implants**	You pay 45%	You pay 50%

**12 month waiting period must be satisfied before benefits can be received.

Status	SunLife Base	SunLife Buy Up
Employee	$15.28	$20.61
Employee + Spouse	$29.57	$39.87
Employee + Children	$39.31	$53.85
Family	$53.45	$73.11

***Rates are per pay period (24 pay periods)**

Sun Life

Voluntary Vision

Vision Plan: This is a comprehensive plan for all vision services. You may use any provider for your vision services; however, using an in-network provider will reduce your out-of-pocket cost. You pay 100% of the Vision Premium.

Features	In-Network	Out-of-Network
Eye Exam	You pay $10	Up to $30
Plastic Lenses (1 time per 12 months) Single Bifocal Trifocal Standard Progressive Premium Progressive Lenticular	 You pay $25 You pay $25 You pay $25 You pay $25, 80% of charge less $120 allowance You pay $25	 Up to $25 Up to $40 Up to $60 Up to $55 Up to $60
Lens Options UV, Tint, Coating Polycarbonate Anti-Reflective	 You pay $0 You pay $40 You pay $45	 Up to $5 N/A N/A
Frames (1 time per 24 months)	You receive up to $130 allowance and then you receive a 20% discount on amounts over $130	Up to $75
Contacts (1 time per 12 months) Elective or necessary, if lieu of glasses	You pay $0 up to $105, 15% discount on balance over $105	Up to $84

Status	Rates Per Pay Period (24 Pay Periods)
Employee	$3.34
Employee + Spouse	$6.35
Employee + Children	$6.68
Family	$9.82

QUESTIONS?

Call EyeMed customer service at 888-299-1358 or call the phone number on the back of your ID card or visit www.eyemed.com

Dependent Care Spending Account

We sponsor flexible spending accounts administered by HealthEquity to help you pay for everyday expenses on a pre-tax basis. The FSA year is January 1, 2025 – December 31, 2025. The FSA benefit helps you pay for dependent care expenses.

Dependent care: You can set aside pre-tax contributions for dependent care expenses up to $5,000 per plan year. No dollars may be carried over into the next plan year.

Contributions

Trying to determine your election amount? It's best to plan ahead and it may be helpful to consider the following:

- Your employer will deduct your DCAP contribution from your paycheck automatically, before taxes are taken out. Mid-year changes to your election amount are restricted unless you have a lifestyle changing event.

Contributions can be made as follows:

- $2500 for married parents filing taxes separately
- $5000 for married parents filing taxes jointly (this amount can be split between parents if both are offered a DCAP; however, the total amount can't exceed $5000 between them)
- $5000 for a single parent

Reimbursements

It's easy and convenient to complete your DCAP claim form online. Just log into your account, click the claims submission link and choose the DCAP claim form. The site will direct you to what fields are required. Once you have completed the form, all you'll need to do is upload your supporting documentation (i.e., a provider signed/completed claim form or provider invoice with tax ID) and submit it electronically to HealthEquity for payment. Claim Submission Deadlines may apply, please see plan document after enrolling.

Eligible Providers

There are several types of providers that are eligible to provide care for your dependent(s). Some of the most common examples of providers are:

- Childcare centers
- Nursery school and/or preschool care centers
- Qualified day care providers over the
- age of 19 – please note these providers cannot be your tax dependent or a parent or legal guardian of the child

Qualified Expenses

- Licensed Day Care Facilities
- Preschool Programs
- In-home Child and Dependent Care Services
- Elder Care
- Special Day Camps providing care
- After School Care

Non-qualified Expenses

- Kindergarten Tuition
- Overnight Camp
- Lunches and Food Items
- Activity Fees and late fees
- Education Programs

HealthEquity

Ancillary Plans

All benefit-eligible employees are enrolled in life insurance, accidental death & dismemberment (AD&D), short-term disability (STD) and long-term disability (LTD) plans provided by Prudential. We pay 100% of the premium for you.

LIFE AND AD&D (Employee Only)
You are covered for 1x your salary up to $50,000 maximum and a minimum of $10,000 for the basic life plan. The original amount of the Life and AD&D benefits will reduce as you age and terminate upon your retirement or termination of employment. Now is a great time to review or update your beneficiary.

VOLUNTARY LIFE INSURANCE AND AD&D
You may elect optional life insurance and accidental death and dismemberment (AD&D) insurance. These plans are paid 100% by you and are intended to supplement the provided Basic Life and AD&D Insurance described above. Evidence of insurability may be required for applications for coverage over the guaranteed issue amounts listed in the chart.

	VOLUNTARY LIFE AND AD&D
Employee Benefit	Maximum benefit is 5x your annual earnings to the maximum of $500,000. Sold in $10,000 increments. Guaranteed issue amount of $110,000.
Spouse Benefit	Maximum benefit is $250,000. Sold in $5,000 increments, not to exceed 100% of the employee's elected amount. Guaranteed issue amount of $15,000 **Please note:** the Optional Dependent Term Life coverage amount on your spouse cannot exceed 100% of your Optional Term Life coverage amount.
Children Benefit (to age 26)	Maximum benefit is $10,000, not to exceed the employee's elected amount. Sold in $2,000 increments. Please note: The Optional Dependent Term Life insurance coverage amount on your children may not exceed 100% of your Optional Term Life coverage amount.

Prudential

Voluntary Life and AD&D Rules

Employee Status	Voluntary Life - Employee	Voluntary Life - Spouse
Late Entrants	All amounts if enrolling more than 31 days from when you are first eligible to enroll are subject to EOI Satisfactory to Prudential.	All amounts subject to EOI satisfactory to Prudential.,
Annual Enrollment	Currently enrolled Employees only may increase coverage in $10,000 increments not to exceed $50,000 and not to exceed the guaranteed issue limit of $110,000 without evidence of insurability. Elected amounts in excess of the above plan design or over the guarantee is subject to evidence of insurability.	Any increases or late entrants must submit evidence of insurability satisfactory to Prudential.
New Hires	New Hires may elect up to the Guarantee Issue of $110,000 without evidence of insurability. Any amounts over the Guarantee Issue require evidence of insurability satisfactory to Prudential.	Spouses may elect up to the Guarantee Issue amount of $15,000 without evidence of insurability. Any amounts over the Guarantee Issue require evidence of insurability satisfactory to Prudential.
Life Events	Any enrollment elections must be completed within 31 days of the life event. Enrollments over the Guarantee Issue require evidence of insurability satisfactory to Prudential.	Any enrollment elections must be completed within 31 days of the life event. Enrollments over the Guarantee Issue require evidence of insurability satisfactory to Prudential.

* Children are never subject to EOI

Prudential

Voluntary Life & AD&D

The premiums are shown per $1,000 increments.

Employee	Rates
15-24	$0.065
25-29	$0.075
30-34	$0.093
35-39	$0.128
40-44	$0.176
45-49	$0.282
50-54	$0.433
55-59	$0.705
60-64	$1.126
65-69	$1.978
70-74	$3.569
75+	$7.227
Child	$0.435 per $1,000

Spouse	Rates
15-24	$0.088
25-29	$0.100
30-34	$0.126
35-39	$0.184
40-44	$0.264
45-49	$0.414
50-54	$0.646
55-59	$0.990
60-64	$1.692
65-69	$2.892
70-74	$5.154
75+	$10.322

AD&D Coverage	Rates
Employee	$0.010
Spouse	$0.016
Child	$0.016

STD & LTD

Short Term Disability Insurance helps protect against unexpected financial hardship if you are disabled due to an injury or illness and unable to work.

Long Term Disability Insurance secures a portion of your income if unable to work due to an injury or illness for an extended period.

Short Term Disability and Long Term disability are paid 100% by Family Service Rochester.

Employee	Short Term Disability Details
Coverage amount	66.7% of your pre-disability earnings
Maximum monthly benefit amount	$1000 weekly
Minimum monthly benefit amount	$25 weekly
Maximum benefit period	13 weeks
Elimination period	0 calendar days accident / 7 calendar days sickness
Pre-existing condition	None

Employee	Long Term Disability Details
Coverage amount	60% of your total monthly earnings
Maximum monthly benefit amount	$6,000 per month
Minimum monthly benefit amount	The greater of $100 or 10% of the gross monthly benefit
Maximum benefit period	To Social Security Normal Retirement Age
Elimination period	90 days
Pre-existing condition	3/12 pre-existing exclusion applies.

Guidance Resources Through Prudential

An Overview of Your GuidanceResources® Program

No matter what's going on in your life, GuidanceResources® is here to help.

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges. This flyer explains how GuidanceResources can help you.

Confidential Counseling on Personal Issues

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service is staffed by GuidanceConsultants℠—highly trained master's and doctoral-level clinicians who will listen to your concerns and schedule an appointment with a telephone counselor. Call anytime with personal concerns, including:

- Depression
- Marital and family conflicts
- Job pressures
- Stress and anxiety
- Alcohol and drug abuse
- Grief and loss

Financial Information, Resources and Tools

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Getting out of debt
- Retirement planning
- Tax questions
- Estate planning

Legal Information, Resources and Consultation

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

- Divorce and family law
- Debt obligations
- Landlord and tenant issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

Online Information, Tools and Services

GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to www.guidanceresources.com.

Each time you return to the site, you will find personalized, relevant information based on your individual life needs. You can:

- Review in-depth HelpSheets℠ on topics you select
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools

WE ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK.

Call: 800.311.4327
TDD: 800.697.0353
Online: guidanceresources.com
Your company Web ID: GEN311

Accident

Accident Insurance

can pay you money for covered accidental injuries and their treatment.

How does it work?

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

What's included?

Wellness Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a health screening test, such as:

- Blood tests
- Chest X-rays
- Stress tests
- Colonoscopies
- Mammograms

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Ages 17 and up
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

How much does it cost?

Monthly Premium	
You	$12.61
You and your spouse	$20.79
You and your child(ren)	$22.76
You, your spouse and child(ren)	$30.94

For illustrative purposes only. Actual cost may vary.

Accident Continued

Accident Insurance – Schedule of Benefits

Covered injuries	Benefit amount
Fractures	
Open Reduction (dependent on location of injury)	$150 to $7,500
Closed Reduction (dependent on location of injury)	$75 to $3,750
Chips	25% of closed amount
Dislocations	
Open Reduction (dependent on location of injury)	$300 to $6,000
Closed Reduction (dependent on location of injury)	$150 to $3,000
Burns	
At least 10 square inches, but less than 20 square inches	2nd degree – $0 3rd degree – $2,500
At least 20 square inches, but less than 35 square inches	2nd degree – $0 3rd degree – $5,000
35 or more square inches of the body surface	2nd degree – $1,000 3rd degree – $10,000
Skin grafts for 2nd and 3rd degree burns	50% of burn benefit
Skin graft for any other accidental traumatic loss of skin	
At least 10 square inches, but less than 20 square inches	$150
At least 20 square inches, but less than 35 square inches	$250
35 or more square inches of the body surface	$500
Concussion	$150
Coma	$10,000
Ruptured disc	$800
Knee cartilage	
Torn with surgical repair	$750
Exploratory surgery or cartilage shaved, only	$150
Laceration	$25–$600
Tendon/ligament and rotator cuff	
Surgical repair of one	$800
Surgical repair of two or more	$1,200
Exploratory surgery without repair	$150
Dental work, emergency	
Extraction	$100
Crown	$300
Eye injury	$300

Accident coverage is a limited policy.

Emergency and hospitalization benefits	Benefit amount
Ambulance (ground, once per accident)	$400
Air ambulance	$1500
Emergency room treatment	$150
Emergency treatment in physician office/urgent care facility	$75
Hospital admission (admission or intensive care admission once per covered accident)	$1,000
Intensive care admission (same as above)	$1,500
Hospital confinement (per day up to 365 days)	$200
Intensive care confinement (per day up to 15 days)	$400
Medical imaging test (once per accident)	$200
Outpatient surgery facility service (once per accident)	$300
Pain management (epidural, once per accident)	$100

Treatment and other services	Benefit amount
Surgery benefit	
Open abdominal, thoracic	$1,500
Exploratory (without repair)	$150
Hernia repair	$150
Physician follow-up visit (2 visits per accident)	$75
Chiropractic visit (up to 3 visits per calendar year)	$25
Therapy services (up to 10 per accident)	
Occupational therapy	$25
Speech therapy	$25
Physical therapy	$25
Prosthetic device or artificial limb	
One	$750
More than one	$1,500
Appliance (once per accident)	$100
Blood, plasma and platelets	$400
Travel due to accident Transportation of more than 50+ miles from residence; 3 trips per accident; max 1,200 miles per round trip	$0.40 per mile
Lodging (per night up to 30 days per accident)	$150
Rehabilitation unit confinement (per day up to 15 days; max 30 days per calendar year)	$100

Accidental death and other covered losses	Benefit amount
Accidental death*	
Employee	$50,000
Spouse	$20,000
Child	$10,000
*The accidental death benefit triples if the insured individual is injured as a fare-paying passenger on a common carrier: Employee–$150,000; spouse–$60,000; child–$30,000	
Initial accidental dismemberment — one benefit per accident, not payable with initial accidental loss	
Loss of both hands or both feet; or	$15,000
Loss of one hand and one foot; or	$15,000
Loss of one hand or one foot;	$7,500
Loss of two or more fingers, toes or any combination; or	$1,500
Loss of one finger or toe	$750
Catastrophic accidental dismemberment† — once per lifetime, not payable with catastrophic loss Loss of both hands or both feet; or loss of one hand and one foot	
Employee (prior to age 65)	$100,000
Spouse and child	$50,000
Employee (ages 65–69)	$50,000
Spouse and child	$25,000
Employee (70+ years old)	$25,000
Spouse and child	$12,500
Accidental loss — paralysis, sight, hearing and speech Initial accidental loss — one benefit per accident, not payable with initial dismemberment	
Permanent paralysis; or	$15,000
Loss of sight of both eyes; or	$15,000
Loss of sight of one eye; or	$7,500
Loss of the hearing of one ear	$7,500
Catastrophic accidental loss† — once per lifetime, not payable with catastrophic dismemberment Permanent paralysis; or loss of hearing in both ears; or loss of the ability to speak; or loss of sight of both eyes	
Employee (prior to age 65)	$100,000
Spouse and child	$50,000
Employee (ages 65–69)	$50,000
Spouse and child	$25,000
Employee (70+ years old)	$25,000
Spouse and child	$12,500
†Catastrophic accidental loss benefit — payable after fulfilling a 365 day elimination period.	

Accident Continued

See Schedule of Benefits for a complete listing of what is covered.

THIS IS A LIMITED BENEFITS POLICY.

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.
Individuals must have comprehensive medical coverage to be eligible for this accident insurance.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- committing acts of terrorism;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- operating, learning to operate, serving as a crew member of or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger;
- engaging in hang-gliding, bungee jumping, sailgliding, parasailing, parakiting;

- participating or attempting to participate in a felony or being engaged in an illegal occupation;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. Unum also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.

In addition to the Exclusions listed above, Unum will also not pay the Catastrophic Accidental Dismemberment or Catastrophic Accidental Loss benefit for the following:

- injuries that are caused by or are the result of a person driving or operating a motor vehicle and is determined to have a blood alcohol level exceeding the legal limit as defined by state law.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date you are no longer in an eligible group;
- date your eligible group is no longer covered;
- date of your death;
- last day of the period for which you made any required contributions; or last day you are in active employment. However, as long as premium is paid as required, coverage will continue in accordance with the layoff and leave of absence provisions of this policy. Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

THIS IS A LIMITED BENEFITS POLICY
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GA-1 et al. or contact your Unum representative.
Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

Whole Life

Whole Life Insurance

can pay money to your family if you die. It can help them with basic living expenses, final arrangements, tuition and more.

How does it work?

You can keep Whole Life Insurance as long as you want. Once you've bought coverage, your cost won't increase as you age. The benefit amount stays the same, too — it doesn't decrease as you get older. That means you get protection during your working years and into retirement.

Whole Life Insurance also earns interest, or "**cash value**," at a guaranteed rate of 4.5%.* You can borrow from that cash value, or you can buy a smaller, paid-up policy — with no more premiums due.

What's included?

A "Living" Benefit

You can request an early payout of your policy's death benefit (up to $150,000 maximum) if you're expected to live 12 months or less. It would reduce the benefit that's paid when you die.

Long Term Care Rider

You may be able to use your death benefit to pay for long term care. Subject to rider conditions. See your plan administrator for more information.

Who can get coverage?

You	You can purchase coverage for as little as $3 weekly, as long as the minimum benefit is at least $2,000. The benefit amount is based on the premium amount you select, your age when coverage begins, and whether you use tobacco.
Your spouse: Individual coverage	Available for your spouse, ages 15-80, even if you don't purchase coverage for yourself. if you leave your employer, you can keep this coverage and be billed at home. You can purchase coverage for as little as $3 weekly, as long as the minimum benefit is at least $2,000. The benefit amount is based on the premium amount you choose, your spouse's age when coverage begins, and whether they use tobacco.
Your children: Individual coverage	Your children and grandchildren can have individual coverage, but you must purchase coverage for yourself. if you leave your employer, your children can keep their coverage. You can purchase coverage for each child for as little as $1 a week.
Your children: Term Life coverage	You can also purchase a Child Term Life benefit up to $10,000, which can be added to an employee or spouse policy. Eligible children, legally adopted children and stepchildren are covered from 14 days until the earlier of their 25th birthday or the date your policy ends. At that time, the child has a right to buy an individual Whole Life policy at up to 5 times the amount of their rider.

Why should I buy coverage now?

- It's more affordable when you're younger. Once you've bought coverage, your cost stays the same as long as you keep it.
- The cost is conveniently deducted from your paycheck.
- Whole life gives you valuable protection in addition to any term life insurance you might have.

What else can I add?

An Accidental Death Benefit

This increases the payment your family would receive if you die from a covered accident before age 70.

- Available for you and your spouse, age 15-65
- Doubles the death benefit, which could add up to $150,000 extra coverage

This option will increase your cost.

See Human Resources for rates

Critical Illness

Critical Illness Insurance

can pay money directly to you when you're diagnosed with certain serious illnesses.

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a benefit payment in one lump sum. You can use the money however you want.

Why is this coverage so valuable?

- **The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.**
- **You can use this coverage more than once.** Even after you receive a payout for one illness, you're still covered for the remaining conditions. If you have a different condition later, you can receive another benefit.
- This insurance pays you once for each eligible illness. However, the diagnoses must be at least 90 days apart, and the conditions can't be related to each other.

What's covered?

- Heart attack
- Blindness
- Major organ failure
- End-stage kidney failure
- Benign brain tumor
- Coronary artery bypass surgery (pays at 25% of lump sum benefit)
- Coma that lasts at least 14 consecutive days
- Stroke whose effects are confirmed at least 30 days after the event
- Permanent paralysis of at least two limbs due to a covered accident

Coverage is also included for:

- Cancer
- Carcinoma in situ — pays 25% of your coverage amount. (Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.)

Why should I buy coverage now?

- It's more affordable when you buy it through your employer.
- The cost is conveniently deducted from your paycheck.
- You can keep coverage if you leave the company or retire. You'll be billed at home.

What else is included?

A Wellness Benefit

Every year, each family member who has Critical Illness coverage can also receive $50 for getting a health screening test, such as:

- Blood tests
- Chest X-rays
- Stress tests
- Colonoscopies
- Mammograms
- And other tests listed in your policy

Please refer to the policy for complete details about these covered conditions. Coverage may vary by state. See exclusions and limitations.

Effective date of coverage: Coverage becomes effective on the first day of the month in which payroll deductions begin. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

Critical Illness Continued

Who can get coverage?

If you didn't get coverage for you or your spouse when you were first eligible, both of you will have to answer medical questions now. If you're newly eligible, you and your spouse are guaranteed coverage now with no medical questions. If you already have coverage, you and your spouse can increase it up to the maximum available, but will be subject to medical questions. To purchase spouse coverage you must purchase coverage for yourself. New coverage may be subject to pre-existing condition limitations.

You:	Choose $10,000 or $20,000 of coverage. Coverage is guaranteed up to $10000 if applicable. If you do not sign up now but decide to apply later, you will have to answer a few medical questions.
Your spouse:	Spouses from age 17 to 64 can get $10,000 or $5,000 of coverage during this enrollment as long as you have purchased coverage for yourself. Spouse coverage is guaranteed up to $5,000, if applicable.
Your children:	Dependent children from newborns to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses, plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Monthly premium for $10,000 of coverage		
Age	Non-tobacco	Tobacco
0-24	$5.50	$8.30
25-29	$6.10	$10.10
30-34	$7.90	$14.10
35-39	$10.80	$20.90
40-44	$15.40	$30.40
45-49	$21.10	$42.10
50-54	$27.80	$56.20
55-59	$36.50	$71.60
60-64	$46.80	$85.80
65-69	$52.60	$89.40
70-99	$94.30	$144.10

Cost of coverage example

Example: The cost of $10,000 of coverage for a 50 year old non-tobacco user would be $27.80 + $1.60 = $29.40.

Wellness benefit premium of $1.60 is in addition to the base premium

Actual billed amounts may vary. For illustrative purposes only.

Exclusions and limitations

Pre-existing conditions

Benefits for a pre-existing condition (defined as a sickness or injury, or symptoms of a sickness or injury, whether diagnosed or not, for which you received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicine, or had been prescribed drugs or medicine to be taken in the 12 months just prior to your effective date) will not be paid during the first 12 months the policy is inforce.

Continuity of coverage

This policy will not limit or exclude coverage for a pre-existing condition or benefit waiting period that would have been covered under the policy being replaced. These provisions will be waived to the extent that similar limitations or exclusions were satisfied under the policy being replaced if the employee (and spouse):

- Are replacing the same amount(s) of coverage that the employee (spouse) had inforce; and
- Apply for coverage when first eligible.

Exclusions and limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- Participating or attempting to participate in a felony or being engaged in an illegal occupation;
- Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not; or
- Participating in war or any act of war, whether declared or undeclared; or
- Committing acts of terrorism; or
- Being under the influence of or addicted to intoxicants or narcotics. This would not include physician-prescribed medication, taken in the prescribed dosage.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage under the policy ends on the earliest of the:

- Date this policy is canceled;
- Date you are no longer in an eligible group;
- Date your eligible group is no longer covered;
- Date of your death;
- Last day of the period for which you made any required contributions; or
- Last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the portability provision or in accordance with the Layoff and Leave of Absence provisions of this policy.

Coverage on your dependent children ends on the earliest of the date your coverage under this policy ends or the date a dependent child no longer meets the definition of dependent children.

Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form CI-1 or contact your Unum representative.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Employee Assistance Program

COMPSYCH EMPLOYEE ASSISTANCE PROGRAM

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

Interactive Digital Tools

Our digital self-care platform, myStrength®, offers interactive behavioral health tools and resources. Log on for:

- Guided programs on anxiety, chronic pain and opioids, depression, mindfulness, sleep, stress, substance use and more
- Personalized resources on physical health conditions including smoking, diabetes, coronary disease
- Secure access through GuidanceResources® Online

Call: 800-272-7255;
TRS: Dial 711

Your toll-free number gives you direct, 24/7 access to a Guidance Consultant, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com

App: GuidanceNowSM

Web ID: COM589

Retirement Plan

Mutual of America Financial Group

How to Set Up Your Account

Identity Verification

Step 1: Go to www.mutualofamerica.com/signup.

- Enter your personal information (last name, DOB, Zip Code and last four digits of SSN), and then your information is verified against our database to confirm that you have an active plan account. *(If the data entered does not match, you'll receive an error message and will need to correct the data before moving forward.)*

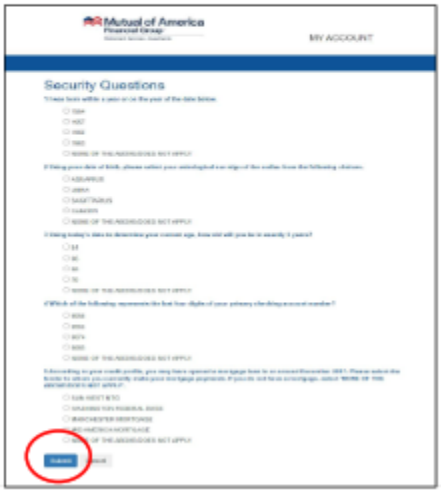
How to Set Up Your Account

Identity Verification

Step 2: Answer your security questions.

- Your answers are submitted to Experian when you click "**Submit**."

(If you answer a question incorrectly, you'll receive an error message. Select "Try again" to restart the Identity Proofing process.)



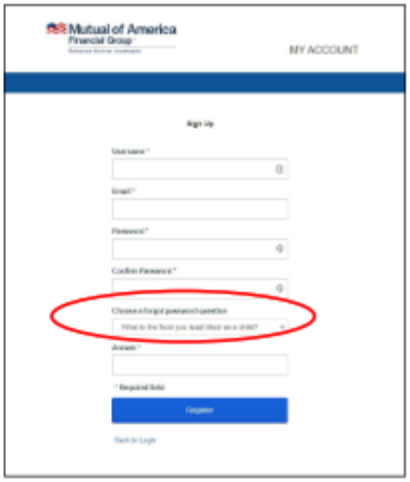
Mutual of America Financial Group

How to Set Up Your Account (continued)

Account Setup

Step 3: Set up username and password.

- After establishing your username and password, you'll need to enter your email address and choose a security question from the dropdown under "Choose a forgot password question" and provide the appropriate response in the "Answer" field.
- You will receive a confirmation email that includes a verification link.
- After you complete the email verification, you will be directed to the page to set up Multifactor Authentication.



Mutual of America Financial Group

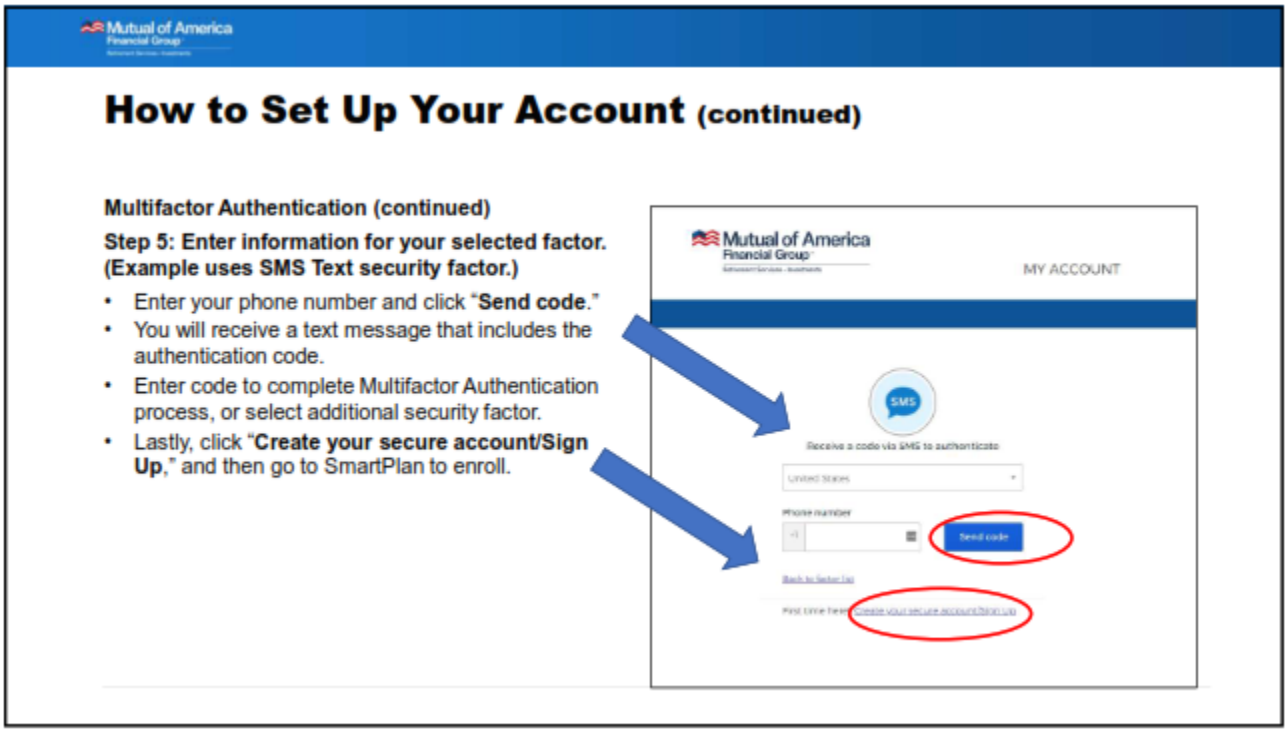
How to Set Up Your Account

Multifactor Authentication

Step 4: Set up Multifactor Authentication.

- You must complete at least one security factor to complete the registration process. Clicking on "**Set Up**" displays the enrollment form for each factor.
- There are four security factors available: Okta Verify (which requires installing the Okta app on your phone), SMS Authentication, Voice Call Authentication and Email Authentication.
- The security factor you select will be the method we use to contact you for identity verification during subsequent login attempts to your account.

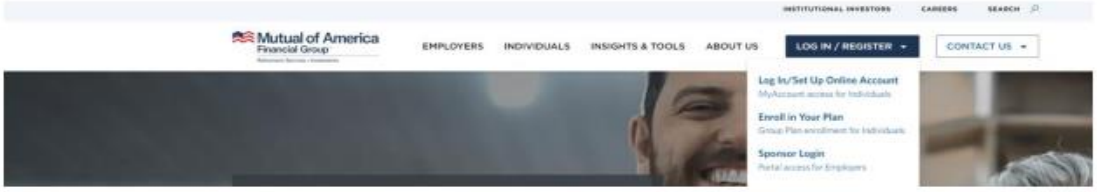
Retirement Plan



How to Log Into Your Account

Step 1: Go to www.mutualofamerica.com

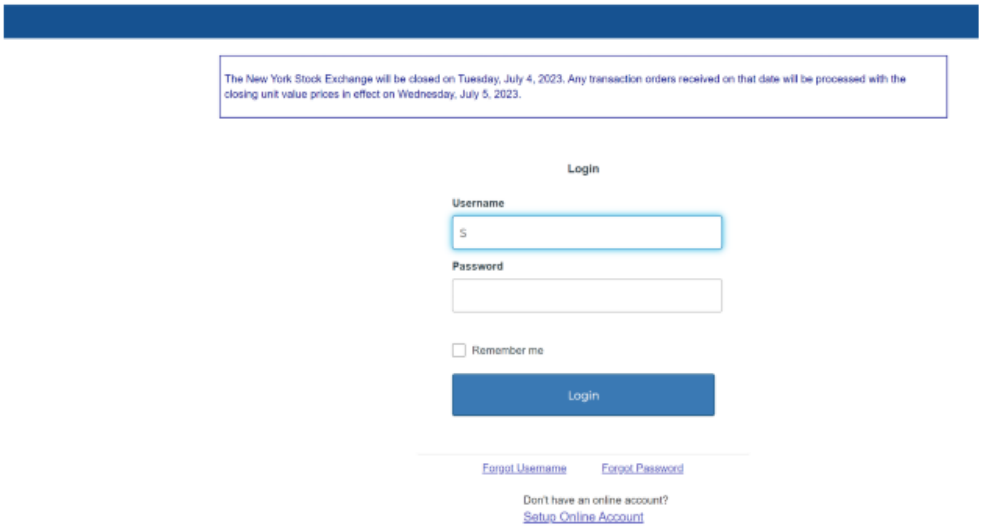
Step 2: Select "***Login/Register***" and then click on "***Log In/Set Up Online Account.***"



Step 3: If you know that you have already established an online Mutual of America account, then enter your Username and Password here. If you know that you have not set up an online account yet, then click "***Set Up Online Account***" and go through the process of setting it up. If you have an online account but forgot your Username and Password then, first click "***Forgot Username***" to establish a new Username. Then, if you forgot your password, click "***Forgot Password***" to establish a new password.

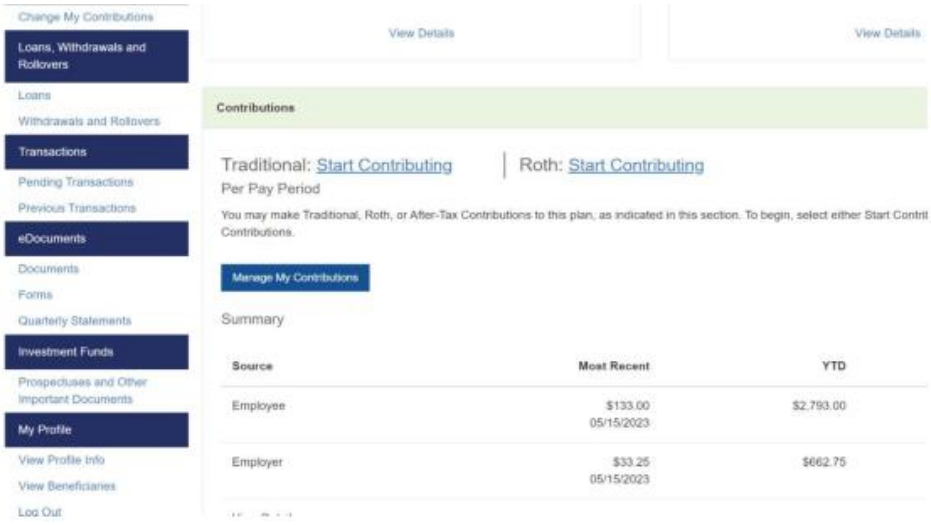
Retirement Plan

How to Log Into Your Account (continued)



Step 4: Once you have established a Username and Password, then login to your account.

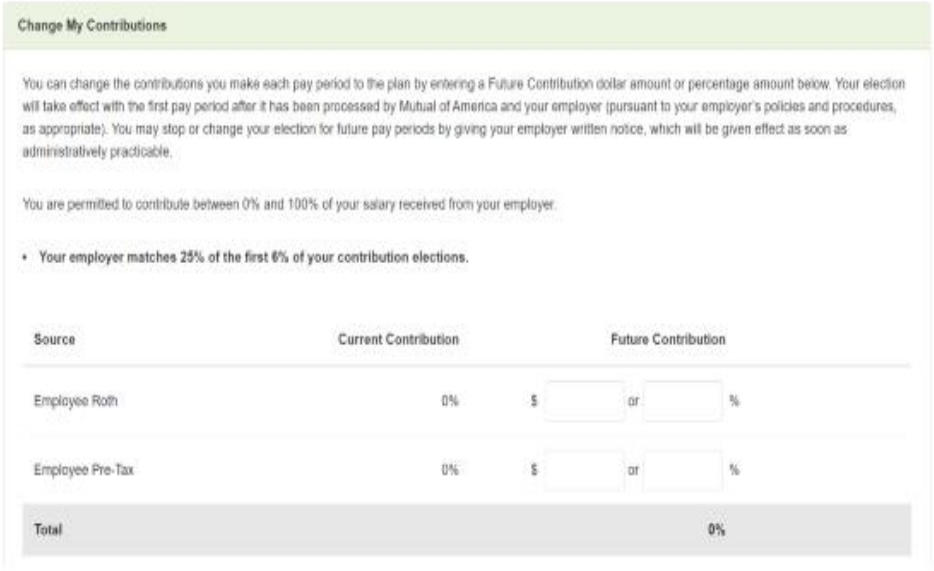
Step 5: Once you have logged in to your account, the dashboard screen which looks like below will appear. To change or elect your contributions, you will click "***Manage My Contributions***."



Step 6: Then elect your contribution percentage or flat dollar amount put inputting them into the appropriate box and then click ***"Continue."***

Retirement Plan

How to Log Into Your Account (continued)



Change My Contributions

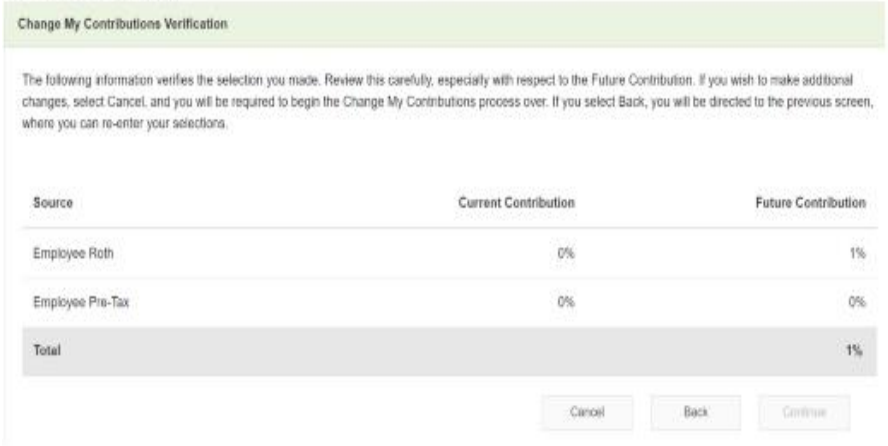
You can change the contributions you make each pay period to the plan by entering a Future Contribution dollar amount or percentage amount below. Your election will take effect with the first pay period after it has been processed by Mutual of America and your employer (pursuant to your employer's policies and procedures, as appropriate). You may stop or change your election for future pay periods by giving your employer written notice, which will be given effect as soon as administratively practicable.

You are permitted to contribute between 0% and 100% of your salary received from your employer.

- **Your employer matches 25% of the first 6% of your contribution elections.**

Source	Current Contribution	Future Contribution
Employee Roth	0%	$ or %
Employee Pre-Tax	0%	$ or %
Total		**0%**

Step 7: Verify your contribution elections and then click "Confirm" to complete the transaction. Make sure you receive a confirmation number. If you did not receive a confirmation number, it means that the transaction did not go through.



Change My Contributions Verification

The following information verifies the selection you made. Review this carefully, especially with respect to the Future Contribution. If you wish to make additional changes, select Cancel, and you will be required to begin the Change My Contributions process over. If you select Back, you will be directed to the previous screen, where you can re-enter your selections.

Source	Current Contribution	Future Contribution
Employee Roth	0%	1%
Employee Pre-Tax	0%	0%
Total		**1%**

Cancel Back Continue

Benefit Resource Center

Benefit Resource Center

BRCMT@usi.com | Toll Free: 855-874-0742
Monday through Friday 8:00am to 5:00pm Mountain,
Pacific and Alaska Standard Time

We speak insurance.

Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

Contacts

Benefit Plans	Carrier	Phone Number	Website
Medical	Meritain	800-952-3455	www.meritain.com
Dental	SunLife	800-786-5433	www.sunlife.com
Vision	EyeMed Vision Care	888-299-1358	www.eyemed.com
Life and AD&D	Prudential	800-778-2255 or 833-626-1865	www.prudential.com
Voluntary Life	Prudential	800-778-2255 or 833-626-1865	www.prudential.com
Short and Long-Term Disability	Prudential	800-778-2255 or 833-626-1865	www.prudential.com
Employee Assistance Program	ComPsych	800-272-7255	www.compsych.com
FSA Plan	Home Equity	877-924-3967	www.healthequity.com
Telemedicine	Nice Healthcare	NA	www.nice.healthcare Or download the app (for QR code see page 25)
Accident /Critical Illness/Whole Life Insurance	Unum Life Insurance Company of America	800-854-1446	www.unum.com
Retirement Plan	Mutual of America	612-540-6938	Jacob.hameed@mutualofamerica.com

Next Steps

To make your benefit elections, please click on the link to log into iSolved

On the left choose **“Benefits”** then “**Benefit Enrollment”.**

Please choose **“Continue”** to navigate through the Benefit Enrollment Options.

Note: On the left you will see where you are at in the steps.

***Please make sure to waive any options you do not want!**

QUESTIONS? NEED FORMS?
Contact Holly Hollar at: hhollar@familyservicerochester.org

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE − FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Cindy Lefebre-Westendorf
4600 18th Ave NW
Rochester, MN 55901
507-287-2010 x 1067
clefebre@familyservicerochester.org

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

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

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from Family Service Rochester About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Family Service Rochester and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Family Service Rochester has determined that the prescription drug coverage offered by the Meritain Plan for the plan year January 1, 2025 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the Meritain Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Meritain Plan creditable coverage.
- You may stay in the Meritain Plan and also enroll in a Medicare prescription drug plan. The Meritain Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Meritain Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Meritain Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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

You should also know that if you drop or lose your current coverage with Family Service Rochester and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every

month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Family Service Rochester changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2025
Name/Entity of Sender:	Family Service Rochester
Contact Position/Office:	Cindy LeFebre-Westendorf
Address:	4600 18th Ave NW, Rochester, MN 55901
Phone Number:	507-361-2193 x 1067

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
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 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)

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

Name of Entity/Sender:	Family Service Rochester
Contact--Position/Office:	Cindy LeFebre-Westendorf
Address:	4600 18th Ave NW, Rochester, MN 55901
Phone Number:	507-361-2193 x 1067

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Family Service Rochester	4. Employer Identification Number (EIN) 41-0553453	
5. Employer address 4600 15th Ave NW	6. Employer phone number 507-287-2010	
7. City Rochester	8. State MN	9. ZIP code 55901
10. Who can we contact about employee health coverage at this job? Cindy LeFebre-Westendorf		
11. Phone number (if different from above)	12. Email address clefebre@familyservicerochester.org	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    Those working on average 30 hours per week.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Spouse and children of eligible employees.
  - ☐ 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.